

# Editorial

This edition of New Doctor considers certain issues related to the health experience of Indigenous peoples in Australia. Three years ago, another special edition of New Doctor considered these issues. Since then, much has changed but unfortunately much has stayed the same and some things have become worse.

Of particular significance for many involved in Aboriginal health issues has been the premature death of Puggy Hunter in September 2001 having only just turned fifty.

Puggy was the inaugural and long serving chairperson of the National Aboriginal Community Controlled Health Organisation (NACCHO). Despite being unwell and requiring dialysis three times a week Puggy was still flying around the country attending meetings and fulfilling his role as NACCHO chair.

I was fortunate to be able to interview Puggy in February 2001 when I was researching a PhD. The interview was conducted in the renal unit of a major teaching hospital in Perth whilst he was undergoing dialysis.

During that interview, Puggy said that one of the fundamental issues in Aboriginal health was the inability of non-Aboriginal Australians to fully comprehend the reality of poor health for Aboriginal peoples.

To illustrate this Puggy commented on the uncertainty that exists for many Aboriginal people due to the impacts of the poor health that so many experience.

He reinforced the point by relating a conversation he had had with the then Minister for Health, Michael Wooldridge. Puggy had told the minister that the impact of poor health was such that 'I do not even know when I leave my house whether I will return'.

Such uncertainty is not the experience of most non-Aboriginal Australians. Unfortunately for us all, on

the third of September 2001 Puggy did not make it home. His death is a loss for all Australians for many reasons.

Puggy was able to express with great clarity the issues of relevance to Aboriginal health and the importance of self determination in Aboriginal health. In New Doctor # 70 we reproduced an article by Puggy Hunter from the first issue of NACCHO News (Sept 1998).

In that article, Puggy wrote that trying to get support for Aboriginal Community Controlled Health Organisations (ACCHO) so that the real issues in Aboriginal communities could be addressed was, more often than not, like taking two steps forward and one step back. A fact that he attributed to the political climate of the time. Nearly four years on, the struggle for better resources and improvements in Aboriginal health seems to have progressed only incrementally at best.

Puggy commented to me one day that it was difficult trying to effect change in Aboriginal health policy because most non-Aboriginal people, even those in significant decision making positions, did not really know the reality of Aboriginal peoples' lives.

He contrasted this with the fact that many Aboriginal people were well aware of the differences between Aboriginal and non-Aboriginal Australian lives.

This situation prevails despite the 'countless' inquiries and reports into Aboriginal health over the past twenty years, the recommendations of which have 'time and time again' stated the need for:

- self-determination;
- community development of Aboriginal people at all levels of health service delivery;
- stop the buck-passing between the Commonwealth and State governments (Hunter 2001 NACCHO News 10: 16)

In the tribute issue of NACCHO News (Sept 2001) published in commemoration of Puggy is an article that he wrote shortly prior to his death. This reminds us of the urgent need for bipartisan support for action related to Aboriginal health because 'we can not afford to keep reinventing the wheel every time a new party gets elected'. It is time to:

"... put an end to the zigzagging and change in direction on Aboriginal health that goes on every time governments change ... we urgently need long term strategies"

(Hunter 2001: 16)

This issue of government intent, as expressed in their policies and practices, is of great significance in Aboriginal health matters.

Arguments for substantial change have been around for decades. The impacts of past and continuing attitudes and actions are key factors in frustrating improvements in the health experience of Aboriginal peoples.

In differing contexts, these matters are discussed by Naomi Mayers, John Daniels and Ros Kidd in this issue of New Doctor.

The ongoing poor health experienced by Aboriginal peoples is a basic human rights issue. We are fortunate to be able to publish for the first time the speech by Naomi Mayers written for the Working Group on Indigenous Peoples held in Geneva in 1999.

This paper reminds us of the reluctance of governments and their agents to fully embrace the urgency of Aboriginal health status. It also discusses, at length, the extreme resistance of decision makers to community based initiatives designed to create significant change.

This issue of New Doctor also includes "The Geneva Declaration on the Health and Survival of Indigenous Peoples" which was produced by this working group. The declaration underlines the close

linkage between struggles for improved health of Indigenous peoples around the world. It recognises the ongoing influence of colonial action and the fundamental importance of self-determination to health in Indigenous communities.

The paper by Ted Wilkes, Shane Houston and Gavin Mooney provides a practical illustration of the relative under-resourcing of ACCHOs compared with mainstream services.

ACCHOs are under-funded based on health care needs even before the proportion of work that relates to culturally secure care is taken into account.

A paper by Alison Creagh and myself returns to the theme of racism in medicine and the linkage to basic human rights, drawing on three recent publications from Britain and Australia.

An article by Scott Douglas raises concerns about the recent moves to establish privately funded medical schools in Australia. There are troubling equity issues associated with an even greater emphasis on ability to pay than is already the case in our inequitable higher education system.

We also publish a brief but wide-ranging submission from the Doctors Reform Society to the Social Policy and Community Development Committee of the Australian Labor Party. This summarises the society's current views on several important issues.

David Paul

Footnote:

Some of Puggy Hunter's thoughts on Aboriginal health matters can be found in the first ten issues of NACCHO News or from his presentations to the National Rural Health Conferences accessible at:

[www.ruralhealth.org.au/sixthconf/hunteraddress.htm](http://www.ruralhealth.org.au/sixthconf/hunteraddress.htm)

and

[www.ruralhealth.org.au/fifthconf/hunterpaper.htm](http://www.ruralhealth.org.au/fifthconf/hunterpaper.htm)

# Aboriginal Health in Australia: Some Historical Observations and Contemporary Issues

Naomi Mayers

Mrs Naomi Mayers OAM is Deputy Chairperson of National Aboriginal Community Controlled Health Organisations and CEO of Aboriginal Medical Services Cooperative Limited, Redfern NSW Australia. This paper was presented to the Indigenous Health Forum of the United Nations Working Party on Indigenous Populations, Geneva, 23 July, 1999

## 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 High 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.

# Backgrounding the Declaration on the Health and Survival of the World's Indigenous Peoples

John Daniels

Dr John Daniels is Medical Director, Aboriginal Medical Service, Redfern. With Naomi Mayers, John Daniels participated in the WHO consultation on Indigenous health in Geneva in July 1999.

The Declaration on the Health and Survival of the World's Indigenous Peoples was developed during the 1999 WHO Consultation on Indigenous Health in Geneva.

The document is based on the relevant fundamental tenets of the world's Indigenous cultures. Important features of the Declaration include:

- (i) a definition of Indigenous health incorporating Indigenous peoples' holistic world view including the life-death-life cycle;
- (ii) the right of Indigenous peoples to control their health systems as a corollary of the basic right of all peoples to self-determination (this latter generic right is articulated in the UN Universal Declaration of Human Rights and adopted by reference in the Draft Declaration on the Human Rights of the World's Indigenous Peoples which in turn is adopted by reference in the attachments to the Declaration on the Health and Survival of the World's Indigenous Peoples);
- (iii) a statement of the broad determinants of Indigenous health viz that the health of the world's Indigenous peoples is influenced principally by factors external to the health sector and include economic, social, environmental and cultural factors consequential on the effects of past and ongoing colonialism;
- (iv) a call to action on the part of governments including an explicit statement to the effect that while there is an abundance of policy and written undertakings, governments have been slow to commit resources.

The Declaration was developed as a collaborative process involving delegates of many of the world's Indigenous peoples. It reflects the commonality of their cultural, religious and intellectual understandings as well as the extraordinary similarities of their historical experience of colonialism.

It is not surprising that much of the Declaration has thematic resonance with the National Aboriginal Health Strategy (NAHS) written 10 years earlier in 1989. Equally, the National Aboriginal Health Strategy Evaluation in 1994 showed that the NAHS had not been implemented. In that sense, while this country's record of achievement in Aboriginal health is outrageously poor, there is something of an international fraternity of neglect and indifference when it comes to Indigenous health.

The Declaration was received with special note by the WHO. The current Director General gave her personal endorsement to the moral urgency of coordinated international action to improve the health of the world's Indigenous peoples. In recognition of the collective accumulated wisdom of Indigenous cultures, she said "the world's Indigenous peoples teach us how to live". There was every appearance that the WHO would take leadership within UN agencies to give effect to the Declaration and a program of action.

While there has been a measure of progress, it is difficult to find diplomatic language to adequately characterise the fact that nothing of substance has happened. WHO is beset by ideological tensions and some of them involve the clinical epidemiology/bio-medical modellers versus the ever dwindling "health for all" school. The philosophical underpinnings of the Declaration are seen by some as being contrary to the current trends in health policy of many of the countries in the World Health Assembly, the governing body of the WHO.

It is difficult to prognosticate but there may be a basis for future optimism. The Draft Declaration on the Human Rights of the World's Indigenous Peoples is scheduled to be presented to the UN General Assembly in 2004, the last year of the Decade of the World's Indigenous Peoples.

The Draft Declaration is simply a derivative document of the Universal Declaration of Human Rights i.e. it contains no rights other than those in the Universal Declaration. The indications are that the General Assembly will endorse the Draft Declaration.

It will be diplomatically difficult for countries like Australia with Indigenous peoples not to sign the new Declaration because they would be open to the charge that they support human rights for all except Indigenous peoples.

International forces are of critical importance in the health and welfare of the World's Indigenous peoples and have been particularly influential in whatever progress has occurred in Australia from at least the 1967 referendum onwards.

The passage of the Declaration of the Human Rights of the World's Indigenous Peoples may motivate member states and UN Agencies including the WHO to begin to address their collective responsibilities to the health of Indigenous peoples. The Geneva Declaration was considered at the United Nations Economic and Social Council, Permanent Forum on Indigenous Issues in New York, 13-24 May 2002. The outcome of this is yet to be clarified.

# The Geneva Declaration on the Health and Survival of Indigenous Peoples

## Preamble

We, the representatives of indigenous communities, nations, peoples and organizations attending the International Consultation on the Health of Indigenous Peoples, held in Geneva from the 23-26 November 1999, and organized by the World Health Organization, reaffirm our right of self-determination and remind States of their responsibilities and obligations under international law concerning health, including the health of Indigenous Peoples;

Concerned that the health of Indigenous Peoples in every region of the world is acknowledged to be in a poor state due to the negation of our way of life and world vision, the destruction of our habitat, the decrease of bio-diversity, the imposition of sub-standard living and working conditions, the dispossession of traditional lands and the relocation and transfer of populations;

Welcoming the initiative of the World Health Organization for convening this International Consultation with Indigenous Peoples;

Recalling United Nations General Assembly resolution 48/163 proclaiming the International Decade of the world's Indigenous People (1995-2004), resolution 50/157 establishing the Programme of Activities for the Decade, as well as the World Health Assembly resolutions WHA47.27, WHA48.24, WHA49.26, WHA50.31 and WHA51.24, with a view "to strengthening international co-operation for the solution of problems faced by Indigenous Peoples in areas such as human rights, the environment, development, education and health";

Calling on the various institutions of the United Nations to act in partnership with Indigenous Peoples' communities, nations and organizations, to recommend to governments that they address the particular needs of Indigenous Peoples who experience disproportionate poverty, illness, social exclusion, habitat destruction and oppression and to develop policies which will enhance the health and survival of Indigenous Peoples worldwide to reverse this disparity;

Believing that a partnership between Indigenous People and the World Health Organization in co-ordination with other specialized agencies and bodies within the United Nations system plays an essential role with respect to the promotion of the health of Indigenous Peoples and our health systems;

Considering the non-recognition of the health knowledge and practices of Indigenous Peoples, and the limited access to health services, both of which we condemn as expressions of discrimination and intolerance;

Believing that the leadership of Indigenous Peoples in all aspects of development and implementation of health programmes is essential for the health needs of Indigenous Peoples;

Acknowledging that Indigenous Peoples have developed effective and viable scientific knowledge and systems of health that have contributed, and continue to contribute, to the health and survival of all humanity;

Reaffirming our commitment to our civil, political, economic, social and cultural rights, including the right to benefit from our own resources and our right to develop them;

Reminding the international agencies and other bodies of the UN system of their responsibility, and the obligation of States, towards the promotion and protection of Indigenous Peoples' status and rights, and that a human rights approach to indigenous health and survival is based on the said international responsibility and obligation to promote and protect the universality, indivisibility, interdependence and interrelation of the rights of all peoples; and finally;

Reaffirming the indivisibility of human rights with regard to the health and survival of Indigenous Peoples as essential to an effective and meaningful response to the health needs of Indigenous Peoples.

## Part I

### Rights and Interests of the World's Indigenous Peoples

Considering that the rights, philosophy and principles contained in the United Nations Draft Declaration on the Rights of Indigenous Peoples and all existing international instruments dealing with human rights and fundamental freedoms are essential for the attainment of the health and survival of Indigenous Peoples;

We hereby solemnly declare, affirm and assert that Indigenous Peoples are equal in dignity and in rights to all other peoples and, as such, have the right of self-determination;

In accordance with the status and rights of Indigenous Peoples, we:

- Affirm the right to control preventive and curative health systems and programmes in our own communities and the means to train and involve indigenous personnel in all facets of health;
- Affirm the right to the highest attainable physical, mental, social, cultural and spiritual health and survival, commensurate with Indigenous Peoples' definition of health and wellbeing;
- Call on Governments to recognize the sciences, systems of knowledge, sacred and ceremonial sites, doctors, medicine people and practices of Indigenous Peoples in health and medicine;

- Insist on free access to quality and culturally appropriate health care according to our needs, funded by the State without discrimination, that extends to support services, and to ensure accessibility of services for all Indigenous Peoples, including those in isolated, marginalized and remote regions and communities;
- Call for urgent and decisive actions to protect and preserve the integrity of indigenous territories, to stop environmental degradation and to ensure access to healthy and safe traditional food sources;
- Call for the promotion of adequate nutritional programmes and to support the campaign against substance abuse;
- Call on governments where Treaties, agreements and other constructive arrangements exist, that the original spirit and intent of these international agreements be honoured, respected and implemented;
- Call on the World Health Organization to make a substantial contribution within the context of the International Decade, in the form of a special study on the health of Indigenous Peoples, with the co-ordination, collaboration and participation of the Indigenous Peoples; and finally,
- Invite all Indigenous Peoples to support and promote this Declaration and to consider it as part of a global campaign, to obtain the largest possible participation of Indigenous Peoples in the elaboration of future documents and strategies on the health and survival of the Indigenous Peoples.

## Part II

Indigenous Peoples' Concepts of Health and Survival, Expressions of Culture and Knowledge Essential to the Health and Well-Being of Indigenous Peoples

Indigenous Peoples' concept of health and survival is both a collective and individual inter-generational continuum encompassing a holistic perspective incorporating four distinct shared dimensions of life. These dimensions are the spiritual, the intellectual, physical and emotional. Linking these four fundamental dimensions, health and survival manifests itself on multiple levels where the past, present and future co-exist simultaneously.

For Indigenous Peoples, health and survival is a dynamic equilibrium, encompassing interaction with life processes and the natural laws that govern the planet, all life forms, and spiritual understanding.

Expressions of culture relevant to the health and survival of Indigenous Peoples includes, but is not limited to, individual and collective relationships, family and kinship systems, social institutions, traditional justice, music, dances, ceremonies, ritual

performances and practices, games, sports, language, narratives, mythology, stories, names, land, sea and air and their resources, designs, writings, visual compositions, permanently documented aspects and forms of Indigenous culture including scientific and ethnographic research reports, papers and books, photographs, digital images, film and sound recordings, burial and sacred sites, human genetic material, ancestral remains, and artefacts.

## Part III

Policies, Strategies and Mechanisms of Action

While there are some policies and legal frameworks in the national and regional contexts which address the health needs of Indigenous Peoples, there is still an enormous gap between policy and action.

This gap is mainly caused by a lack of political will on the part of governments to implement existing policies. It also stems from the failure to recognize Indigenous Peoples' rights to self-determination, and to adhere to the principles of holism, meaningful participation, mutual respect and reciprocity, and to recognize the validity and revitalization of indigenous cultures and institutions.

Existing appropriate policies on health are also threatened by some programmes and activities of the World Bank, International Monetary Fund, and the World Trade Organization which often have negative impacts on the health of Indigenous Peoples. The WHO must take responsibility for engaging these institutions to rectify their policies and programmes and the imbalances and inequities in the World Trade Organization Treaties which have adverse health impacts. This would include overview of regional trade agreements such as the North American Free Trade Agreement and MERCOSUR.

Policies and programmes should be formulated in the following areas:

1. Capacity building through human resource development and empowerment strategies.
2. Research programmes designed for indigenous health with the leadership of Indigenous Peoples.
3. Education programmes for health professionals and others involved in health services to make their practice more culturally appropriate.
4. Proposals to rectify the inequities and imbalances in globalisation.
5. Increased funding and resources for Indigenous Peoples' health.
6. Effective co-ordination between various United Nations bodies.

## 7. Ensuring participation of Indigenous Peoples at all stages of policy development and implementation.

As an example of a successful policy, Indigenous Peoples welcome the recent establishment of the Circumpolar Co-operative Programme, "Health and Environment of Indigenous Peoples", conducted in partnership between Indigenous Peoples, the Arctic Monitoring and Assessment Process, the United Nations Environmental Programme (UNEP) and the WHO.

Indigenous Peoples urge the implementation of the following mechanisms of action:

- Constitutional and legislative mechanisms that oblige national governments to recognize Indigenous Peoples and to fulfil their health needs based on their own specific priorities and aspirations.
- Constitutional and legislative mechanisms that oblige national governments to abolish harmful practices and stop all programmes and research activities that are conducted without the free prior and informed consent and the meaningful participation of Indigenous Peoples.
- Mechanisms to monitor and evaluate the implementation of policies, in order to identify the gaps between policy and effective action.
- Mechanisms for complaints, arbitration, redress and remedial measures.

## Part IV

### Broad determinants of Health and Well-Being of Indigenous Peoples

The health of Indigenous Peoples is overwhelmingly affected by determinants outside the realm of the health sector, namely social, economic, environmental and cultural determinants. These are the consequences of colonization, and are amenable to intervention to protect and improve the health of Indigenous Peoples.

As a means of achieving this, we call on the World Health Organization and other United Nations institutions, along with their member states, to act in partnership with Indigenous Peoples to address, among others, the following;

- The loss of identity due to removal from family and community, displacement and dispossession of lands, resources and waters, and the destruction of Indigenous Peoples' languages and cultures, all of which have impacted the ability of Indigenous Peoples to be productive, contributing members of society;

- The impact of environmental degradation caused by mega-projects, extractive industries, and toxic waste disposal including trans-boundary contaminants.
- The need to promote sustainable forms of development rather than promote this type of industry;
- The need for community development as a participatory process;
- The limited choice and accessibility to professional care, including the lack of culturally appropriate healthcare provision, that reflects our values, beliefs and traditions;
- The effects of war, declared or undeclared, conflicts and vigilantism.

In order to be intellectually rigorous, scientifically sound, socially just and morally defensible, indigenous health strategies require concerted action on the part of governments and responsible agencies in relation to the social, economic and cultural determinants of the health of Indigenous Peoples. They should adopt a precautionary principle when working on development with Indigenous Peoples and act in good faith by being transparent in their dealings with Indigenous Peoples.

## Part V

Nothing in this Declaration shall be construed as diminishing or extinguishing existing or future rights Indigenous Peoples may have or acquire.

## Appendices

### Appendix One

Relevant international resolutions which support the claims of Indigenous Peoples to enjoy good health.

- WHA51/24
- WHA47.27
- WHA48.24
- UNGA48/163 International Decade of the World's Indigenous People
- UNGA 50/157 Programme of Activities for the International Decade of the World's Indigenous People
- Commission on Human Rights Resolution 1995/32
- United Nations Draft Declaration on the Rights of Indigenous People

### Appendix Two

"Health and Environment of Indigenous Peoples" the Arctic Monitoring and Assessment Process, the United Nations Environmental Programme (UNEP) and the WHO.

### Appendix Three

International Health Instruments: An Overview by Allyn L. Taylor, Douglas W. Bettcher, Derek Yach, Katherine Deland and Sev S. Fluss (under publication).

# Discovering Whiteness

Rosalind Kidd

This paper was presented by Dr Rosalind Kidd at the Unfinished Business Conference, Melbourne, June 2002.

Ten years ago, when I first started researching the activities of Queensland's Aboriginal department, I had several aims: to acquire for myself a knowledge of government operations during the twentieth century; to do a thorough job in accessing the widest possible range of information; and to come up with new ways of conceptualising practices such as exile to reserves, separation of children from their families and forced labour. In particular, I wanted some sense of how Aboriginal families experienced these and other aspects of a century of 'care and protection'.

This talk today is about my journey of discovery. I started off as a middle-class middle-aged woman researching for a PhD thesis and ended up, after reading hundreds of files and thousands of documents, sitting in a room surrounded by paper and thinking: What if this had been me? How would I have coped? What does it mean that I now have this knowledge?

The complexity of this suffocating system of controls, the scope and depth of unbelievable deprivation absolutely beggars belief. Here's a brief background.

Since the turn of the nineteenth century in Queensland and around Australia, each state gave itself total power over Aboriginal lives. As settlement appropriated all the fertile land Aboriginal families were deported even from dry areas. It was claimed their presence near waterholes or rivers frightened the cattle.

Carted off to missions and settlements according to the provisions of carefully crafted 'protection' laws, people died of diseases and starvation because the institutions were invariably located on useless land and the government refused to provide funds sufficient for survival.

People who escaped to look for food and work were hunted down and returned in chains. On reserves work was compulsory and unpaid until the late 1960s, rations and housing condemned as pathologically substandard and the whole sorry mess handed to Aboriginal community councils in the late 1980s. And now these conditions are largely blamed on poor council administration and misplaced ATSIC priorities.

Every employed Aborigine in Queensland was contracted by the government for 51 weeks out of 52, with or without his or her family. To refuse such separation was to be beaten or banished, usually to Palm Island. Some never saw or heard from families again.

On the backs of this workforce of between 4000 and 5000 men, women and children, the Queensland pastoral industry developed and prospered. Surveys showed that Aboriginal

workers were often regarded as more skilled than whites, but a gentlemen's agreement struck in 1919 between government and pastoralists set Aboriginal pay at 66% the white rate for the next 50 years.

That was the stated procedure. But in some years workers actually received as little as 31% and never, during its control of private wages that only ceased in 1970, did the government ensure even this money was received by the worker.

The government maintained a system blighted by fraud; it extracted levies from pitiful earnings; it misused and mismanaged trust funds; and it seized around 80% of private savings to generate revenue for the state on the facile pretext that the money was 'idle' and 'surplus to needs'.

Account holders, some with considerable finances of which they were kept totally ignorant, lived and died in grinding poverty. Now we begin to understand the despair and destitution of today.

What most appalled me was the sheer bloody mindedness and perversity as decade after decade power compounded power, entrenching a punitive system for the sake of maintaining controls, in the face of mounting evidence of outcomes patently contrary to publicly stated aims.

What I found most offensive was the realisation that during all of these years, when the causal factor was so clearly the pernicious system itself and the men who implemented it with such dogmatic determination, it was the people who were blamed, misrepresented, maligned and discounted as the root cause of their own damnable circumstances. As is still so often the case today.

If you are driven from country which has sustained you for generations, if you are denied access to rental housing or casual accommodation, if those of you in work are denied the cash you are earning, if you are thereby struggling in shanties without the clean water, sanitation, shelter, food, clothing and schooling that is mandated for all other Australians - how does it feel to be told it is your failure to provide a good home environment that alerts authorities to the need to 'rescue' your children from your negligence.

How does it feel to know, from experience, that you might never see your little ones again? To realise from the cold hard facts of your position that you can't afford to follow to be near them? To know from bitter experience that the authorities will neither listen to your protests nor respect your heartache?

What does it mean for ourselves as Australians to know now, as surely as I know from the evidence, that these children who were taken into government 'care and protection' - and the adults they became - were trapped, across many generations, in conditions as bad, and often worse, than those from which they were deemed to have been 'rescued'.

Here are some sketches of conditions on government settlements. On Palm Island in the 1930s nearly every baby died who was not breastfed because the only alternative was arrowroot and condensed milk. Here the doctor asked head office whether it was 'worthwhile trying to save them' by providing vitamin-enriched formula.

At Cherbourg, the government's showpiece institution, the walls of the dormitory were described as 'literally alive with bugs ... beds, bed clothing, pillows and mattresses are all infested ... all pillows were filthy because the previous matron withheld pillowslips to save washing'.

In the 1950s malnourished dormitory children succumbed to tuberculosis because, as the expert reported, they slept several to a bed in overcrowded and badly ventilated barracks. The government was warned that the encaging of large numbers of children and unmarried women behind barbed wire and locked doors was artificial, unnatural and pernicious, but dormitories continued to be used, even into the 1970s, as places of detention.

For around 70 years the Queensland government simply ignored its own law requiring every child be given a regular education. As early as 1905 the chief protector had obtained advice from the crown solicitor that Aboriginal children were not exempted from this basic right. Yet the government had no intention of providing standard teachers, classrooms or learning resources for these wards of state.

Until the 1950s lessons were limited to half a day so children could work in the afternoons. They had to make do with cast off and outdated materials from the white schools with unpaid native monitors as teachers. Only in the last few decades has orthodox schooling been provided. Yet the public was told Aboriginal children were intellectually backward.

And in the wider community it was the atrocious conditions on the department's own reserves, where basic amenities were deliberately vetoed on the grounds that they might encourage people to reside there, that were reported time and time again as the sole grounds that children were refused access to local schools.

The department even denied local councils permission to erect necessary amenities and dismissed white lobbyists as socialist meddlers. From the 1960s, in the name of assimilation, it sanctioned the eviction of families and the destruction of their huts 'on health grounds' - conditions for which the department was itself responsible - when it knew no alternative accommodation was available. In the 1970s, as federally-funded low-rent houses proliferated, families trying to help each other out risked

eviction as departmental agents warned against overcrowding and 'unsuitable' visitors.

I am horrified and ashamed to read the machinations of this pitiless system. I am ashamed to know that many families with large bank accounts had to go cap in hand to ask permission to make small withdrawals, permission that was frequently refused. Shame turned to disgust now I know that the government knew of and was consistently warned of widespread frauds by both employers and police but always refused to implement the simplest check - namely that people see some record of what was being done to their own savings.

Disgust turned to anger now I know that the government itself was taking money from savings for trust accounts it mis-used and purloined. It engineered 'consent' for deductions to pay for improvements on departmental reserves, it seized the bank interest and, in the late 1950s, it simply wrote itself a regulation so it could invest hundreds of thousands of pounds of those savings in development projects of regional hospitals when Aboriginal patients were dying of cross infections in the under-resourced and inadequately staffed equivalents.


I am horrified and ashamed to have lived oblivious to such calculated inhumanity. I am also diminished. My sense of myself as a member of a just society is fractured as surely as if I had stepped on a landmine.

I am horrified at how late it was in life that I came to learn the terrible realities endured by Aboriginal families at the hands of governments. And this knowledge is very confronting: because I am one of the millions of Australians who have never gone hungry, I have never been cast adrift from my family, I have always had a roof over my head, a warm bed and my wages in my hand to spend on my needs.


It's not just a case of 'adding in' this untold history. This evidence cannot be characterised as a few awkward last pieces to be fitted in to an almost-completed national jigsaw - as our prime minister seems to suggest. This is not simply a matter of adjusting the colour and contrast of a two-dimensional representation of our 'development' from the primitive to the modern.

What this evidence reveals is a submerged operational dynamic within our national psyche. The diminishment and degradation of Aboriginal agency in Australian history is the diminishment and degradation of us all. Knowing only part of our history, our identity is open to manipulation and distortion. Embracing the true content and outcomes of government management of Aboriginal lives will replace much of the 'whiteness' of our identity with the multi-colours of reality.

White explorers did not, like conquering heroes, 'open up' the outback and pave the way for 'civilisation'. They were watched, guided and often rescued by those whose country it was, those who knew it infinitely better, those who moved and endured lightly on the landscape. White miners, stockmen and settlers did not 'pioneer' life in the bush. Most re-



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mote properties and towns were dependent on the labour of thousands of Aboriginal men, women and children, more than 1000 working full time by 1880 in Queensland alone. Time and time again in the twentieth century pastoralists stated they could not survive without cheap black labour.

These facts are indicative of more than history untold. They also represent debts unpaid: debts of acknowledgment, debts of regret and, in practical, accountable terms, financial debts.

In Queensland alone, calculations show Aboriginal labour, unpaid and underpaid in the pastoral industry and in developing the communities, to be more than a billion dollars in today's value, just calculating from the 1940s.

In Queensland today the state admits it has profited from this forced labour but while this profit amounted to around half a million dollars annually the state is currently offering about \$55 million 'in the spirit of reconciliation', as they put it, 'so we can move on'. That's \$4,000 for some workers and half that for others for decades of work.

But this is not some unfortunate blight on our past to be 'whited out' with an amount the departmental budget can comfortably accommodate. My argument is that their wages and savings, denied, missing or misappropriated, are their legal right. They are not within the province of the government to bestow 'in the spirit of reconciliation'. These workers helped build each state. Aboriginal workers and Aboriginal families are integral to our nationhood, not a late addition.

It would seem, in our present political climate, that we have a fight on our hands to reclaim this dynamic - our multi-coloured past and present. Well, so be it. History is far too important to leave to the whims of temporary politicians. And this is a good fight, a purifying fight, a fight to claim truth for our nation and our identity.

My personal belief is that it is also a unifying fight. We can stand together and work for truth in our history, for the expansion rather than the contraction of our knowledge, for the inclusion rather than the ostracism of our brothers and sisters.

We can demand acknowledgment and dignity for those denied it by our forebears and, sadly, by many of our peers. We can be enriched by their stories, their experiences, their culture. And I have found, without question, that I also am empowered through this fight to disseminate knowledge and to win justice.

I am still only 51, but I am taller, stronger and richer through my friendships and this shared struggle. I am fighting because to know is to be indelibly implicated: the choice is to walk away or to take action - literally, for truth and justice.

My reward is to look my children and grandchildren in the eye and say - Yes, I learned of it; Yes, I am ashamed and disgusted; and Yes, I am doing all in my power to change it.

# Cultural Security: Some Cost Estimates from Derbarl Yerrigan Health Service

Ted Wilkes, Shane Houston and Gavin Mooney

Ted Wilkes works at the Institute of Child Health Research, University of Western Australia - formerly, Derbarl Yerrigan Health Service, Perth. Shane Houston works within the Health Department of Western Australia and the Social and Public Health Economics (SPHERE) Group, Curtin University. Professor Gavin Mooney is also from the SPHERE Group at Curtin University.

## Introduction

In Australia, the normal definition of equity that health services work with is that of equal access for equal need. Often, in looking at the issue of resource allocation on an equitable basis, the emphasis is very much on need and too little or not at all on the access dimension. With respect to Aboriginal and Torres Strait Islander health services clearly the issue of access is crucial. For Aboriginal people to use health care in the mainstream is more difficult - the barriers are higher - than for non-Aboriginal people. This element relates primarily to cultural security or more accurately lack of cultural security. For example, there can be language barriers for Aboriginal people and the Commonwealth Grants Commission (CGC, 2001) has suggested a rather arbitrary figure of 10% extra for resources to cover this issue.

## Defining Cultural Security

The definition of Cultural Security and some of its implications have been summarised by one of us (Houston 2001) as follows:

“Cultural Security is a commitment that the construct and provision of services offered by the health system will not compromise the legitimate cultural rights, views, values and expectations of Aboriginal people. It is a recognition, appreciation and response to the impact of cultural diversity on the utilisation and provision of effective clinical care, public health and health systems administration.

Cultural Security is about ensuring that the delivery of health services is of such a quality that no one person is afforded a less favourable outcome simply because they hold a different cultural outlook.”

Aboriginal culture describes and prescribes minimum and expected cultural obligations first between different people and second between people and their environment. Aboriginal people have long seen the nature of health and health servicing as encompassing the physical, mental, spiritual and environmental domains of life and therefore reflective of culture. The inclusion in the health domain of these matters is more an extension of culture than it is of modern concepts of intersectoral linkages and aetiology. These - what are in essence cultural obligations - have been supplanted over the past three decades by the evolution of western health science. This western conceptualisation has come to see the provision of services to the whole person and their environment as “holistic care”. To

Aboriginal people holistic care is different; it is fundamentally a cultural obligation.

One major difficulty that any analysis of Aboriginal Health Services faces is the lack of operational guidance as to what precisely a culturally secure service would look like. As far as we can discover, this is something that has to date not been identified clearly in any jurisdiction in Australia although there may be lessons to be learned here from the experience in New Zealand and the United States. This needs to be rectified and has begun to be addressed in the Health Department of Western Australia at the present time in a Background Paper entitled “Aboriginal Cultural Security” (Houston 2001). That paper makes several recommendations both in principle and practice for addressing holistic health in a culturally secure framework. As such, this is a major step forward. There remains, however, much work to be done to identify operationally precisely how services would be provided within a culturally secure framework. This needs to be done in a sufficiently detailed way that will allow these to be costed inter alia to help to establish appropriate levels of funding for the future.

There is thus a body of work to be done for Aboriginal and Torres Strait Islander health services, but also, in fact, for mainstream services, to determine first, what culturally secure health services look like and secondly, their cost. As identified by Houston (2001), this is stated to be: “Identifying the cost and other purchasing implications of Cultural Security, including the construction of a quality outlook in and multifaceted specification of Cultural Security in funding arrangements.”

## Identifying and Costing Cultural Security

Language is clearly only one aspect of cultural security. Other barriers arise for Aboriginal people in the fact that mainstream services are based on non-Aboriginal values. We believe it is important to recognise that such factors are at work not only in more traditional communities but also in metropolitan Australia. This is evidenced by the fact that, even though mainstream services may be located ‘just around the corner’, Aboriginal people often travel long distances to get to Aboriginal Medical Services (AMS’s) such as Derbarl Yerrigan Health Service in Perth and Redfern in Sydney. (This also creates higher costs per visit in these AMSs since the visiting patterns of Aboriginal people are very different and the clinical services provided when the patient is there - and often the patient’s family as well - are greater and more varied.)

As of now however and despite looking across the country, it

has not been possible to discover relevant studies which have examined the barriers for Aboriginal people through lack of cultural security. No study has been found to date which has costed out what would be involved in making services culturally secure. If language costs are rightly stated at an additional 10% (as the CGC suggest), then cultural security in its full sense is such that to implement a culturally secure service would have to be considerably more expensive. (We report relevant work of a novel nature below, which was conducted specifically for this paper.)

While rejecting the philosophy which suggests that cultural security in Aboriginal and Torres Strait Islander health care is equivalent to mainstream plus-some-add-ons, nonetheless to attempt to satisfy those who take this stance two forms of analysis have been conducted.

First, the services which Derbarl Yerrigan Health Service provides have been examined from the perspective of what the mainstream would provide, what Derbarl Yerrigan Health Service does on top of that and then estimating the extra costs involved. Given the very different philosophies involved in these two sets of services, such a comparison is clearly a very inexact science. It is rather like trying to establish the 'add-on' costs of a melon compared to an orange.

Second, as a more direct comparison within a single philosophy of health service provision, services in mainstream general practice and in sexual health in a public health unit have been analysed to allow comparison between what is provided for Aboriginal clients and what is provided for non-Aboriginal clients. There is no suggestion that these services are culturally secure. They are such, however, that more time and effort are required for Aboriginal clients within these mainstream services than for non-Aboriginal clients. Anything that would be culturally secure in this context would inevitably be yet greater in terms of any cost differential. Thus in so far as such costs are relevant to issues of cultural security they are minimum estimates and the 'true' figures will be higher.

On the first survey at Derbarl Yerrigan Health Service, three components were involved. First, 12 members of staff were asked to complete diaries over a period of two weeks during March 2001. These were used to try to assess what staff do with their time and how that differs from what the equivalent mainstream services do. The information from this was also fed into the second and third components of this survey.

Second, three workshops of staff were held to obtain information more generally about staff time particularly with respect to what was over and above 'mainstream' activities.

Third, and in the light of information gleaned from parts one and two, forms were completed for staff covering 62% of the salary bill. These classified their typical working week into "Equivalent to mainstream services" and other activities which covered seven different classes of non-mainstream activities including Cultural; Transport; Social Welfare; Housing Support; Education; Follow-up; and Other (non-mainstream).

While these were the terms used in the collection of information from staff at Derbarl Yerrigan Health Service, their use here is culturally specific. As a result they represent more than that which most readers might at first sight take out of them. Aboriginal culture is premised on social and spiritual obligation that reaches beyond the immediate family to include relationships and the environment. These terms in the context of Derbarl Yerrigan Health Service and cultural security include these wider implications.

The crucial figure emerging from this is that only 57.0% of the salary expenditure covered is related to services that are deemed to be 'Equivalent to mainstream' and consequently 43.0% is on services that are deemed to be not normally provided through mainstream services. These other categories of services in descending order of spending are Cultural (8.6%); Social Welfare (8.1%); Transport (7.4%); Education (6.9%); Follow-up (5.1%); Housing Support (3.8%) and Other (non-mainstream) 3.2%. It follows from this that it is estimated that for every dollar spent on "mainstream equivalent" services, there are 75 cents spent on what amount to culturally secure aspects of care.

#### Costs for Aboriginal Patients in the Mainstream

In addition to the work done to establish the costs of Cultural Security at Derbarl Yerrigan Health Service, this study also looked at some of the additional costs that arise in mainstream services in treating Aboriginal clients. Two small surveys of general practice were conducted in Canning Division and Swan Hills Division in March 2001.

What emerged suggested that for the practices concerned, of whom 15 responded, on average the amount of time involved in dealing with Aboriginal clients was about 40-50% per consultation plus paperwork etc. higher than for non-Aboriginal clients. The percentage was, however, quite varied with some indication that those who saw a greater proportion of Aboriginal patients and who perhaps were as a result more aware of their needs, allocated a higher proportion of time to these clients than did those who saw fewer Aboriginal and Torres Strait Islander patients. A variety of issues were raised regarding the reasons for the extra time but the two that consistently arose were related to missed appointments and chasing up on Medicare cards/numbers.

In sexual health a small survey conducted by the East Perth Public Health Unit of Aboriginal clients and non-Aboriginal clients showed the following results (see table next page).

It is clear from this that very substantially greater resources are used in Aboriginal cases than in non-Aboriginal cases. For example the staff time involved in finding contacts was on average over 220 minutes for Aboriginal clients and under 40 minutes for non-Aboriginal clients. It is difficult from such a small and not necessarily representative sample to say precisely how much greater costs are in this instance. The raw figures suggest however that they are much greater in Aboriginal cases than non-Aboriginal cases.

Conclusion

It is clear from these simple studies that it is possible to make some estimates of the extra costs involved in providing culturally secure health services for Aboriginal and Torres Strait Islander people. The estimates made here for Derbarl Yerrigan Health Service suggest that these additional costs can be quite considerable. The figures from the small surveys of mainstream services also suggest that treating Aboriginal patients here also incurs substantial extra costs. What is also clear however is that much more research is needed to establish more firmly what these costs are in both Aboriginal Medical Services but also in mainstream services.

Acknowledgements

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Differences with Contact Tracing between Aboriginal and Non Aboriginal Clients							
		Gon = Gonorrhoea	Chl = Chlamydia	NnG = No name given	RoA = Referred to other agency		
		IcT = Inform contact Themselves	Nel = Not enough Info	N/A = Not applicable			
Aboriginal clients							
Age	Gender	Disease	Time to find (mins)	Number of Contacts	How many we found	How many not found	Time to search
17	Female	Gon/Chl	240 mins	1	1	N/A	197 min
13	Female	Gon	330 mins	1	1	N/A	RoA
19	Male	Gon	75 mins	NnG	N/A	N/A	N/A
19	Female	Chl	175 mins	3	1	2 Nel	40 mins
15	Female	Gon/Chl	350 mins	NnG	N/A	N/A	N/A
13	Male	Chl	90 mins	1	1	N/A	50 mins
18	Female	Chl	180 mins	NnG	N/A	N/A	N/A
13	Female	Chl	350 mins	1	1	N/A	RoA
16	Female	Chl	205 mins	2	2	N/A	130 min
19	Male	Gon	240 mins	1	1	N/A	RoA
Non Aboriginal clients							
20	Female	Chl	75 mins	2	IcT	N/A	N/A
23	Female	Chl	75 mins	1	1	N/A	20 mins
28	Female	Chl	30 mins	1	1	N/A	10 mins
18	Male	Chl	5 mins	1	IcT	N/A	N/A
27	Male	Chl	30	1	IcT	N/A	N/A
27	Male	Chl	20	2	IcT	N/A	N/A
33	Male	Gon	35 mins	1	0 Nel	N/A	N/A
16	Female	Chl	45 mins	2	IcT	N/A	N/A
20	Male	Chl	15 mins	1	1	N/A	5 mins
22	Male	Chl	60 mins	3	2	1 Nel	30 mins

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# Health, Racism and Human Rights: "I'm not racist, but..."

David Paul and Alison Creagh

Dr David Paul and Dr Alison Creagh are general practitioners in Western Australia.

Promotion and protection of health are inextricably linked to promotion and protection of human rights and dignity (Jonathan Mann 1994, in BMA 2001, p. 311)

This opening quote from the recent British Medical Association's publication on human rights and the medical profession offers a useful reminder of the important linkage between health and human rights. These are not new notions. The World Health Organisation's definition of health reminds us that health is a fundamental human right (WHO 1978).

Nearly twenty years after the Declaration of Alma Ata, the Jakarta Declaration on leading health promotion into the 21st century clearly identified human rights as one of the key determinants of health (WHO 1997). Article 25 of the Universal Declaration of Human Rights, adopted in 1948, states that everyone has the right to a standard of living sufficient to ensure the health and well being of themselves and their family (UNHCHR 1998).

Despite such a long history of international instruments reiterating this link, much debate continues about whether 'health' should be considered to be a human right, or simply an ideal to aim for (BMA, 2001 pp 311-346). Such debates may seem a distraction to many of us but their very persistence signals the need for ongoing discussion of such important issues.

It is useful to revisit the prerequisites for health which include:

... peace, shelter, education, social security, social relations, food, income, the empowerment of women, a stable eco-system, sustainable resource use, social justice, respect for human rights, and equity. Above all, poverty is the greatest threat to health (WHO 1997).

It is clear that human rights have an enormous impact on the health of communities and of individuals. The British Medical Association (BMA), along with many others including the World Health Organisation, acknowledge that these prerequisites are more crucial to health than the availability of health care services (BMA 2001). The BMA's list of determinants of health is not quite as comprehensive as the World Health Organisation's but it does include 'security from violence and unjust discrimination' (BMA 2001, p. 312). Much work has been done to address the issues of shelter, education, and others, but perhaps the most complex of these factors to address in present day Australia is that of 'unjust discrimination'. In this article we look at this issue with particular reference to racism in health care settings.

Three publications from last year offer the opportunity to consider these issues more closely. These are: *Racism in Medicine: an agenda for change* edited by Nancy Coker; *The Medi-*

*cal Profession & Human Rights: handbook for a changing agenda* by the British Medical Association; and *Forgetting Compliance: Aboriginal health and medical culture* by Kim Humphery, Tarun Weeramanthri and Joseph Fitz. Each, in their own way, has much to offer when considering racism and the continuing connections in health care settings.

Health professionals role in society:

A common theme in these publications is that health professionals have a responsibility to take a lead in addressing racism in society. This is not a new concept. As long ago as 1947 it was recognised by the BMA that:

Doctors must be quick to point out to their fellow members of society the likely consequences of policies that degrade or deny fundamental human rights. (BMA 1947, in BMA 2001, p. xix)

Some of the arguments for health professionals taking a lead in pointing out the erosion or denial of human rights include that they are often the first to encounter evidence of human rights violations, and that they are generally highly respected and therefore have a responsibility to set an example (Decker in Coker 2001; BMA 2001). Whilst status and respect are issues that can at times be exploited to enhance the privileges of the medical profession, they can also be utilised for social good. The debates in Australia surrounding asylum seekers or environmental concerns are recent obvious examples. Health professionals have had the opportunity to see the problems that exist with forced detention, to recognise the impacts on health, have felt a duty to speak out about these issues and have been heard to an extent by the wider community.

What is Racism?

It is easy for some to ignore the existence and effects of racism. Nancy Coker's *Racism in Medicine: an agenda for change* reveals how close to the surface racist behaviour is in the British health system. Drawing on the experiences of a diverse range of health practitioners, many examples of both subtle and overt racism are articulated in this very accessible book. She reminds us that "Racism, in general terms, consists of conduct or words or practices which disadvantage or advantage people because of their colour, culture or ethnic origin" (Coker 2001, p. 8).

Blatant acts of racism are obviously impactful and readily identifiable. Of great concern is Coker's warning that racism even in its more subtle form "is as damaging as in its overt form" (Coker 2001, p. 8). Racism becomes entrenched when beliefs about "us" as superior and "them" as inferior become constructed as self-evident truths. These truths then become rooted

in societal and organisational norms and are sustained through language, media, professional values, education and legislation. An example of a "self-evident truth" is that of "complacency" and Aboriginal Australians, which will be discussed later in this article. There is also the notion of "cultural racism" which Lena Robinson considers to be a philosophy which values mainstream beliefs and attitudes more highly than other belief systems (in Coker 2001).

Institutional racism, according to Nancy Coker is:

... the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen ... in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people [our emphasis] (Coker, 2001, p. 12).

Aspects of institutional racism include the systems and processes of the organisation, the culture of the organisation, and individual attitudes and behaviours of those with in it (Arora, Coker & Gillam in Coker 2001, p. 146). This emphasises that whilst racism may be unintended, it is nevertheless still racism, with a significant impact on those at whom it is targeted.

For example, some who use the common phrase, "I'm not racist, but ...", followed by a racist comment, perhaps honestly believe that they are not acting in a racist manner. Belief and intent do not minimise the impact of racist acts.

Considering racism along with other abuses of human rights, the British Medical Association (BMA) quotes the 1998 statement by the American Association for the Advancement of Science:

Moral disengagement by perpetrators of violence often hinges on the view that their victims are somehow less human than they are because of the political culture under which they live ... (BMA 2001, p. 48).

The BMA goes on to discuss other factors which enable abuses to occur, including:

... the labelling or devaluing of a victim group, which is then blamed for societal problems such as unemployment, violence and erosion of standards (BMA 2001, p. 48).

In other words, there is a construction of difference which is unfortunately similar to the racial hierarchies that dominated the racialised science so popular around the 1930s. These concepts of labelling, devaluing and viewing others as less human has very disquieting resonance with the Howard government's statements on refugees and asylum seekers.

As an example, how often did we hear such statements as "We don't want those sort of people in Australia", referring to the supposed, and now known to be untrue, issue of children be-

ing thrown overboard. Creating a political culture which dehumanises asylum seekers, or casts them as lesser, is likely to enable further abuses against their rights to occur.

Racism in health care:

Like native races of other countries, if a cure can be effected by one or two applications of a drug, the blackfellow is willing to undergo treatment; but should any prolonged treatment be necessary, then the aboriginal, with his child-like mind, does not persist, but soon evades further medication (Anton Breinl, 1912 in Humphery, Weeramanthri & Fitz 2001, p. 93).

It would be easy to dismiss this overtly racist statement as a thing of the past, but many would agree that direct racism such as this remains an important issue in society including in contemporary health settings (Humphery, Weeramanthri & Fitz 2001; Coker, 2001). Overt racism may be relatively easily identified but it becomes more difficult to identify racism when cross cultural communication occurs.

Poor communication can result in less than satisfactory service provision, according to Lena Robinson (in Coker 2001, p.191). Robinson identifies many areas in which communication can result in negative outcomes for their clients. These include:

- non-verbal communication misunderstandings. For example, uses of eye contact, personal space, and touching may differ in different cultures, leading to the misinterpretation of messages;
- variations in levels of comfort with self-disclosure in different cultures. For example, for cultural reasons some people may be much more concerned about self-disclosure reflecting badly on the client's family than are others;
- the need to recognise, and allow for, the impact of racism on people's self-disclosure patterns;
- respect for, and awareness of, language use. As an example, "Black English" may be an important component of identity formation for young men in Britain. Use of this form of language may communicate assertiveness, for example, and understanding this is important for good health care practice;
- participation in societal norms about a language "pecking order". An example Robinson outlines is of a woman who spoke three languages, none of which included English. She was made to feel small and insignificant by health care providers due to her inability to speak English; and
- using racist language, often unconscious due to entrenchment in societal norms. For example, use of the terms "underdeveloped", "living in huts", "you people". (Robinson in Coker 2001, pp 198- 204).

Communication issues are no less important in an Australian context. A literature review of Australian studies by Humphery, Weeramanthri & Fitz (2001, pp. 31-32) found that health care providers:

- generally had difficulty seeing health in a social and cultural context;
- tended to “Europeanise” very communicative Aboriginal people and to “Aboriginalise” those who were less communicative;
- displayed indifference or anger towards people who were less communicative;
- showed considerable racism in the language used in their dealings with Aboriginal people;
- tended to deny the special needs of Aboriginal people; and
- often held views that stereotyped Aboriginal people as unhygienic, negligent and “non-compliant”.

In addition, they found that some Government health services were, in general, not conducive to the care of indigenous patients and lacked a commitment to the employment and training of Aboriginal staff (Humphery, Weeramanthri & Fitz 2001). The authors explored the apparently common notion held by health care providers that “Aboriginal people are more likely to be non-compliant with treatment”. Based on research undertaken in the Northern Territory, they found that there was no evidence that Aboriginal people were less likely than others to adhere to recommended treatment. They concluded that:

Compliance ... is not a medical issue ... it is not ... solvable within the medical encounter, but is irrevocably connected with interactional issues of cultural sensitivity, communication and time... and with... structural issues of poverty, dispossession, marginalisation and institutionalised racism (Humphery, Weeramanthri & Fitz 2001, p. 26).

Their recommendations were along the same lines as those from the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) some ten years earlier:

... where there is a high level of non-compliance by a range of Aboriginal patients with advice tendered to them by health professionals, the health professionals should examine their styles of operation with a view to whether those styles can be improved (Johnston 1991, Vol 4, p. 262)

The final report of the RCIADIC also advised that health professionals in mainstream services should consider inadequacies of the service they offered as well as the previous experiences, attitudes and knowledge of the people they were trying to serve. A high level of non-adherence by Aboriginal people should be seen as a warning sign to health care services, administrators and personnel, that there may be problems in their own styles of operating (Johnston 1991, vol 4, p. 240).

The word “adherence” is preferred over the term “compliance” as it is less value laden and implies greater agency on the part of the person responding to the advice they have been given. Even more preferable is the phrase “a person’s capacity to participate in health care treatment” which is now used more commonly. This is more inclusive than “adherence”, as it gives an indication that the capacity of people to participate may be influenced by many factors. It is these factors which influence non- or partial participation, not racist views such as “difficult clients who do not care about their own health”.

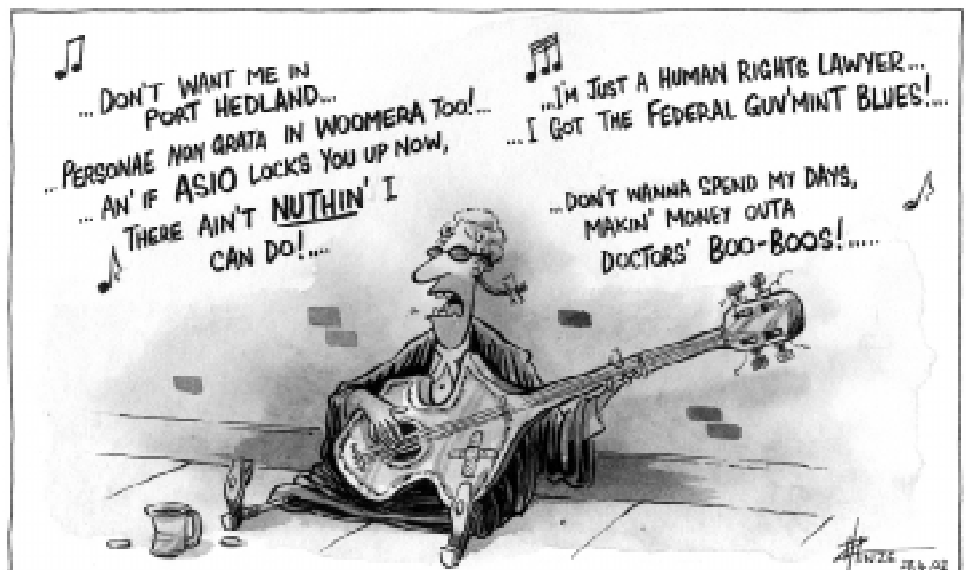
Addressing racism in society:

Recognising or acknowledging racism as a health issue is one thing. Addressing and preventing it is another. Indeed, racism may be a more difficult issue to address than other determinants of health, such as clean water and an adequate food supply, even though racist decisions can obviously influence the availability of such requirements.

Whilst tackling racism is difficult, acknowledging its presence is an important beginning point, as denial means that it may often not even be on the agenda as an issue of importance (Coker 2001). Coker also argues that tackling racism is part of a broader struggle against oppression, which includes that based on social class, culture, sexuality, gender and skin colour.

Persisting inequity requires moving beyond the concept of “equal opportunity” as this ignores the particular needs of the peoples involved. Instead, we need to begin by rethinking our ideological beliefs about the superiority of certain “races”.

Arora, Coker and Gillam’s chapter in Coker (2001) propose the development of “cultural competence” as a means of countering institutional racism. This involves the recognition of the diverse and differing needs of people with different backgrounds and aiming to meet these needs. This may require the developing of skills as well as acquiring resources to meet those needs.



The paper by Wilkes, Houston and Mooney in this issue of *New Doctor* reveals the huge disparity between mainstream services and an Aboriginal Community Controlled Health Organisation (ACCHO) in relation to the proportion of the ACCHOs budget spent on providing a culturally secure service. In the study they report that for every dollar spent on "mainstream equivalent" services, there is a further seventy five cents spent on culturally secure aspects of care. This is without even considering the issue of higher rates of illness.

#### Addressing racism in medicine:

Reminiscent of the findings of the Royal Commission into Aboriginal Deaths in Custody, Coker suggests that health professionals should go beyond cultural awareness training. In particular, they should move their focus from the problems caused by perceptions of ethnicity and difference to looking at the way mainstream services can marginalise individuals and groups who have different cultural traditions. She suggests that the challenge for medicine and medical institutions is to begin to explore and understand the mechanisms that perpetuate the ideology of superiority among the medical professions, where it resides and how it is transmitted.

The issue of "special service" provision for minority groups is discussed by Arora, Coker and Gillam in Coker (2001). Whilst they recognise the need for such separate services, they reason that these are often vulnerable to short term funding, that workers in these services are generally accorded lower status, and particularly, that their existence relieves mainstream services from their responsibility to deliver change. Instead, they argue for "mainstreaming", which would require all policy and planning to take account of local diversity.

This is perhaps an understandable ideal but it is a flawed argument. That mainstream services should be culturally secure is incontestable. Even if this is eventually achieved, it does not diminish the right of marginalised groups to targeted services. It is not an either or situation, the onus is on funding bodies and decision makers to ensure security and adequacy of funding and resources as well as mechanisms to ensure that mainstream services become and remain culturally secure.

Why is it that mainstream services are not placed on short term funding if they are not better at meeting the health care needs of all of their clientele? Part of the answer lies in what Robinson (in Coker 2001) describes as the important tendency, by those from majority groups, to minimise the importance of cultural factors including an inability to acknowledge the potential and real impacts of life in a racist society. So what does all this mean for medical practitioners and their representative groups? Nancy Coker suggests some clear steps which may help to shift awareness, policy and practice. These include:

- clearly articulate a decision to act on racism;
- acknowledge the contribution made by those from minorities;
- create easily accessible channels for reporting racism;

- to act on these; and
- to ensure safety for those who report racism.

#### Conclusions:

As discussed earlier, health professionals are well placed to identify racism and to have a leading role in changing society's attitudes. Coker (2001) suggests that the challenge is to win people's hearts and minds, not just to comply with legal requirements. In the foreword to *The Medical Profession and Human Rights: handbook for a changing agenda*, Wendy Orr's outline offers some guidance for the medical profession to take into the new millennium. These include:

- doctors will inevitably be faced with human rights challenges in the course of their work - these may be dramatic or subtle, overt or covert;
  - most doctors are not adequately prepared to deal with these challenges;
  - an individual doctor can take a stand on a human rights issues but is much more likely to do so successfully if supported by other doctors and / or the organized profession;
  - medical associations have a crucial role to play in educating doctors about human rights issues.
- (BMA 2001, pp. xvi-xvii)

Finally, it is useful to recall Naomi Mayers comments in her speech to the Indigenous Health Forum reproduced in this issue of *New Doctor*. Mayers reminds us that there is no such thing as subtle or mild racism because "subtlety is not a term which can be applied readily to racial prejudice".

She also remind us that Aboriginal peoples have been repeatedly treated with contempt rather than respect and that despite a lot of rhetoric "nothing has changed" in the colonial relations that persist in Australia. It is time for change to occur as a matter of urgency.

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# Privatising medical education

Scott Douglas

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In 1998, the Higher Education Funding Act (1988) was substantially amended to permit publicly funded Australian Universities to charge fees to Australian citizens and permanent residents outside the Higher Education Contribution Scheme (HECS). This represented a fundamental shift in the delivery of higher education in Australia. Although attending university under HECS is by no means free, the government-restricted size of the fees charged and the nature of available government-sponsored loans ensure that access to higher education in Australia has been largely based on merit and not the ability to pay.

The 1998 changes mean that universities are free to set their own fees for non-HECS places and government has no responsibility to provide low interest loans for those places. There were a number of limitations placed on this freedom for universities, most importantly in this case being the fencing off of medicine from these changes. Medicine remains one of a very short list of degrees that can only be accessed through HECS.

All this has come into question over the past few years as first the University of Notre Dame Australia in Perth (Notre Dame), followed by Bond University on the Gold Coast (Bond) expressed interest in establishing up-front, fee-paying graduate-entry medical schools. Bond is not recognised by the Higher Education Funding Act (1988), and the Act was amended firstly to exempt Notre Dame from particular requirements of the Act and then to remove it from the list of approved institutions altogether. This appears to mean that Notre Dame and Bond are free to charge fees for medicine if they wish.

The Australian Medical Students' Association (AMSA) represents over 8,000 medical students from eleven universities around the country. AMSA has opposed such developments on a number of grounds since they were first mooted, including the threat posed to existing medical education through loss of academic and clinical staff from established institutions to new ones and questions over the ability of private fee-paying medical schools to improve services to areas of unmet need in the community.

But foremost among medical students at the University of Western Australia (UWA), and shared with others around the country, is concern over equity of access to medical education, especially for prospective students of less economically privileged backgrounds. Whilst it is now well accepted that there is a need for more doctors in Western Australia, it is vital that access to a career in medicine remains based on merit and open to people from all socioeconomic backgrounds.

But why should medicine remain exempt from the impact of up-front fee-paying when other disciplines, from

Law to Engineering, Commerce to Arts, are not? There is a strong argument that equitable access to education should be available to all, not just to those who wish to study medicine. Unfortunately, for the time being this argument has been lost. There is also a strong case to make that medicine is unique, due to the pivotal role of doctors in safeguarding the health of the community and the enormous powers granted to them in that role.

Therefore access to medical education must, over and above other disciplines, be open to people of all socioeconomic backgrounds. Unique or not, it is vital that the protection granted to medicine under the Higher Education Funding Act (1988) is maintained with universities operating outside the Act unable to undermine this.

The proposal by Notre Dame has occupied most of AMSA's attention on this subject, as it was the first to be mooted and for some time appeared to be progressing very rapidly. Representatives from Notre Dame, including the Dean of the College of Health and the Head of the School of Medicine have been willing to meet with students in the past, and this has been appreciated. However Notre Dame has been unable to provide detailed responses to most student concerns and the question of equity raised by up-front fee-paying in medical education remains essentially unanswerable.

AMSA has been working to ensure that politicians at State and Federal levels of government are aware of student concerns, as fully described in the document "AMSA Policy and the University of Notre Dame Australia" (ed: see page 22). Although it appears unlikely that Notre Dame or Bond will need explicit government permission to operate, cooperation with State and Federal health departments will be required at some point.



The Australian Democrats have given some support to AMSA concerns, Kay Patterson and Brendan Nelson have indicated that they are aware of the issues and some Western Australian politicians have indicated formal responses are on their way. More pressure will be brought to bear on Federal politicians to ensure this issue receives its due attention.

AMSA has also contacted the Colleges and other professional bodies, such as the Doctors Reform Society. It is vital that doctors themselves play an important role in debating medical education and the directions it may take in the future. AMSA is following up the responses received so far to ensure that as many medical professionals as possible are aware of the issues at stake.

Although government approval may not be required, any medical curriculum must be accredited by the Australian Medical Council (AMC), based on the recommendations of its Medical Schools Accreditation Committee (MSAC). The next meeting of the MSAC is in October, when it is expected that Notre Dame will put forward a proposal that would set in motion the 18-month AMC accreditation process.

Notre Dame faces real challenges in meeting AMC criteria that emphasise improving access of historically under-represented groups to medical education (a challenge for a fee-paying course given under-represented groups are largely those of lower socioeconomic backgrounds), exposure to health care in areas of unmet need (a challenge for a curriculum that, at present, will be based entirely in private practice) and the importance of research (a challenge for an institution that does not at present engage in biomedical research).

The challenge for AMSA is to ensure that the members of the medical profession, State and Federal governments, the AMC and the Australian community as a whole recognise both the particular problems evident in the Notre Dame curriculum and the general implications of fee-paying medical students.

Whilst the number of medical students must be sufficient to ensure equity of access to health care for all Australians, to compromise equity of access to education in the process is not an acceptable solution.

**Note:**

Information regarding the proposal to establish a medical school by the University of Notre Dame Australia has been obtained directly from staff members and from the Notre Dame website <http://www.nd.edu.au/health/medicine/index.shtml>.

Whilst every effort has been made to ensure accuracy, this cannot be guaranteed at the time of publication due to the rapidly changing and at times confidential nature of the information.

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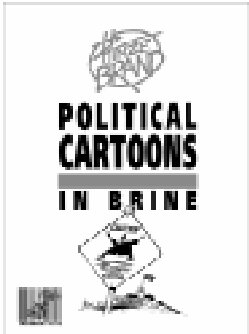


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## AMSA Policy and the University of Notre Dame Australia: New Private Medical Schools

AMSA (Australian Medical Students Association) believes that new medical schools should only be established if doing so would serve areas of the Australian population currently under-represented in the profile of medical students and graduates. (Policy adopted 9/1997)

The existing medical student population is composed predominantly of students from middle-upper class backgrounds. Whilst there is some debate about the size of the impact of Higher Education Contribution Scheme (HECS) fees on participation of students from lower socioeconomic backgrounds, a medical school with significantly higher fees operating outside the HECS system would undoubtedly be less accessible to such students.

It is a significant equity issue that prospective medical students from higher socioeconomic backgrounds will have a greater number of chances to study medicine in Western Australia compared to those from lower socioeconomic backgrounds. The extent of this difference is yet to be identified. Current HECS fees for medicine are approximately \$6,000 per year for a six-year course - about \$36,000 for the degree.

The University of Notre Dame Australia (Notre Dame) has claimed it may be able to offer a four-year course from \$16,000 per year, although this has by no means been confirmed. But even if it was, at \$64,000 for the degree it is almost double that of the HECS course - and is outside the HECS system of repayments. International students at the University of Western Australia (UWA) pay their way at around \$35,000 per year - \$210,000 for the degree. Notre Dame would have to identify some notable areas for improved efficiency to even match this cost when one considers the economies of scale - about 240 students at Notre Dame, about 750 at UWA.

Notre Dame has claimed that students may be able to access the Postgraduate Education Loans Scheme (PELS) to pay for their fees. Whilst this scheme shares many of the advantages HECS offers, the magnitude of the debt will still be substantially higher and it would be highly surprising for PELS to be made available. PELS is for non-research postgraduate degrees.

All graduate entry medical schools in Australia, including the source of Notre Dame's purchased curriculum, provide undergraduate degrees - the Bachelor of Medicine, Bachelor of Surgery. Whilst entrants must be graduates, the degree is not postgraduate.

This is similar to the situation with graduate entry law degrees - government funding is through HECS, not PELS. Thus it would appear highly unusual for PELS to be made available to Notre Dame students. This would mean that commercial loans would need to be accessed, further increasing the cost

of the degree and hence further narrowing the socioeconomic background of its students.

There is a reasonable argument for having both graduate and undergraduate entry options available to the citizens of a given state. This is the case in all states bar Tasmania and Western Australia at present, although in Queensland only undergraduate entry is available in Townsville and only graduate entry is available in Brisbane.

It is understood that graduate entry increases diversity of backgrounds and life experiences amongst students and may allow less advantaged students only able to complete a basic science degree as school leavers to enter medicine later in life. However this option is best made available at a public university with HECS funding, as is the case at all other graduate entry medical schools in Australia.

The UWA Faculty of Medicine and Dentistry is at this time developing a proposal for a concurrent undergraduate and graduate entry HECS funded medical degree to be introduced in the near future. This option would provide an opportunity for graduate entry into medicine for Western Australians, whilst ensuring that the course would be available to students from the widest possible range of socioeconomic backgrounds.

AMSA believes that new medical schools should only be established if there is evidence that similar outcomes could not be achieved by increasing the intake at existing medical schools. (Policy adopted 5/2001). As consensus grows that an increase in the number of medical graduates around Australia and in Western Australia in particular is required, it must also be recognised that the most efficient way to achieve this increase is to increase intake at existing medical schools.

The establishment of any new medical school should be based on evidence of an ability to achieve a desirable and clearly stated outcome for the health care of the population that could not otherwise be met by existing institutions. There is no such evidence that the establishment of a medical school at Notre Dame would result in outcomes that could not be achieved as well (or better) by further development and expansion of the existing UWA medical school. Political concerns should not influence decisions that must focus on the efficient and equitable provision of medical education for the benefit of the community.

The proposed concurrent graduate and undergraduate entry medical school being developed by the Faculty of Medicine and Dentistry, University of Western Australia, provides the logical answer to the question posed by a doctor shortage. UWA has a long history of teaching and research in the basic, para-clinical and clinical sciences central to medical education and has the staff and laboratory resources necessary to pro-

vide that education. With the needs of rural Australia coming to the fore in medical education, UWA's Rural Clinical School (with sites in Kalgoorlie, Geraldton, Esperance, Port Hedland, and Broome) and established programmes such as Rural Orientation Week (first year) and Rural General Practice attachments (sixth year) constitute a far more attractive and comprehensive programme to provide rural exposure to medical students than Notre Dame's on-paper plan to place students in Geraldton, Bunbury and Broome.

It must also be recognised that, if established, Notre Dame will be the only fee-paying medical school in Australia. As such, it is likely to attract a significant number of students from around the country. The likelihood of interstate students remaining in Western Australia to address community need after graduation needs to be carefully assessed.

If another institution should become involved in medical education in Western Australia, it would make far more sense for that to be an interstate or international institution that can collaborate in the pursuit of excellence in medical education, or another publicly subsidised Western Australian university with established degrees in biomedical sciences and allied health disciplines.

AMSA believes that any new medical school should only be established after detailed planning for selection procedures, academic and clinical staffing, and the entire course curriculum. (Adopted 5/2001)

The decision to go ahead with the establishment of a new medical school needs to be made after thorough planning of every element of the new school. The medical degree is too short and too important for planning to be done 'on the run' and for initial student cohorts to be used as guinea pigs. AMSA recognises the role of the Australian Medical Council in accrediting the curriculum of Australian medical schools, and believes that, for new schools, the entire curriculum and educational infrastructure should be accredited prior to any decision to proceed with the school.

The University of Notre Dame has indicated entry to its degree would depend on performance in the Graduate Australian Medical Students Admissions Test (GAMSAT), marks in a prior degree, a letter of application and performance in a structured interview (a similar model to other graduate medical schools in Australia). This entry procedure plays a central role in Notre Dame's plan to recruit students likely to work in areas of unmet need and to ensure that the fee-paying requirement does not result in students with inappropriate attitudes towards wealth and the wellbeing of the community. However it must (unfortunately) be recognised that prospective students will provide the answer they know the institution wants to hear. What Notre Dame wants is already public knowledge, even though the school itself does not exist other than on paper. To put such an emphasis on the selection procedure at an institution that, by virtue of its fee-paying nature, will attract students of a higher socioeconomic status is a risky decision.

The near total absence of biomedical science teaching at the University of Notre Dame cannot go unnoticed. Whilst the proposed curriculum has been purchased from an existing medical school and it is intended that teaching will be provided by experienced UWA staff (creating problems of its own, see below), it seems almost beyond belief that a university without a science faculty could be permitted to offer a medical degree.

AMSA believes that any proposal for a new medical school should only result in an increased total number of Australian medical graduates if:

- there is evidence that the medical workforce in Australia requires augmentation; and
- there is a concomitant increase in the number of post-graduate medical specialty training places. (Adopted 5/2001)

Many academic, professional and governmental bodies are now beginning to agree that there is a doctor shortage in Western Australia. Certainly, the number of doctors per head of population in Western Australia is significantly below the national average (220 per 100 000 to 245 per 100 000, 1998, Australian Institute of Health and Welfare). It would therefore seem logical to increase the number of medical graduates being produced in Western Australia.

However this shortage should not come as a surprise. There has been a notable failure by Federal governments over many years to allocate places for medicine in line with population increase in Western Australia - the number of graduates has barely increased since the early 1980s. Due to the great importance of ensuring medicine is a degree available to Australians of all socioeconomic backgrounds - that is, the importance of all medical degrees being HECS-funded - there is an obligation on the Federal government to ensure that an adequate number of HECS-funded places are available. This has obviously not been the case in Western Australia for many years.

In addition to population increases, workforce issues such as decreased working hours and increased job flexibility will also contribute to the need for a greater pool of doctors in the community in the near future. Again, these doctors should be representative of the community they serve, hence training for them must be HECS funded.

It should also be pointed out that simply increasing the number of medical students trained in Western Australia will not solve the problem of the shortage of doctors in Western Australia if postgraduate training positions do not also increase in line with this. AMSA is still unsure whether or not existing training places are adequate for the existing number of graduates. A substantial increase to these numbers would be required if graduate numbers were to increase. The University of Notre Dame is not currently acting to ensure this will be the case.

AMSA believes that the establishment of new medical schools

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should not occur to the detriment of the resources of existing medical schools. (Adopted 5/2001)

It is unacceptable for students at existing schools to be disadvantaged for the sake of diverting resources to a new school, regardless of the new school's anticipated outcomes. The University of Notre Dame make strong claims on their website that medical education at the University of Western Australia will not be adversely effected by the establishment of their own medical school. Whilst this commitment is laudable and indeed must be adhered to, exactly how teaching will be provided for 60 new students per year under a different curriculum from a limited pool of clinicians will avoid effecting UWA has not yet been explained.

Notre Dame currently indicate that all hospital training would take place in the private sector. Whilst this prevents UWA and Notre Dame students from physically competing for space on the same wards, it does not avoid the fact that many clinicians work in both the public and private sectors and would not be willing to teach two different groups of students at different hospitals under different curricula. Although the hospitals are different, the pool of qualified clinical teachers is the same.

Notre Dame has also indicated they will contract UWA academic staff to give lectures based on Notre Dame's curriculum. As lecturers balance teaching, research, and often clini-

cal duties in a hectic timetable, it is already difficult for students to access them. To add duties at another university would heighten this effect to the detriment of current students.

The emphasis on Problem Based Learning (PBL) at Notre Dame is in line with current trends in medical education around Australia, although the PBL model has been used for decades overseas. A significant impact on the efficacy of a PBL model is the availability of appropriate tutors to run the sessions. UWA already experiences significant difficulty in recruiting enough tutors for their own PBL sessions. For Notre Dame to provide tutors for 60 medical students per year in a curriculum with an increased emphasis on PBL would undoubtedly increase the difficulties faced by UWA to provide adequate teaching.

Whilst the need for more medical graduates in WA is becoming more recognised, it must be realised that you cannot solve a doctor shortage by opening a new, stand-alone medical school producing 60 graduates per year if it jeopardises the quality of an existing medical school producing 120 graduates per year.

AMSA believes that Australian medical schools (both faculty and students), the medical profession and the general public should be consulted at every stage of the process of establishing a new medical school. (Adopted 5/2001)

Consultation with relevant stakeholders is vitally important to promote understanding and acceptance of a proposal. Moreover, stakeholders can provide invaluable feedback and information that would improve and further develop a proposal. In the case of new medical schools, the stakeholders are clearly going to be extant medical schools, current medical students, practising doctors and the public in general (including consumer organisations). Consultation with these groups on a proposal for a new medical school will ensure that issues raised in this document are recognised and considered prior to the development of a firm commitment.

Thus far, there has been very limited consultation undertaken by the University of Notre Dame. There has been some effort made to identify the opinions of the public and the medical profession relating to the kind of doctors people want. But there has been no effort to discover whether there is any community support for a fee-paying medical school to be established in the first place.

Whilst there is some ongoing contact between Notre Dame and UWA staff, there has been no UWA student involvement in the planning process since 2000. The dominant opinion of current medical students at UWA is strongly against a fee-paying medical school of any kind and there is widespread concern about the impact such a school would have on teaching at UWA. Representatives from Notre Dame have been willing to meet with student representatives but there are many concerns that have not been adequately addressed.

# DRS Submission to the Social Policy and Community Development Committee of the ALP

August 2002

The Doctors Reform Society (DRS) is an organization of Australian doctors and medical students. Members support health care reforms to ensure the healthcare system is just, equitable and providing quality care for all regardless of social or economic status.

The Doctors Reform Society was formed in 1973 to support a proposal by the then Labor Federal Government for a publicly-funded universal health insurance system. Medibank (now Medicare) was successfully created despite opposition from the Australian Medical Association. The DRS has continued to lobby for the maintenance and strengthening of a strong public health system in the face of continued efforts by significant sections of the medical profession and the major political parties to move back to a more costly and less available private health system.

The Australian population wants a decent public health system. Since the introduction of Medicare no government has won a federal election unless they promised to maintain Medicare. It was Liberal party policy up to and including the 1993 federal election to scrap Medicare. They could not win until they stated support for Medicare.

The DRS calls on the ALP to reform its health policy in the following areas to provide a high standard public health service that all Australians expect:

## 1. The Private Health Insurance Rebate

Abolish the 30% private health insurance rebate and spend the money on public health.

The private health insurance rebate is a tax concession for the generally better off. It is not health funding. It does not help the public health system but supports a more costly two-tiered system to the detriment of universal care. Expanding the private system at the expense of the public system takes us to a position of a private system for the better off and a safety net for the rest. Safety nets for health just mean lower quality health care, a more expensive health care system, and a more divided Australia.

The 30% private health insurance rebate has not delivered any net benefit to health care. It is a cruel hoax on the thousands of Australians who have been bullied into taking out private health insurance. Many will soon enough realise that despite their large premium outlays they will still be left with signifi-

cant out of pocket expenses. It is also a cruel hoax on the many low income Australians who will see billions of dollars frittered away on a tax rebate to the well off instead of spent directly on public health initiatives.

This government has little interest in providing taxpayer funded assistance to most industries. It should be remembered that the cost of the private health insurance rebate is more than all the government assistance to the mining, manufacturing and primary agricultural industries combined. Does the ALP really want to continue this?

The facts:

- no increased access to public hospitals since availability of rebate;
- rebate on extras goes to fund golf club memberships, gym fees and the like for the well off;
- patients in private hospitals still regularly left with large 'gap' fees despite private health insurance;
- over-servicing in the private sector encouraged in view of profit motive;

**" It should be remembered that the cost of the private health insurance rebate is more than all the government assistance to the mining, manufacturing and primary agricultural industries combined."**

- provision of services in the private sector is more costly than in the public sector (at least twice as costly) and the tax payer pays more for the same treatment of a private patient in a private hospital compared with a public patient in a public hospital (see MJA Sept 2000);

- research suggests that the rebate has not increased private health insurance cover. (Instead, the recent increase appears associated with the lifetime health cover legislation.)

- numbers of people covered by private health insurance have already started to decline and will presumably return to pre-rebate days in due course;
- despite the large influx of people into private health insurance premiums are already starting to rise beyond the inflation rate;
- people are expecting comprehensive private health care but miss out because of the 'cherry picking' of the private hospitals who prefer patients with high cost procedural illnesses;
- there is likely to be a core of the population who will maintain private health insurance with or without the rebate. Prior to the rebate about 29% of the population were covered by private health insurance. They will probably stay if the rebate is removed again;
- the money spent on the rebate is mind-boggling. It is sufficient to run an extra sixteen 500 bed public hospitals

around Australia. Such an increase in capacity would quickly see most waiting lists disappear;

- making the private system more profitable will drag staff away from public hospitals. As a result the public system will either run with insufficient or inadequately trained staff, or have to increase wages to attract and maintain staff;
- many Australians do not live near a private hospital (e.g. in rural and regional Australia) and are forced to pay for a form of insurance they may never use.

## 2. Dental health

Introduce a comprehensive dental health program.

The introduction of a comprehensive dental health program as recommended and costed by the National Dental Health Alliance, would require \$750 million. This is a fraction of the rebate given to private health. More money per person is currently spent fixing the teeth of the privately insured than the uninsured. A comprehensive dental health program would replace and improve on the dental health scheme that the Labor Party astutely introduced and the current government abolished.

## 3. Pharmaceuticals/PBS

Ensure the continuing viability of the Pharmaceutical Benefits Scheme for all Australians

There are two major reasons for the huge increases in the cost of the PBS. The first is that new high technology drugs cost more. Not as much as the pharmaceutical industry would like us to believe, but definitely more and there is nothing that will change that.

The second is that more expensive drugs are used when cheaper ones, or no drugs at all, would provide as good or better treatment. This occurs for many reasons, one of which is the power of the industry advertisers. They spend 25% of their budget on advertising. They are leaders in running successful profitable expanding businesses. They know their advertising money works, and it works to make us as doctors prescribe more.

Mechanisms to improve efficiency and control costs should include:

- Greater use of price-volume agreements;
- Greater control over pharmaceutical promotion;
- Ban pharmaceutical promotion from computerised prescribing packages;
- Extend the co-regulatory power of the Therapeutic Goods Administration (TGA) to control all forms of pharmaceutical promotion, not just advertising;
- Remove tax deductibility for drug company promotional expenses;

- Better doctor and consumer education;
- Rejection of the industry push for direct to consumer advertising;
- Encourage the integration of best-practice therapeutic guidelines into computerised prescribing programs, increase drug detailing to advise doctors on best-practice guidelines, increase the budget and scope of Quality Use of Medicines programs aimed at doctors;
- Improve the functioning and transparency of the Pharmaceutical Benefits Advisory Committee by more open scrutiny of the workings of the PBAC and related committees and an end to the culture of secrecy surrounding such important matters.

## 4. Primary Care

Primary care services are the backbone of the health care system. Funding models that move away from fee for service and reward quality general practice and preventive care rather than six

**“The Federal Government should consider setting up government funded medical centres employing salaried GPs, nurse practitioners and allied health staff”**

minute medicine are paramount.

The Federal Government should consider setting up government funded medical centres employing salaried GPs, nurse practitioners and allied health staff and utilising the public hospital pathology services

as an alternative to fee for service general practice and the rash of recently corporatised for profit medical centres.

## 5. Cost-shifting

Large amounts of effort and resources are wasted by both the Federal and State health departments trying to shift costs from one section of government to the other or vice versa. For example, State governments can save money in ophthalmology services by simply not providing a service or providing a rudi-



mentary service to deal with dire emergencies or to provide window dressing. As a result patients with cataracts, glaucoma and diabetic eye disease are forced to seek treatment in the private sector (usually at significant cost) or go blind! This practice is most readily seen in those areas where extended in-patient treatment is not needed.

The least that could be done is to have transparent reporting of hospital funding from both State and Federal Governments and legislated commitments to maintaining that funding. However that would not address the many situations where patients miss out such as the example above.

We recommend the ALP consider pooled funding options as presented to the Senate Inquiry into Public Hospital funding. The standing ALP proposal of Medicare Alliance requires co-operative State Governments. Even if it was implemented there would still be many ways in which Governments would avoid their responsibilities as they have done for years.

## 6. Workforce issues and training.

Australia is not training enough doctors to meet the needs of the population at all levels. Deficiencies are apparent throughout the country especially in rural areas. Specialist numbers are most deficient in the public sector in the highest-earning specialties. Public hospitals train these specialists, many of whom never serve in the public sector after training.

The DRS recommends:

- Increase the number of fully salaried specialist positions in public hospitals;
- Part time public hospital specialist positions should be salaried rather than fee-for-service;
- Specialist colleges increase the transparency of their selection criteria for entry into training;
- The training of general practitioners in selected work currently performed by specialists should be encouraged, especially in areas of under supply of specialist services;
- Non accredited registrar positions in teaching hospitals with approved specialist training positions should be upgraded to approved training positions;
- Specialist colleges be required to increase the training positions in those specialties in which there are shortages or projected shortages.

## 7. Corporatised medicine

The ALP needs to develop policy to restrict the takeover of Australian medical care by large, profit-driven corporations which are often overseas-owned.

The corporatisation of general practice, pathology and radiology services is continuing at a rapid pace with almost no opposition from Government. Shortly a

substantial amount of these services will be run by large corporations interested in profits and returns on investment rather than health care. The consequences for individuals with illness and the treasury will be enormous.

## 8. Medical Indemnity

The ALP must develop policies to address these issues. A no-fault national insurance scheme for the severely handicapped or injured would be fairer and dramatically reduce pressures on medical indemnity funds.

Irrespective of the reasons for the rapid rise in insurance premiums (increases which were occurring well before September 11) the fact remains that recent premium increases will have a dramatic effect on the delivery of health care:

- general practitioners will stop bulk-billing as their premiums rise. This is already happening;
- general practitioners will stop doing procedural work, which will have its greatest impact in regional areas where much surgery, anaesthetics and obstetrics is performed by GPs; It will also raise costs as, for many procedures, GPs are paid a lower rebate than specialists;
- specialist services will be more restricted as specialists limit their work, avoiding high risk areas of practice; This is notably already occurring in obstetrics;
- junior doctors will avoid training in high risk specialties resulting a severe shortage of some specialists in the future;
- patient costs and gap payments will increase so doctors can recoup their premium increases.

Federal and State governments should recognise that this is a prime time to recruit specialists to full-time public hospital positions as employer-indemnified positions have become more attractive.



### 'The saddest baby I have ever seen'

(extract from The Age, 10 July 2002 by Penelope DeBelle)

A baby boy born behind razor wire at Woomera was described this week as the saddest baby a childhood expert had ever seen. When New South Wales child and adolescent psychiatrist Sarah Mares saw the baby at the Woomera detention centre at five months of age, the little boy lay there, silent and withdrawn, with no expectation that anyone would bother with him. Dr Mares said that at five months babies should be at their most indiscriminately friendly and sociable, smiling and talking, looking around for engagement. "This was the saddest looking baby I have ever seen," Dr Mares, director of training at the NSW Institute of Psychiatry told the Human Rights and Equal Opportunity Commission children in detention inquiry in Adelaide this week. "He was, I would say, emotionally neglected."

The mother and father were not to blame, she stressed, but detention had reduced them to a point of mental illness where they could not effectively parent. They were filled with despair at having brought their children to such a terrible place. The baby's birth had been traumatic; women having babies in detention do so under a rural "best practice" scenario that confines them to hospital them after 36 weeks, often away

from their families. This woman, according to separate evidence to the inquiry last week, had given birth to the boy, unwillingly by caesarean section.

She is not alone. The South Australian Government-funded Child and Youth Health Unit told the inquiry some of the gravest violation of human rights in detention appear to be happening to pregnant women, women with newborns and their families. "Several women who have been interviewed have said that they have had a caesarean section without informed consent," the submission said. The inquiry's Commissioner Sev Odwoski asked those making submission to describe the effects of detention on children and the answers were consistent and similar. Anger, fear, anxiety and lethargy were common, as were developmental delays or outright regression in children who lost language and social skills they already possessed.

The head of the department of psychological medicine at Adelaide's Women's and Children's Hospital, Jon Jureidini who visited Woomera last month, said: "I could not envisage a situation where a child could be even remotely adequately treated in this environment." And the damage being done to the intellectual and emotional development of these children was potentially lifelong, he said. "I think it is a matter of urgency to examine just how damaged these children are."

