

# Exclusion from access: this has stifled our development

**Pat Anderson**, CEO, Aboriginal Medical Services Alliance of the Northern Territory and Chairperson of the Co-operative Research Centre for Aboriginal Health

**FACILITATOR:** Our next speaker is Pat Anderson. She is the CEO of the Aboriginal Medical Service Alliance of the Northern Territory and Chairperson of the Co-operative Research Centre for Aboriginal Health. Prior to that she was the Chairman of Australia's peak body for Community Controlled Aboriginal Health Services, NACCHO. Please welcome to the podium Pat Anderson.

**PAT ANDERSON:** Thank you. Good morning everybody. First of all, I'd like to pay my respects to the traditional custodians of Mparntwe Arnernte people on whose land we meet today and I do that in a most heartfelt way. I thought the Warlpiri women yesterday evening in the riverbed were just fantastic. So I'd like to acknowledge them and thank them as well as Pat Dodd and Pat Miller, I know both women really well.

I'd also like to thank the Alliance, especially Gordon Gregory, John Wakerman and the conference organisers for giving me this platform today. And to my colleague, Peter Sutton, on the platform, whose valuable contribution to today's proceedings and the current debates around Aboriginal policy are welcome. And I'm sure we're going to have a lively discussion later in this session. All I can do at this point is to proceed with my point of view. I think it's going to be an interesting discussion.

My talk today will explore some of my organisation's perspectives on the Aboriginal health debate. In this presentation I will make a couple of assumptions. One is that we will agree that our understandings of health are a social construction. Another is that any given individual or population's state of health is formed and reproduced through complex interactions from an array of genetic, behavioural and social factors.

My organisation, the Aboriginal Medical Services Alliance of the NT, AMSANT, is the peak representative body for the Aboriginal Community Controlled Health Services in the NT. And there's a similar body in every state. Not surprisingly, from this perspective, I will be focusing on two fundamental principles underlying these services. Self determination and comprehensive primary health care.

In recent times the concept of Aboriginal self determination has come under renewed scrutiny. Some of this attention is well deserved, productive and therefore should be welcomed as a positive contribution to our struggle, to always improve our policies and practices. However, much of it is not. Derived as it is from a classically conservative framework that cannot accept that Aboriginal and Torres Strait Islander peoples have a fundamentally different world view from that of the dominant social systems that have attempted to colonise this world view and who we are.

For many decades Aboriginal and Torres Strait Islander peoples have struggled for self determination and the struggle continues, often struggling for the right to define the pace and style of development and the manner of the relationship between the colonial or the dominant society and us. This is a constant struggle, I don't think people really realise how much effort goes into this.

In Australia we have developed many forms of organisations and structures to address this issue. The Aboriginal Community Controlled Health Organisations are one such expression of this struggle. In the NT these organisations have often led broader social struggles in their local areas, acting as advocate bases for the local population on issues from land rights to racial discrimination and of course health service quality and access.

From their inception the Aboriginal Community Controlled Health Organisations have understood the importance of community control of primary health services where the local community defines the nature and scope of the services and the context of their delivery. We have successfully developed and delivered these services for over 30 years in the NT while around us nationally we saw the demise of Community Controlled Health Services for non-Aboriginal people under the combined opposition of state health departments and the AMA.

Aboriginal Community Controlled Health Services are over 30 years old. There's a lot of experience and expertise in the Aboriginal community about delivering quality comprehensive primary health care to our communities.

The Aboriginal Community Controlled Health Organisations have modelled one of the key elements of primary health care as envisaged by the 1978 World Health Organisation Alma-Ata Declaration, that of community control of health services to maximise local health gain. That's its basic tenant.

In more recent times the importance of this aspect of primary health care has been reinforced through the social determinants of health research that has clearly identified the control factor as being an important determinant of health that is identifiable and measurable with clear biological pathways. On this point we have always been quite clear, primary health care services are inextricably linked with the social and political development of our communities and this is a critical issue for our community's health.

But before going too much further, talking about primary health care, I should explain what I mean by this often used term and people use it in all kinds of ways. I will start by saying, I mean comprehensive primary health care, not selective medical health care. Thus, I am placing the Aboriginal Community Controlled Health Organisations firmly in the Alma-Ata Primary Health Care Model.

A model that is being reappraised internationally since the failure of the watered down versions that emerged post Alma-Ata and the near collapse of primary health care services in many third world countries under the neo-liberal economic policies of the International Monetary Fund and World Bank in recent decades. A leading advocate of this model is the Peoples Health Assembly, an international coalition of community based groups who will meet in Ecuador in July this year. That will be their second global consultation.

I will borrow from an AMSANT member organisation this definition of comprehensive primary health care which outlines six key principles that we see important to our practice.

- (1) Universality. Access to quality primary health care is a human right. It's a fundamental basic human right and a right to us as citizens.
- (2) Community control, participation and self reliance. Communities and individuals should have the maximum control possible over the social, economic and physical environments that influence their health. Primary health care services should promote self reliance at a community level and in terms of health promoting both behaviours at an individual level. This includes taking responsibility for accessing health services, where they are available, that is. Services have a role in supporting community development as an integral part of their program delivery.

- (3) Provide comprehensive primary health care. Community controlled primary health care services must address the main health problems in the community providing promotive, preventative, curative and rehabilitative, in other words, comprehensive care.
- (4) Respect Aboriginal culture. Positive cultural identity, good self esteem and active cultural practices are an essential element in the health of Aboriginal populations.

And I'll expand a little bit, just a little bit, because this is vexed, a little later.

- (5) Address social inequality to address health inequality. To address the broader social determinants of health, particularly social inequality, it is necessary to: (a) build community capacity to take action; (b) integrate where applicable these issues into health service programs; and (c) develop collaborative relationships with organisations active both within the health sector and in other sectors.
- (6) Employ multi-disciplinary health teams. In order to effectively deliver comprehensive primary health care, a range of health professionals working in a health team environment is desirable.

This is the ideal, our objective that we haven't really deviated from. To have these well functioning, comprehensive, primary health care services under Aboriginal community control, supporting the process of Aboriginal self determination.

So, what's gone wrong? Why is there such a disparity between health status of Aboriginal people and the rest of the population? You might well ask. Why, if you have these community controlled services and you've had 30 years of self determination, why are Aboriginal people suffering appalling health statistics?

Two of my colleagues representing AMSANT recently were essentially blamed by a conservative politician at a Senate Select Committee here in Alice Springs last year for the current state of Aboriginal health. Well, at least the organisations they were representing were being blamed. This was absolutely totally clear. This process though misses four very important points.

First, health services, while contributing massively to a population's health cannot solely be held responsible for that population's health profile. Although, as I will outline later, they can make a marked improvement, there's no doubt.

And here is a second and related point. There are a number of other contributing social determinants at play, such as social inequalities, access to quality education and environmental health factors that help to determine the population's health status. Thirdly, and more fundamental to the logic of the argument of the good senator, when we have self determination and fully funded primary health services for all Aboriginal and Torres Strait Islander peoples, then the criticism may hold some validity.

What we have instead in Australia, we've had this 30 years of intense struggle to try and gain the right to self determination. This doesn't mean that it's been achieved. This has been a constant. Most of our energies go into justifying who we are and why we need our own services and we're sick, sick, sick of having to do it.

In Australia, despite popular myth to the contrary, self determination was not something given to us by Gough Whitlam, it was a policy pursued by Aboriginal activists that gained popular support and was adopted in a form by the Federal Labour Party. Governments of both political

persuasions have either embraced or rejected it, depending upon their ideology at the time and the current reading of their opinion polls.

This gap between reality and rhetoric is illustrated by the difference between the rhetoric of ALP National Land Rights Policy, remember that, and the reality of the backdown by the Hawke Labour government, between the rhetoric of Keating's Redfern speech and the reality of his Mabo legislation. So they say words but in fact their actions are entirely different.

So let's be clear. We haven't had self determination. We are still having the struggle in this country to gain that right. In the NT, where many Aboriginal people have the NT ?? Acts, although it should be noted not all, have land rights, people were effectively punished for gaining these land rights through previous NT government withdrawal or refusal to deliver services.

Central Australia abounds with these examples, from the Tanami to just down the road here at Amoonguna. The NT government has either refused to supply services such as police or water or power or even health services since the granting of the Land Rights Act. While things have improved somewhat in the last few years, there is still considerable inertia in the bureaucracy to doing things that may be seen to be endorsing the concept of community control and Aboriginal self determination. There's a real psychological fear here.

And the current government is saying very clearly now, as evidenced by Amanda Vanstone at her National Press Club address just recently, said that, this government will not be working with Aboriginal organisations, they want to get to the real people and just deal directly with families, extended families and bypass anything that's organised.

AMSANT has pursued a program of national health policy reform since its inception over 10 years ago with considerable success. Why did we have to do this? Because we still did not and still do not have access to quality, comprehensive, primary health care services, despite the evidence of their valuable contribution to health gain.

Many Aboriginal people in the Northern Territory do not have access to resident general practitioners, having instead an overworked nursing post supported by Aboriginal health workers. There are some very complicated arrangements at the moment which has improved the situation but it is extremely complex and convoluted and slow.

Which brings me to my fourth point. Where Aboriginal people do have a community controlled health organisation, these are massively underfunded for the task they are attempting to address. This was most recently noted in amongst others, the 2004 Commonwealth Review of Aboriginal Primary Health Care Services and the 2004 AMA commissioned report on Aboriginal Health. And it's clear from those reports, when you compare them to the funding formula under the Primary Health Care Access Program just how much there is a discrepancy in the funding that's really needed. The Primary Health Care Access Program is needs based.

So there's evidence that Aboriginal health is clearly and definitely underfunded. Does it matter? Well, yes, it does, of course. First, it should be seen as a right to have access to comprehensive primary health care services and, secondly, these services are necessary to address the current state of Aboriginal health in the Northern Territory. And, secondly, where such Aboriginal medical services exist the achievements, despite the limited funding available to these services, are measurable.

We've seen improvements in early childhood and the survival of our babies. Our services make a difference in chronic disease management and prevention through screening, early detection,

effective treatment and immunisation and health promotion campaigns with respect to TB, hepatitis B, HIV, alcohol and other substance misuse and emotional and social well-being.

Some of these improved outcomes include the evaluation of the Katherine West Co-ordinated Care Trial has shown that the percentage of patients with well controlled diabetes improved from 19 per cent to 32 per cent in less than three years. By 1995 the birth weights of Aboriginal children in Alice Springs were as good as those of non-Aboriginal children. There is clear evidence that the use of simple medications by the primary health care sector has halved the progression of renal disease and renal mortality in Aboriginal people.

Recent research has shown an 85 per cent reduction in Aboriginal mortality in the 0-5 age range in the NT over the last 40 years as well as improvements in adult mortality rates. We know that primary health care services contribute significantly to improvements in child health status. A number of our services in the NT have made major impacts upon establishing community standards for health seeking behaviours amongst individuals, moving people away from just being passive recipients of crisis, patch-up health services towards being active agents in managing their chronic diseases and lifestyle factors.

Evidence from a review of the Alice Springs Hospital Emergency Department shows that Aboriginal clients appropriately use hospital services, attending that department for emergency issues and accessing their local Aboriginal community controlled health organisation for primary health care services. So there's been a real shift in people's behaviour.

These improvements are only small and it's complicated – nobody talks about the improvements in Aboriginal health but that's a whole other debate. But I've taken that risk here because I see this audience is a bit more informed and there is a knowledge base here.

In addition to these outcomes at a national level, in a time of sustained attacks on the notions of universality in health care, the Aboriginal Community Controlled Health Services have led a campaign that has extended and strengthened Medicare and PBS. I would argue that without our work in these areas, both these schemes would have been at a much greater risk and possible demise. Added to that, there is a bulwark role that we have played in sustaining the concepts of Alma-Ata and community control of local health services.

The effects of our campaigning for health policy reform have gone well beyond our own sector at a time when the very concept of universal health care has taken such a hammering. We have also doggedly pursued a campaign for medical workforce reform to address the maldistribution of health professionals in remote areas.

And outside the health sector, AMSANT had consistently called upon governments to meet their obligations to their Aboriginal citizens, both in towns and out bush, in the provision of policing services, education opportunities and public health services. These services are often those that government fails to deliver, vacating the field, avoiding their responsibilities and then fobbing Aboriginal people off with the excuse that we have our culture to sustain us.

Now, culture is a dynamic and enduring thing but it should not be used as a substitute for access to services that we should have as citizenship rights. Don't you have a culture? Is that why you get schools, police, water, telephones and electricity? Of course not. As any remote, non-Aboriginal person will tell you, you only get these services if you can exercise political pressure.

Paradoxically when we do this, that's "us", get organised, develop services and peak bodies, we are attacked for not being real black fellas. Apparently "real" Aboriginal people can't get organised. And here we see our culture being used against us. The old caste system comes back

— or it's never really gone away — comes back into use. People don't use overt language like half-caste or full-blood any more, well, at least not openly in public affairs policy forums.

Instead they use a more sophisticated code but we know the coded language as well. And unfortunately this politicised language is used by both Aboriginal and non-Aboriginal people to manipulate and divide Aboriginal people in policy debates.

For me, the ongoing development of the Aboriginal Community Controlled Health Organisations is an expression of our culture, as is our demand for the right to self determination. I said earlier that culture is a dynamic thing and that includes culture being a changing expression of our world. That means we must be able to have the political space to openly debate these issues. Unfortunately we are so often, like other political movements, forced onto the defensive and constantly under attack, both overtly and covertly, making it very difficult for Aboriginal people to challenge our own structures and practices, without being labelled as either playing into the hands of the enemy or worse, actually being the enemy.

To attack us for pursuing the right to self determination on the one hand but to say that culture is a substitute for basic services reflects an unwillingness to really engage with Aboriginal people and our aspirations and realities. We demand that Aboriginal people should have the right to access services that are appropriate to our needs. This, we believe, can best be achieved through direct government funding of Aboriginal Community Controlled Health Organisations.

These organisations must be accountable, really accountable, to both their communities and for the services they are funded to provide. We don't have a problem with that, of being answerable for all the money that we receive. Of course these organisations must continually review their processes and ensure that they remain responsive to their communities and offer the best possible services. This is without question.

However, it would greatly help if these services were adequately funded to deliver the services at the level and in the manner required, as expressed by that particular community. It would help if we didn't have to continually fight amongst ourselves and constantly fight the government for the scraps of some of the systems.

And one of the best ways to kill off open discussion is to have these organisations under continual external political pressure, such as we have experienced under both Territory and National governments since our inception.

I've used the Northern Territory as an example because it's not appropriate for me to use other places and other countries, but a lot of what I've said I think equally applies in all jurisdictions.

I thank you for this opportunity to present AMSANT's view on the current national Aboriginal affairs debate and how this intersects with our health. It's this constant explaining and justifying who we are which is a health hazard, believe me. Many of you know people who have actually died on the job, so to speak.

AMSANT looks forward to a continuing productive partnership with you and the rural health movement and I'd like to say that AMSANT acknowledges and recognises all the delegates and the intellect and the commitment that's in this room today. Thank you very much.