
Building Aboriginal Health

from the ground
upwards

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Good afternoon ladies and gentlemen, brothers and sisters

Three months ago, the most significant change in Aboriginal health policy in recent times occurred. The Commonwealth government accepted direct responsibility for Aboriginal health and transferred responsibility for the funding of Aboriginal primary health care from ATSIC to the Commonwealth Health Department.

As you probably know, Congress, along with the Aboriginal Medical Services Alliance - Northern Territory (or AMSANT) played a major role in lobbying for this change.

There is a common but mistaken view that we argued for the shift solely on the grounds that the Health Department had more "expertise" in Aboriginal health than ATSIC.

It is true that there is more knowledge of health matters within the Health Department than within ATSIC. A major reason for this is that ATSIC has (unfairly in my view) been expected to be experts on *everything* to do with Aboriginal people. Roads and reconciliation, land and language, health and housing: the response of the mainstream has been to dump all these issues in the too-hard basket, and then to give that basket to ATSIC.

However, the Commonwealth Health Department bureaucracy is not the authority on matters of the health of our people. If there are any such things as "experts" in Aboriginal health, they are the Aboriginal community controlled health services. These services are intimately linked to the community they serve, by history, by culture, and by management. Staffed by, and under the day-to-day control of their community, they have been recognised by the National Aboriginal Health Strategy and the Royal Commission Into Aboriginal Deaths In Custody as the voices of our people.

They are the only organisations that can effectively address the health problems of our people.

This is not to say that Aboriginal health services have "the answer" - no one has "the answer" to the health of our people. But it is the Aboriginal community and their organisations that are best placed to be able to work towards the answers. It is a hard struggle, but we can learn from our mistakes, make changes, progress.

Bureaucracies, on the other hand, however well-meaning, have a habit of not recognising the mistakes they make, of hiding them when they do recognise them, and of defending them to the end if they can't hide them. None of this is compatible with our right to self-determination and with our health needs.

What I am saying is that the Commonwealth Health Department is not going to solve the problems of Aboriginal health. We did not, and do not, expect them to try. It was not because of their supposed "expertise" that we advocated their taking responsibility for the primary health care.

Instead, what we want is for them to support the Aboriginal community in their attempts to grapple with the problem.

To this end, we wish to develop an open and cooperative partnership between the community and the Commonwealth Government. We believe that it is only through such a partnership that the appalling health status of our people can be addressed.

Crucial to this relationship are two central policy issues: direct funding of all community controlled health services, and a regional approach to Aboriginal health planning and delivery.

For the rest of my time today, I want to talk about our view on how to build effective Aboriginal health organisations from the ground up, from the local, to the regional, and then to the national levels. This means putting the emphasis on local and regional structures first, national ones second.

This "bottom - up" approach is not just rhetoric. It is vital to be able to make any changes in our health. Why is it so important?

Although we speak of "Aboriginal Australia", this masks considerable local and regional differences amongst our people. This seems to be very difficult for non-Aboriginal people to grasp, and for much of the period of colonisation, we have been treated as if we were all the same.

But all Aboriginal people are not the same.

Aboriginal Australia is a network of interconnected Aboriginal nations, with their own languages and ways of life. In the same way, perhaps, Europe is made of different nations, and although it is plain that all Europeans have things in common, no-one would suggest that the people of Finland are the same as the people of Italy or Greece.

It would be more accurate, perhaps, to talk of Australia's indigenous *peoples*, rather than *people*.

And although the health of Aboriginal people seems to be always and everywhere worse than that of the colonisers, different regions and communities face different health problems, or the same health problems but to different degrees.

I believe that all Aboriginal people (including Torres Strait Islanders) have certain interests in common - for example, access to appropriate, effective, health care under their own control. But although Aboriginal peoples have certain problems in common, different regions (and different communities within those regions) will have their own priorities and ideas about how to deal with those problems. It is each region's - and each community's - right to work out their own solutions to the problems they face.

This is the essence of self-determination.

Yet non-Aboriginal Australia is constantly designing nation-wide strategies to deal with health problems as if we were all the same, or as if one or two individuals could speak for all Aboriginal people. The non-Aboriginal bureaucratic culture is a very "top-down" model of problem solving. It has failed since non-Aboriginal people interested themselves in our health. I am convinced it will continue to fail.

Congress, and many others, have been proposing the alternative "bottom-up" process as the most effective way to tackle the problem. Not only is it our right; it is also the right way to go.

How would this new way of tackling Aboriginal health work? What would it look like? Of course, it is up to each region and community to decide for themselves their own path, but our ideas are as follows.

First, every community that so wishes must be resourced to have its own community controlled Aboriginal health service. These services must be resourced not just for the delivery of "sick care", but the whole range of comprehensive primary health care, using a community development model.

Each service needs the resources to allow them to get direction and information from the Aboriginal people it serves: not an easy task when those people may be living scattered across thousands of kilometres of country.

Communities that do not feel ready to run their own health service must be assisted by government to have as much control over their health services as they, the community, feel is appropriate.

This step, full and proper resourcing of community controlled health services, will give us a strong foundation from which to tackle the next layer of the problem - regional health planning.

Structures must be set up that allow the Aboriginal community to plan and set health priorities in their own region. Some health problems - STDs and other communicable diseases, for example - cannot be effectively tackled at the local level, and need cooperation and planning across regions.

Regional health planning structures need to be resourced to have regular meetings throughout the region. They will need secretarial support. They will need to be allowed the time to sit down, debate, and come to decisions about health policy and delivery in their area.

The Aboriginal Medical Services Alliance and Congress have prepared papers detailing how such structures might work in the Northern Territory. In Central Australia, we have already had meetings of a Central Australian Aboriginal Health Council, but have been unable to continue with this due to a lack of funding. However, we emphasise that regional structures will differ across the country, according to the wishes of the Aboriginal people of that region.

With the community controlled health services as the foundation, and the regional health planning structures as the walls, all that needs to be added to complete the building is the roof: a national level Aboriginal health council.

Commonwealth Health have already committed themselves to setting up such a body. We believe it should be made up of representatives from the regional health planning structures. And again, it will need a well-resourced and independent secretariat, and will need the resources and time to be able to meet to consider those aspects of Aboriginal health which need to be tackled at a national level.

So, the idea is this: first, build strong foundations (Aboriginal health services). Based on these, build the walls (regional health planning units). And last, put the roof on top (a national Aboriginal health council). This is true bottom-up health planning. This will take into account the diversity and difference, as well as the unity, amongst our peoples. Locally based, it will also allow for regional and national approaches where necessary.

This is going to require a change from past practice. The standard bureaucratic process is to proceed in the opposite direction: to try and put up the roof first, perhaps then add the walls, and last, if there's any money left, build the community foundations. It is no wonder that structures built this way collapse. We have seen this in the past. We demand that it doesn't happen again.

In short, Aboriginal health must be resourced at the local level to function effectively at a regional level. And it must be resourced at the regional level to be able to contribute effectively to a national level.

Of course, this demands more resources for Aboriginal health. It is no use trying to pretend that more money is not needed, when Aboriginal people make up 1.6% of the Australian population, yet only 1.26% of health funding is for Aboriginal programs.¹

More importantly, it demands flexibility, imagination, and good-will from the bureaucracy.

¹ *Second Report of the Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner*, Human Rights and Equal Opportunity Commission, 1994, AGPS, Canberra

For those who would say that these demands are impossible, I would remind them that, as we have seen just recently in the Pacific, indigenous people are not willing to be patient for ever. Even peoples with a strong commitment to peace and cooperation get tired of being peaceful and cooperative if their rights continue to be denied.

I am not suggesting that the kind of reaction to French colonisation that occurred recently in Tahiti is likely in the near future in Australia. I am saying that we, like our Indigenous brothers and sisters elsewhere, are not prepared to be patient for ever.

Our people and our health organisations have long been advocating the kind of changes I have outlined above. Now, the Commonwealth Government has taken clear responsibility to tackle Aboriginal health. If we do not see progress towards more effective models of health delivery soon, we will not just turn away and shrug our shoulders. We have spent too much effort, and the health of our people is too poor to allow that reaction.

Instead, we are investigating other methods addressing the failures of non-Aboriginal Australia. One way of doing this is through international forums. The rights of our people to health are guaranteed by international agreements, to which the Australian Government has committed itself. If our rights continue to be denied, it is only reasonable that we point this out to the international bodies concerned.

In other words, if non-Aboriginal Australia is not prepared to properly resource our people to tackle the health problems caused by colonisation at the local, regional, and national level, we ourselves will take the issue to the international arena.

Thank you.