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Position Paper

Treaty & Health

July 2002

Central Australian Aboriginal Congress.

For close to thirty years since its establishment in 1973, Congress has been a strong advocate for the rights and needs of the Aboriginal population of Alice Springs. Congress is an organisation of Aboriginal people for Aboriginal people, controlled by Aboriginal people. Congress established a health service in 1975, and now runs a comprehensive primary health service that includes: a medical (clinic) service, community health programmes (including a bush mobile medical service servicing outstations within 150km of Alice Springs), a male health programme, a dental clinic, a women's health service and birthing centre (the Congress Alukura), a child care centre, an education and training branch for Aboriginal Health Workers, a social and emotional wellbeing centre and a youth outreach programme. Congress is currently seeing over 7,000 individual clients a year. In addition Congress has an active involvement in various research programmes and a policy and advocacy programme. Through our membership of the Aboriginal Medical Services Alliance of the NT (AMSANT), the peak body for Aboriginal Community-Controlled Health Services in the NT, Congress staff and management are active in a number of territory and national health planning and policy bodies.

Congress has pioneered community-control of health service delivery and development. Today Congress successfully embodies the principles and functions of these services. Both the National Centre for Epidemiology and Population Health[1] and the Northern Territory Aboriginal Health Forum[2] have recognised the central role of community control and advocacy work on policy as being fundamental to community–controlled health services. The inaugural meeting of Congress in 1973 laid the foundation for Congress to articulate the community's, "guaranteed right to self determination and Autonomy with respect to their own social, economic and political affairs"[3]. From this mandate Congress continues to speak out on these matters, with particular emphasis upon the relationship between these principles and our people's health.

Sovereignty & Treaty.

Aboriginal society was a sovereign society prior to colonial invasion. Aboriginal sovereignty was not ceded to the colonisers during or after invasion. We retain our sovereignty. Through the exercising of our cultural practices and through the establishment of our community-controlled organisations, such as Congress we daily express this sovereignty and our right to self-determination.

No formal treaties or agreements were made with Aboriginal people about land ownership or governance relations. Each colony took the land (by force) and claimed to impose its administration (governance structure) over Aboriginal people. In Central Australia this was undertaken by force with many of our people being killed in officially sanctioned police actions.

At the time of federation only the settler population was involved in the drafting of the Constitution and the negotiations for the basis of confederation (the Commonwealth).

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[1] Legge, D., McDonald, DN. & Benger, C. Improving Australia's health: the role of primary health care.

[2] NTAHF, Core Functions of Aboriginal Primary Health Care

[3] Perkins, N. Central Australian Aboriginal Congress: Pan-Aboriginalism and Self-Determination.

The open hostility of the Colonies (and after 1901 the newly established States), towards Aboriginal people over the legitimacy of this conquest of the land, and over ongoing land conflicts, was reflected in these governments retaining the right to make laws regarding Aboriginal people and the right to manage land as reflected in the Australian Constitution section 51 as it was proclaimed.

The lobbying for the transference of these powers to the Commonwealth, culminating in the successful 1967 referendum amendments to the Constitution, reflected Aboriginal peoples' understanding that they may have been afforded greater protections of their rights at this level.

The sovereignty rights of First Nation peoples has, at an international level, gained political currency in recent years and is most comprehensively expressed in the draft United Nations Declaration of Indigenous Rights. The recognition of these specifically indigenous rights is increasingly being accepted in other colonial settler societies *ie* Canada, the United States and New Zealand/Aotearoa.

The exercise of sovereignty rights is an act of self-determination, a right also accorded to Aboriginal people and similarly recognised internationally.

The recognition of sovereignty rights does not have to diminish the legitimacy of the National Government. In fact by recognising the unique rights of Aboriginal people as the first nation peoples of Australia and making a treaty with them the Commonwealth Government may strengthen its claim to being a legitimate and mature national government in the eyes of both the international community and its own people. Other colonial settler societies have recognised that a nation can have treaties with its own Indigenous populations[4].

The making of a Treaty recognises Aboriginal peoples' Sovereignty. How that Treaty outlines the exercise of those rights will further give expression to that sovereignty.

A Treaty must be entered into freely to both (all) parties, based upon the mutual recognition of each other's rights and needs. For a Treaty to have affect, the signatory parties have to undertake to abide by its provisions and to enact them.

Health & Treaty

What are the health implications of a Treaty?

Congress recognises two impelling arguments connecting the state of our people's health with the treaty making process. For Aboriginal peoples whose spiritual belief system is based in the land and who have a holistic notion of health, the link between a Treaty and health can be quite strong:

- if the Treaty process provides for access to the land. It does not have to be quantified that access to land under this belief system is a prerequisite to good

[4] In the USA this was recognised in law by Supreme Court Justice Marshall in three decisions (1823, 1831 &1832- 'the Marshall Trilogy'), in Canada the Constitution of 1980 recognised existing Treaties and the Canadian Indigenous peoples right to self-determination and in NZ/Aotearoa the establishment of the Waitangi Tribunal in 1975 gave recognition to the Treaty of Waitangi.

health outcomes. In itself this access to land may not guarantee good health as other matters may work against this, but without land access, good health status is unattainable.

and

- if the treaty gives recognition to Aboriginal sovereignty and the right to self-determination, the exercising control over our lives. This has always been a key health demand of the Aboriginal health movement. This understanding of the need for community and individual control as a health determinant is supported by the academic world through what is called the social determinants of health movement, which has identified the relationship between disempowerment and poor health status.

Why are Health outcomes (as measured by life expectancy) better in Countries that have treaties with their Indigenous populations?

The fact that the gap between the life expectancy of Indigenous populations and the non-indigenous populations in the colonial settler societies of Canada, USA and NZ/Aotearoa is smaller than that between the Australian population as a whole and the Aboriginal population is often remarked upon.

Table 1. Life expectancy in years at birth for selected indigenous populations of NZ/Aotearoa, USA, Canada and Australia. (from Kunitz 1994 & 2000, Cunningham, J. & Paradies, Y 2000, Ross &Taylor 2001 AIH&W 2000 & IHS 1999)

	Maoris		*US Indians*		*Canadian Indians*		*Aust Aborigines*	
Year	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
1920's	47	45	NA	NA	NA	NA		
1930's	46	46	NA	NA	NA	NA		
1940's	48	54	51.3	51.9	NA	NA		
1950's	57	58	58.1	62.2	NA	NA		
1960's	61	65	60	65.7	59.6	63.5	50 (NT)*	
1970's	63	67	60.7	71.2	57.8	60.3		
1980's	65	68	67.1	75.1	64	72.8	54	61.6
1990's	67.2	71.6	67.6	74.7	67**	67**	56{53.7}***	63{58.9}***
Total pop/ Non-Indigenous	75.3+	80.6+	72.5++	78.9++	75++	77++	76++	82++
Gap in life expectancy	8.1	9	4.9	4.2	8	10	20{22.3}****	19{23.1}****

- * NT figure only, ** Canadian Inuit average total male & female data Kunitz 2000*** {WA, SA & NT} only data, ****comparison with {WA, SA & NT} data only.
- + Non-Maori population, ++all races (or total population)

Table 1 shows that the gap in life expectancy between Aboriginal and non-Aboriginal people is dramatically larger than between indigenous and non-indigenous populations in comparable countries.

The reasons for this variation lie in the unique experiences of each of the Indigenous populations of these societies. A range of factors must be considered in order to answer why this situation occurs.

"…..health status improvement is related to a set of factors operating together, rather than to the presence or absence of one particular factor. These factors

are environmental health, access to health care, socio-economic status, social inequality and psychosocial factors."[5]

Treaties may have a role to play in these factors through, providing clear and effective institutional arrangements for the provision of health (and other) services, overcoming the adversarial nature of state & territory government relations with Indigenous populations, establishing Indigenous rights in law and through establishing the rights of peoples giving individuals a greater sense of their own strength within the system and a lessoning of a sense of helplessness or powerlessness.[6]

Does a Treaty guarantee access to, or the funding of, health services?

The answer based upon overseas experiences is both yes and no. A Treaty is only as good as the political will to enact its provisions. In Canada, the USA and NZ for most of the time that there have been Treaties they have either been ignored or broken by the settler national or state (provisional) governments.

In Canada and NZ it has only been relatively recently (the early 1970's) that the Treaties have started to be acted upon. In Canada the Treaties have been reaffirmed and new Treaties have been negotiated and old ones re-negotiated. In 1982 as part of the Canadian Constitution section 35 recognises Indigenous self-determination and the Treaties. In NZ the Waitangi Tribunal was established in 1975 to re-commence its enactment.

In the United States the Snyder Act 1921 set up the Bureau of Indian Affairs and the Indian Health Service (IHS) as part of that Governments interpretation of its Treaty Obligations.

In Canada the Government 's position is that Health service access is a right of all Indigenous peoples as Canadian citizens, even though they are prepared to recognise other services as being within the realm of Tribal council responsibility for treaty purposes.

Not all Indigenous people in Canada or the US are covered by the provisions of the Treaties, or the funding that is attached to health services based upon this coverage because not all people had Treaties signed with them or as in the case of Canadian Metis were not until recently officially recognised as being an Indigenous People.

In the US only around half of the American Indian/Alaskan Indian population is covered by Treaties and only about 60% has access to the IHS.[7]

Minimal services had been provided since the mid 20th century through the Bureau of Indian Affairs of the Department of the Interior. As a result of attempts by western congressmen to weaken and destroy the bureau during the 1940s, responsibility for

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[5] Ross, K. & Taylor, J. Improving Life Expectancy and Health: A Comparison of Australia's Aboriginal & Torres Strait Islander People and New Zealand M.Ori.

[6] ibid

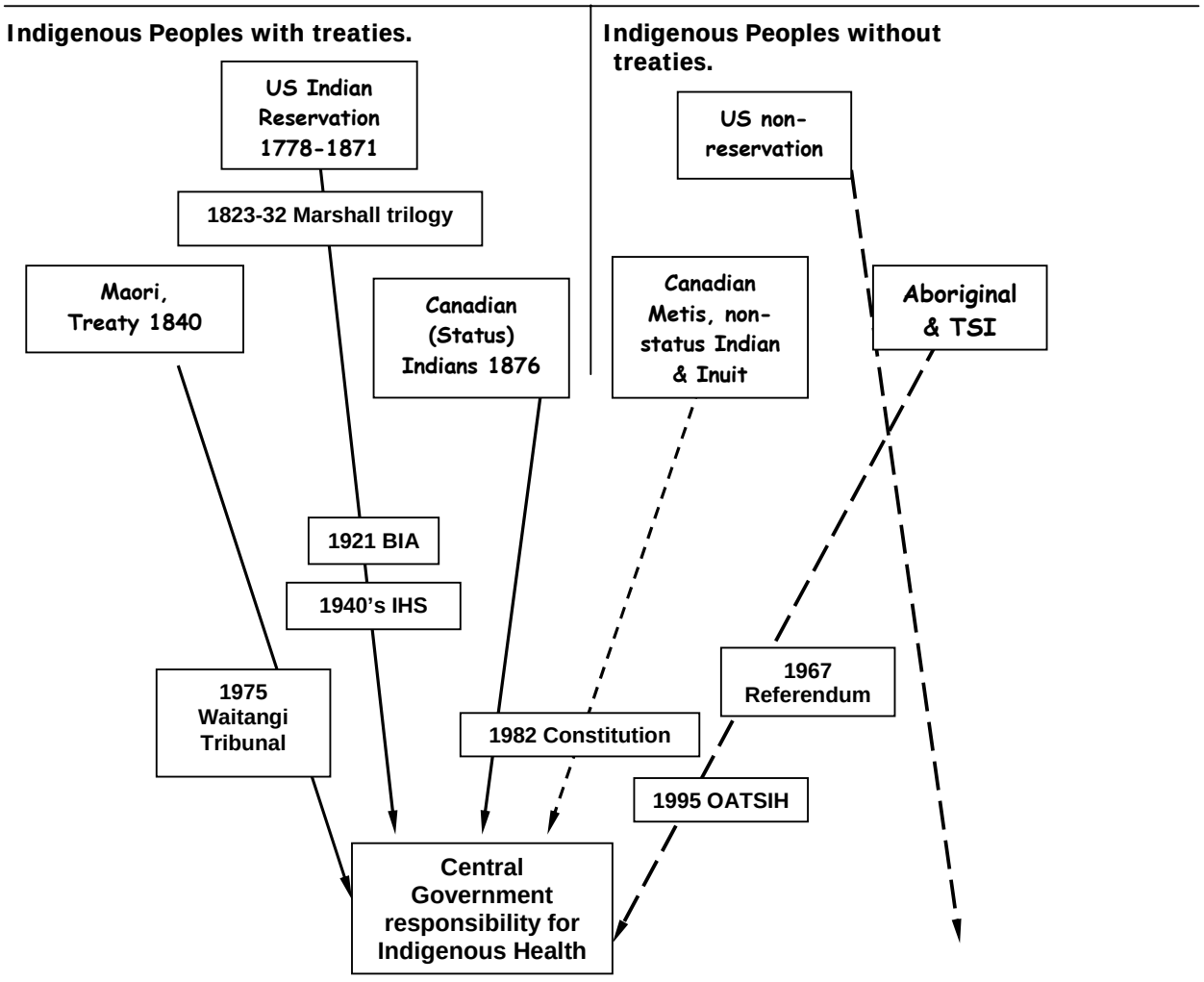
[7] Grossman, D., Krieger, J. et al found that urban non-IHS American Indian populations had a growing rate of infant mortality mot experienced in rural IHS American Indian population, and lower birth weights. Other indicators, such as life expectancy were the same across both communities.

health services was placed with the US Public Health Service. The transfer thus created the only US national health program for civilians, providing virtually the full range of personal and public health services to a defined population at relatively low cost. Policy changes since the 1970s have led to an emphasis on self-determination that did not exist during the 1950s and 1960s. Programs administered by tribal governments tend to be more expensive than those provided by the Indian Health Service, but appropriations have not risen to meet the rising costs, nor are the appropriated funds distributed equitably among Indian Health Service regions. The result is likely to be an unequal deterioration in accessibility and quality of care.

In both countries the distinction between Treaty Indians and other Indigenous Peoples causes frictions.

Treaties have been used by resurgent Indigenous movements to lever commitments from their governments. A treaty can raise the administrative obligations of the Commonwealth Government above parliamentary political will (not the case in the USA) and embed it in a higher authority within the Western system ie the Constitution (Canada) or as an agreement to be interpreted through an Independent Tribunal (New Zealand/Aotearoa).

Figure 1. Timeline of events related to Indigenous health & treaties (*not to scale*).



What should an Australian Treaty have in it about Health?

Congress believes that the treaty process requires extensive consultation with all Aboriginal people before any political commitments between any Aboriginal organisations is made with any level of Australian government.

Congress views the concept of a treaty as a potentially useful tool for Aboriginal people to gain recognition of their sovereignty and to codify relations between Aboriginal peoples and the Australian government. Any Treaty must not cede Aboriginal sovereignty, exclude any section or group of Aboriginal people or diminish any gains wrought from the system through existing reforms.

Congress sees two aspects of the treaty process that could strengthen Aboriginal peoples access to and control over health services and their delivery.

1/ Guaranteed Health Service delivery by the Commonwealth Government.
This would recognise that it is the Commonwealths responsibility to provide or to ensure the provision of those citizenship rights that relate to health services (and other services education, environmental health etc) ie the right to enjoy all the standards to access that the non-Aboriginal community has,
and….
2/ Self-determination rights as First Nation peoples. Making a sovereignty Treaty with (and within) the Australian nation that gives:

- Recognition of land rights,
- Recognition of Aboriginal sovereignty and the right to self-determination ***including Aboriginal community-control of services such as health services* and *core partner status for Aboriginal sectoral peak bodies in Aboriginal policy and planning under national, state and territory framework agreements (as exemplified by the Aboriginal Health Framework Agreements currently existing at the state and territory level).***

These twin tenets would guarantee Commonwealth responsibility to fund Aboriginal health services to a level required for Aboriginal people to enjoy similar health status as the non-Aboriginal population and that these services were delivered under Aboriginal community-control. Implicit in this understanding, and requiring to be made explicit in any treaty wording, is that Aboriginal health will require additional funding levels than that provided to the non-Aboriginal population. This is based on two factors. As recognised in the Primary Health Care Access Programme (PHCAP), until such time that an equalisation of Aboriginal health status with that of the non-Aboriginal population is realised, a multiplier will have to be applied to the per capita health expenditure figure being allocated and accessed through the Medical Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS) and other funding sources. As well in order to effectively resource the community-controlled organisational process additional funding is required to facilitate thorough and effective community participation, management and board control. This would be an on going additional allocation that recognises the centrality of Aboriginal self-determination in effective programme and service delivery and governance[8].

[8] RCIADIC 1991

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