

“Sharing Responsibility or Shifting Responsibility?”

**Mick Gooda
Chief Executive Officer**

**Cooperative Research Centre for
Aboriginal Health**

**National Conference of the
Australian Medical Association**

Darwin

May 28 2005

(Check against delivery)

Thank-you Dr Glasson and Dr Meadows for your introductory remarks and thank-you all for the opportunity to speak with you today and welcome to Darwin.

I would like to firstly acknowledge the Larrakia nation on whose country we are meeting today.

In common with other Aboriginal nations across the length of this country the Larrakia have fought courageously to defend their country and their customs.

More than 200 years since Britain claimed Australia as its own the Larrakia and other Aboriginal nations continue that fight.

The spear, woomera and waddi may have been replaced by an array of political and legal weapons but the purpose of our fight remains the same; to maintain our ownership of country, our languages, our culture and our independence as the first nations of Australia.

I make these points at the top of my talk this morning to reiterate that our fight for independence and survival continues unbroken until today.

There is no more critical battlefield than our fight for physical, emotional and spiritual well-being.

Our very survival depends on our success in this area; return of land, maintenance of culture and language, and economic independence will matter little if we continue to die in what is middle age for other Australians.

Conversely, we do not want to achieve improved health outcomes at the expense of our ownership of country or at the expense of our languages and culture.

Our health statistics might eventually match those of white Australia but at the cost of us becoming indistinguishable from white Australia?

So then, our health and our identity as distinct peoples within Australian society are inseparable.

I was asked to speak to you today about the Howard Government's Shared Responsibility Agreements or SRAs and provide some advice on what role the AMA might play in making the new Howard Government arrangements in Indigenous affairs work for Aboriginal people and communities.

That's a more difficult ask than you might imagine.

Information about the new arrangements is extremely hard to come by.

And as I understand it, there remains enormous confusion within the Government's own circles on this matter. Talk to different senior bureaucrats and different Commonwealth ministers and the story varies.

In fact, so flexible have these new flexible arrangements become that they appear to be, like a blank page, everything to everybody.

And I'm sure that you can all imagine that if information is hard to come by for bureaucrats within the system and for people like myself, who are experienced political players, then just imagine the lack of information and resultant confusion in our communities.

This lack of information sadly exemplifies the approach of too many Governments; it is an approach grounded in paternalism and an aversion to heeding Aboriginal voices in a meaningful way.

"We know what's best for Aboriginal people and we'll implement our policies without the need for adequate dialogue or negotiation with Aboriginal people themselves," seems to be the thinking of most Australian governments.

So this brave new world of mutual obligation, reciprocity, improved coordination and flexibility in Aboriginal affairs has been given birth with little or no information made available to those on whose behalf we are told the policies were developed.

The very development and implementation of this new world has occurred with little or no consideration to the voices and opinions of Aboriginal and Torres Strait Islander people themselves.

I would argue that one of the impacts of such arrogance in policy development and implementation is the further marginalisation and disempowerment of Aboriginal people.

Marginalisation and disempowerment are among the many social determinants that impact severely on Aboriginal health.

Denied the opportunity to control our own business, to design and manage our own health services and programs and to meaningfully influence government policies, and facing an almost relentless barrage of negative media reports and day-to-day experiences of racism that continually challenge and undermine our self-esteem and confidence it is little wonder that our health outcomes remain so appalling.

As Dr Ian Ring, comparing Australia's singular lack of success in lifting health outcomes for Aboriginal people with that of New Zealand and North America, has written in the Medical Journal of Australia:

I quote....

“It is arguable that colonial paternalism, an official policy of assimilation, and a lack of formal recognition through treaties have together acted to create and reinforce a sense of powerlessness in Australian indigenous people which is relatively less in other indigenous groups. It may well be that these intangible factors are adversely affecting indigenous health in Australia.”

In an opinion piece supporting a treaty between Indigenous and non-Indigenous in Thursday's Age newspaper, Sydney legal academic Sean Brennan writes that, ***“The World Health Organisation has found that social exclusion is a contributor to poor health, and that law reform can enhance inclusion. In Australia, Aboriginal health is a national crisis, with life expectancy 20 years lower than in the non-Aboriginal population.***

Brennan goes on to argue:

“Given this, is it a coincidence that life expectancy is better in Canada, where treaty-making occurs and the constitution protects aboriginal rights? Or New Zealand, where the Treaty of Waitangi influences public policy? Or the United States, where the political independence of Native American nations has long been recognised?”

So, in my view, the actual processes and mechanisms that have created the so-called new approach, including shared responsibility agreements, are themselves undermining our strength and self-confidence and causing further damage to our ability to turn our collective health around.

But this is only the start of the problems with SRAs.

Aboriginal people acknowledge our responsibilities to address our own health problems. In fact the whole political movement to create Aboriginal Medical Services as Aboriginal-controlled organisations rests on the premise of acceptance of that responsibility.

We understand that our ill-health **is** a legacy of colonialism and decades of destructive government interventions but we also understand that ultimately we are the only ones able to solve that legacy and in health we are doing so through the development of self-managed Aboriginal Medical Services.

The final responsibility for improving our health must rest with ourselves but to meet that responsibility we need governments to provide adequate and equitable resources to primary health care in particular but also to improving the myriad social determinants that have such a destructive impact on our health.

Housing, employment, a decent education, environmental health infrastructure, access to health care and economic opportunities are all major determinants for health and are all services that Australians expect as a citizenship right.

It follows that these basic citizenship rights are part of Governments' responsibilities to their constituents; the Australian people.

However, when it comes to Aboriginal citizens, these basic citizenship rights are not always available and particularly in the case of remote Aboriginal communities are rarely accessible.

We are extremely concerned that the Commonwealth's mutual obligation/shared responsibility policy direction will see Aboriginal people forced to make concessions and commitments to governments in exchange for rights and services given unconditionally to other Australians

Aboriginal people should not negotiate SRAs for access to those services to which we are entitled to as citizens, such as health, education, employment and infrastructure.

These need to be provided by governments as a matter of course. To do otherwise would further reinforce Aboriginal people's status as second-class citizens not entitled to the same rights as other Australians.

The Central Australian Aboriginal Congress, one of the twelve partner organisations to the CRC Aboriginal Health, has identified a list of principle social determinants of Aboriginal health in the Alice Springs area.

According to Congress these are: access to health systems and services, alcohol and other drugs, individual and collective autonomy and control as opposed to passive welfarism and lack of governance, education and employment.

Congress, as an Aboriginal Medical Service, is focused on improving access to quality primary health care services and has achieved amongst the highest access rates recorded for any health service in Australia for marginalised people, including people living on the town camps.

Congress is able to do this because it takes its responsibilities very seriously and is owned and controlled by the very community it serves.

The question must be asked, however, whether the Australian and Northern Territory Governments are meeting their end of the bargain in the Central Australian region.

As an illustration of the gap between rhetoric and reality I want to tell you about the Western Desert Nganampa Waltyjta Palyantjaku Tjutaku Aboriginal Corporation and that organisation's efforts to improve the treatment of end-stage renal disease patients undergoing dialysis.

One of the most tragic stories of Aboriginal ill-health is the hundreds of people from remote communities and outstations across the country who are forced to leave their homes permanently to undergo dialysis in regional centres.

Many of these patients are senior members of our communities and holders of vast amounts of cultural knowledge and consequently their removal from communities is extremely disruptive not only for themselves and their families but for the whole community and threatens the survival of cultural practices so essential for the maintenance of our spiritual and emotional health.

Many people forced by renal disease into regional centres see the move and dialysis treatment as little better than a death sentence.

So people in the remote western desert community of Kintore decided to address this issue by proposing an option for home dialysis which would allow one or two patients at a time to return to Kintore from Alice Springs for a two or three week period.

Both the Territory and Commonwealth governments were less than enthusiastic at this initiative from the Western Desert people and it initially failed to attract any government funds.

Western desert people decided not to accept the government's funding knock-back as the end of their dream and established the Western Desert Dialysis Appeal.

Western Desert artists donated paintings to the appeal and in 2000 \$1.1 million were raised by auction to progress that dream.

The NT Government then purchased a machine for home dialysis which allows patients to travel back to Kintore for treatment for short periods.

The first of these patients returned to Kintore last September and there have been eight more since.

While I am pleased to report to you that the NT Government recently offered recurrent funding for two renal nurses to support patients, total Commonwealth contributions until this time have amounted to purchasing a sink for the Kintore Dialysis room.

The Cooperative Research Centre I head up has supported the Western Desert Dialysis project and assisted in an evaluation of its effectiveness.

That evaluation report, though not finalised, is indicating some real health and economic benefits from the project.

These include improved health promotion opportunities in educating Western Desert people on renal health and earlier presentations for treatment as people lose the terrible fear of dialysis.

A reduction in emergency evacuations of patients from Kintore after they have returned there from Alice Springs without medical authorisation has also seen economic benefits for the NT Government.

The predicament of the Western Desert dialysis project presents us with a test of the Commonwealth's sincerity to respond meaningfully to Aboriginal community-based health initiatives.

If the new Commonwealth arrangements are not able to ensure the long-term sustainability of such demonstrably valuable community-based initiatives then the new arrangements will have failed.

The Alice Springs Indigenous Coordination Centre is presently negotiating a Shared Responsibility Agreement with the Western Desert dialysis mob and we await the outcomes of these negotiations with interest.

I do hope the AMA will also keep a keen eye on this developing situation and offer its support to the process.

We are also concerned that the outcomes being negotiated for inclusion in SRAs seem to be based more on government than community priorities.

This skewed determination of priorities presents a dangerous return to paternalism and, in the long run, threatens the survival of the effective community-controlled health services that I represent.

It undermines the intellectual capacity and independence of Aboriginal communities and organisations and sadly reflects our greatest fear; a move by governments to return to the days of mainstreaming and assimilation.

I note with trepidation recent calls by ex-Tasmanian Liberal Minister and more recently CEO of the Tiwi Local Government, John Cleary, for the abolition of community-controlled Aboriginal Medical Services and for a return to government-controlled clinics in our communities.

Mr Cleary's call, which received prominent media coverage, is contrary to the aspirations of our people and contrary to all the evidence which supports Aboriginal control of our own health services and programs.

There is a real fear amongst Aboriginal people that in its desire to overturn the arrangements established by the Hawke/Keating Governments, the Howard Government will destroy the achievements of Aboriginal people over the past decades.

One of these successes has been the establishment of effective and well-managed Aboriginal community-controlled medical services.

In finishing I want to ensure that I am not leaving the impression that our concerns with SRAs are based on a rejection of greater

accountability, or of improved coordination or governance or of greater flexibility.

Indeed all these ideas have been advocated by significant parts of the Aboriginal leadership and community for decades now.

We want partnerships with Governments, we want accountability and transparency and we want and need greater coordination and flexibility in the way government services are designed and delivered to our communities.

Ultimately we want and need and demand that our voices are heard, that we are treated with dignity and respect and that our status as the first peoples of Australia with a distinct relationship to this land and a distinct culture is recognised and respected.

I ask the AMA to continue to support us in these efforts and I look forward to working closely with the AMA national leadership to achieve this.

Ends