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Item 4(c): Health
Intervention by Les Malezer, Foundation for Aboriginal and Islander Research Action

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Mr Chairman

We recommend that the Office of the High Commissioner on Human Rights convene an international workshop on Indigenous Peoples and the human right to health.

We recommend that the Special Rapporteur on the Right to Health be asked to examine the situation of disparity of health standards for Indigenous Peoples in the developed countries.

We are disappointed that there is not a report to this session from WHO. Further we note that WHO reported to the last session of the Commission on Human Rights that, in relation to Indigenous Peoples, it was preparing its Global Strategy and will involve governments, UN partners, NGOs and stakeholders (refer to E/CN.4/2004/???). It is disappointing to discover that this is exactly the same information provided to the previous session of the Commission (refer to E/CN.4/2003/???), revealing in fact that WHO is not, at the Global level, addressing Indigenous health.

We understand that WHO may be operating in some regions in close coordination with Indigenous Peoples however it is imperative that the organisation understand the need to have a global strategy and to address the health of Indigenous Peoples in developed and developing countries alike. I provide some health information relating to Aboriginal Peoples and Torres Strait Islander Peoples in Australia to make this point.

[Much of the following information is from the fact sheet 'The Health Emergency', contained in the information kit 'Indigenous Health in Australia' published by the Fred-Hollows Foundation.]

Aboriginal Peoples and the Torres Strait Islander Peoples, according to recent study of 100 cases, had the second worst quality of life after the Chinese, while Australians had the fourth highest quality of

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life.

We will live, on average, 25 years less than Australians with a life expectancy lower than for populations in Myanmar, Papua New Guinea and Cambodia. In some regions our median age at death is 47 years. We live between 8 years and 13 years less than Indigenous Peoples in Canada, New Zealand and the USA.

Many Aboriginal kids are at a health disadvantage from birth. Twice as many Indigenous children are born at low birth weight than other Australian babies. The rate of low birth-weight Aboriginal babies has increased in the late 1990s and is greater than in developing countries such as Ethiopia, Senegal, Tanzania, Zimbabwe, Indonesia, and Lebanon. Low birth-weight is related to life-long health disorders such as coronary heart diseases, type 2 diabetes, central obesity and hyertension.

Infant mortality is three to four times higher for Aboriginal peoples than for the Australian population, and again is significantly higher than Indigenous populations in Canada, New Zealand and USA.

Indigenous children are hospitalised more often and suffer from high rates of respiratory and intestinal infections, eye and ear infections. In remote areas, they are three times as likely as non-Indigenous children to die before the age of one.

The major cause of illness is preventable infections. Aboriginal children in remote communities in the Northern Territory suffer so many middle ear infections in early childhood that only 7% have normal healthy ears. By 21/2 years old, 25% have perforated eardrums and it is estimated that up to half of Aboriginal children in remote communities have hearing loss.

The current rate of ear infections in remote NT communities ranges from 8% to over 50%. The World Health Organisation regards a rate of 4% as a 'massive public health problem'.

In later life Aboriginal people are hospitalised at about twice the rate of non-Indigenous people. Compared with the population as a whole the rate of rheumatic heart disease is 6-8 times higher; rates of diseases of the circulatory system are about three times higher; respiratory disease is four times more common; diabetes occurs four times more often; and kidney disease is nine times higher (in some regions, 25 and even 60 times higher).

Similar first world countries, such as New Zealand, Canada and the USA have made huge improvements in the health of Indigenous peoples in the past 30 years. In these countries the gap in life expectancy between Indigenous and non-Indigenous people has narrowed to between four and 10 years – compared with a gap of about 20 years in Australia.

Indigenous people are more likely to be unemployed (20%), and those who are working earn 40% less than other Australians. On the whole, Indigenous Australians are poorer, more disadvantaged, less educated and have less access to adequate health care than other Australians.

The gap between Indigenous and non- Indigenous Australians is widening because their circumstances have not kept pace with improvements in the health and well-being of non-Indigenous Australians. As a result the level of relative disadvantage faced by Indigenous Australians has continued to grow over time.

Despite government claims of increased expenditure on Aboriiginal issues and the appalling differences in the standards of health between Indigenous and non-Indigenous people in the same country, the evidence shows that the government is actually spending less per capita on Indigenous health.

The Commonwealth spends more, per person, on non-Indigenous Australians through MBS and PBS than it does on Indigenous Australians. In 1998-99 it was estimated that for every $1.00 spent per person for the general population on the Medical Benefits Scheme (MBS) and Pharamceutical Benefits Scheme (PBS), only $0.37 was spent per Indigenous person. Commonwealth spending on Indigenous people through programs it administers is about 18% less per person than for non-Indigenous people.

Hospital expenditure on Indigenous people is twice as high. This reflects a failure to deliver adequate primary health care that results in higher cost hospital treatment.

As a number of reports in recent years have identified, the resources needed to achieve significant improvement within a reasonable time frame include additional $250 million per year for provision of primary health services, additional $50 million per year for training of Indigenous health workforce and community health education, and a minimum of $3.5 billion targeted over a reasonable time frame to address the backlog of community and infrastructure needs.

As a final comment, I would like to highlight the appalling attitude by governments in Australia towards the empowerment of Indigenous Peoples over health issues.

The Queensland State government has recently decided to implement laws banning alcohol in Aboriginal communities. These laws were passed to supposedly address the levels of alcoholism and violence in the communities but were not discussed with the communities. In a misguided effort to by-pass anti-racism laws the government made the legislation applicable to geographical boundaries but did not hide its intention to target the Aboriginal population that predominates in these areas.

The Aboriginal Coordinating Council (ACC), a peak body that comprises representatives from the Aboriginal governments in these communities, has strongly opposed these laws. In retribution, the State Government has threatened and subsequently decided to terminate the ACC. This mean and vindictive attitude, in defense of racist laws, is a reflection on the government's actions in 1897 when it passed the first of the racist laws in Australia, entitled the Aboriginal Protection and Prevention of the Sale of Opium Act 1897.

It took 87 years for that legislation to be finally repealled, but the Queensland government has taken only 20 years to re-instate it. As further intimidation of the Aboriginal Peoples the government has declared that it is going to turn the Aboriginal communities into mainstream townships and create non-Indigenous local government.

This appalling attitude toward Indigenous Peoples rights is an exposure of racism and intimidation by the non-Indigenous governments and population of Australia.

Thank you, Mr Chairman