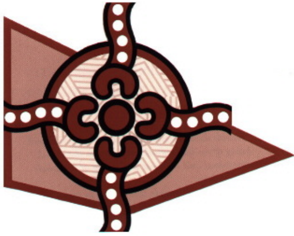
Victorian Aboriginal Community Controlled Health Organisation Inc.



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Victorian Aboriginal Community Controlled Health Organisation

Submission to the Department of Human Services Review of the Health Act 1958

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Background

The Victorian Aboriginal Community Controlled Health Organisation, (VACCHO) was founded in 1996 and currently represents Twenty-Six diverse members across Victoria. Each member is an Aboriginal community controlled organisation. The majority are multifunctional services with health as a central part of their responsibility and some are full health services. The role of VACCHO is to build the capacity of its membership and to advocate for issues on their behalf. Capacity is built among members through strengthening support networks, increasing workforce development opportunities and through leadership on particular health areas. Advocacy is carried out at a state and national level on all issues relating to Aboriginal Health with a range of private, community, and government agencies.

VACCHO is committed to improving the well being of Aboriginal people in Victoria. This is supported by our commitment to maximise the capacity of the Aboriginal community in determining their health and wellbeing by ensuring community participation and community ownership.

Aboriginal community controlled health organisations have a proud history as long lasting, democratic, grounded organisations assisting in both capacity building in the community as well as providing direct services to the community.

There is a demonstrated need during these uncertain times in Aboriginal affairs for the Victorian Aboriginal Community to support and develop its community organisations and its people. By joining together VACCHO members gain strength, share knowledge and speak with a firm voice. This helps to make VACCHO a stronger organisation able to assist and strengthen its members.

An executive board governs the Victorian Aboriginal Community Controlled Health Organisation. Board members are elected from representatives of Aboriginal Community Controlled Health Organisations (ACCHOs) across Victoria.

The Health of Indigenous Victorians in 2004 still remains at a standard unacceptably lower than the rest of the population. Koori babies are twice as likely to be of a low birth weight or die before 28 days compared to non-indigenous babies. Koori youth are 2 to 3 time more likely to die from injury, accident and suicide than their non-Indigenous peers. Among Elders and older Kooris, circulatory (Heart), respiratory (Lung) and renal (Kidney) disease take a heavy toll.

The higher death rates among infants and young adults, and the premature death of older people and elders has placed an enormous burden on Indigenous people and communities in Victoria and all over Australia. This burden or trauma has had, and continues to have an impact across the cultures social structure. When elders die prematurely much of the knowledge that they possess dies with them leaving gaps in the history, especially in a

culture where oral history not written history is the norm. These gaps also effect the community wellbeing (Leadership skills lost, etc) as well as individual and family wellbeing.

Generation after generation Koori people die on average over 20 years before their non-indigenous fellow Victorians.

Government Context

The Australian Government recently implemented far-reaching changes to Aboriginal and Torres Strait Islander affairs. More that $1 billion of former ATSIC/ATSIS programmes have been transferred to mainstream Australian Government agencies. It is unclear to date how these funds are to be distributed and whether the $1 billion removed from direct control by Aboriginal organisations will be available for Indigenous health. It is clear however that political commitment to community controlled organisations administration of funds have shifted to a lower government priority, while program setting remains with the community.

At the core of this change is a whole-of-government approach to building partnerships with Indigenous Australians in the delivery of government services at the local and regional level.

In this changing environment VACCHO remains the peak Victorian Aboriginal Health voice through participation on peak forums such as Victorian Advisory Council on Koori Health, the executive board of the National Aboriginal Community Controlled Health Organisation and the VACCHO executive's participation on forums throughout Victoria.

Underlying these circumstances is Australia's commitment and obligations to international treaties and conventions. These include 'the international convention on civil and political rights' and 'the Ottawa charter on public health' to which Australia was a signature and significant contributor.

Other significant factor that have bearing on the environment in which VACCHOs activities take place is the passage of *the "Constitution (Recognition of Aboriginal People)Bill.* This bill indicates an important symbolic step in the conciliation process.

VACCHO will seek to explore and facilitate greater coordinated service delivery in this dynamic environment. This will be achieved by VACCHO and its member organisations building stronger partnerships with commonwealth, state and local governments and by looking towards regional and local approaches where appropriate.

Vision

VACCHO's vision is that Aboriginal people will have a high quality of health and wellbeing. Thus enabling individuals and communities to reach their full potential in life. This will be achieved through the philosophy of community control.

Values

Health does not simply mean physical wellbeing but refers to the social, emotional and cultural wellbeing of the whole community.

Aboriginal people have a whole of life view incorporating the cyclical concept of life, death and the relationship to the land.

Community control is the key strength in the community. The imposition of structures without community control as their central tenant has shown to fail, as it is Indigenous Australians who are bested placed to demonstrate what program/services work best for them.

Aboriginal Health services will strive to achieve the state where every individual is able to achieve their full potential as a human being and as a member of their community.

Each Aboriginal community needs its own community based, locally owned, culturally appropriate and adequately resourced, primary health care facility.

In the National Aboriginal Health Strategy health was defined in the following terms:

'Aboriginal health is not just the physical well being of an individual but is the social, emotional and cultural well being of the whole community in which each individual is able to achieve their full potential thereby bringing about the total well being of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life.' (NAHS, 1989).

This definition of health parallels definitions outlined in the Ottawa Charter for Public Health and is supported by human rights principles under the International convention of civil and political rights and underlined by the International Covenant on Economic, Social and Cultural Rights.

The New Health Act

The revised Heath Act should contain a set of **guiding principles**. It should establish a role and structure for the establishment of a **Health Commissioner**. The Act should establish responsible **relationships between the State and Local governments** and the communities which they serve including a process for the engagement **of local Aboriginal communities** and their participation in the operation of the Act.

The new Act should address questions of **nuisance** in a sensitive manner. This should include the abolition of the crime of public drunkenness and the definition of nuisance in a broader based definition of nuisance in terms that incorporates community input and is able to address such variable events as small groups singing in a park and crowds attending events such as the Formula one grand prix.

The new Act should reconcile the current data collection activities to ensure that information for planning and program delivery is accurate and that personal information is protected and confidential. The **improvement if data collection** should include improvements to address the paucity of data in relation to Aboriginal and Torres Strait Islander identification.

The Act should enshrine the "**Siracusa principles**" to ensure that compulsion, coercion and containment is used only as a last resort. The application of the Siracusa principles to a contemporary Health Act in a modern state will necessarily recognize the different requirements of different communities and the differences in their relationships to mainstream organizations and authorities.

In relation to the Aboriginal community of Victoria the application of the Siracusa principles under the Health Act would ensure that in the application of the Act that all reasonable measures are taken prior to the use of any powers of coercion, containment or compulsion. This could include engagement with community organizations relating to the person who is considered as the subject of the order. Interventions could include consultation with the individual or group concerned and the engagement with the community at large including community organizations representing the interests of Aboriginal people. Other more traditional interventions could include education and social contracts.

Guiding Principles.

The new Act should contain Guiding Principles for any decision or order made under the Act. The Guiding Principles should include the following:

- Principle of realisation of human rights which recognises that respect for human rights promotes public health and requires that any decision or order be consistent with internationally accepted human rights norms;
- Principle of non-discrimination, which requires that, with the exception of 'special measures' designed to address disadvantage, discrimination on any ground (including, in particular, the ground of social or socio-economic status) be prohibited;
- Principle recognising that socio-economic status is a critical determinant of health status; that civil, political, economic, social and cultural factors, including poverty and discrimination, contribute to health inequalities and ill health. Further, that any decision or order consider and address these factors;
- Principle recognising that social and economic disadvantage can impair access to health services or programs, and that public health policies and programs should be developed in such a way as to ensure appropriate access for people experiencing such disadvantage; and
- Principle of participation requiring that persons affected or likely to be affected by a decision or order be consulted and provided the opportunity to participate in the decision-making process. Special measures may be required to ensure that impediments to participation, including homelessness, poverty and illiteracy, are identified and addressed as part of the consultation process.
- Principle of recognition of Aboriginal People, this would ensure that the Act recognizes, in line with recent constitutional changes in Victoria, the specific status of Indigenous people as the original and inalienable first people of Victoria. Recognition of Indigenous prior ownership would permit the development of specific strategies and programs, conditions under the act and statutes for addressing Indigenous disadvantage and working toward an equality of health for all Victorians.

Commissioner for Public Health

In order to oversee this process the new act should be overseen by a commissioner.

Under the current *Health Act 1958* (Vic) there is a clear conflict of interest between the Secretary's primary responsibility for implementing the Act and his or her power to conduct inquiries into matters of public health. This conflict arises because, in many cases, the Secretary will be required to inquire into his or her own policies, programs and procedures.

Furthermore, under the current *Health Act 1958* (Vic), there is no provision for the establishment of an independent investigatory or complaints resolution body in relation to matters of public health.

It is axiomatic to the promotion and protection of public health that the new Act provide for the establishment of an independent statutory body, the Commissioner for Public Health, with the power to:

- Initiate and undertake investigations and inquiries regarding matters of public health and the extent to which the right to the highest attainable standard of health is protected, respected and fulfilled;
- Receive and consider complaints regarding matters of public health, including in relation to the extent to which the right to the highest attainable standard of health is protected, respected and fulfilled;
- Make determinations regarding matters of public health, including the extent to which the right to the highest attainable standard of health is protected, respected and fulfilled; and
- Make and enforce such orders as are necessary to improve or enhance public health, including by increasing the extent to which the right to the highest attainable standard of health is protected, respected and fulfilled.

Other functions of the body should include:

- Educating the community about matters of public health, including the right to the highest attainable standard of health and social and economic determinants of health such as homelessness, poverty and discrimination; and
- Advising governments about matters of public health, including the right to the highest attainable standard of health and social and economic determinants of health such as homelessness, poverty and discrimination.

These proposed powers and functions are substantially similar to those conferred on the New South Wales Community Services Commission in respect of community services, which has recently been amalgamated with the New South Wales Ombudsman.

State, Local Government and community relationships.

The Health Act of 2005 should address consideration to the clarification of relationships and responsibilities between the State and local governments and their combined relationship with the communities they serve.

Local government has a local knowledge and responsibility to plan to ensure health opportunity for all, to address threats to health under their responsibility and to respond to events that threaten health. It is also their responsibility to ensure that the communities that constitute the population of their responsibility are engaged in a best practice planning process and delivery of services in line with the Ottawa charter principles of public health.

This would require planning and coordination. Local government plans should be an obligation under the new health statutes. The coordination, analysis and evaluation of this planning process should be a responsibility of the health commissioner working with the local government authorities.

Throughout this planning cycle local government authorities would be obliged under best practice principles to undertake consultation with local Aboriginal community organizations. This obligation should be linked to funding. The Health Commissioner should include in the review and analysis process consultation with Aboriginal peak organizations.

Specific Areas of the Act which are of particular concern to the Aboriginal Community of Victoria

Nuisance

The current Act provides a range of measures to address nuisance. The new Act should compile a range of measures from other Acts to address nuisance in broad and inclusive terms. Statutes to address nuisance should be consolidated under the new Health Act to include issues such as public drunkenness and noise. The offence of public drunkenness should be abolished in this process.

The use of the nuisance provisions should be triggered in the event of a complaint and not be subject to the volition of council officers.

The new Act should list specific causes of what constitutes nuisance. The definition of nuisance should be specified and not defined in general terms such as “risk to health”.

Data collection, utilisation, protection and Management.

Data is essential to the proper planning, monitoring and evaluation of the Health Act. The collection and use of data is of concern for all Australian community members and particularly so to the Aboriginal community members. Well managed data can be of great benefit, poorly managed data can be used to accuse or discriminate.

Concerns about the use of data by authorities has lead to a significant number Indigenous people declining to participate in the census.

The task of data collection and management is so important that it is essential that is controlled by the Act.

There is concern as to how data is collected, how it is reported, and how it is used. Protocols are essential to the appropriate collection and use of data. These should be developed in conjunction with peak Aboriginal community bodies such as VACCHO.

For the proper planning and evaluation of Health programs it is vital to identify Aboriginal and Torres Strait Islander status. This data should be collected for hospital usage and general practitioner visits though current strategies require improvement. Data is also required for evaluating the Health Act.

Data should be collected under the Health Act to ensure its implementation and its appropriate application. Data collection should also assist the development and targeting of activities specified by the Act. In order for this to occur data collected through the Health Insurance Commission under Medicare should be able to be linked to data collected under Hospital utilisation. This information should be supplemented with the collection of data, including information on Aboriginality, collected prior to any use of the powers under the Act to contain, coerce or compel individuals or organizations.

The collection of data under the Health Act should be the responsibility of the Commissioner for Health. Disaggregated data should be available to Aboriginal peak organizations to plan health promotion and to identify any underlying discrimination.

Containment, Coercion and Compulsion

The history of treatment of Aboriginal people makes incarceration, containment and coercion particularly sensitive and traumatic issues for Aboriginal people and communities. The history resulting in the Royal Commission into Aboriginal Deaths in Custody is testament to this.

Any provisions under the Health Act which engage in methods of containment, coercion and compulsion must take the social and cultural aspects and impacts of these approaches into account.

The UN's siracusa principles would indicate that these approaches should be used as exercises of power of last resort.

Alternatives to containment, coercion and compulsion include education, community development and the provision of alternatives. These can be developed in consultation with communities. The recommendations of the Royal Commission into Aboriginal Deaths in custody can be used as guidance in drafting legislation around coercion, containment and compulsion.

Testing the draft bill with case examples and challenges

VACCHO is keen to be involved in the further development of the Act. VACCHO is keen to review drafts of the proposed Act.

In reviewing a draft we would seek to ensure that the principles outlined in this submission are included in the draft bill.

The draft health Act will be tested against hypothetical and real case scenarios as a way of evaluating how well it meets the requirements of Victoria's Aboriginal community represented by VACCHO and its members.

The following challenges as examples of the areas where the Health Act may have specific impact of concern to Victoria's Aboriginal communities.

#1 An intoxicated Indigenous person in a public space, possibly with complications of mental illness.

#2 An extended family group living under one roof in what has been defined as "overcrowded' or "unfit" conditions.

#3 LGA responsibility to establish, implement and review Aboriginal Health plans.

#4 Victorian Government responsibility to establish, oversee, implement and review Aboriginal Health plans

#5 The establishment of a 'public health commissioner' to oversee the implementation, and manage appeals and complaints under the health act.

#6 Data on the Aboriginal status of people experiencing an epidemic (of e.g. gastroentitis) is not collected by the LGA leading to a failure to identify the source of the problem and the majority community affected.

#7 The policing of people sleeping in a public area leads to their dispersal and moving into seclusion where they are less likely to be services by community service organizations to have their long term homelessness addressed.

#8 Traditional methods of preparing food are desired to be used for a community function.

#9 A hospital consistently fails to ask patients about their Aboriginal or Torres Strait Islander status.

#10 A congregation of Aboriginal People in a public space or traditional gathering place. Under what conditions can they be moved on or asked to disperse?

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