



Australian
Human Rights
Commission

everyone, everywhere, everyday

Australia the Healthiest Country by 2020

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Australian Human Rights Commission Submission
to the National Preventative Health Taskforce

2 January 2009

The Commission would like to commend the government on its commitment to achieving a healthier nation by 2020, and for its actions in this area including COAG reforms to state/territory health funding agreements. As well as setting new directions for the improvement of physical and human infrastructure, it is also critical that the Commonwealth provides national, ethical leadership. The WHO Ottawa Charter for Health Promotion, which scopes the determinants that build healthy populations, is essentially a human rights framework. The total environment – including justice, housing, education, cultural liberty, diet, social participation and economic equity (all of which are derived from the Universal Declaration of Human Rights and its associated conventions) – determines health.

The government has committed to developing an approach to social inclusion as a means to raise the standard of living of Australian citizens, especially those who are excluded *inter alia* on the grounds of disability, unemployment, indigeneity and homelessness. However, we feel there is limited recognition that one of the critical pillars of social inclusion is culture. Exclusion because of cultural barriers (including racism) is a human rights issue and has the potential to impact on more than 20% of the Australian population.

This exclusion, however, is not solely an issue of human rights neglect; it is also an issue of missed opportunity. Ignoring the cultural dimensions of health can lead to unnecessary morbidity and consequent costs to the health care system and other human services infrastructure and expenditures, as well as loss of productivity, impacting upon taxation revenues. Furthermore, understanding the health of diverse populations pays dividends in terms of research and service delivery design.

Given word restrictions for submissions, the Commission is restrained from going into these issues in detail. Whilst acknowledging the papers focus on identified priorities - this is unfortunate given the limited discussion in relation to culture (with the exception of Indigenous Australians) in this discussion paper, and other strategic-setting consultations of government are making similar, significant human rights omissions.

However, the Commission does welcome the paper's broad recognition of the determinants of health, particularly those beyond the bio-medical model and individual responsibility.

The Commission recommends and notes:

- How people feel about health, and how they conceptualize disease and healing, are all connected to culture. A national promotion and prevention strategy - in a country with approximately 20% of the community born overseas – that does not adequately address the impact of culture is potentially discriminatory and inadequate.
- Greater emphasis on other high risk groups, in particular:
 - humanitarian entrants and asylum seekers
 - members of minoritised faith communities
 - African, Central Asian, and other new and emerging communities
 - communities with low levels of functional English and/or educational attainment
 - ageing diaspora communities
 - CALD youth at risk
 - CALD individuals with multiple disadvantage
- The increased disadvantage for health, health literacy, and ability to navigate a western health care system for these communities is high.

- Where the issue of 'ethnicity' is a factor, the paper is unclear between the relationship of (variously) "ethnic background", "culture", "being born overseas" or specifically of "middle Eastern", "Pacific islander" "European" as factors linked to health risks in these groups. The implication is bio-medical deficit rather than determinants of health based links.
- Acknowledging the impact of the identified health priorities (obesity, tobacco and alcohol) the strategy potentially remains strongly disease-focused, missing the opportunity to actually tackle the social determinants of health.
- The Commission recommends the task force should consider how the health prevention strategy relates to emerging social inclusion policies that are part of a whole-of-government approach.
- The Commission recommends the current and future impact of mental health should be included. There is a high risk of individuals managing mental health problems by engaging in health damaging behaviours (such as smoking, drinking). Undiagnosed and untreated trauma experienced by humanitarian entrants is of concern.
- The established relationship between racism, discrimination, mental health (and physical) and social exclusion, be properly acknowledged.
- Addressing these issues should be undertaken in consultation with ethnic, migrant, refugee/humanitarian organisations and communities.
- A key strategy for supporting prevention (p44) is a "skilled [health] workforce". There is limited mention of the issue of health system, service and organisational cultural competency or professional development in this area. There is strong evidence that our western health system (including preventative systems) continues to be a barrier to accessing information and services by many CALD communities.

This brief submission has outlined some of the key points we feel should be considered by the task force. It is based upon published multicultural and health promotion literature both 'grey' and peer reviewed. These comments refer to issues relating to CALD background communities; they do not necessarily apply to Indigenous communities. The Commission has participated in a separate submission on the behalf of the Close the Gap Campaign Steering Committee for Indigenous Health Equality.

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