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Political determinants and Aboriginal and Torres Strait Islander women: don't leave your integrity at the political gate

Introduction

When the British colonized Australia, they did so under a paternalistic ideology that remains evident today as Australian federal, state, territory and local governments continue to implement paternalistic policies.¹ Paternalistic policies are those that restrict choices to individuals, ostensibly in their 'best interest' and without their consent.¹ The goals of such policies are to change individuals' behaviours in areas such as gambling, smoking, consumption of drugs and alcohol, or the reliance on welfare payments. The Oxford Dictionary of Philosophy² refers to paternalism as "the government being the parent", p. 270. With this definition, and the gender-specific word 'paternalism', it is little wonder that Aboriginal and Torres Strait Islander women have been the victims of extraordinarily high levels of sexism, domestic violence, marginalization, work-place lateral violence and racism.

The 2011 Australian Census³ showed that Aboriginal and Torres Strait Islander women experience poorer health than non-Indigenous women due to their life circumstances. These circumstances are evident across employment and education where 39 per cent of the Indigenous females

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were employed compared to 55 per cent of the non-Indigenous females; and 4.6 per cent overall of the Indigenous compared to 20 per cent of the non-Indigenous people have completed a bachelor degree or higher degree.³ Educational attainment and employment are intrinsically linked to economic opportunity. The higher levels of education reduce societal disadvantage. Failure to address these fundamental social determinants in early life contributes to life-long disadvantage.⁴ This paper discusses social and political determinants as major contributors to the gross inequality experienced by Aboriginal and Torres Strait Islander women.

Social Determining Factors

Social determinants of health are about “the cause of the cause”.⁵ Poorer health outcomes are not narrowed to someone’s lifestyle choice or risky behaviour. Understanding the social determinants of health requires looking at the relationship between cause, social factors and health outcomes. Social factors are those societal factors that influence health throughout life and include housing, education, access to healthcare and family support.⁴

Diagram 1 highlights an example of the circular relationship between the causes of the social factors and the social factors themselves across a person’s life stages. The unborn Aboriginal and/or Torres Strait Islander child of parents with high drug and/or alcohol intake, low income and low education will be born into an environment influenced at the macrosocial level by history, culture, discrimination and the political economy. This first stage of inequality can manifest in increasing risky behaviours such as smoking, drinking, unhealthy eating, and lack of exercise. These behaviours have been associated with intellectual impairment that continues through all life stages.⁴ Quite often, as the child moves through her or his life span, the continuous exposure to drugs and alcohol from adults becomes part of the

Diagram 1: Relationship between causes, social factors and life stages.

child's assumption of the normality of risky behaviour and the cycle continues. Alternatively, the child born into this situation may commit suicide.⁶

Inequities experienced by a person are influenced by their social and economical circumstances and are often reflected in their lifestyle choices with Australian society placing the responsibility of the choice of behaviour on the individual. Yet, the community health programmes focus on communal approaches rather than what influences individual's lifestyle choices. A failure to address the causes leading to social factors that underpin the individual's lifestyle choices reveals a half-hearted attempt by governments and institutions to understand the sociostructural causes of illness and health.⁷ When governments invest long-term resources and time into understanding the sociostructural causes of illness and health, they will be able to recognize that Aboriginal and Torres Strait Islander women are constantly subjected to unnecessary inequalities that mitigate against making positive lifestyle choices for future generations.

Structured inequities within society are based on unequal distribution of power, wealth, income and status.⁸ A woman's social class position can influence her life opportunities. The ability to move up and down the class system is directly impacted by socioeconomic position or status- including education, employment and income.⁹ This definition of socioeconomic position epitomizes the gross inequalities that continue to exist in Australian society. Inequities in health are heightened because social class not only includes education, employment and income but also differential access to power.⁹ Social class structures are characterized by factors including race, sex/gender, ethnicity, Indigeneity and religion. Fundamentally, it is structural issues of class and political disadvantage that place Aboriginal and Torres Strait Islander women close to the bottom of the socioeconomic ladder.

Political Determinants

From colonization of Australia until the present day, the policy decisions for Aboriginal and Torres Strait Islander people made by National, State and Territory governments, churches and other institutions have had dire effects on Indigenous peoples' health and well-being.¹⁰ Inequitable policies contributed to inequalities in health resulting from unequal distribution of power and resources between Indigenous and non-Indigenous people.^{11, 12} Governments have consistently failed to take a holistic view to addressing social determinants of health. Whether or not an equitable or non-equitable health outcome was the aim of those people guiding decision-making processes for social and economic policies, inequality has been the

end result.¹² The impact of these policies on Indigenous population health reflects a political failure of the system with regard to the basic human rights of Aboriginal and Torres Strait Islander people and their good health and well-being.

Denial of a human right directly violates a person's right to self-determination. These rights should be protected by a covenant to which Australia is a signatory—*The International Covenant on Civil and Political Rights* (1966) (The Covenant).¹³ It states that “all peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development” (*Article 1 Section 1*).

The level of Australia's commitment to this covenant became questionable with the implementation of The Northern Territory National Emergency Response (the Intervention) in 2007. This was a federal government action that ignored one of its own government-funded reports highlighting the critical importance of working with Aboriginal and Torres Strait Islander people in the design and implementation of initiatives for Aboriginal and Torres Strait Islander communities.¹⁴ In less than six months, following the politically motivated “Intervention” that was introduced just prior to an election, the Australian parliament introduced a complex legislative package consisting of five Bills, all 450 pages long and passed in parliament on the same day.¹⁵ The bills were primarily associated with welfare reform. In 2008, a national emergency response by the Australian government took effect and was administered across all of the Northern Territory using the political rationale ‘to protect Aboriginal children’.¹⁶

How Have These Policies Affected Health Outcomes?

Welfare data published in 2016¹⁷ show that Indigenous children in the Northern Territory were being removed from families at 9.8 times more often than that of non-Indigenous children based on ‘reforms’ in the five new ‘welfare reform’ Bills. The Northern Territory Indigenous death rates are still 2.3 times higher than those of non-Indigenous people, and Indigenous people experience assault victimization at six times the rate of non-Indigenous people.¹⁸ The 2014/2015 Social survey found that fewer than half of Aboriginal and Torres Strait Islander people aged 15 years and over were employed, and males were more than twice as likely as females to be working full time.¹⁹ The deplorable outcomes of these politically motivated policies are most clearly illustrated by the understanding that Aboriginal and Torres Strait Islander women between the ages of 20 and

24 years are four times more likely to commit suicide than are the other woman.²⁰

Failure and Responsibility of Government

These outcomes demonstrate the political failure of Australian governments at national, state, territory and local government's levels to work with the Aboriginal and Torres Strait Islander people, and the lack of integrity surrounding equitable policy administration, leadership and governance. The argument is not to suggest that Australia had deliberately created inequitable policies targeting Aboriginal and Torres Strait Islanders including women — but the outcome is the same even when the action was by omission or was not deliberate. Many policies developed for Aboriginal and Torres Strait Islanders over a long period of time have contributed to the shameful inequity in Australian society between Indigenous and non-Indigenous people. This level of inequity is even more dramatic with regard to Indigenous women.

The covenant is not the first one that Australia has signed or the first declaration or covenant that Australia has violated to the disadvantage of Aboriginal and Torres Strait Islander women—their health and well-being (and of the entire Indigenous population). Australia played a key role as one of eight nations involved in developing the United Nations' *Universal Declaration of Human Rights* with Australian Dr HV Evatt as the President of the United Nations General Assembly²¹ Until a referendum allowed Aboriginal and Torres Strait Islander people to become citizens there was scant regard to Article 2: "Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status".²²

The gap in health outcomes between Aboriginal and Torres Strait Islanders and other Australians is becoming more apparent and calls for a new and more effective response. The effects of discriminative policies are now being exposed more often – thus, they become more visible. Non-Indigenous services account for 80 per cent of Indigenous expenditure, and there is a lack of transparency and clarity evaluating how these organizations address policies developed by government for Aboriginal and Torres Strait Islander people.²³ Fifty per cent of the Indigenous Australian population is under the age of 22¹⁸ and their health, as that of their elders, remains dire. Without understanding their cultural ways of doing and knowing and without working with Aboriginal and Torres Strait Islander women in making policy decisions, there will be no progress in achieving health equality for this population group.

Conclusion

Western culture remains the dominant culture in Australian society. Its worldview has shaped Australian society and is constantly in conflict with the cultural identity and knowledge of Aboriginal and Torres Strait Islanders²⁴ including that of women. Recently, Australian Indigenous leaders have set out a blueprint for action in the *Redfern Statement*.²⁵ This blueprint acknowledges that Aboriginal people have provided solutions. Without a change in leadership attitudes, governance and administration, Aboriginal and Torres Strait Islander women will continue to be disadvantaged, and their health will continue to suffer. It is high time that Australian policymaking recognized the above issues and acted with integrity on the deficits because we will not have equality until Australia recognizes the impact of the political determinants of health as identified throughout this paper.

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