

## Indigenous health and human rights

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This article considers the gross inequality between the health status and life expectation of Indigenous<sup>1</sup> and non-Indigenous Australians and the current policy responses to it from a human rights perspective. It outlines a proposal for a human rights-based campaign for achieving health and life expectation equality within a generation (approximately 25 years).

This article is based on work first published in the *Social Justice Report 2005* of the Aboriginal and Torres Strait Islander Social Justice Commissioner (ATSISJC 2006) and now re-printed as a standalone publication titled *Achieving Aboriginal and Torres Strait Islander Health Equality Within a Generation — A Human Rights Approach* (ATSISJC 2007b).<sup>2</sup> It also draws on other work on Indigenous health completed by my office in the past year (ATSISJC 2007a).

### I. Indigenous health inequality

Over 1996–2001, there was an estimated difference of approximately 17 years between Indigenous and non-Indigenous life expectation (ABS and AIHW 2005, 148). Over 1999–2003, in Queensland, South Australia, Western Australia and the Northern Territory, 75 per cent of Indigenous males and 65 per cent of Indigenous females died before the age of 65 years, compared to 26 per cent of males and 16 per cent of females in the non-Indigenous population (ABS and AIHW 2005, 151). For all age groups below 65 years, the age-specific death rates for Indigenous peoples were at least twice those experienced by the non-Indigenous population (ABS and AIHW 2005, 152).

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- 1 Throughout this article, I refer to Aboriginal and Torres Strait Islander peoples as 'Indigenous peoples'. In doing so, I acknowledge the distinct cultures and societies of different Aboriginal peoples and Torres Strait Islanders. The term 'peoples' is also used to recognise the collective dimension of the livelihoods of Indigenous people, with distinct cultural beliefs that differentiate them as a group from other Australians.
- 2 To obtain a copy, please send your request with your name, delivery address and a check or money order for A\$20 to: Publications Officer, Human Rights and Equal Opportunity Commission, GPO Box 5218, Sydney NSW 2000; also available online at <[www.humanrights.gov.au/social\\_justice/sjreport05/chap2.html](http://www.humanrights.gov.au/social_justice/sjreport05/chap2.html)>.

There are a number of disturbing indicators and trends that reveal an entrenched health crisis in the Indigenous population. These include high rates of chronic diseases among the adult population — such as renal failure, cardio-vascular diseases and diabetes (ABS and AIHW 2005, 152). High rates of poor health among Indigenous infants do not bode well for the future adult population (ABS and AIHW 2005, 79).

Since 1973, a series of detailed strategies and national frameworks have been put in place that state the goal of achieving health equality for Indigenous peoples. The latest of these is the National Strategic Framework for Aboriginal and Torres Strait Islander Health, which is designed to guide the national response to Indigenous health equality over 2003–2013 (NATSIHC 2003).

However, while there have been improvements made in some areas since the 1970s (notably in reducing high rates of infant mortality), overall progress in equalising the health status of Indigenous and non-Indigenous Australians has been slow and inconsistent (Thomson 2003, 490). Overall, the inequality gap between Indigenous peoples and other Australians remains wide and has not been progressively reduced.

A major failing in the approach of Australian governments to date is that they have not 'activated' their commitments to Indigenous health equality by setting them within an achievable timeframe, linking them to time-bound targets and benchmarks, as required in human rights-based approaches. Governments have instead left the achievement of equality to an unspecified future time. By doing so, all Australian governments have been unaccountable for progress in achieving Indigenous health equality and they have not matched their commitments with the necessary funds and program support to realise them.

It is not a lack of financial resources that is the cause of this implementation failure, but a lack of political will. Introducing accountability into the approach of Australian governments to Indigenous health equality through the use of time-bound health equality targets and benchmarks is vital if their existing commitments to Indigenous health equality are to be realised in the near future.

### *Inequality of opportunity to be healthy*

The inequality in health status and life expectation endured by Indigenous peoples is linked to systemic discrimination over many decades and its legacy in the present day. In particular, Indigenous peoples today do not have an equal opportunity to be as healthy as non-Indigenous Australians in relation to primary health-care services and health infrastructure, and both of these are subject matters of the right to health (UNCESCR 2000).

Equal access to primary health care has long been recognised as being vital to ensuring health equality between population groups, and particularly vital as part of an address to chronic diseases which, as noted, are found in significantly higher rates in the Indigenous, compared to the non-Indigenous, population (Dwyer et al 2004, xii–xiii).

In this light, it is disturbing that in 2004 it was estimated that Indigenous peoples enjoyed 40 per cent of the per capita access of the non-Indigenous population to primary health care provided by mainstream general practitioners (Britt et al 2002, 114). There are many reasons for this. Because a higher proportion of the Indigenous population live in rural and remote areas, the shortage of medical professionals in these areas has a greater impact on Indigenous peoples when compared to the non-Indigenous population (ABS and AIHW 2005, 5). In fact, many remote communities have only basic health-care facilities (ABS and AIHW 2005, 182). Even where services are available, Indigenous peoples also have significantly less access to motor vehicles to get them there (ABS and AIHW 2005, 183).

However, Indigenous peoples do not tend to use mainstream primary health care, even where it is otherwise available and physically accessible — for example, in urban areas (CGC 2001, 116 and 135). Fees charged for health services (including top-ups charged by general practitioners) will act as a greater barrier to Indigenous peoples' access to the services than for the non-Indigenous population (ABS and AIHW 2005, 183). Non-use can also be attributed to a lack of cultural 'fit' for Indigenous peoples — for example, language barriers, or the perception that mainstream services are not welcoming to Indigenous peoples (ABS and AIHW 2005, 184–85). Australian governments have long accepted the importance of maintaining distinct health services in urban centres for Indigenous people as a consequence of this.

Per capita Medicare under-spend estimates have been used to assess the quantum of the Indigenous primary health-care shortfall. Estimates of the shortfall range from \$250 million per annum (Deeble 2003, 5) to \$570 million per annum, depending on the quality of service offered (Econtech 2004, xi). However, the true extent of the shortfall is not known, and there is a need for an audit of health services, particularly primary health-care services, in Indigenous communities in order to arrive at an authoritative quantification.

'Health infrastructure' is a term used here to describe all the things that support good health but are not health services. Examples include potable water supplies, healthy food supplies, healthy housing, sewerage and sanitation, and so on. A high standard of health infrastructure, particularly housing, in communities is associated with high health status (AIHW 2005, 39).

In relation to health infrastructure, a century of neglect in Indigenous communities has left what could be a \$3–4 billion project for this generation (ATSIC 2001). It was estimated in 2001 that, at the current rate of funding, it would take at least 20 years to achieve an equal standard of health and other necessary infrastructure in Indigenous communities (ATSIC and CRCATH 2002, 10). Housing in particular is recognised to be of a much lower standard in Indigenous communities, as compared to that in non-Indigenous communities (AIHW 2007, 211; AIHW 2005, 27–54). Overcrowding is a particular health concern (AIHW 2005, 39).

### *Social determinants*

Outside of the scope of the right-to-health subject matters, a wide range of social factors (such as income, educational achievement and so on) determine good or bad health in a population group. These are known as the ‘social determinants’ of health. In parallel with social determinants theory, it is a basic tenet of human rights law that political, civil, cultural, social and economic rights are interconnected: that impacting on the enjoyment of one right will impact on the enjoyment of others.

Research has demonstrated associations between an individual’s social and economic status and their health. In short, poverty is clearly associated with poor health (Marmot and Wilkinson 1999). Indigenous peoples in Australia experience socioeconomic disadvantage on all major indicators (ABS 2002).

Psychosocial stress is unhealthy, chronic stress that contributes to poor health (Shaw et al 1999, 32–37). It arises when an individual perceives that they have little or no control over their environment: their life, their family’s life and their community’s life (Brunner and Marmot 1999, 17). It can impact on the body’s immune system, circulatory system and metabolic functions through a variety of hormonal pathways and is associated with a range of health problems, from diseases of the circulatory system (notably heart disease) (Brunner and Marmot 1999, 32–37); mental health problems (Marmot 1999, 124); violence against women; and other forms of community dysfunction (Wilkinson 1999, 260–65).

While poverty is an example of a social determinant that will impact on both Indigenous and non-Indigenous Australians, there are some social determinants evident in Australia that will only impact on Indigenous peoples.

The unfinished business of colonisation and ongoing second-class status afforded Indigenous peoples in Australian society is an example. This includes the ongoing difficulty with reconciliation and the ongoing uncertainty surrounding the issues of land, control of resources, cultural security and the rights of self-determination and

sovereignty, as well as issues surrounding the ongoing, intergenerational impacts of the Stolen Generations practices on many Indigenous Australians (ABS and AIHW 2005, 143).

Racism too is likely to affect the social and emotional (as well as mental and physical) health of Indigenous Australians in a way not experienced by most other Australians (Williams et al 2003, 200).

To the degree that recognising Indigenous peoples' right to self-determination supports communities to regain control of their lives, including through the maintenance of traditional cultures (Zubrick et al 2005, 102), it can be understood as having positive health impacts (UNCESCR 2000). It is also a stepping stone to the goal of social and economic equality. Experience from overseas confirms that Indigenous communities' control over their own affairs can be crucial to their social and economic regeneration (Cornell 2002). In terms of the right to health, this principle is also reflected in Indigenous communities' right to control their health services, re-affirmed in Art 23 of the Declaration on the Rights of Indigenous Peoples.

### *Policy responses to Indigenous health inequality*

There have been a number of developments in Indigenous policy over recent years in which Australian governments have made a major priority of commitments to addressing Indigenous health inequality.

At a general level, through the processes of the Council of Australian Governments there is now a joint commitment from all governments in Australia to coordinated service delivery with the objective of addressing Indigenous disadvantage, including health inequality. Progress in addressing these commitments is able to be measured against the Overcoming Indigenous Disadvantage Framework on a biennial basis (SCRGSP 2005).

In addition to these general commitments, specific commitments have also been made at the inter-governmental level to address Indigenous health inequality, notably the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013 (NATSIHC 2003) (or the National Strategic Framework).

To summarise, the National Strategic Framework has as its goal the achievement of Indigenous health equality, but it does not set a timeframe, or targets or benchmarks, for achieving this. In particular, it contains a commitment to providing Indigenous communities with 'comprehensive' primary health care and it recognises the importance of addressing a wide variety of related issues outside of the health sector

which have an impact on the wellbeing of Indigenous peoples (NATSIHC 2003, 13). A number of national strategies and commitments in relation to environmental health workers, housing and the supply of food have also been developed under the umbrella of the National Strategic Framework.

The combination of these commitments and defined policy approaches provides a substantial foundation from which to address Indigenous health inequality. However — and crucially — the accountability mechanisms attached to these commitments are minimal and ineffective and are not linked to timeframes, targets and benchmarks. Governments have instead left the achievement of equality to an unspecified future time.

But there is no reason for the lack of urgency evident in policy. Evidence shows that dramatic improvements in health status can be achieved, and that gains on many issues can occur within even short timeframes. Other comparable countries have made greater progress in improving the health status of indigenous peoples in short timeframes (NATSIHC 2003, 12).

## II. The human rights-based approach to health

This section outlines the human rights-based approach to health. Human rights provide a framework for addressing the consequences of the health inequality experienced by Indigenous peoples in Australia. They provide a system to guide policy making and to influence the design, delivery and monitoring and evaluation of health programs and services. It is also a system for ensuring the accountability of Australian governments for Indigenous health.

There are three main issues at the international level which are drawn on in setting out a human rights-based approach to health. These are the application of overarching principles of non-discrimination and progressive realisation in the context of the right to health; the recognition in international practice of the connection between human rights standards and participatory development processes; and the content of the right to health itself.

### *Non-discrimination and the progressive realisation principle*

Article 2 of the International Covenant on Economic, Social and Cultural Rights states that:

1. Each State Party to the present Covenant undertakes to take steps ... to the *maximum of its available resources*, with a view to *achieving progressively* the full realization of

the rights recognized in the present Covenant by *all appropriate* means, including particularly the adoption of legislative measures.

2. The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. [Emphasis added.]

The non-discrimination principle outlined above (in Art 2(2)) applies to all human rights. It establishes a baseline position that all people are entitled to be treated equally and to be given equal opportunities.

There are two key features of governments' obligation 'to take steps' in Art 2(1). First, it requires governments to introduce specific measures to address the lack of equality experienced by a particular group within society, such as Indigenous peoples.

Each of the main human rights treaties contains a provision which encourages (and indeed requires) governments to redress inequality in the enjoyment of economic, social, cultural or civil and political rights. For example, Art 2(2) of the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) requires governments to pay attention to the socioeconomic situation of ethnic or minority groups 'in order to ensure that their development in the social, economic and cultural spheres takes place on an equal footing with that of the general population' (Valencia Rodriguez 1991, 131).

These provisions are sometimes referred to as 'special measures' provisions. They are a form of differential treatment that is considered non-discriminatory. This is because they are aimed at achieving substantive equality *or* equality 'in fact' *or* outcome — to raise the disadvantaged group to a position of actual equality with the advantaged group.

The rationale for such measures is that 'historical patterns of racism entrench disadvantage and more than the prohibition of racial discrimination is required to overcome the resulting racial inequality' (Race Discrimination Commissioner 1997, 40). Special measures are time limited, in that they can only be justified for so long as there is a situation of inequality which they are aimed at redressing. They cannot, therefore, lead to the maintenance of separate rights for different racial groups and are not to be continued after the objectives for which they were taken have been achieved (UNCESCR 1991).

Second, the obligation 'to take steps' in Art 2(1) also means that governments must progressively achieve the full realisation of relevant rights, and do so without delay.

Steps must be deliberate, concrete and targeted as clearly as possible towards meeting the obligations recognised in the Covenant (UNCESCR 1991).

This approach requires that governments identify appropriate indicators, in relation to which they should set ambitious but achievable benchmarks, so that the rate of progress can be monitored and, if progress is slow, corrective action taken. Setting benchmarks enables government and other parties to reach agreement about what rate of progress would be adequate. Such benchmarks should be specific, time bound and verifiable; set with the participation of the people whose rights are affected, to agree on what is an adequate rate of progress and to prevent the target from being set too low; and reassessed independently at their target date, with accountability for performance (United Nations Development Programme 2000).

### *The human rights-based approach to development*

There have been a number of developments at the international level in recent years which have seen a clearer understanding emerge of the relationship between human rights and development and poverty eradication.

These have emerged largely as a result of the objective set in 1997 by the Secretary-General of the United Nations, Kofi Annan, to mainstream human rights into all UN activities. This has been reaffirmed through the Millennium Declaration of 2000 and the commitment of all countries to achieve the Millennium Development Goals (MDGs) by 2015.

The focus of the MDGs is very much centred on developing nations. The usual context in which the involvement of countries like Australia is discussed is in relation to international aid, technical assistance and debt relief. But the implications of this focus on poverty eradication clearly relate to the situation of Indigenous peoples in Australia. It is ironic that the Australian Government has committed to contribute to the international campaign to eradicate poverty in third world countries by 2015, but has no similar plans to do so in relation to the extreme marginalisation experienced by Indigenous Australians.

One of the most significant outcomes of this focus on integrating human rights and development and poverty eradication activities has been the agreement among the agencies of the UN of the Common Understanding of a Human Rights-based Approach to Development Cooperation (UN 2003)

This document outlines the human rights principles that are common to the policy and practice of the UN bodies. The Common Understanding states that these



principles are intended to guide UN programming in relation to health, among other issues. This includes all development cooperation directed towards the achievement of the MDGs.

The Common Understanding has three principles: namely, that all programs, policies and technical assistance should further the realisation of human rights; that human rights standards guide all development cooperation and all phases of programming; and that development cooperation contributes to the development of the capacity of 'duty-bearers' to meet their obligations and of 'rights-holders' to claim their rights (UN 2003).

### *The right to the enjoyment of the highest attainable standard of health*

Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) recognises 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. This right is reaffirmed at Art 24(2) of the Declaration on the Rights of Indigenous Peoples.

The key elements of this right are that it is not a right to be healthy; rather, it is a right to opportunities to be healthy. This includes the right to 'the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health' (UNCESCR 2000). Of note, this includes health services and health infrastructure, discussed previously.

And vitally, across the citizens of any state, it is the right to an equal opportunity to be healthy regardless of race, sex and so on. This means not only that health services and health infrastructure should be available in the first place, but that these should be accessible to everyone without discrimination — that is, physically accessible (reachable) and economically accessible (affordable). It is also vital that they be acceptable in terms of the cultures of the peoples using them (UNCESCR 2000).

To realise this provision of opportunities and equal opportunities to be healthy, effective national planning is essential. Designing accountability mechanisms is an essential part of the planning process and should involve identifying appropriate right-to-health indicators and benchmarks. These should include provisions on the targets to be achieved and the timeframe for their achievement (UNCESCR 2000).

Specifically in relation to Indigenous peoples, the UN Committee on Economic, Social and Cultural Rights has advised governments that Indigenous peoples in many cases

have the right to special measures to advance their health, and that health services should be 'culturally appropriate, taking into account traditional preventive care, healing practices and medicines' (UNCESCR 2000).

### III. Indigenous health inequality and Australia's compliance with its human rights obligations

There are two aspects of the current health situation faced by Indigenous peoples in Australia that raise concerns in terms of human rights compliance.

The first is that the extent of health inequality experienced by Indigenous peoples raises issues of compliance with Australia's human rights obligations. The size of the inequality gap indicates the need for urgent attention to this issue and has been highlighted by a series of UN committees (United Nations Committee on the Rights of the Child 2005; United Nations Committee on the Elimination of Racial Discrimination 2005). This has been acknowledged by successive governments in Australia (Australian Government 2004a, 2004b).

The second issue to consider receives less attention — namely, whether the current processes in place to address Indigenous health inequality comply with the key elements of the human rights-based approach to health.

The human rights-based approach to health is practical in that it acknowledges that inequality and discrimination may be the result of long-term — perhaps even historical — treatment and cannot be overcome in the short term. While a rights-based approach does not excuse such inequality, it is primarily focused on considering the steps that are currently being taken by governments to address this situation.

Accordingly, it is focused on determining the *suitability* of the steps being taken. For example, do the steps taken by government respect, protect and fulfil the right to the highest attainable standard of health for Indigenous peoples? Are programs and services accessible, available, appropriate and of a sufficient quality? Do they involve the full participation of Indigenous peoples? Do they target the systemic barriers faced by Indigenous peoples?

It is also focused on determining the *adequacy* of the steps being taken. For example, are they meeting core minimum obligations? Are they resulting in a progressive improvement in the realisation of the right to health for Indigenous peoples? Is the rate of progress sufficient, given the extent of the inequality? Do data collection, performance monitoring and evaluation processes exist which enable progress to be

monitored? Are programs targeted, delivered and financed at a level that is capable of addressing the level of inequality?

From this perspective, there are a number of aspects of the current approach to Indigenous health that *do* meet the requirements of the human rights-based approach to health. In terms of positives, Australian governments have committed, through the National Strategic Framework, to the goal of achieving health equality for Indigenous peoples, including the provision of comprehensive primary health care to communities through the use of Aboriginal Community Controlled Health Organisations. The participation of Indigenous peoples in the design of Indigenous health programs, as set out in the National Strategic Framework, is also in line with human rights approaches (NATSIHC 2003).

But there are also aspects of the current approach that *do not* meet these requirements — notably that the National Strategic Framework does not reflect the progressive realisation principle by including time-bound targets and benchmarks. And, outside the health sector, there is an absence of an overarching strategic response to public health issues (notably health infrastructure) faced by Indigenous peoples.

#### IV. The campaign for Indigenous health equality

Perhaps the factor that is most striking, in its absence from the current framework, is the lack of a timeframe for achieving Indigenous health equality. The absence of such timeframes promotes a lack of accountability of governments. It sends a tacit message that it is fine for things to simply drift along.

Such targets, of course, need to be linked to the capacity of the health sector. The progressive realisation principle, however, requires that this be done *in a time-bound manner* and as expeditiously as possible. Resourcing should be increased to the maximum extent possible and rolled out in accordance with regional plans and benchmarks.

In relation to the health equality campaign proposed in the *Social Justice Report 2005* (ATSISJC 2006), the campaign proposes that Australian governments commit to achieving equality of health status and life expectation between Indigenous and non-Indigenous people within 25 years. This recommendation seeks to place a time dimension on the goal and aims of the National Strategic Framework for Aboriginal and Torres Strait Islander Health, as well as on the commitments of the Council of Australian Governments to overcome Indigenous disadvantage. It aims to provide a long-term vision to focus government activity.

There is sufficient evidence to demonstrate that such an improvement in Indigenous peoples' health status is achievable in this timeframe. International figures demonstrate that optimally and consistently resourced primary health-care systems can make a significant difference to the health status of populations, as measured by life expectancy, within a decade. For example, during the 1940s and 1950s in the United States, Native American life expectancy improved by about nine years, and an increase in life expectancy of about 12 years took place in Aotearoa/New Zealand over two decades from the 1940s to the 1960s. Figures from within Australia demonstrate dramatic improvements in infant mortality (for example, in Central Australia, from 200 per 1000 in the mid-1960s to around 50 per 1000 by 1980) through the provision of medical services (Dwyer et al 2005, 40). A number of programs in Australia have also achieved rapid improvement in Indigenous peoples' health in response to specific program interventions. For example, death rates among Indigenous people from pneumonia have dropped 40 per cent since 1996 due to the rolling out of pneumococcal vaccinations (Ring and Brown 2002); and the Strong Babies, Strong Culture program has shown that significant reductions in the number of low-birth-weight babies can occur within a matter of years (ABS and AIHW 1999, 87).

This target cannot stand in isolation. It must be supported with the establishment of other, more detailed, targets and benchmarks on a number of discrete, smaller indicators relating to health status that can exist over the short and medium term. The Overcoming Indigenous Disadvantage Framework and the Aboriginal and Torres Strait Islander Health Performance Framework provide an appropriate basis for establishing time-bound targets and benchmarks in the short and medium term across a variety of contributing areas that should ultimately contribute to the achievement of equal rates of life expectancy.

Such targets and benchmarks also need to be developed at a regional level and with recognition of the variations in health status between communities. Additional work is required to ensure that data collection methods can support such disaggregation and account for regional variations.

In addition, broader commitments at the level of the Council of Australian Governments to address Indigenous disadvantage can also improve Indigenous health to the degree they address the social determinants of health.

Inequality of opportunity for Indigenous peoples must be addressed as a foundation element of the campaign: the campaign recommends that Australian governments should also commit to achieving equal access to primary health care and health infrastructure within 10 years for Indigenous peoples.

This will require improving processes to ensure needs-based assessment of resource allocations, as well as targets and benchmarks across a range of matters. An equitable distribution of primary health care rests on a prior effort to increase the numbers of health professionals to provide the services. It was estimated in 2001 that 500 new general practitioners and over 3000 new nurses and Aboriginal health workers were needed (Deeble 2003, 5).

Aboriginal community controlled health organisations have a vital role to play in the provision of primary health care. There should be continued support for Aboriginal community controlled health services. Aside from giving effect to the right of Indigenous peoples to self-determination, there is evidence that they are a highly effective means for delivering primary health care (Dwyer et al 2005, 91–106).

The expansion of community controlled health services must take place alongside efforts to improve the accessibility of mainstream services. It should also be accompanied by health-care programs focusing on specific diseases. If, through these programs, early-stage symptoms are detected, not only can suffering be prevented, but cost savings can be made.

Addressing the Indigenous health funding shortfall is a shared responsibility between levels of government. Generally, the funding of primary health care is a responsibility of the federal government — but savings made here can prevent engagement of Indigenous peoples with the secondary and tertiary systems, which are predominately responsibilities of the states and territories. The states and territories also have significant responsibilities for service delivery in areas which impact on health outcomes, such as housing.

In light of the comprehensive national frameworks and strategies in place, it would appear that there exists a solid basis for governments to work together to address the projected funding shortfall. Additional funding to the states and territories could be made contingent on the agreement of states and territories to match federal contributions. This was done in the negotiation of the Australian Health Care Agreements for 2003–08 (Prime Minister 2003).

## **Conclusion**

The failure of the policies and programs of the past 20 years to achieve significant improvements in Indigenous health status, let alone to reduce the inequality gap, reveal two things that Indigenous peoples and the general community can no longer accept from governments.

First is the making of commitments to address Indigenous health inequality *without* putting into place processes and programs to match the stated commitments. Programs and service delivery must be adequately resourced and supported so that they are capable of achieving the stated goals of governments.

Second, and conversely, is the failure of governments to commit to an urgent plan of action. It is not acceptable to continually state that the situation is tragic and ought to be treated with urgency, and then fail to put into place bold targets to focus policy making over the short, medium and longer term, or to fund programs so that they are capable of meeting these targets. A plan that is not adequately funded to meet its outcomes cannot be considered an effective plan. The history of approaches to Indigenous health reflects this: Australian governments have proved unwilling to fund Indigenous health programs based on the need and, as a result, plans have failed.

Addressing inequality in health status is not insurmountable, although it will require long-term action and commitment. Committing to a 25-year campaign timeframe to achieve this is feasible. It is also a long time in which to accept that inequality would continue to exist.

Over 40 Indigenous and non-Indigenous organisations are currently working in partnership for Australian governments to commit to the campaign for achieving Indigenous health equality within 25 years. In December 2006, the coalition published an open letter calling for an end to Indigenous health inequality in *The Australian*. In April 2007, Olympians Catherine Freeman and Ian Thorpe helped launch the campaign at the Telstra Stadium in Sydney. The partners are currently working towards hosting a National Indigenous Health Summit in March 2008, at which we are hoping Australian governments will adopt the campaign targets.<sup>3</sup> ●

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3 For more information about the campaign, and in order to show your support for it, see the Commissioner's campaign webpage at <[www.humanrights.gov.au/social\\_justice/health/index.html](http://www.humanrights.gov.au/social_justice/health/index.html)>.

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