A Public Lecture By Mr Warren Mundine
4 October 2013

Thank you to Marie Ellis for her Welcome to Country on behalf of the Arrernte nation. I also would like to acknowledge and pay respect to the traditional owners of the land on which we meet and also to acknowledge and pay respect to my own Bundjalung and Gumbaynggirr ancestors.

It’s great to be here tonight in Alice Springs. I’d like to start by thanking Professor Paul Zimmet AO for inviting me to give tonight’s Oration and also to Baker IDI Central Australia and its team for hosting me.

It’s been a busy time since the Prime Minister formally appointed me to Chair his Indigenous Advisory Council. A change of government always puts people on high alert, especially in areas like Indigenous affairs which are so impacted by government.

I understand the uncertainty that change brings. However, I genuinely believe that our new Prime Minister, Mr Tony Abbott, and Minister for Indigenous Affairs, Senator Nigel Scullion, want to see real improvements for Indigenous people and to close the gap between Indigenous and non-Indigenous Australians, as all people should. And they, and I, are determined to make it happen. We believe there is no better time than now to achieve real change. Corporate Australia, Business, the Australian community and Indigenous people are all supportive. And for the first time there is an Indigenous person in the Prime Minister’s office.

We are here today to talk about Indigenous health. And the reason we talk about Indigenous health is because Indigenous people generally have significantly poorer health than other Australians and typically die much younger.

I have already reached the life expectancy of an Indigenous male of my generation. And last year I nearly became a statistic too, undergoing quintuple by-pass surgery after the doctors found a
75% blockage in the main artery to my heart. I also have diabetes. I have previously been obese. Fortunately I’ve never smoked or I would be dead.

The bad news for my detractors is that as long as I look after my new arteries I could well live to be 90 like my father did, and I fully intend to.

But having passed my statistical life expectancy and cheated death I now live - psychologically at least - on borrowed time.

So I no longer have the time or the patience to wait while the gap between Indigenous and non-Indigenous Australians in health and life expectancy stagnates or closes at a glacial pace. And I no longer have the time or patience to mince my words.

We can only close the gap between Indigenous and non-Indigenous Australians in health by properly addressing the socio-economic standing of Indigenous people. We can only do that by looking at this issue through an economic and commercial lens.

In preparing for this speech I looked through some of the statistics in Indigenous health. Although not news to me, the figures are quite staggering.

- Cardiovascular disease death rates are almost 2 times higher for Indigenous people.
- End-stage kidney disease is 6 times higher among Indigenous Australians, and Indigenous people are 8 times as likely to begin dialysis or receive a kidney transplant.
- Indigenous people are almost 4 times as likely to die of kidney disease.
- Type 2 diabetes rates for Indigenous men are 3 times higher and for Indigenous women it is 4 times. I actually don’t think I know any Indigenous people over the age of 40 who don’t have Type 2 diabetes.
- Around 7% of Indigenous deaths are caused by alcohol, including deaths from suicide, road accidents, assault, liver cirrhosis or stroke.
- Alcohol-related injury from traffic accidents is 20% to 30% higher for Indigenous people. Indigenous men and women, respectively, are assaulted at 6.2 and 33 times that of other Australians and half the assaults are alcohol-related.
- Life expectancy for Indigenous boys born between 2005 and 2007 is about 67 years and for Indigenous girls about 73 years. In both cases this is around 10 years less than for non-Indigenous Australian children born in the same period.

Now I know that improvements have been made in many areas in recent years. Baker IDI told us this afternoon that the Northern Territory is the only part of Australia that is meeting its Closing the Gap targets in health. That is great news and a credit to health professionals and organisations on the ground here. And we need to keep up that momentum and particularly focus on prevention and reducing the risk factors that are associated with poor health.

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Four of the leading risk factors in Type 2 diabetes, cardiovascular disease and chronic kidney disease are physical inactivity, being overweight or obese, poor diet and tobacco smoking. Excessive drinking is also a leading risk factor for cardiovascular disease.
So it is not surprising that the statistics for these risk factors are also not good for Indigenous people.

About half of the Indigenous population smoke daily, twice that of other Australians. Overweight and obesity is about 1½ times higher for Indigenous women. (There’s not much of a gap for Indigenous and non-Indigenous men – basically the weight statistics for all Australian men are not great.)

Indigenous people are more likely than non-Indigenous Australians to be sedentary or to exercise at low levels. This isn’t surprising given the high rate of Indigenous unemployment and incarceration. People who don’t have much to do generally don’t do much.

One of the biggest areas of concern for me is maternal health and the health of babies born to Indigenous mothers. These children represent the future of Indigenous people. Many of them enter the world already well behind non-Indigenous babies in terms of health.

Indigenous people are over-represented at both ends of the spectrum of alcohol statistics. On the one hand, a higher percentage of Indigenous people than non-Indigenous don’t drink at all. However, at the other end of the scale, a higher percentage of Indigenous people in the late teens, early 20s and over 35s age groups drink at risky or high risk levels.

Cardiovascular disease is more common in regional and remote Australia, where about two-thirds of Indigenous people live. It is also higher among people from the lowest socioeconomic groups.

These aren’t just statistics of course. These are real people. Some of whom are friends and family of people in this room, including me. Some of whom are not too far from where we are right now. On the way to my hotel coming in from Alice Springs airport this afternoon, we drove past the Emergency department of the hospital. Outside were perhaps a dozen people who are living examples of the gap in Indigenous and non-Indigenous health: Aboriginal people in wheelchairs with amputated limbs; in a cast and neck brace from an accident or perhaps an assault; some drinking sugary drinks; obese and/or smoking. And some of them had young children with them.

One of the biggest areas of concern for me is maternal health and the health of babies born to Indigenous mothers. These children represent the future of Indigenous people. Many of them enter the world already well behind non-Indigenous babies in terms of health. Instances of foetal alcohol syndrome and low birth weight are higher in Indigenous babies. These have long term and in some cases irreversible health consequences.

This afternoon Professor Zimmet was telling my wife and me about just how long term and irreversible the consequences of poor maternal health can be. We know that diabetes, poor nutrition, smoking and alcohol misuse during pregnancy can harm unborn babies. There is a growing body of data which suggests that this harm can be permanent; that poor maternal health can permanently change how the baby’s genes react to their environment.

For example, children born during the Dutch winter famine last century showed increased instances of diabetes, heart disease, obesity, schizophrenia and impaired cognition, many problems surfacing 30 to 40 years later. In China, a sharp increase in the rates of diabetes and heart disease is thought to be the result of damage done in-utero during famine under the rule of Mao Zedong.
Even for something as basic as dental health, Indigenous people are behind. They have higher rates of tooth decay and higher severity of decay. Tooth decay is caused by poor diet and poor oral hygiene. It’s a fair bet that those Indigenous parents who can’t get their kids to school are also not getting them to brush their teeth or paying much attention to what they eat.

Dental health is also worse in communities without fluoridated water, one of the most successful and cost-effective ways to improve dental health. However, remote and very remote areas - where 21% of Indigenous people live – are often not connected to town water and do not have fluoridation. By contrast only 2% of non-Indigenous Australians live in those areas.

Access to health services by Indigenous people is also an issue. Whilst, most Indigenous people live in urban or semi-urban areas, the population distribution of Indigenous people is more skewed to outer-regional, remote and very remote areas. About two-thirds of non-Indigenous Australians live in major cities whereas only a third of Indigenous Australians do. So Indigenous people tend to live in areas where there is generally lower access to services of any kind.

As many of you would know, some Indigenous people fear hospitals, particularly older people and those living in traditional communities. Some are also reluctant to see non-Indigenous health workers. These kinds of fears and hesitations are fairly common amongst colonised peoples.

All of this further contributes to the health gap.

I could go on all night quoting facts and statistics but it all paints a singular picture - a tapestry of interconnected health problems, risk factors and social issues that all contribute to and reinforce each other.

We were a family of 13 but at any given time we had up to 20 people living in the house; like extended family members who needed to be near Grafton hospital or sick relatives whom my mother was looking after.

My father worked as a grader driver which was a good job for an Aboriginal man back then. Still, there wasn’t a lot of income to feed and house us all. There were many nights my mother didn’t eat a meal. From time to time the bills went unpaid and the utilities were cut off.
Like most poor families we had a very basic diet – sausages, offal, potatoes, bread. Meat and fruit were expensive - chicken was a treat and we grew fruit and vegetables in the backyard. A meal I loved as a kid was Johnny Cakes – damper fried in dripping.

We were an example of the working poor. But at least we were working and my father had secured equal pay through his union. My parents sent us to Catholic schools which were not segregated and we were educated in classrooms side by side with non-Aboriginal children.

Many Aboriginal people were doing much worse: working for tea, bread and damper and meagre (if any) wages; living on missions; not able to attend mainstream government schools; living under the complete control of government or the mission managers.

In the early 1970s there was a major shift in Indigenous policy in Australia. The law was changed to mandate equal pay for Indigenous people and the government provided them with a welfare framework. Many Aboriginal people working as stockmen or domestics lost their jobs. The station owners were not willing or able to pay them full wages. Those people became full time recipients of government assistance. They received money and services from the government for which they didn't have to do anything in return.

Indigenous people were also given the same rights and entitlements as non-Indigenous Australians, including an entitlement to drink alcohol. Mission schools were closed and Indigenous children could go to government schools, although some communities did not have an established government school.

Indigenous people embarked on a new existence, ushered to live into town camps and other settlements; missions became former missions. There they would receive housing and other services and be taken care of. The older people coined the phrase “sit-down money” – and they weren’t being complimentary. People who had worked all their lives found it demoralising and insulting to lose their jobs and abruptly become unnecessary; their contribution no longer valued.

You see, my family were the fortunate ones. Poor but still working. Living independently. Not sitting down.

My family lived in poverty but still we lived relatively well compared to other Indigenous families. It’s therefore not hard to see why Indigenous health today is so bad and why there exists such a huge gap between Indigenous and non-Indigenous health and life expectancy.

Poverty is both a cause and a result of poor health. People living in poverty live in environments that make them sick – with inadequate housing or overcrowding, for example. Poor health in turn keeps people and communities in poverty.

Worse still if you are poor and not working. The sit-down money provided to Indigenous people for the last four decades has kept them in poverty. My family eventually lifted out of poverty because we worked. My parents lived

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better than my grandparents. My siblings and I lived better than my parents. Our children and grandchildren, in turn, live better again.

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If we want to lift people out of poverty then we need to get it right in three crucial areas – education, employment and the economy.

The most effective way to get people out of poverty is to get them into a job. For that they need an acceptable level of education and they need to live in a real economy. Many Indigenous people don’t.

I have written and spoken extensively on this over the past year and I would urge you to read the speech I gave at the Garma Festival in August. The full speech is published on the Australian Indigenous Chamber of Commerce website and an edited version was published in The Weekend Australian.

The failures in Indigenous health are a subset of a broader failure of Australia’s strategy in Indigenous affairs over forty years. Like health, there are a myriad of interconnected problems and issues in Indigenous affairs that all contribute to and reinforce each other.

In my Garma speech I spoke about the need for commerce in Indigenous communities to create jobs and social stability, education and training to enable those communities to have a job-ready workforce and the right conditions for investment.

At the moment there are not enough jobs in remote Indigenous communities, not because of remoteness but because there is almost a complete absence of commerce.

There are more jobs in urban communities but too many lack the education or training to fill them or are trapped in inter-generational welfare dependency.

This is not just a problem for Indigenous people I might add. I think Noel Pearson was one of the first to warn that inter-generational welfare dependency in some suburbs of Australia’s major cities would take those communities down the same path as dysfunctional Indigenous communities. I expect the health statistics in those populations are also pretty bad.

Education, employment and economy can provide a ladder for Indigenous people to lift out of poverty. And ensuring good maternal health is essential to the long term health futures of Indigenous people. These will be the most fundamental and effective contributors to better Indigenous health.

One of the things we need to do as a matter of utmost priority is get more Indigenous people working in the health sector. Improving Indigenous health is not just about Indigenous people as patients. We also need Indigenous people to be health workers.

Of course we also have to address the immediate health crisis amongst Indigenous people and reduce the risk factors, like smoking, diet, alcohol misuse and physical inactivity.
One of the things we need to do as a matter of utmost priority is get more Indigenous people working in the health sector.

Improving Indigenous health is not just about Indigenous people as patients. We also need Indigenous people to be health workers. We need more Indigenous doctors, nurses, midwives, researchers, dentists, dental hygienists, physiotherapists, occupational health therapists, optometrists, disability carers, aged care workers and I could go on.

Training and actively encouraging Indigenous people to work in the health sector addresses Indigenous health in many ways. Firstly, it means putting Indigenous people in jobs, which is the best way to lift them out of poverty.

Secondly, it should help improve access to health services in remote and regional Australia. Demand for health services in remote and regional areas usually outweighs supply. We also know that the Indigenous population is skewed towards remote and regional areas. People who come from those areas are also more likely to want to work there. So if more Indigenous people from remote and regional communities who work in the health sector, it should help meet the demand for health services on the ground.

Thirdly, and very importantly, having Indigenous people as health providers helps to address the fears and reluctance of some Indigenous people to access services. Overall, Indigenous people will be more likely to access health services if there are more Indigenous health providers.

I think there may be a perception that the health sector involves high-skilled jobs that are more likely to be out of reach for Indigenous people - that it’s better to start with lower skilled industries for long-term Indigenous unemployed. Sure, it takes a long time to become a doctor or a researcher. All the more reason to be focussed now on the increasing number of young Indigenous people who are getting a first rate education.

But not every job in the health industry is high skilled. For every high skilled professional job there are many supporting, administrative and lower skilled jobs that don’t require a University degree. Some even provide a pathway to higher skilled jobs in the future.

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Indigenous employment is not all about mining and trades. The health and disability sectors in Australia are huge employers and we need to get Indigenous people working in those sectors too.

Baker IDI Central Australia is a great example of how health services with Indigenous health professionals on staff can make a difference.
We must also be willing to think innovatively and not be tied down by “how-we’ve-always-done-things”. Because we know that how-we’ve-always-done-things hasn’t yet achieved a closing of the gap.

I think it is important to set objectives and targets with real timeframes. In recent years I have been involved with the initiative to train 1000 Indigenous accountants by 2021. Why shouldn’t we also try to train 1000 Indigenous doctors or set targets for other health professionals? Targets and timeframes provide a tangible benchmark and create momentum. If targets are not met then people can identify why and what needs to change.

Last year in a speech, and again recently in an interview with Ellen Fanning on SBS, I talked about an idea for using the military to assist with urgent Indigenous health needs in the short term. It’s a very simple idea. The Australian military employs a large contingent of doctors, nurses and other health providers to provide medical services on the ground during military and emergency operations. They are trained to go into a region, set up a temporary hospitals and health facilities and provide medical services, including major surgery, to military personnel and survivors of disasters where the military has been deployed to assist.

When they are not on duty, these teams need to do training exercises. So why not deploy them to parts of Australia that have inadequate access to health services and where there are people with untreated medical conditions. They could set up a temporary facility to provide Indigenous people with the opportunity to have health check-ups and screenings, surgeries, dental checks and procedures, ante-natal checks, vaccinations and even health education. It would mean Indigenous people could have health treatment without having to travel to a hospital which they may be afraid or unable to do.

This idea would not require a major infrastructure investment – the military need to do training anyway. What’s more, the military are already trained to work with communities across a range of cultural backgrounds and language barriers where particular sensitivities are required.

Finally, we need to address the poor health of Indigenous people today and the prevalence of health risk factors amongst them. We can only do this with programs and services that have demonstrated outcomes and results.

We must also be willing to think innovatively and not be tied down by how-we’ve-always-done-things. Because we know that how-we’ve-always-done-things hasn’t yet achieved a closing of the gap. It’s not about the volume of services or who provides them or how much we are spending or how many people are involved or how much activity occurring on a day to day basis.

The only important factor in looking at Indigenous health programs is the outcomes they are achieving for Indigenous people – how many Indigenous people have stopped smoking or misusing alcohol as a result of the program; how many Indigenous people have lost weight or taken up regular exercise; how many Indigenous people have obtained and maintained a job, and how many have got jobs in the health sector; how many Indigenous people have experienced an improvement in their health; how many Indigenous people have given birth to healthy babies. And so on.

If you operate, or provide funding, to an Indigenous program then these are the questions you need to ask. Every company that donates to or funds Indigenous programs should know what actual outcomes the programs have achieved; what is the bang for
their buck. It is ok to ask questions and scrutinise programs against measurable results. Actually it’s essential. And if, in doing so, you find more activity than outcomes, or if you find that the outcomes are just not there, then the program needs to be reoriented.

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Organisations like the National Aboriginal Community Controlled Health Organisations and the Australian Indigenous Doctors Association are essential to this process. They are on the ground and have strong networks amongst the health providers at the coal face. They also want to achieve outcomes.

We need good and effective working relationships between organisations like those, health providers, Indigenous leadership and other operators of Indigenous programs.

Australia should be able to solve these problems. We don’t live in a third world country. Australia has plenty of skills, money, resources and brain power. Most importantly the Australian people - and all Australian governments, without exception - want to see the gap in Indigenous health closed.

I would like to see it closed in my lifetime.

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In taking on the role of Chair of the Prime Minister’s Indigenous Advisory Council I do understand the enormity of the task at hand and the challenges that we will encounter. However, like the Prime Minister and the Minister for Indigenous Affairs, I believe that the time is now. I look forward to taking on the challenges ahead because I believe that real change is achievable.