

cohealth ltd

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Committee Secretary
Parliamentary Joint Committee on Human Rights
PO Box 6100
Parliament House
Canberra ACT 2600

By email: **18Cinquiry@aph.gov.au**

Dear Committee Secretary

On behalf of cohealth I am pleased to make this submission to the Parliamentary Joint Committee on Human Rights Inquiry into Freedom of Speech in Australia.

Giving consideration to the social determinants of health, cohealth's position is to respond **no to all of the questions contained within the Inquiry's Terms of Reference**. Our reasons are set out below.

Yours sincerely

Lyn Morgain

Chief Executive



about cohealth

cohealth is Australia's largest not-for-profit community health service, operating across 14 local government areas. Our mission is to improve health and wellbeing for all, and to tackle inequality and inequity in partnership with people and their communities.

Our service delivery model prioritises people who experience social disadvantage and are consequently marginalised from many mainstream health and other services. This includes Aboriginal and Torres Strait Islanders, refugees and asylum seekers, and our data reveals that more than 30% of our clients speak a language other than English, with 112 separate languages reported by those using our services.

cohealth recognises that health is affected by many factors including social inclusion and participation, education, housing, employment, and access to fresh food, and we are committed to addressing these underlying causes of health inequality. To this end, we work directly with people and in the community through advocacy, health promotion and education to improve health and connectedness.

social determinants of health

The social determinants of health are the conditions in which people are born, grow, live, work and age. These conditions are shaped by the amount of power, money and resources that an individual has, all of which are influenced by public policy choices. Social determinants of health affect factors that are related to health outcomes, such as education, employment and income, food security, housing, transport and service access, and social status. These determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between individuals and communities.

A social determinants approach to public health posits that addressing social determinants of health is a primary approach to achieving health equity - "when everyone has the opportunity to 'attain their full health potential' and no one is 'disadvantaged from achieving this potential because of their social position or other socially determined circumstance'¹." Social determinants of health such as poverty, unequal access to health care, lack of education, stigma, and racism are underlying, contributing factors of health inequality. cohealth is committed to achieving improvements in people's lives by reducing health inequality, and thus takes a keen interest in a broad range of policy settings that have the potential to either positively or negatively impact on the underlying social determinants of health.

¹ Brennan Ramirez LK, B.E., Metzler M., Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health, Centers for Disease Control and Prevention, Editor. 2008, Department of Health and Human Services, Atlanta, GA.



the impacts of discrimination on health

There is extensive national and international evidence that demonstrates that ethnic and race based discrimination has a negative impact on health and wellbeing. A recent international review² found:

- a link between self-reported discrimination and depression and anxiety (major contributors to the disease burden);
- a probable link with a range of other mental health and behavioural problems; and
- Emerging evidence of a link with poor physical health, such as diabetes, obesity and high blood pressure.

These links were noted to exist regardless of age or gender, and across a range of ethnic/racial groups, and was found to remain even after other factors that might also be used to explain poor mental health outcomes for different ethnic/racial groups (especially social and economic disadvantage) are taken into account.

This international evidence is echoed in Australian research, which has found that

- being the target of ethnic and race-based discrimination is associated with stress and chronic conditions (such as diabetes, heart disease and cancer), as well as smoking, substance use, psychological distress and poor self-assessed health status among Aboriginal and Torres Strait Island people³; and
- that among people from migrant and refugee backgrounds, discrimination contributes to depression, poor quality of life, psychological distress and substance misuse.⁴

These negative health consequences arise for a number of reasons, including restricted access to the resources required for health – such as education, employment and housing; internalisation of negative messages resulting in decreased psychological wellbeing; increased stress and anxiety due to fearing or experiencing discrimination; increased engagement in behaviours that are damaging to health (such as smoking and drug/alcohol use) in an effort to self-manage stress; and direct psychological and physical harm arising from ethnic or race based abuse and violence.

² Paradies Y 2006b, 'A Systematic Review Of Empirical Research On Self Reported Racism and Health', International Journal Of Epidemiology, vol. 35, pp. 888–90.

³ Larson A, Gilles M Howard PJ & Coffin J 2007, 'It's Enough to Make You Sick: The impact of racism on the health of Aboriginal Australians', Australian and New Zealand Journal of Public Health, vol. 31, no. 4, pp. 322–9

⁴ Sundararajan V, Reidpath DD & Allotey P 2007, 'Ethnicity, discrimination and health outcomes: a secondary analysis of hospital data from Victoria, Australia', Diversity in Health and Social Care, vol. 4, no. 1, pp. 21–32



potential impact of reforms to 18C & 18D on discrimination and health

cohealth notes that the main thrust of the questions contained within the terms of reference is whether the Racial Discrimination Act (RDA) as it is currently constructed:

- unduly limits freedom of speech; and
- should have the associated complaints processes reformed.

cohealth is concerned that these questions send the message that the government sees the right to personal freedom of speech as more important than the right of ethnic and racial minorities to be protected from hate speech and its effects. This perception arises for a range of reasons, including:

- the fact that changing Part IIA of the RDA would in reality provide greater scope, and tacit Government endorsement for, people to legally use racist hate speech and/or vilify ethnic and racial minorities; and
- the fact that any changes to the way the RDA is enforced would mean that racially or ethnically based hate speech is treated different to other forms of discriminatory activity contained in legislation.

This perception is important. The previously referenced research found that institutional discrimination - that is the extent to which the State, laws and policies of a society lead to different and unfair outcomes for a social group, or otherwise signal that discriminatory behavior is acceptable - contribute to the kinds of poor health described above. The very holding of this inquiry, and the questioning of whether race hate protections should be reduced, sends a message to ethnic and racial groups that in the eyes of the Government they are less important, less included, less valued and less protected than other members of Australian society. This has the potential to contribute to significantly reduced health and wellbeing for the reasons described previously.

Furthermore, should changes actually be made to the RDA, cohealth is strongly of the view that this will lead to an increase in (now State sanctioned) racially or ethnically based hate speech and discrimination, with significant negative consequences for the health of vulnerable ethnic and racial communities.

For these reasons then, cohealth responds 'no' to all questions contained within the Inquiry's Terms of Reference, and strongly recommends against any change to the RDA as it is currently written and operates.

