VicHealth's response to the consultation on Victoria's Equal Opportunity Act 1995

CONTENTS

Executive Summary

VicHealth welcomes the discussion paper for consultation on Victoria's *Equal Opportunity Act 1995*. We strongly support the Victorian Government addressing the barriers to equal opportunity. This is one means of protecting and promoting public health and reducing inequalities in health status between groups within the population.

In summary VicHealth submits that:

- There is a strong body of evidence that both interpersonal and systemic discrimination are problems in Victoria and that they have significant health, social and economic consequences.
- Addressing discrimination, in particular systemic discrimination, is important both to protect and promote human rights, health and social cohesion and to maintain economic momentum through full labour force participation.
- The law is an important instrument for addressing discrimination. However efforts should not be confined to this. Rather, legal and legislative strategies should be part of a 'whole of government', cross-sector approach to addressing discrimination in Victoria. Such an approach would support a range of intervention methods in a mutually reinforcing fashion. In addition to legislative reform, these would include social policy reform, public education programs, education and training with relevant work forces, support for individuals and groups who are exposed or vulnerable to discrimination and work to assist public and private sector organisations to address discrimination and promote equality.
- Law reform is needed to integrate positive developments in equal opportunity law nationally and internationally as well as to respond to emerging patterns, and improved understanding of, discrimination. In particular there is a need to improve legislative responses to systemic and indirect forms of discrimination.
- The collection of participation, usage and other data by government and government-funded services will be critical to the success of efforts to reduce discrimination, in particular systemic discrimination. Data enables discrimination to be more readily identified for the purposes of planning future interventions and evaluation and monitoring of their effectiveness. The lack of Indigenous data reporting at a national benchmark standard is of immediate concern and limits the potential for the state to plan effectively to address substantive inequality for Indigenous Victorians.
- Both social policy and law reform should be underpinned by the principles of the importance of substantive equality and of generating a positive obligation to address discrimination.
- The Human Rights and Equal Opportunity Commission's functions should be broadened to enable it to deploy a broader range of strategies in addressing discrimination. However, this should be accompanied by an increase in its resource base to ensure that it is able to fulfil these functions effectively.

Introduction

About VicHealth

The Victorian Health Promotion Foundation or VicHealth is a statutory organization established under the Tobacco Act 1987. VicHealth forms partnerships with different groups to make health a central component of our daily lives.

It does this by working for all Victorians, through partnerships at all levels of government and in different sectors and by creating innovative programs based on research and evaluation. This, in turn, helps others who can influence good health. Working with others also creates a broader base from which to draw solutions.

VicHealth's vision is of a community where:

- health is a fundamental right;
- everyone shares in the responsibility for promoting health; and
- everyone benefits from improved health outcomes.

The Foundation's mission is to build the capabilities of organizations, communities and individuals in ways that:

- change social, economic, cultural and physical environments to improve health for all Victorians; and
- strengthen the understanding and the skills of individuals in ways that support their efforts to achieve and maintain health.

VicHealth's current priorities are:

- Reducing harm from tobacco and alcohol
- Creating active communities and promoting healthy eating
- Promoting mental health and wellbeing

In addition, VicHealth acknowledges the primary goal of tackling health inequalities when undertaking work in each of these action areas.

In this submission, VicHealth draws on its research and practice experience in a range of areas, with a particular emphasis on its work in addressing:

- Health inequalities (with an emphasis on those populations that face the greatest health inequalities: Indigenous Victorians, people with a disability, people with low socioeconomic status and new arrivals from a refugee background. In addition, VicHealth acknowledges the different health outcomes that exist when analysed by gender.)
- Race based discrimination (focussing on discrimination affecting Victorians from Indigenous and migrant and refugee backgrounds).
- Violence against women

VicHealth is supporting extensive programs of work in response to each of these issues (see www.vichealth.vic.gov.au for more detail) and is keen to continue to work in partnership with government and others to support activity to address discrimination and promote equality.

Scope of our response

Consistent with our expertise we focus in this submission on those questions related to:

- The relationship between discrimination and the protection and promotion of public health
- The application of methods and approaches which have been successful in addressing other pubic health issues to the task of reducing discrimination

In relation to those questions concerned with the detailed operation of the law, where relevant we comment in principle on the outcomes we would desire in order to achieve positive improvements in health. However, since it is beyond our expertise to do so, we do not comment on the specific legal changes which would be required to achieve these outcomes.

VicHealth's understanding of discrimination

Definitions

Within VicHealth's program of activity to address ethno-racial discrimination, we have used the following definitions:

Interpersonal discrimination refers to directly perceived discriminatory interactions between individuals, whether in their institutional roles (for example, between employer and employee) or as public or private individuals (for example, between shopkeeper and shopper) (Krieger, 1999).

Institutional discrimination, or **systemic discrimination**, refers to discriminatory practices carried out by state and non-state institutions (Krieger 1999). It occurs when policy and procedures or laws disadvantage a specific group. Institutional discrimination involves the application of beliefs, values, presumptions, structures and processes by the institutions of society (be they economic, political, social or cultural) in ways that result in differential and unfair outcomes for one or more social groups. It can also involve a failure to acknowledge historical discrimination against a particular group that has resulted in that group today occupying an inferior or unequal position in society (UNISA 2006). Institutions validate these rules and understandings that are often seen as being universal, but which actually reflect and protect dominant social interests (Gopalkrishnan 2004). In the past, institutional discrimination has been quite overt, as in the case of Apartheid in South Africa or the White Australia policy, but today is more likely to be a product (whether deliberate or unintentional) of the ethno-centric viewpoints of policy and decision-makers.

The causes of discrimination are complex. However VicHealth's research indicates that factors influencing discrimination lie at multiple levels including:

- In individual behaviours and experiences
- In day-to-day organisational environments (e.g. sports and recreation environments, education facilities, and in workplaces)
- At the community level (e.g. through the influences of peer cultures)
- At the societal level (e.g. through policies, programs and legislation, media and popular culture).

The public health sector's experience in addressing other health issues with multiple and complex causes (e.g. tobacco control, motor vehicle related morbidity and mortality) suggests that efforts are most likely to be successful when multiple and reinforcing strategies are used at each of these levels.

A spectrum of interventions

There are opportunities to prevent discrimination across a spectrum of

- Primary prevention – taking action to prevent discrimination before it occurs
- Secondary prevention – focusing on the early signs of discrimination occurring with the aim of reducing the risks associated with exposure
- Tertiary prevention – strategies to minimise the impact of discrimination once it has occurred and to prevent ongoing exposure (e.g. complaints mechanisms, counselling).

While optimally the focus of public policy effort ought to be on primary prevention, recognizing the pervasive nature of discrimination and its social, economic and health consequences, VicHealth believes that any strategy to address discrimination would encompass interventions along this spectrum.

A multi-strategy approach

Although legislative reform is important in a multi-strategy, mutually reinforcing approach, also of importance are:

- Community education and other direct programs to promote awareness of discrimination, its impact and means of addressing it and to support affected individuals and groups to respond effectively to discrimination should it occur
- Communications programs to address underlying attitudes and behaviours which contribute to discrimination and to strengthen social norms against it
- Community development activity to engage affected groups in addressing discrimination
- Activities targeted to key work forces across sectors to implement strategies to prevent discrimination
- Activities targeted to organizations to implement initiatives to prevent discrimination and promote equality (e.g. the development of policies and procedures, organisational auditing)

- Reform of policies and programs to eliminate discrimination
- Research, monitoring and evaluation to increase understanding of discrimination and its impacts and to assess the effectiveness of resource allocation and legislative reform.

Relationship to review discussion paper

While VicHealth strongly supports reform of the Equal Opportunity Act, it is of the view that the Act and the Victorian Human Rights and Equal Opportunity Commission are components of what ought to be a 'whole-of-government' approach to reducing discrimination and promoting substantive equality.

The Commission would have an important role in resourcing and supporting such an approach. It would have a role in relation to most of the strategies outlined above and a resource base commensurate with this range of functions.

However there is a need for strong government leadership and engagement on this issue. In this respect we note with interest the Western Australian Government's recent initiative in the area of substantive equality.

While promoting diversity and eliminating discrimination are not the same thing, they are complementary. Accordingly, a 'whole of government' anti-discrimination strategy should be implemented in a way which is synergistic with policy and program efforts to promote diversity.

Positive obligation and substantive equality

Given the health, social and economic costs of discrimination and consequent inequality, VicHealth supports the notion that both legislative and policy reform in this area should be guided by the principle of achieving a positive obligation to both avoid discrimination and promote equality.

VicHealth affirms the Review Panel's recognition of substantive equality. Substantive equality is recognised within the public health literature as vertical equity (Mooney 2000), to recognise the unequal treatment (such as resource allocation) that is necessary to provide to some sections of the population in order to achieve fair and just outcomes for everyone. For example, the poorer health outcomes for people of low socioeconomic status requires these populations to receive a greater investment of public spending in order to ameliorate this disadvantage.

Is law reform needed? [1]

VicHealth strongly supports changes to the law in order to improve equality of opportunity and the elimination of discrimination in Victoria. Specific changes are addressed further in this submission. Generally speaking, however, we support the need for change on the following grounds

- There is increasing evidence that systemic discrimination contributes to unequal outcomes experienced by certain groups in Victoria, in particular those from migrant,

refugee and Indigenous backgrounds, women, people with disabilities and those in low income households (see below for further discussion). As indicated in the Discussion Paper the current Act has a limited capacity to address systemic discrimination.

- Research supported by VicHealth suggests that more blatant and direct forms of discrimination are still a problem. However, also of concern is evidence of more subtle, covert and indirect forms of discrimination (see below for further discussion). There is a need to strengthen the law to deal with these contemporary concerns.
- In the decades since the Equal Opportunity Act was introduced there have been significant developments in the management of discrimination and equal opportunity both nationally and internationally. Victoria could benefit from adopting changes applied in other jurisdictions where these have proven effective in improving the operations of the law and its impacts

Social and economic costs and benefits of reducing discrimination [2]

Reform of the Equal Opportunity Act has a number of potential benefits:

Health Benefits

- As discussed in greater detail below, discrimination is associated with poor physical and mental health.
- Addressing discrimination can help to ensure that resources are more equally distributed and that society functions more effectively through improved social cohesion, by providing better health for all, and through enhanced economic activity. Greater social equity policies within a country are positively associated with better health outcomes, including infant mortality and life expectancy. Countries with longer years of pro-redistributive governance (enacting equity-enhancing policies such as promoting full employment for both genders, highly regulated labour markets, strong public health expenditure and universal health coverage) have lower rates of infant mortality and higher life expectancy. (Navarro, et al 2006).
- People who take action in the face of discrimination (for example by seeking redress or social support) are at a lower risk of suffering associated mental health consequences than are those who deny there is a problem or keep it to themselves (O'brien Caughey, OCampo & Muntaneer, 2005, noh and casper, 2003, Krieger and Sidney 1996; Brondo, Reippi et al 2003 cited in VicHealth 2007). This suggests that there would be health benefits in law reform which has the effect of improving the accessibility, acceptability and effectiveness of remedial action.

Economic benefits

- Addressing discrimination can help to ensure that all individuals are able to realise their potential and to participate in the Victorian economy. Both the OECD and the Australian Productivity Commission assert the importance of encouraging labour force participation by all members of the community: "Population ageing requires urgent action to better mobilise under-represented groups. Unless their participation rates are increased, population ageing will lead to a significant slowdown in labour force growth, with adverse consequences for future growth prospects. In sum, the

economic and social returns to fostering greater participation are very high (OECD 2003)". Productivity Commission projections forecast a reduction in aggregate workforce participation from 63.5% in 2003-04 to 56.3% by 2044-45. This concern has been noted by the Council Of Australian Governments in 2006, which recognised that "while the nature and extent of labour force participation is largely a matter of individual choice, features of the policy environment may distort such choices. To grow the economy will require policies that support and encourage greater participation." (Abhayaratna & Lattimore 2006).

- Analysis by the Productivity Commission suggests that mental health problems, when averted, have the greatest potential to increase individual productivity. The link between exposure to discrimination and poor mental health is particularly strong (see below)
- Discrimination can undermine diversity by acting as a barrier to individuals and groups reaching their potential. In turn, diversity – especially cultural diversity - has been found to be associated with increased productivity (Putnam 2007).
- Demonstrating that Victoria is committed to eliminating discrimination ensures that the state remains an attractive destination for migrants in an increasingly competitive global market. Increased settlement of migrants has been identified as a significant plank in the Victorian Government's overall vision for growing Victoria's population (Department of Premier and Cabinet 2004)).
- To VicHealth's knowledge there are no Australian studies that have systematically explored the economic costs of discrimination for governments. However, in addition to the costs discussed above these include those associated with:
    - Responding to grievances through formal complaints mechanisms. Estimates made on the basis of 1999 NSW data indicate that when all costs are considered these averaged around $55,000 per case (EEO NSW 1999)
    - Reduced productivity and absenteeism. An estimated 70% of workers exposed to violence, harassment or discrimination take time off work as a result (EEO NSW 1999). Discrimination can also affect overall workplace morale and productivity (Nichols, Sammartino et al 2005);
    - Staff turnover and recruiting and inducting replacement staff (Blank, Dabaday & Citro et al 2004); and
    - Health care and social service costs associated with the long- and short-term consequences of discrimination (eg. treatment and rehabilitation, income support payments).

  This suggests that there would be significant cost savings if the law were strengthened to prevent discrimination.

Social benefits

- Discrimination has the potential to undermine harmonious intercultural relations and community cohesion. As recent national and international events attest it can, at its worst, lead to large scale community conflict and violence warranting Police intervention.
- In a society free of discrimination people from diverse backgrounds are better able to contribute their unique perspectives and traditions. These in turn enrich society. This

is best illustrated in the positive contributions migrant, refugee, indigenous and other Victorians from diverse backgrounds bring in terms of academic, artistic and cultural skills and ways of understanding and ordering family, working and civic life.

- Addressing discrimination would foster a fairer and more equal Victoria.

Evidence that discrimination (whether individual or systemic) is still occurring [2.11]

Attitudes toward diverse groups

Attitudes surveys are important indicators of the problem of discrimination both because there is the potential for negative attitudes to be manifest in behaviour and because attitudes at the individual level both reflect and reinforce broader systemic patters related to discrimination and equality.

A survey undertaken by researchers Forrest and Dunn for VicHealth (herein referred to as 'the Victorian Survey') found that Victorians have a high level of support for cultural diversity, with nearly 90% agreeing that 'it is a good thing for society to be made up of different cultures (VicHealth 2007).

Overall Victorians reject the 'old racisms' based on socio-biological differences. Nearly 87% of Victorians reject the notion that races are unequal while 82% reject the proposition that it is not a good idea for people from different race to marry one another (VicHealth, 2007).

Whilst there appears to be increasingly tolerant attitudes, researchers note that these are countered by the increasing emergence of other beliefs, which are often covert and subtle, that underlie contemporary intolerance. These covert attitudes can have a potentially negative impact on the health of those discriminated against.

In particular, three themes appear significant:

- The identification of certain groups as not 'belonging' or 'fitting into' Australian society. (Dunn, Forrest, Pe-Pau & Smith 2004, McAllister & Moore 1989; Pedersen et al 2005). More than one in three (36%) respondents in the Victorian survey identified cultural or ethnic groups that they believed do not fit in – the most frequently mentioned groups being Muslim Victorians, people from the Middle East and Asia (VicHealth 2007).
- Discomfort with difference and resistance to migrant groups maintaining their cultural heritage (Forrest & Dunn 2007). Thirty-eight percent (38%) of respondents thought 'Australia is weakened by people sticking to their old ways' (VicHealth 2007).
- Denial that privilege and intolerance exist in Australian society (Bonnett 1997).

Covert forms of discrimination are of particular concern as there is evidence that their mental health consequences are greater than when acts are more obviously

discriminatory (Guyll, Mathews & Bromberger; Stetler 2001, Chen &Miller 2006 cited in VicHealth 2007). It is also more difficult to take action in the face of ambiguity and this in turn can compound health impacts.

Indigenous people in Australia experience entrenched discrimination (Cowlishaw, 1997; Department of Immigration and Multicultural Affairs, 1997; Dunn and McDonald, 2001, Human Rights and Equal Opportunity Commission (HREOC), 1991). Australian research on racism has found that racist attitudes and behaviour are relatively common. In Western Australia, 52% of urban residents and 69% of residents of a regional centre revealed prejudice against Aboriginal Australians (Pedersen, Griffiths, Contos, Bishop, et al, 2000).

Reported experiences

Indigenous people in a 2001 survey reported racism at twice the rate of non-Indigenous Australians including experiences of being treated with disrespect and being discriminated against in shops and restaurants (Dunn, Ghandi, Burnley & Forrest, 2003).

A further study in 2005 reconfirmed these findings and found that reported prejudice experienced by Indigenous Australians was more than twice of other Australians in the education system, and nearly four times that of other Australians in dealings with police and when seeking accommodation (Dunn, Forrest, Pe-Pua, & Smith, 2005). This study found that racism in everyday life was experienced by 43% of Indigenous Australians compared with approximately 25% of other non-Indigenous Australians (Ibid).

A cross-sectional study in Western Australian found that more than 40% of Aboriginal people reported treatment in the recent past that was so severe as to produce a strong emotional or physical response. The study noted that Aboriginal respondents who reported negative treatment were more likely to have poor health (Larson, Gillies, Howard & Coffin 2007).

The Victorian Survey 2006 found that a sizeable proportion of people surveyed who were born in countries where English was not the main language spoken reported experiencing discrimination due to their ethnic origin at some time:

- nearly two in five had experienced discrimination in the workplace (three times as likely as those born in Australia)
- 30 percent had experienced discrimination in education (twice as likely as those born in Australia)
- 18 per cent reported having experienced discrimination in housing (four times as likely as the Australian born)
- 19 per cent reported having experienced discrimination in policing (three times as likely as those born in Australia)
- One third reported experiencing discrimination in a shop or restaurant
- 45 per cent reported having such experiences at as sporing or other public event.

For most, reported experience was at the less frequent end of the scale, however concerning proportions reported that they had experienced discrimination often including 7.4 per cent in the workplace and 6.2 percent in education, 4 per cent in a shop or restaurant and 15 percent in a sporting or public event.

Evidence of systemic discrimination

Evidence on systemic discrimination comes from a range of sources as there is no rigorous, methodical collection of data to monitor unjust and unfair treatment of vulnerable population groups in our community. Levels of participation across various social indicators are the main form of evidence that demonstrates that institutional discrimination may be influencing access to the socioeconomic resources necessary for health and wellbeing.

This evidence creates some tension in the underlying assumptions that can acknowledge or deny institutional discrimination is at work. For example, is it disadvantage that is influencing access or is it discrimination and how can we tell? The delineation between discrimination and disadvantage would influence the policy responses necessary to implement effective action. This section reviews the available evidence that demonstrates that certain groups are limited in the access to the resources necessary for good health. This evidence is then reviewed in terms of whether it is a marker of disadvantage or discrimination and explains why institutional discrimination is influencing these outcomes.

Evidence of disproportionate access to socio-economic resources

Evidence of lack of access to employment

- In 2004-05, the unemployment rate (12.9 per cent) for Aboriginal and Torres Strait islanders was 3 times the rate for non-Indigenous people (4.4 per cent) (Steering Committee for the Review of Government Service Provision 2007).
- There is an unemployment rate of 8.6% for people with a disability compared with 5% for non-disabled people (Australian Bureau of Statistics 2004a). Within the Australian Public Service, the proportion of employees with a disability declined from 5.3% in 1992 to 3.6% in 2003 (Howe 2007).
- People aged 15-64 with a disability had a much lower level of involvement in the paid workforce: a participation rate of 53% compared with 81% for people without a disability (ABS Disability, Ageing and Carers Australia 2003).

Evidence of lack of access to education

- While education rates have steadily increased over the past decade, by 2006 about 40.1% of Indigenous students finished a Year 12 education, compared with 75.9% of non-Indigenous students. Indigenous young people were also approximately 15 times less likely to have a bachelor degree or above and around 23% less likely to

have a certificate or diploma than all young Australians (Australian Institute of Health and Welfare 2007).

- 44% of people with a disability (compared with 29% of those without), had left school at Year 10 or below (Howe 2007).
- One in four (24%) of people aged 15 – 64 with a profound or severe core-activity limitation had completed Year 12, compared to one in two (49%) of those without a disability. In addition, 14% of people with a profound or severe core activity limitation had completed a diploma or higher qualification compared to 28% for people without a disability (ABS 2003).

Evidence of lack of access to income and wealth

- In 2004-05, average weekly household income for Indigenous Australians was $340, compared to $618 for non-Indigenous households (Steering Committee for the Review of Government Service Provision 2007).
- Average national weekly earnings, based on full time ordinary earnings show a gender pay gap of 19.4% for Australia and 19.04% for Victoria. When overtime, leave loading, etc are taken into account, the disparity is 23.98% for Australia and 23.04% for Victoria (ABS 2007a).
- The median gross personal income for people aged 15-64 years with a disability was just over half of the income for those without a disability (ABS 2003). This median is equivalent to a current working definition of poverty and deprivation in Australia, and a standard definition of poverty in the UK (Saunders 2007, Palmer et al 2007). ***That is, the median gross personal income for people with a disability in Australia is equivalent to our contemporary standard measure of poverty.***
- One in four (24%) of people aged 15 – 64 years with a disability were in the lowest 20% bracket of gross household income, compared with one in 10 of those without a disability (ABS 2003).

Evidence of lack of access to housing

- There is an over-representation of overseas-born residents in private rental low-income households (Australian Housing and Urban Research Institute 2007).
- Across Australia in 2004/05, 25.4 per cent of Indigenous people aged 18 years and over lived in home owner/purchaser households. In Victoria, this figure is just under to 40% (Steering Committee for the Review of Government Service Provision 2007). For the most recent year of comparable data (2002), 27.4 Indigenous people 18 years and over lived in a home owner/purchaser household compared with 73.7 per cent for non-Indigenous people (Steering Committee for the Review of Government Service Provision 2007).
- In 2006, there were 2,559 Victorians waiting for accommodation, including 1606 people whose need was classified as urgent or high priority (Coalition for Disability Rights 2006).

Evidence of lack of access to community and health services

- Between 1995 and 2004/05 there was a statistically significant decrease in the proportion of Indigenous people in non-remote areas who were engaged in moderate

or high levels of exercise (from 30.3% to 24.3%) (Steering Committee for the Review of Government Service Provision 2007).

- Within organised sport, the proportion of the population involved as players and non-players was similar for Australian-born (31.3%) and for migrants from mainly English speaking countries (26.1%), yet significantly lower for migrants from non-English speaking countries (12.6%) (Australian Bureau of Statistics 2007g).
- Compared to the participation in sport and physical activity of all Australian adults (62.4%), participation was lowest for migrants from Southern and Eastern Europe (42.5%) and those from North African and Middle Eastern background (31.2%). Participation levels amongst women from North Africa and the Middle East were only 19.5% (Cortis et al. 2007).
- Children's participation (for ages 5 – 14 years) in organised sport is much lower for children born in non-English speaking countries (30%) compared with children born in mainly English-speaking countries (38%) or in Australia (41%). This trend is also observable amongst children's involvement in a range of cultural activities and sport outside of school hours. 56.1% of children from non-English speaking countries were involved in any after school activity, compared with 72.7% involvement amongst migrants from mainly English countries and 73.9% involvement amongst Australian-born children (Australian Bureau of Statistics 2006).
- Compared with the corresponding figures for 1998, the participation rates recorded in 2003 for persons with a disability were lower for almost all combinations of disability status and sex. There was a drop of 3% (from 27.6% to 24.6%) in the overall participation rate for persons with a disability. Other significant falls in participation rate included the overall rate for males with a disability (by 4% from 32.2% to 28.2%), the rate for males with a mild core activity limitation (by 19.7% from 33.7% to 27.1%), and the rate for females with a moderate core activity limitation (by 24.2% from 21.6% to 16.3%) (Australian Bureau of Statistics 2007c).

Evidence of lack of access to fair treatment under the law

- When apprehended by police, Indigenous people are half as likely to be given a caution compared with non-Indigenous people (Department of Justice 2005).
- Between 2000/01 and 2004/05, Victorian Indigenous people were slightly more likely to be sentenced to prison than community-based orders, and 12% less likely to be released on parole when in prison (Department of Justice 2006).
- In 2003/04, youth "were nearly three times less likely to be cautioned when processed by police" than non-Indigenous youth (Department of Justice 2006).
- Similar findings are emerging for particular ethnic groups. Recent longitudinal research with Sudanese young people found 56% of study participants were approached by police for questioning, compared with 30.6% of the full sample of newly arrived young migrants from other countries being approached (Gifford 2007).
- Recent trends in the prison population show increases in the numbers of females, Indigenous people, those with mental health concerns, and prisoners with complex health-related conditions, including multiple illicit substance use, alcohol problems and communicable diseases (Brouwer 2006).

- Over-representation of people with cognitive impairment in the criminal justice system, which is compounded by policing issues such as police attitudes, police questioning and taking (or not taking) of statements, evidence, proof of fitness to be tried and services for offenders (Coalition for Disability Rights 2006).

Evidence of lack of access to transport

- In 2003, 275,700 people living in Victoria with a disability (i.e. 30% of all Victorians with a disability) had some difficulty with public transport access (Australian Bureau of Statistics 2004a). This figure is confirmed by findings reported by the Productivity Commission in 2004 that found that 31.1% of people with disabilities reported difficulties using public transport.

Evidence that this inequitable treatment is the result of institutional discrimination

It is not always possible to unequivocally state that this lack of access to the resources necessary for good health are the result of systemic processes that are discriminatory, however, there is some evidence that institutional discrimination is at play. Disadvantage – such as lack of education and income (which may themselves have resulted from past experiences of discrimination) may be a driving influence behind lack of access to these resources. However there is some proof when looking amongst common groups that contemporary institutional discrimination is also an influence. For example, amongst newly arrived immigrants from refugee backgrounds, some from European countries have settlement patterns that increase opportunities much faster than for those migrants from North Africa, Lebanon, the Middle East and Vietnam. This can be shown despite qualification-levels and length of settlement time in Australia. Similarly, workplaces with a higher proportion of male employees tend to operate differently to workplaces and industries with higher female employment, again pointing towards institutional discrimination being a driving influence.

- Within existing hospital services Indigenous patients are not receiving the same quality of medical care as their non-Indigenous counterparts (Coory & Walsh 2005).
- Although Indigenous people have mortality rates three to five times greater than other Australians, per capita spending on Indigenous health is only 1.2 times that of the non-Indigenous population (AMA 2007).
- In a 2001 survey on racist attitudes over a fifth (23%) of Indigenous respondents reported experiences of racism in their dealings with police. Indigenous respondents had by far the highest rates of such racist experiences. (Dunn, Forrest, Pe-Pau & Smith 2004). When apprehended by police, Indigenous people are half as likely to be given a caution compared with non-Indigenous people (Department of Justice 2005). These practices also contribute to systemic discrimination in civic engagement, as over-representation in the justice system, and in prison, limits Indigenous people's right to vote in elections (HREOC 2007)
- In WA, researchers found "that there is a segmented labour market where racially and culturally visible migrants, especially those from refugee backgrounds, are allocated the lowest jobs regardless of their human capital (formal qualifications, skills and experience)" (Colic-Peisker & Tilbury 2007).
- Research collated by the Commonwealth Parliamentary Library found that people from North Africa, Middle East and from Vietnam "have rates of unemployment much

higher than other overseas-born persons". At June 2005, unemployment rates were 12.1% for people from North Africa and the Middle East and 11% for people from Vietnam. This compared to a rate of 5.3% for all overseas-born, and 6.2% for those born in all non-English speaking countries.

- After some settlement in Australia (three and a half years), 47% of migrants from Anglo-Celtic backgrounds originating from the UK and America were using their qualifications in taking up employment opportunities, compared with 31% of migrants from non-English speaking backgrounds (Ho & Alcorso 2004).
- Lebanese, North African and Vietnamese migrants have lower household income, employment status and housing conditions than "white" new arrivals from Europe, Great Britain and New Zealand with the same length of settlement time in Australia (Borooah & Mangan 2007).
- Women with dependent children are much less likely to be employed than men with dependent children, and women continue to experience a gender pay gap of up to 18.4%, with individual enterprise bargaining exacerbating the gap, resulting in women tending to end up with lower negotiated wages than men (Pay Equity Working Party 2005).
- Workplaces with a high proportion of male employees had a more diverse mix of pay-setting methods; predominantly female workplaces tended to be more reliant on award minimum standards than collective agreements; workplaces with a large proportion fo male employees were more likely to pay higher wages than those workplaces with a large proportion of female employees (Snapshot report, Vic industrial relations survey 2006).
- A study of 1101 working Victorians found that unwanted sexual advances are disproportionately experienced by women (3.5-fold higher risk than among men) and workers in the most precarious employment arrangements (compared to permanent full time workers: casual full-time workers experienced 4.2-fold higher risk and contract workers fully 10.6-fold higher risk) (LaMontagne et al, 2007)
- Earnings gaps for recent arrivals persist despite length of settlement in Australia (Teicher et al. 2002)
- Lack of data is a key form of systemic discrimination as it acts to entrench disadvantage amongst certain population groups by keeping lack of access and other unequal distribution of resources invisible. For example, the lack of Victorian data that is able to be reported in the Productivity Commission's annual reports on indigenous disadvantage indicators severely limits the capacity of the State and non-government sector to plan accordingly. In the 2007 report by the Steering committee for the Review of Government Service Provision, the authors note that "Data from … Victoria… are considered to be of insufficient quality for analytical purposes". This impacts on the reporting of health outcomes including smoking during pregnancy and hospitalisations due to tobacco and alcohol use, which are influenced strongly by experiences of discrimination.

Violence against women as a form of discrimination

The United Nations have identified violence against women – in particular that occurring in the home – as a form of discrimination given its impact on women's capacity to participate in both the public and private realms (United Nations 2007). Gender inequality (to which discrimination makes a contribution) is also an underlying cause of this violence (UN 2007; VicHealth 2007a).

Violence against women is a prevalent problem with the most recent well designed Australian survey indicating that:

- One in three women had experienced physical violence since the age of 15;
- Nearly one in five women had experienced sexual violence since the age of 15.

Promoting safe environments for women is a critical objective in efforts to address discrimination affecting women and to promote gender equality.

What is the impact of discrimination? [2.12]

Impact of discrimination on individuals

Interpersonal and institutional discrimination make separate contributions to poor health (Krieger 1999; Gee 2002; Schulz, Williams et al 2000; Nazroo 2003, Karlsen & Nazroo 2002). Discrimination is a human rights violation both in its own right and because it compromises the attainment and enjoyment of other human rights, including the right to health (WHO 2000).

In addition, interpersonal and institutional discrimination also operate in concert to deny access to opportunities for some groups in the community. For example, in employment, interpersonal discrimination may be the influencing factor in a business, whereby the staff member responsible for recruitment does not review migrant applicants fairly. This discrimination is entrenched when there are not the organisational policies in place that would ensure equitable treatment of all applicants. Thus the lack of capacity for a business to monitor the equity of its recruitment decision-making processes is an example of institutional discrimination.

Institutional discrimination also operates independently to deny access to opportunities for some groups. For example, the lack of acknowledgement of Aboriginal culture and history in education is seen by many Aboriginal community leaders as contributing to the lower school retention rate for Indigenous students (Baum, Anderson & Bentley 2007).

Discrimination impacts on health in a number of ways. It impacts:

- Directly on mental health, such as incidence of depression and anxiety
- Indirectly on physical health including influencing health behaviours such as smoking, drinking and drug use; and through impacts of stress on the body

- On social inclusion by increasing stigma which in turn limits access to the health and community services necessary to maintain health (Link & Phelan 2006; Dressler, Oths et al 2005; Nicols et al 2005; Williams & Williams-Morris 2000);
- By limiting access to the socio-economic resources necessary for health (education, employment, income, housing, safety as indicated in the box below).
- By provoking stress as well as fear and other negative emotions, which in turn can have negative impacts on mental health and on the immune, endocrine and cardio-vascular systems (Brondolo, Rieppi et al 2003, Harrell, Hall et al 2003; Hays, Cochran et al 2007; Williams & Williams-Morris et al 2000);

Further, negative evaluations and stereotypes can be internalised by affected individuals and groups leading to unfavourable self-evaluations that affect psychological well-being (Williams & Williams–Morris 2000). This may be referred to as 'internalised racism' or 'internalised oppression'. Studies suggest that internalised oppression is associated with an increased risk of depression, alcohol consumption and psychological stress (ibid);

Links between access to economic resources and poor health outcomes

- unemployment, insecure employment and unfavourable working conditions have all been associated with low self-esteem, feelings of depression and mental health problems in young people (Morrell et al. 1998).
- There is an association between unemployment and a range of health concerns including low self-rated health, cardiovascular disease, and drug and alcohol abuse (Australian Institute of Health and Welfare 2007).
- People with lower educational attainment rate their own health more poorly and report a number of illnesses more often than those with a bachelor degree or higher (Turrell et al. 2006).
- People with degree qualifications are more likely to have better physical and mental health than people with Year 11 or lower qualifications (Stanwick et al. 2006).
- Better education leads to a better overall self-assessed health status, which, in turn, leads to higher labour force participation. In particular, having a degree or higher qualification strongly improves labour force participation (Laplagne et al. 2007).
- People living in rented accommodation were significantly more likely to report fair or poor health, to be smokers, to have recently visited a doctor, or to have a higher number of serious health conditions than home owners (Waters 2001)

Some of the evidence to demonstrate the ***mental health impacts of discrimination*** includes:

- A review of population-based studies of the association between perceptions of racial and ethnic discrimination and health indicates that discrimination is strongly associated with depression (Paradies 2006). It is also possible that there is a link with poorer mental wellbeing outcomes such as anxiety and stress, and poor self esteem (Ibid). Depression and anxiety are predicted to be the greatest single contributors to disease burden in Australian women and third in men by 2023 (Begg, Voss et al 2007).
- In studies where there was a positive association between poor mental health and self-reported discrimination it was:
  - ⇒ across age cohorts, including children and young people;
  - ⇒ for both men and women;
  - ⇒ after taking into account other factors that might also explain poor outcomes for different cultural groups, especially social and economic disadvantage;
  - ⇒ across a range of ethnic and racial groups; and
  - ⇒ across different countries including America, Canada, New Zealand and the Netherlands (VicHealth, 2007).
- Children of parents affected by discrimination are at higher risk of developing behavioural and emotional problems (Mays, Cochran et al 2007, Caughey, O'Campo et al 2004).
- Discrimination affecting one generation may also compromise the social and economic prospects of future generations, contributing to intergenerational cycles of poverty and disadvantage (Mays, Cochran et al 2007, Rollock & Gordon 2000);
- The discrimination and stigma felt by people living in disadvantaged areas "is internalised by people who came to believe the stereotypes. This absorption of prevailing negative attitudes can be understood as analogous to the effects of 'internalised racism'. Internalising negative attitudes and beliefs towards oneself undermines confidence and reins in aspiration" (Warr 2005).
- Institutional practices that preclude access to aides and equipment for people with disabilities was found in one survey to contribute to stress and depression in 70% of respondents (Melbourne Citymission 2006).
- A recent VicHealth supported study suggests that intimate partner violence alone contributes 9% to total disease burden in women aged 15-44, of which over 60% was contributed by associated mental health problems (VicHealth 2004).

Evidence that demonstrates the ***physical health impacts of discrimination*** includes:

- Amongst Indigenous Australians, 62% of health-related behaviours (such as smoking and excessive drinking) are significantly associated with racism (Paradies 2007).
- Aboriginal people who reported negative racially based treatment were more likely to have poor health on measures of mental health, physical health and self-rated health (Larson et al. 2007).
- Research in Australia shows that for Indigenous people the stress caused by being the target of racism is associated with chronic conditions such as diabetes, heart disease and cancer as well as smoking, substance use and poor self-assessed health status (Paradies 2007, Altman et al 2004).

- In one recent Melbourne survey, delays to purchases of aids and equipment for people with disabilities contributed to physical ill health for 62% of respondents (Melbourne Citymission 2006).
- Affected individuals may attempt to manage the stress associated with discrimination by engaging in behaviours which are themselves damaging to health (eg smoking, alcohol use) (Cooper & Friedman et al 2005; Yen, Ragland et al 1999).
- People with psychiatric disabilities have less access to some procedures for circulatory disease (and subsequent survival), even in a universal health care system that is free at the point of delivery (Kisely et al. 2007).

There is evidence that stigma and discriminatory attitudes lead to social exclusion, and this in turn limits access to opportunities to participate fully in community life. For example, in a study with Norlane and Corio residents of Victoria – an area with a high level of socioeconomic disadvantage - the researchers found the stigma of living in the area "was one of the most persistent issues that people raised in the interviews" (Warr 2005). This led some people to avoid stigmatization by staying as much as possible within the local area, for example, "Helen, a sole parent of two children, spends most of her time in the local area where she is less likely to be confronted by the stigma" (Warr 2005).

New technologies have recently begun to be used in ways that may reinforce stigma and contribute to institutionally discriminatory practices. For example, recent technology has identified that people under the age of 20 have a keener auditory sense at higher pitches. This has led to the use of a "sound repellent" to be used outside shopping malls to act as a deterrent to young people congregating in the area (The Age, 30/11/05). Such use of technology can contribute to the feelings of stigma and discrimination felt by young people in their use of public space and contributes to "how they are excluded from the social life of the community by virtue of their age" (Morrow 2000).

Intersecting forms of discrimination [3.4.6.1]

International evidence demonstrates that the health implications of different forms of discrimination, for example race discrimination and sex discrimination, are cumulative (Krieger 1999)

Impact of discrimination on community wellbeing

Interpersonal and institutional discrimination also impact on our society more broadly and this has both economic and social costs, including:

- Decreased social cohesion, leading to greater animosity, perceptions of fear and potential for violence in the community
- Decreased equitable distribution of resources which contributes to greater inequality for all in health, safety from crime, and labour market outcomes
- Reduced potential for economic growth and limited workforce participation – an important driver for economic sustainability in an ageing population.

The discrimination felt by people living in areas of greater disadvantage impacts negatively on social cohesion: "Living in stigmatized neighbourhoods has been observed to corrode trust between neighbours, engender social isolation and limit opportunities for interaction with other communities (Warr 2005 citing Cattell 2001). This study also found increased costs in service provision for these community members due to their feelings of disenfranchisement and distrust in the service delivery system.

The impacts of discrimination are not confined to those directly subjected to it, but can also create a climate of apprehension and fear that may curtail the activities and aspirations of others, both from similar cultural backgrounds (as demonstrated by Szalacha et al 2003; and Harrell 2000), as well as in the wider community (such as demonstrated in the Australian Unity Wellbeing index which saw a much higher level of fear and lack of security in the surveys immediately following September 11, 2001).

Means of preventing discrimination [3]

Good practices for addressing discrimination

VicHealth has recent supported a review of strategies to support the primary prevention of interpersonal ethno-racial discrimination. While there is very little evaluated work in this area, drawing on the work of a number of researchers, a range of promising practices were identified (Table One). Many of these would be transferable to other forms of discrimination.

Drawing on Pederson et al's work (Pedersen et al 2005) it also identified a number of promising approaches to addressing interpersonal discrimination including:

Building empathy

This involves strategies which encourage people to 'walk in the shoes of the other'. Studies show that empathy is positively associated with tolerance and there is some evidence that building empathy can bring about attitudinal change.

Addressing false beliefs and stereotypes

This involves strategies which address inaccurate beliefs or stereotypes about different cultural groups (e.g. the belief that refugees receive overly generous welfare support). Research demonstrates that such beliefs often co-exist with discriminatory attitudes and that addressing these can help to shift negative evaluations.

Building and invoking social norms

It has been hypothesised that changes in attitudes can be achieved by invoking positive social norms (for example, through messages highlighting the fact that most Australians do not support discrimination) or by generating community or organisational-level consensus in support of diversity. As discussed above, this approach may also involve community and societal-level reforms to ensure that there are clear sanctions against intolerant behaviours.

Continues overleaf

Table 1. Promising strategies for the primary prevention of interpersonal discrimination affecting migrant and refugee communities

Public health strategy	Promising strategies
Direct participation programs	Initiatives to promote learning about other cultures and to address false beliefs and stereotypes Anti-discrimination/pro-diversity community and school-based education programs Deliberative polls[1] Programs increasing contact and cooperation among groups between whom there is social distance[2]
Communications and social marketing	Anti-racial discrimination/pro-diversity training for journalists Media policies and procedures, guidelines and ethical codes designed to promote fair reporting on issues relating to ethno-cultural communities Inclusion of anti-discrimination messages in entertainment media Resources to raise awareness of and address discrimination/promote cultural diversity Whole-of-population and geographically targeted communications campaigns[3]
Community development	Cultivating local leaders to take a stand in support of cultural diversity/against discrimination Cultivating leadership within cultural communities to serve as advocates for their community Initiatives to build cross-cultural networks and cohesion within communities
Workforce and organisational development	Anti-discrimination/diversity management training Policies and protocols to address discriminatory behaviour/promote diversity at the organisational level Strategies to address institutional discrimination
Advocacy	Campaigns to promote national leadership in support of cultural diversity/against discrimination Activities to promote positive changes in policy and programs at the organisational and societal levels
Policy and legislative reform	Laws and policies to generate social norms against discrimination and in support of diversity (for example, racial vilification legislation, anti-discrimination legislation) Social policy platforms to address institutional and systemic discrimination
Research and monitoring	Use of research findings to raise awareness of the problem of discrimination and its impacts or to promote the benefits of diversity

[1] While their format varies deliberative polls generally involve engaging a group in hearing about and discussing an issue, with participants being polled before and after this deliberation. [2] Measures to increase contact between cultural groups are effective in reducing discrimination providing that certain conditions are met. [3] Practice and rigorous evaluation in this area is sparse and findings are mixed.
Source: Table compiled from reviews conducted by Donovan and Vlais 2004; Pedersen et al 2005; Paradies 2005; and an overview of strategies prepared by the Council for Aboriginal Reconciliation (nd).

Inducing dissonance

This approach involves highlighting the discrepancy between discrimination and other values. In the Australian context this may involve drawing attention to the contradiction between discrimination and the widely held values of egalitarianism or giving people 'a fair go'.

Promoting dialogue

Studies show that approaches that engage people in discussion about issues of discrimination and diversity are more effective than those relying exclusively on imparting information.

Emphasising commonality and diversity

Strategies are most likely to be successful when they emphasise both the similarity and differences between groups. Evaluation of past interventions suggests the importance of achieving balance between these potentially competing messages. There is a risk in emphasising commonality that 'out-groups' will only be accepted on terms acceptable to the 'in-group'. However, interventions which emphasise differences run the risk of compounding social cleavages.

In the report of this research VicHealth recommended that the McCaughey Centre (The VicHealth Centre for the Promotion of Mental Health and Community Wellbeing, University of Melbourne) lead the development of an evidence informed framework to guide primary, secondary and tertiary-level interventions to address inter-personal and institutional racial and ethnic discrimination in Victoria.

VicHealth is currently supporting the *Building Bridges* program which aims to reduce discrimination by supporting positive intercultural contact. It is anticipated that it will undertake further work in trialling and evaluating anti-discrimination strategies in the Victorian context in 2007 in partnership with a range of others.

These initiatives will help to inform future program and policy development in Victoria. While having a focus on race-based discrimination, it is likely that many of the lessons learned will be transferable to other groups affected by discrimination.

Additional powers and functions for the commission to address discrimination [4]

In principle, VicHealth supports the range of functions canvassed in the discussion paper being vested in one body. This ensures a continuous link between the Commission's complaints handling and information provision roles with their current and proposed roles in investigating systemic discrimination, community education and organisational development. However, VicHealth does not have the expertise to assess whether there are policy or legal conflicts associated with some of the proposed new functions in practice.

VicHealth would support the Commission having an extended role in supporting organizations to comply with the provisions of the act, for example through the development of guidelines. However we note that discrimination, in particular systemic discrimination, is a complex phenomenon. In some areas quite specific discipline or sector expertise may be required to understand and effectively respond to discrimination. The Commission's resource base would therefore need to be increased to reflect any expansion in its roles to enable it to develop appropriate expertise in-house or contract this on an 'as needs' basis.

Provision of legal or strategic advice [3.2.1.1]

VicHealth supports the proposal that legal and strategic advice be available to people who believe they have been discriminated against. This is especially important give that those affected by discrimination are often in a powerless position relative to the institution against which they are making a complaint. Members of powerless groups may also have limited familiarity and experience with formal complaints processes.

Advice on how to comply with the EOA [3.2.1.4]

VicHealth supports the provision of specific advice on compliance by the Equal Opportunity Commission on the grounds that it would assist in improving compliance and prevent discrimination. We note that such a function would bring Victoria into line with other Australian jurisdictions.

Broader power to conduct inquiries and make binding recommendations/own motion inquiries [3.2.4.1]

VicHealth supports in principle a broadening of the Commission's investigative powers as this would enhance its capacity to investigate systemic discrimination, particularly where there are complex systemic contributors to unequal outcomes which may not be readily discerned by individuals or even in individual settings. An example of this is the recent finding by the Pay Equity Group that women in predominantly female work places earn less under flexible working arrangements than those in industries with predominantly male workforces.

These powers would also be important to address discrimination affecting vulnerable groups that face barriers to making a complaint. For example, research supported by

VicHealth into work place stress indicates that highly exposed groups, particularly those of lower socio-economic status, are under-represented in worker's compensation data (LaMontagne 2005). People in these workplaces may be unwilling to initiate a complaint fearing its impact on future job-security or income. A similar case applies with regard to practices uncovered in recent media reports, whereby some employers have forbidden workers from migrant backgrounds to speak languages other than English on their lunch break, indicating that doing so would be detrimental to their job promotion opportunities (Sydney morning Herald 1/11/07).

However VicHealth believes that further consideration is required of the proposal to extend the powers of the commission to include the power to conduct inquiries on its 'own motion'. This power would obviate the need for affected groups to take their own action where there are barriers to doing so. However there are also circumstances in which there may be costs and benefits associated with such intervention for the affected group. VicHealth is of the view that it is optimal for these to be assessed by the group itself. For the reasons discussed, VicHealth proposes that the question regarding the Commission's power to initiate 'own motion' inquiries be explored in greater detail in the second phase of the review. In particular this might involve investigating how this power has operated in other jurisdictions and whether there are safeguards that can be applied to prevent the inappropriate application of this power.

'Own motion' hearings in the private sector [3.2.4.2]

VicHealth would support the extension of 'own motion' hearings to the private sector, subject to it being established in the second phase of the review that these have operated without detriment to disadvantaged groups in other jurisdictions and their being adequate safe guards.

Adequacy of current education powers of the commission [3.2.5.1]

Consistent with the evidence of the effectiveness of multi-method approaches to addressing discrimination discussed earlier in this submission, VicHealth strongly supports a broad role for the commission in education. Education strategies have a powerful role in primary prevention and are probably better suited than legislative responses to deal with some of the more indirect and covert manifestations of discrimination where identifying and taking action on discrimination may be more difficult.

Amicus curiae powers [3.2.6.2]

VicHealth would support in principle the Commission having *amicus curiae* powers as such powers would help to ensure that individual cases were argued in a manner which serves the public interest.

Resourcing litigation [3.2.6.5]

In principle VicHealth supports resources being available to resource litigation taking into account the merit of the case and the means of the complainant. Given the limits of its discipline expertise it does not have a view on whether this should be made available through the commission or some other body.

Draft legislation [3.2.7.1] and retrospective review [3.2.8.1]

VicHealth supports the review of draft legislation to ensure compliance with the provisions and principles of equal opportunity legislation. It is beyond VicHealth's discipline knowledge to assess whether existing practices associated with the Charter of Human Rights are sufficient for this purpose. Similarly, it supports the proposal that the Commission have a power to review the effect of laws on equality of opportunity on the request of the Attorney General.

Codes of practice, guidelines and action plans [3.3.1.1; 3.3.2.1; 3.3.3.1; 3.3.3.2; 3.3.4.1; 3.3.4.2]

VicHealth supports in principle the Commission having a role in the development of codes of practice and guidelines (subject again to an adequate resource base). If these were to have legal status, clear guidance would be required as to how these would be developed (e.g.; with engagement from relevant sector players, subject to expert review).

VicHealth encourages the legal enforcement of equality duties, similar to the system in place in the UK, and in use locally regarding the Parliamentary reporting of Diversity reporting annually. All Government -provided and -funded services should be legally responsible for collection of data on use of services by gender, Indigenous status, disability and ethnic status. Such data collection would:

- enable the community to monitor and assess the government's progress in achieving substantive equality
- Improve capacity to manage diversity
- Improve capacity to identify and address areas of possible systemic discrimination (e.g. through procedural changes, education)
- Ensure that Victorian standards meet international best practice, particularly practice in Canada and the UK, in relation to achieving equity.

The Commission could play a key role in assisting services to meet their equality duties and to assist in annual reporting and analysis of results. This issue should be explored in depth in the second stage of the review.

VicHealth supports the requirement to develop action plans and is of the view that the commission should have a role in supporting and monitoring their development. However, further consideration should be given in the second stage of the review as to whether these should be registered with the Commission.

Collection/analysis and use of complaints data

Complaints data – for reasons outlined in the discussion paper - is a limited source of information pertaining to discrimination. VicHealth is of the view that the Commission should have a clear and well resourced research, monitoring and evaluation function in relation to discrimination in Victoria to enable it to better monitor and respond to patterns of discrimination. Complaints data would be one data source.

We note the importance of the *Perceptions of Justice Survey* as a mechanism for collecting data pertaining to discrimination and would support consideration being given to:

- Broadening the range of questions in the survey pertaining to discrimination to provide more detailed information on experiences of discrimination
- Increasing the sample size of the survey to enable analysis to the local area level (for the purposes of identifying geographic areas for the purposes of targeting interventions). This is especially important given evidence of clear geographic patterns in experiences of discrimination (Forrest and Dunn in VicHealth 2007).
- Linking the survey with questions in the *Public Health Survey* and/or the survey conducted by *Community Indicators Victoria* to enable monitoring of the impact of discrimination on health and other measures of well-being.

Objectives and scope of the act [3.4.2.2; 3.4.2.3]

VicHealth strongly supports legislative recognition that according mere formal equality may be an inadequate response to pre-existing inequality. Accordingly we would support the incorporation of the objective of substantive equality into the Act.

However, the achievement of substantive equality is also likely to require complementary social policy interventions, signalling again the need for a multi-strategy approach to addressing discrimination in Victoria. This reflects two fundamental principles of public health introduced earlier in this submission: endorsement of multi-faceted approaches (with a wide-range of stakeholders) in order to achieve effective action, and the principle of vertical equity.

In this submission a range of benefits associated with strengthening discrimination law are noted. An additional advantage to health in incorporating the notion of substantive equality is that in theory it will enable groups to preserve distinctive characteristics which may render them vulnerable to discrimination but which may in other respects be protective for health. For example, a requirement to practice substantive equality would enable people to retain practices intrinsic to their religious or ethnic identity (which is understood to be 'health protective') while still enjoying equal access to resources. This is illustrated in a recent positive example whereby a Victorian Football club made specific arrangements in its training schedule to enable an elite Muslim football player to pray and participate in the Muslim month of fasting. Had the club not allowed this flexibility, the player would have been locked out of the game.

However, processes of achieving substantive equality must recognise the potential for misunderstanding by the wider community which could act to further stigmatise populations already facing discrimination. It is important to acknowledge the strengths of communities and explain their rights to substantive equality when resources are being

allocated in order to avoid further stigmatisation. For example, while Indigenous people have mortality rates three to five times greater than other Australians, per capita spending on Indigenous health is only 1.2 times that of the non-Indigenous population (AMA 2007). However, community attitudes have at times shown limited support for increased redistribution of social spending (Wilson et al 2003) or to have recognised privilege exists in Australian society (Bonnett 1997).

Equal treatment reinforcing disadvantage and inequality [3.4.2.4]

We support this in principle insofar as it applies to groups experiencing disadvantage due to discrimination. We would see it as having particular benefits where there is a need for 'women-only' environments to ensure participation (e.g.; women only swimming for women whose religious beliefs prevents them from mixing with men in recreational environments)

Recognition of prior discrimination and entrenched disadvantage [3.4.3.1]

VicHealth strongly supports the concept of systemic discrimination being recognized in the Act. As indicated above systemic discrimination makes a substantial contribution to poor health and there is strong evidence that is a problem.

VicHealth's effort to understand discrimination to date has been largely through social policy and health, as opposed to legal discourse. However we have encountered some issues which may also be relevant in a legal context, and which will almost certainly require consideration when communicating about future changes to government and non-government actors and the general public.

The meaning of systemic discrimination

We note that the term systemic discrimination (also referred to as institutional discrimination) is used in public policy/health discourse to mean variously

- Discrimination perpetrated by individual actors in their systemic/institutional roles
- Discrimination resulting from the operations of systemic/institutional policies, practices, cultures and structures
- The failure to acknowledge historical discrimination against a group that has resulted in that group occupying an inferior or unequal position in society

It is also used to describe discrimination in a range of contexts including:

- State and non-state organizations
- Government policies and programs
- Broader 'environments' such as popular culture, the culture of specific groups and political ideologies.

There would also appear to be some differences of understanding as to whether certain unequal outcomes are due to discrimination or to a failure to respond to disadvantage. For example, if a health service does not provide interpreters to ensure its non-English speaking patients have equal access to health services is this a form of indirect, systemic discrimination or is it a failure to respond to disadvantage born of migration status? This apparent conceptual ambiguity may in part be addressed by applying principles of substantive equality. However, its clarification is relevant to determining which avenue problems are best addressed through. That is, should it be those designed to address disadvantage (where the emphasis is likely to be on social policy mechanisms) or those for addressing discrimination (where both legal and social policy mechanisms are likely to be relevant)?

VicHealth is of the view that all the forms of, and contexts for, discrimination discussed above are of social policy concern. Nevertheless, for the purposes of legislative reform there will be a need to clearly define the concept of systemic discrimination. There will also be a need to determine which aspects of systemic discrimination are practical to address in a legislative context. Given the complex causes of systemic discrimination in some areas, VicHealth would strongly support both the need for complementary social policy reform in this area and for the commission to have a stronger role in addressing systemic discrimination through its other functions (e.g. education, guidelines).

The need for education and communication about systemic discrimination

In the event that responses to systemic and indirect discrimination are strengthened, VicHealth strongly supports the need for a widespread, well-designed public education and communications program. This should be based on extensive formative research to ensure that messages are carefully and appropriately framed. VicHealth's own experience in communicating with the media, government and the public regarding discrimination suggests that the word carries with it connotations of blame and intent. While these concepts may remain salient for some forms of discrimination, they are likely to be counterproductive when communicating about some of the more modern manifestations of interpersonal and institutional discrimination canvassed in both this response and the Discussion Paper.

A well designed communications and public education program would help to ensure proposed changes are understood and accepted by government and corporate sector actors as well as by the general public.

For similar reasons, as discussed earlier in this submission, provision should also be made for ongoing communication in relation to specific decisions and activities undertaken under the Act to avoid both stigmatising affected groups and the possibility of 'back-lash'.

Onus of responsibility - complaints of direct discrimination [3.4.5.1]

VicHealth supports in principle measures to ensure that the onus of responsibility does not lie primarily with the complainant to prove discrimination has occurred.

Impairment [3.4.7.4]

In principle we would support the proposal that the definition of 'impairment' be amended to include medical record or genetic indicators for a particular condition or the presence in the body of organisms that may cause illness. We support this change both on the grounds of fairness and because the possibility of discrimination in these circumstances may be a factor deterring individuals from participation in health screening and testing which might otherwise be beneficial for individual and population health (eg screening for HIV/AIDS, or breast cancer).

We would also support the proposals that:

- it be made unlawful to discriminate against a person because that person has an assistance animal? [3.4.7.5]

- it be made unlawful to discriminate against someone because of their irrelevant criminal record, on the grounds of fairness and because such discrimination has the potential to entrench existing disadvantage. This is particularly the case given that imprisonment itself may often be the consequence of past exposure to discrimination in the criminal justice system (see elsewhere in this submission)

Sexual harassment [3.4.8.1]

VicHealth strongly supports the Commission having a strong role in preventing sexual harassment and other forms of violence against women, including through non-legislative means (e.g. guidelines, audits, public education etc)

Discrimination against volunteers [3.4.8.3]

VicHealth is of the view that both paid and unpaid workers should be protected by Equal Opportunity legislation (i.e. that discrimination against volunteers should be made unlawful).

Alterations to property to accommodate impairment [3.4.9.1]

VicHealth supports in principle changes to the law to enable tenants or owner-occupiers to make reasonable alterations to parts of a property or common property to accommodate an impairment.

Community grants [3.6.2.1]

As is the case for procurement policies, VicHealth agrees that grants from the private or public sectors to community organizations should also encourage compliance with the EOA.

Other specific non-legislative ways of reducing discrimination

There is a need to monitor new technologies to ensure that they are not serving as vehicles for discrimination, (for example, as is the risk with the development of sound repellent for use in shopping malls to deter young people).

VicHealth also supports alterations to the Victorian Building Regulations to require all new dwellings to be built to be visitable by people with disabilities. Targets should be set to ensure all public and commercial buildings are accessible to people with disabilities into the future. For example, the Coalition for Disability Rights recommends an initial target of 50% access to public and commercial buildings by 2010.

Complaints handling [7,8,9]

In regard to complaints handling VicHealth:

- Urges the review to give particular consideration to the impact of alternative dispute resolution (e.g.; conciliation, mediation) in other areas of the law to assess the extent to which inequalities in bargaining power are likely to disadvantage complainants [4.3.2.1]. This may be a particular concern with regard to sexual harassment.

- Supports the availability of legal advocacy to complainants as a means of increasing the accessibility and fairness of complaints procedures (4.4.2.1)

- Supports in principle a range of complaints functions being vested in the commission to the extent that this does not create a conflict of interest. This will help to ensure a seamless and informed approach to the operation of Equal Opportunity law, education and monitoring in Victoria [4.4.2.1]

- Supports in principle changes to complaints handling to achieve systemic outcomes [4.5.5.1; 4.5.9.1; 4.5.9.3]. This would include a stronger role for the commission in using information from the outcomes of individual complaints in its current and possible future roles in education, advice giving, guidelines development and so on.

- Strongly supports enforcement and monitoring of settlement agreements. As well as supporting enforcement, this would assist in evaluating the effectiveness of provisions and their operations over time [4.5.8.1].

REFERENCES

Abhayaratna J and Lattimore R 2006. *Workforce Participation Rates – How Does Australia Compare?* Productivity Commission Staff Working paper, Canberra.

Altman, JC., Biddle, N. and Hunter B. 2004. *Indigenous socio-economic change 1971-2002: A Historical Perspective*. ANU Centre for Aboriginal Economic Policy Research: Canberra.

Anderson I, Baum F. & Bentley, M. (eds), *Beyond Bandaids: Exploring the Underlying Social Determinants of Aboriginal Health. Papers from the Social Determinants of Aboriginal Health Workshop, Adelaide, July 2004*, Cooperative Research Centre for Aboriginal Health, Darwin.

Australian Bureau of Statistics 2004a, 'Disability, Ageing and Carers: Summary of Findings Australia', Australian Bureau of Statistics, Canberra.

Australian Bureau of Statistics 2006, 'Children's Participation in Cultural and Leisure Activities, Australia', Australian Bureau of Statistics, Canberra.

Australian Bureau of Statistics 2007a, 'Average Weekly Earnings Report', Cat 6302.0, May 2007.

Australian Bureau of Statistics 2007c, 'Culture and Recreation News, Sep 2007', Australian Bureau of Statistics, Canberra.

Australian Bureau of Statistics 2007g, 'Involvement in Organised Sport and Physical Activity, Australia'.

Australian Housing and Urban Research Institute 2007, 'How does housing assistance affect employment, health and social cohesion?' in *AHURI Research and Policy Bulletin*, Australian Housing and Urban Research Instiutute, Melbourne.

Australian Institute of Health and Welfare 2007, *Young Australians: their health and wellbeing 2007.*, AIHW, Canberra.

Australian Medical Association 2007. *Aboriginal and Torres Strait Islander Health: Institutionalised inequity, not just a matter of money.* 2007 AMA Report Card accessed at http://www.ama.com.au/web.nsf/doc/WEEN-73EVGV 21/09/07

Begg, S. & Voss, T. et al (2007), *The Burden of Disease and Injury in Australia 2003,* PHE 82, AIHW, Canberra

Blank RM, Dabady M & Citro CF (eds) 2004, *Measuring Racial Discrimination*, National Academy of Sciences, National Academies Press, Washington DC

Borooah, V. & Mangan, J. 2007, 'Love Thy Neighbour: How Much Bigotry is there in Western Countries?' eds J. Taylor and V. Borooah, University of Queensland, St Lucia.

Brondolo E, Rieppi R et al 2003, 'Perceived racism and blood pressure: A review of the literature and conceptual and methodological critique; *Annals of Behavioural Medicine*, 25(1),55-65

Brouwer, G. E. 2006, 'Conditions for persons in custody: report of Ombudsman Victoria and Office of Police Integrity', Victorian Government, Melbourne.

Coalition for Disability Rights 2006 *Call to political parties: 2006 Victorian State Election*. Fitzrory.

Colic-Peisker V & Tilbury F 2007, *Refugees and employment: The effect of visible difference on discrimination*, Centre for Social and Community Research, Murdoch University.

Cooper H, Friedman S et al 2005, 'Racial/etnic disparities in injection drug use in large US metropolitan areas', *Annals of Epidemiology*, 15(5), 326-34.

Coory MD & Walsh WF. 2005. *Rates of percutaneous coronary interventions and bypass surgery after acute myocardial infarction in Indigenous patients*, Med J Aust, 182(10), 507-12.

Cortis N, Sawrikar P & Muir K 2007, *Participation in Sport and Recreation by Culturally and Linguistically Diverse Women,* Social Policy Research Centre, University of NSW

Cowlishaw G 1997. Where is racism? In G. Cowlishaw & B Morris (Eds.), *Race matters: Australians and 'our' society* (pp. 177–189). Canberra: Aboriginal Studies Press.

Department of Immigration and Multicultural Affairs, 1997. *Racism in Australia 1990–96*. Canberra: AGPS.

Department of Justice 2005, 'Section 3: Statistical Information on Indigenous Over-Representation in the Criminal Justice System', Victorian Government, Melbourne, Victoria.

Department of Justice 2006, 'Victorian Aboriginal Justice Agreement, Phase Two', Indigenous Issues Unit, Department of Justice, Government of Victoria, Melbourne.

Department of Premier and Cabinet, 2004, 'Beyond Five Million: The Victorian government's Population Policy' Victorian Government Department of Premier and Cabinet.

Donovan R J & Vlais R 2006, *A Review of Communication Components of Anti-Racism and Pro-Diversity Social Marketing/Public Education Campaigns,* Report To VicHealth by RJD Consulting Pty Ltd, June

Dressler WW, Oths KS et al 2005, 'Race and Ethnicity in Public Health Research: Models to Explain health Disparities', *Annual Review of Anthropology*, 34(1), 231-52.

Dunn K, Forrest J, Pe-Pau R, & Smith S, 2004 'Experiences of Racism in the Australian Body Politic: Extent, Spheres, and Cultural Unevenness', UQ Australian Studies conference, 'The Body Politic' in Brisbane, 24-26 November 2004.

Dunn K, Gandhi V, Burnley I, Forrest J, 2003. *Racism in Australia: Cultural Imperialism, disempowerment and violence*, New Zealand Geographical Society 22nd Annual Proceedings, pp. 175 – 179

Dunn, K. M., & McDonald, A. 2001. The geography of racisms in NSW: A theoretical exploration and some preliminary findings from the mid 1990s. *Australian Geographer, 32*, 29–44.

Equal Opportunity Commission of NSW 1999, *Managing for Diversity*, Department of Premier and Cabinet NSW

Forrest J & Dunn K M, 2007, *Strangers In Our Midst? Intolerance and Discrimination Toward Minority Cultural Groups In Victoria,* Report To VicHealth.

Forrest J & Dunn K M, 2007, 'Constructing Racism In Sydney. Australia's Largest Ethnicity' *Urban Studies* 44 (4) 699-721

Gee 2002, 'A multilevel analysis of the relationship between institutional and individual racial discrimination and health status', *American Journal of Public Health*, 92(4), 677-84.

Gifford, S. 2007, 'Analysis of date from the Good Starts for Refugee Youth longitudinal study', ed M. Boyd, Melbourne.

Gopalkrishnan N 2004, *Cultural Diversity and Civic Participation in Queensland.* Centre for Multicultural and Community Development, University of the Sunshine Coast

Ho C & Alcorso C 2004, 'Migrants And Employment: Challenging The Success Story', *Journal Of Sociology,* 40(3), Pp. 237–59.

Howe, B. 2007, *Weighing Up Australian Values*, University of NSW Press Ltd, Sydney.

HREOC 1991. *Racist violence: Report of the national inquiry into racist violence in Australia*. Human Rights and Equal Opportunity Commission. Canberra: AGPS.

Karlsen S & Nazroo J 2002, 'Relationship between racial discrimination, social class, and health among ethnic minority groups', *American Journal of Public Health*, 92(4), 624-31.

Kisely, S., Smith, M., Lawrence, D., Cox, M., Campbell, L. A. & Maaten, S. 2007, 'Inequitable access for mentally ill patients to some medically necessary procedures', *CMAJ*, vol. 176, no. 6, pp. 779-84.

Krieger M 1999, 'Embodying inequality: a review of concepts, measures and methods for study', *International Journal of Health Services,* vol. 29, no. 2, pp. 295–352.

LaMontagne AD, Shaw A, Ostry A, Louie AM, and Keegel T (2006): *Workplace Stress in Victoria: Developing a Systems Approach.* Melbourne: Victorian Health Promotion Foundation, 152 pages. See www.vichealth.vic.gov.au/workplacestress.

LaMontagne AD, Keegel T, Vallance D, Louie AM, Ostry A, Wolfe R, and Smith P. "Low paid work, occupational hazards, and health," presented at LOW PAID WORK IN AUSTRALIA: REALITIES & RESPONSES, Brotherhood of St. Laurence & Centre for Public Policy, 17 October 2007, Melbourne. See http://www.public-policy.unimelb.edu.au/events/LaMontagne.pdf.

Laplagne, P., Glover, M. & Shomos, A. 2007, 'Effects of Health and Education on Labour Force Participation, Staff Working Paper.' Productivity Commission, Melbourne.

Larson, Gillies, Howard & Coffin 2007, "It's enough to make you sick: the impact of racism on the health of Aboriginal Australians," *Aust NZ J Public Health,* Vol 31 No 4: 322-9

Link BG, Phelan JC 2006, 'Stigma and its public health implications' *Lancet* 367, 528-9

Mays, V. M., Cochran, S. D. et al. 2007. "Race, Race-based Discrimination, and Health Outcomes Among African Americans." *Annual Review of Psychology* 58: 20 -225.

Melbourne Citymission 2006. *Policy Bites: Equipping Inclusion Forum, Addressing the shortfall for Victorians living with a disability*, Melbourne Citymission, November 2006.

Mooney G 2000 'Vertical Equity in Health Care Resource Allocation', *Health Care Analysis* 8(3): 1065 – 3058.

Morrell, S. L., Taylor, R. J. & Kerr, C. B. 1998, 'Jobless. Unemployment and young people's health', *Med J Aust*, vol. 168, no. 5, pp. 236-40.

Morrow V 2000. 'Dirty looks and trampy places in young people's accounts of community and neighbourhood: implications for health inequalities, *Critical Public Health* 10(2) pp.141-152

Navarro V, Muntaner C, Borrell C, Benach J, Quiroga A, Rodriguez-Sanz M, Verges N, Parsarin MI 2006 'Politics and health outcomes', *The Lancet* 368 (9540): 1033 – 1037.

Nazroo, J. Y. 2003. "The Structuring of Ethnic Inequalities in Health: Economic Position, Racial Discrimination, and Racism." *American Journal Of Public Health* 93(2): 277-284.

Nichols S, Sammaratino A et al 2005, *The Business Case for Diversity Management*, viewed March 2006, www.diversityaustralia.gov.au

Palmer G, MacInnes T & Kenway P 2007 *Monitoring Poverty and Social Exclusion*. Joseph Rowntree Foundation, London, UK.

Paradies Y 2006a, 'Defining, Conceptualising And Characterising Racism In Health Research', *Critical Public Health,* 9(2):, pp. 43–57.

Paradies Y 2006b, 'A Systematic Review Of Empirical Research On Self Reported Racism and Health', *International Journal Of Epidemiology,* Vol. 35, pp. 888–890.

Paradies Y 2007, *Exploring the Health Effects of Racism for Indigenous people*. Keynote address to the Rural Health Research Colloquium, Tamworth.

Pay Equity Working Party 2005, *Advancing Pay Equity – Their Future Depends On It*. Report to the Minister for Industrial relations. February 2005.

Pedersen A, Walker I & Wise M 2005 'Talk does not cook rice: Beyond Anti-Racism Strategies for Social Action' *Australian Psychologist* vol 40, no 1, pp20-30.

Pedersen A, Attwell J & Heveli D 2005, 'Prediction of negative attitudes toward Australian asylum seekers: False beliefs, nationalism and self-esteem', *Australian Journal of Psychology,* vol. 57, pp. 48–60.

Pedersen A, Griffiths B, Contos N, Bishop B, et al. 2000 Attitudes toward Aboriginal Australians in City and Country Settings. *Australian Psychologist.* 2000;35(2):109-17.

Putnam RD 2007 '*E Pluribus Unum;* Diveristy and Community in the Twenty-First Century: Perspectives and parameters' *Scandanavian Political Studies* Vol 30, No 2.

Saunders P, Naidoo Y & Griffiths M. *Towards New indicators of Disadvantage: Deprivation and Social Exclusion in Australia*, NSW Social Policy research Centre, November 2007

Schulz A, Williams D et al 'Unfair treatment, neighbourhood effects, and mental health in the Detroit metropolitan area', *Journal of Health and Social Behaviour*, 41(3), 314-32.

Stanwick, J., Ong, K. & Karmel, T. 2006, 'Vocational education and training, health and wellbeing: Is there a relationship?' National Centre for Vocational Education Research, Adelaide.

Steering Committee for the Review of Government Service Provision 2007, *Overcoming indigenous Disadvantage: Key Indicators 2007*, Productivity Commission, Canberra.

Tiecher J, Shah C & Griffin G 2002, 'Australian immigration: the triumph of economics over prejudice?', *International Journal of Manpower,* 23(3), 209–36.

Turrell, G., Stanley, L., Loopeer, M. d. & Oldenburg, B. 2006, *Health Inequalities in Australia: Morbidity, Health Behaviours, Risk Factors and Health Service Use*, Queensland University of Technology and Australian Institute of Health and Welfare, Canberra.

University of South Australia (UNISA) 20004, *Anti-Racism Policy*, viewed July 2007, www.unisa.edu.au/policies/policies/corporate/C21.asp#Definitions

Secretary General 2006 'In-depth study on all forms of violence against women; Report of the Secretary General'. United Nations general Assembly.

VicHealth 2004 'The health Costs of Violence: Measuring the Burden of Disease Caused by Intimate Partner Violence. A summary of findings' Victorian Health Promotion Foundation, *Victoria.*

VicHealth 2007. *More than tolerance: Embracing diversity for health*, Victorian Health Promotion Foundation, Carlton South
VicHealth 2007a 'Preventing violence before it occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria' Victorian Health Promotion Foundation.

Warr, D. J. 2005, 'Social networks in a 'discredited' neighbourhood', *Journal of Sociology*, vol. 41, no. 3, pp. 285-308.

Waters, A.-M. 2001, 'Do housing conditions impact on health inequalities between Australia's rich and poor?' Australian Housing and Urban Research Institute

Williams, D. R. and R. Williams-Morris (2000). "Racism And Mental Health: The African American Experience." *Ethnicity & Health* 5(3/4): 243-268.

Yen, I., D. Ragland, et al. (1999). "Racial Discrimination and Alcohol-Related Behavior in Urban Transit Operators: Findings from the San Francisco Muni Health and Safety Study." *Public Health Reports* 114(5): 448-458.