



Legally Invisible—How Australian Laws Impede Stewardship and Governance for Aboriginal and Torres Strait Islander Health

Discussion Paper

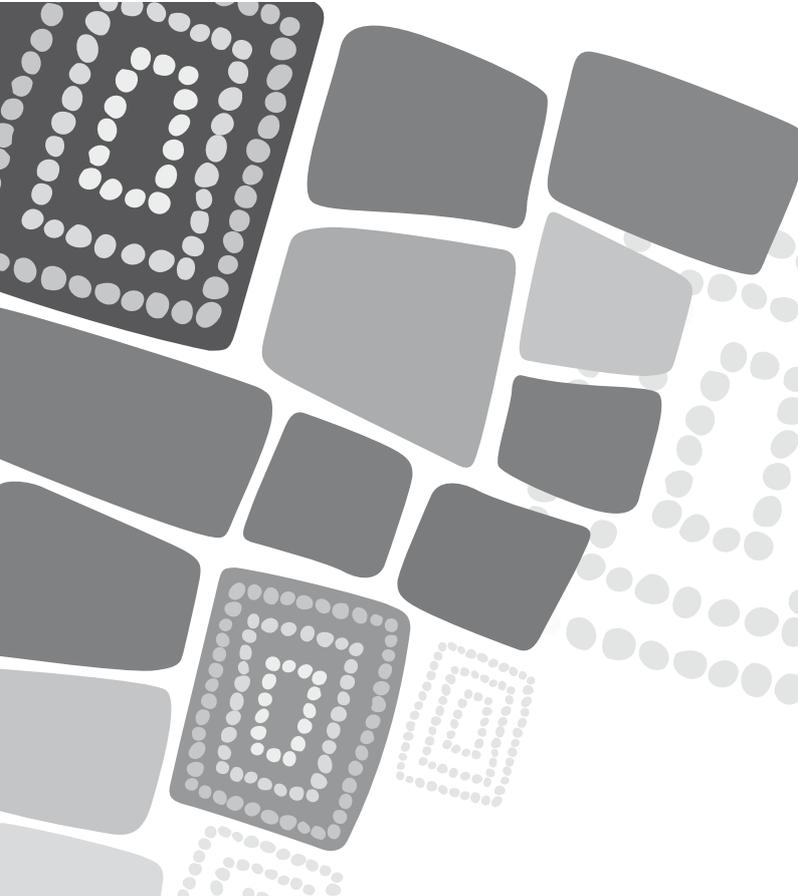
Genevieve Howse



the
Lowitja
INSTITUTE

Australia's National Institute
for Aboriginal and Torres Strait
Islander Health Research

*Incorporating the Cooperative Research Centre
for Aboriginal and Torres Strait Islander Health*



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November 2011



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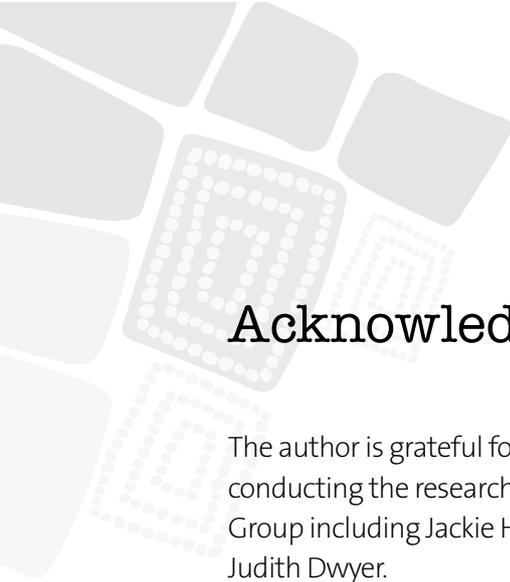
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Abbreviations

| | |
|--------|--|
| ALRC | Australian Law Reform Commission |
| ICCPR | International Covenant on Civil and Political Rights |
| NHHRC | National Health and Hospitals Reform Commission |
| UNDRIP | United Nations Declaration on the Rights of Indigenous Peoples |



Executive Summary

This paper explains the options available for Australian governments to articulate and allocate responsibilities for the health and health care of Aboriginal and Torres Strait Islander people in an enduring, reliable form. It was commissioned by the Lowitja Institute – Australia’s National Institute for Aboriginal and Torres Strait Islander Health Research in response to widespread recognition of problems in the policy and administrative arrangements for health and health care for Australia’s First Peoples, including lack of clarity about the responsibilities of governments at various levels.

Rationale and method

The need to consider this question arises in the context of the universally acknowledged seriousness of ‘the health gap’ – the relatively poor health status of Aboriginal and Torres Strait Islander people – and concerns about the effectiveness of current governance and stewardship arrangements, both nationally and in the Australian jurisdictions (States and Territories).

National stewardship for health has been defined as ‘the careful and responsible management of the wellbeing of the population’ (WHO 2000:viii) and is the responsibility of government, usually through a ministry of health. In broad terms, governance can be defined as ‘the actions and means adopted by a society to promote collective action and deliver collective solutions in pursuit of common goals’ (Dodgson, Lee & Drager 2002:6).

Governance for health is founded in both legislative and administrative arrangements. Currently, administrative arrangements for Aboriginal and Torres Strait Islander health and health care are characterised by diffused responsibilities among national and jurisdictional governments and multiple portfolios, together with high administrative costs in the negotiation, coordination and implementation of tightly specified, time-limited programs and ‘strategies’.

On the other hand, recognition in law is powerful. Legislative duties and functions are the focus of public service departments and agencies. Ministers and secretaries must report compliance and progress against them. Agencies receive recurrent funding in budgets for legislated functions, and policy making and planning activities concentrate on them. International obligations, and the human rights-based approach to health, also favour legislation and national policy (Aboriginal and Torres Strait Islander Social Justice Commissioner 2005:54).

This paper focuses on the question of options for legislative approaches to stewardship and governance for Aboriginal and Torres Strait Islander health, as an alternative to the existing complex and changing administrative approaches.

The current legal and policy framework

A comprehensive review of existing health legislation in Australia found very little specific recognition of the needs of Aboriginal and Torres Strait Islander people in any of Australia’s nine jurisdictions. Where it was found, it generally failed to provide for a mechanism of input to decision making or implementation. This almost total lack of recognition in national and sub-national laws

for the health needs of Aboriginal and Torres Strait Islander people leaves a weak or non-existent legislative structure on which to found stewardship and governance for Aboriginal and Torres Strait Islander health.

Of 69 principal Acts administered by the Commonwealth Department of Health and Ageing (DoHA 2009), three specifically refer to Aboriginal and Torres Strait Islander people and none create responsibility for stewardship or governance. Of the approximately 200 Acts administered by State and Territory health authorities, only South Australia has included specific provisions in its public health law or health service delivery law that could be used to justify policy making, programming and financing decisions. Thus, among the approximately 250 principal Acts administered by the Commonwealth, State and Territory health portfolios, there is no Australian law or series of laws which, taken together, create a legislative structure to secure stewardship and governance for the health of Aboriginal and Torres Strait Islander people.

Three approaches to law and policy

There are three relevant ways of conceptualising laws and legal policy for Aboriginal and Torres Strait Islander health and health care:

- a human rights approach
- therapeutic jurisprudence
- legal pluralism.

The human rights approach (based on international covenants) gives weight to advocacy for a broad-based and holistic approach to stewardship and governance for Aboriginal and Torres Strait Islander health.

Therapeutic jurisprudence is the idea of the law itself having positive or negative therapeutic consequences. Legal pluralism gives weight to an acknowledgment that more than one source of law in Australia may be relevant to stewardship and governance for Aboriginal and Torres Strait Islander health. Both of these latter two approaches, as well as supporting constitutional recognition, also provide a basis for recognition of customary and community-based approaches to health promotion, health education and the prevention of diseases.

Experiences of other countries

Other countries with Indigenous populations and an introduced legal system have grappled with similar issues. No country is exactly like Australia, but examination of the experience of New Zealand, the United States (US) and Canada supports the value for health governance and stewardship of legal recognition, and the need for greater coherence in policy and program responsibility.

Options for law reform

This paper identifies a number of elements necessary to achieve stewardship and good governance, including:

- constitutional recognition as a basis
- governance arrangements that bring together the levers for policy-making
- clarity of responsibility
- an active role for Aboriginal and Torres Strait Islander people.

Three options for law reform are derived from the analysis in this paper. The first is a Commonwealth law that establishes government responsibility for important functions and principles to guide interpretation and administration of all Commonwealth health legislation. The second is nationally consistent laws at State and Territory level (on the model of the national health practitioner registration laws). The third is the development of model provisions for adoption, as required, into State and Territory law.

Conclusions

This review shows that the configuration of Australian laws allocating responsibility for the health of Aboriginal and Torres Strait Islander people fails to set up a structure in which system-wide stewardship and good governance may be undertaken. Instead, the current configuration of laws creates a need to negotiate through a bewildering array of jurisdictions, laws, policies, criteria for funding, and funding streams through, and within which, accountability for health outcomes is diffused and muddled.

Laws and legal systems are capable of change. Recent shifts, and the continuing national conversation about recognition of Aboriginal and Torres Strait Islander people in our Constitution, encourage optimism that the national consciousness may be more open to reform.



Introduction: Rationale and Method

National stewardship for health has been defined as ‘the careful and responsible management of the wellbeing of the population’ (WHO 2000:viii) and is the responsibility of government, usually through a ministry of health. In broad terms, governance can be defined as ‘the actions and means adopted by a society to promote collective action and deliver collective solutions in pursuit of common goals’ (Dodgson, Lee & Drager 2002:6).

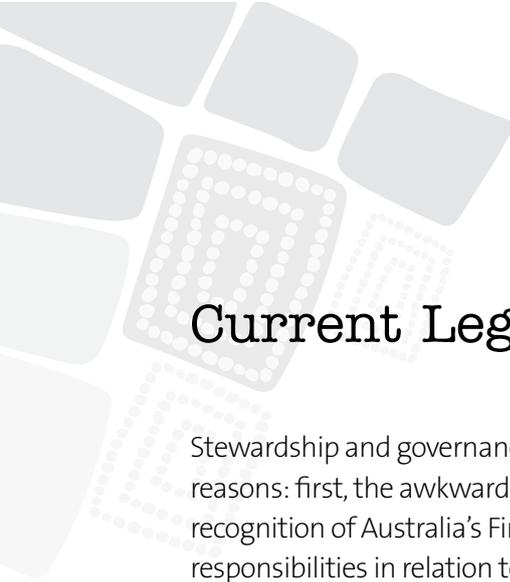
In embracing stewardship of the health system of a nation, the responsible ministry of health must ensure the health sector is properly governed at national and sub-national levels based on government policy, legislated functions and duties, and prevailing domestic and international standards and values where these have been accepted or ratified. Governance of the health system is founded in both legislative and administrative arrangements. An examination of these arrangements reveals the extent to which collective action is enabled through government leadership and makes possible the participation of non-government actors in ongoing decision making in a meaningful way.

This paper focuses on stewardship and governance for Aboriginal and Torres Strait Islander health as each is found or supported in Australia’s laws. It examines whether the configuration of Australian laws allocating responsibility for health and for the affairs of Aboriginal and Torres Strait Islander people is adequate to establish a structure in which system-wide stewardship and good governance may be undertaken. Recognition in law is powerful. Legislative duties and functions are the focus of public service departments and agencies. Ministers and secretaries must report compliance and progress against them. Agencies receive recurrent funding in budgets for legislated functions, and policy making and planning activities concentrate on them.

Australia, as a United Nations (UN) member, is bound by the International Convention on Human Rights, and has also signed the International Convention on the Rights of Indigenous Peoples. Both of these conventions bring obligations relevant to the governance and stewardship of health for Indigenous peoples. In his 2005 report, the then Social Justice Commissioner Tom Calma highlighted government obligations to ‘give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation’ (Aboriginal and Torres Strait Islander Social Justice Commissioner 2005:54). Australia has fulfilled its obligations in this regard in relation to the general population, but it is not clear that it has done so in relation to the Aboriginal and Torres Strait Islander population.

This paper reviews the current legislative basis of responsibility for Aboriginal and Torres Strait Islander health, and then considers relevant laws, cases, treaty obligations and policies using three different and potentially useful frameworks for conceptualising laws and legal policy: a human rights approach, therapeutic jurisprudence and legal pluralism. It also examines the experiences of other countries—in particular Canada, New Zealand and the US—where recognition of the Indigenous populations in constitutions and health laws provides at least a partial basis for good governance and stewardship of the health of the Indigenous population.

Based on this examination, a series of options for law reform to address stewardship and governance for Aboriginal and Torres Strait Islander health is put forward. These options are critiqued against the three conceptualisations and against the degree of political and administrative challenge they would present.



Current Legal and Policy Framework

Stewardship and governance for Aboriginal and Torres Strait Islander health is difficult for two reasons: first, the awkward, piecemeal and historically discriminatory approach to the legal recognition of Australia's First Peoples; and second, the fragmentation of laws and administrative responsibilities in relation to health. The levers of policy, administration, program development, funding and reporting requirements are spread across several laws, governments and ministerial portfolios. These features of Australian law create systemic constraints on good governance for Aboriginal and Torres Strait Islander health.

The arrival of British common law in Australia

The legal relationship between the Commonwealth of Australia (including its predecessor colonial government) and Australia's Aboriginal and Torres Strait Islander population began with a failure to recognise and accommodate the needs and rights of Australia's First Peoples. Subjects of a 'settled' colony became British subjects at settlement and the law that applied to them was British common law. As Justice Deane commented in *Mabo*:

It would be a curious doctrine to propound today that, when the benefit of the common law was first extended to Her Majesty's indigenous subjects in the Antipodes, its first fruits were to strip them of their right to occupy their ancestral lands (*Mabo v. Queensland (No. 2)* (*Mabo*) [1992] 175 CLR 1 at 19).

Terra nullius, or the doctrine that the land belonged to no one, was disposed of by the High Court in the *Mabo* judgment of 1992, but British settlement in Australia still began with the dispossession of its Aboriginal and Torres Strait Islander population. As Paul Keating said in his Redfern speech the same year that *Mabo* was decided:

It begins, I think, with the act of recognition. Recognition that it was we who did the dispossessing. We took the traditional lands and smashed the traditional way of life. We brought the disasters. The alcohol. We committed the murders. We took the children from their mothers. We practised discrimination and exclusion (Keating 2011).

Since settlement, the progress of lawmaking that is sensitive to the particular needs of Australia's First Peoples has been consistently slow. When the Constitution was drafted, it mentioned Aboriginal people twice: first, it prevented the Commonwealth making laws in relation to the Aboriginal race (Section 51 (26)) and, second, it specifically excluded Aboriginal people from being counted in the census (Section 127). Census figures are used to make policy and planning decisions, so the effect of these two powerful exclusions was to make the Aboriginal race legally invisible to the Commonwealth Government. It took until 1967 for the Constitution to be changed by referendum to recognise the existence of Aboriginal and Torres Strait Islander people.

Responsibility for health care in Australia is divided between two levels of government. The Constitution allocates some limited powers to the Commonwealth¹ to legislate with respect to health, with the remainder belonging to the States. The States and Territories are directly involved in providing services, whereas the Commonwealth Government is predominantly involved in funding services, most of which are privately provided (NHHRC 2009:145). As the National Health and Hospitals Reform Commission (NHHRC) (2009:145) notes:

[the two levels of government] have different approaches to funding, different relationships with health service providers, and different responsibilities for various parts of healthcare. The two levels of government also have different capacities to meet the cost of services from their own revenue.

Anderson et al. (2006:2) describe the history of Aboriginal and Torres Strait Islander health systems in Australia, beginning with the fact that ‘Pre-contact health care systems functioned... on three sets of inter-relationships: between people and the land; between people and creator beings; and between people’. The development of a health system for Aboriginal and Torres Strait Islander people post-contact, according to Anderson et al. (2006:3), was confused and piecemeal, with the Commonwealth only really becoming engaged with Aboriginal affairs, generally, after the 1967 referendum (significantly, with the first recognition of Aboriginal and Torres Strait Islander people in Australian federal law).

Commonwealth health laws

The Department of Health and Ageing administers 69 principal Acts (DoHA 2009). Some laws relevant to health system governance include the *National Health Act 1953* and the *Health Insurance Act 1973*. The National Health Act’s long title describes it as ‘an Act relating to the provision of pharmaceutical, sickness and hospital benefits, and of medical and dental services’. It enables various initiatives such as vaccine provision, funding of nursing homes and pharmaceutical benefits. Aboriginal and Torres Strait Islander people are not mentioned. The Health Insurance Act created Medicare. It does not specifically mention Aboriginal and Torres Strait Islander people either, although, like the National Health Act, it does make some provision for people in poverty with the creation of a safety net and it does make some provision for the relaxation of some rules in rural and remote areas, for example in relation to the use of particular pathologists.

One of only three Commonwealth health laws that specifically mention Aboriginal and Torres Strait Islander people is the *Aged Care Act 1997*. According to its long title, it is ‘an Act relating to aged care and for other purposes’, and it twice mentions people from Aboriginal and Torres Strait Islander communities. They are included in the definition of ‘people with special needs’ for the purposes of the Act² and criteria for community care grants in the Act include ‘whether the grant would assist Aboriginal and Torres Strait Islander communities’. Another Commonwealth health law is the *National Health and Medical Research Council Act 1992*, which places a requirement on the Council

1 Quarantine, Section 51(IX); Corporations, Section 51 (XX); External Affairs, Section 51(XXIX); Section 81, appropriation directly to Commonwealth Programs; and Section 96, Financial Grants to States ‘on such terms and conditions as the Commonwealth thinks fit’.

2 Chapter 2, Division 11, Section 11–3.

to include ‘a person with expertise in the health needs of Aboriginal persons and Torres Strait Islanders.’³

The *Disability Services Act 1986* (Cth) relates to the provision of services for persons with disabilities: Aboriginal and Torres Strait Islander peoples are not mentioned. Nor are they mentioned in the *Dental Benefits Act 2008* (Cth), the *Australian Institute of Health and Welfare Act 1987*, the *Health and Other Services Compensation Act 1995* (Cth), the *Private Health Insurance Act 2007* (Cth), the *States Grants (Home Care) Act 1969* (Cth) or the *Nursing Homes Assistance Act 1974* (Cth).

Despite the constitutional power to legislate with respect to Aboriginal and Torres Strait Islander people and the many reports advising of the specific and urgent health needs of this section of the Australian population, no Commonwealth law addresses governance and stewardship for health care.

State and Territory health laws

At the State and Territory level, each department or ministry of health administers many laws within the health portfolio. Among these, each State or Territory has a law about public health and another that establishes the relationship between the government and the entities delivering health services. For example, Victoria has the *Public Health and Wellbeing Act 2008* and the *Health Services Act 1988*.

As in Commonwealth laws, the particular needs of Aboriginal and Torres Strait Islander people get few mentions in such laws despite the fact that several of these State and Territory public health laws have been reviewed and updated in recent years. A standout exception is South Australia, with the *South Australian Public Health Act 2011* mentioning the needs of Aboriginal and Torres Strait Islander people. Reference is made to their particular needs in the objects (Part 2(4)(f)):

to provide for or support policies, strategies, programs and campaigns designed to improve the public health of communities and special or vulnerable groups (especially Aboriginal people and Torres Strait Islanders) within communities.

This is a very new Act and has not yet commenced, but the SA Health website states that it will be progressively introduced over the next two years (SA Health 2011).

In Western Australia (which has a public health bill that is currently under consideration but not yet passed) and Victoria, both public health laws include an object similar to the one in the South Australian Public Health Act about the improvement of the public health of communities. Another object seen in these two laws is ‘to reduce the inequalities in public health of disadvantaged communities’;⁴ however, Aboriginal and Torres Strait Islander people are not specifically mentioned. Interestingly, the WA Health website states that one of the key reasons for reviewing the *Health Act 1911* (WA) is that the current Act is ineffective in tackling Aboriginal environmental health issues (e.g. the *Health Act 1911* does not bind the Crown, with most Aboriginal communities on Crown Land or managed by Crown entities) (Department of Health 2011).

³ Section 20(2)(d).

⁴ WA Public Health Bill 2008, Section 3; *Public Health and Wellbeing Act 2008* (Vic.), Section 4.

Section 3 of the new Northern Territory *Public and Environmental Health Act 2011* includes the following objects:

- b) to provide a flexible capacity to protect the health of particular individuals and communities in the Territory from emerging environmental conditions, or public and environmental health issues, that may impact on their health and wellbeing;
- c) to enable special action to be taken to protect the health of particular individuals and communities in the Territory who are at public health risk or facing particular health problems.

Although these objects certainly seem to envisage the needs of Aboriginal and Torres Strait Islander communities, and could be used to justify action to address such needs, Aboriginal and Torres Strait Islander people are not specifically mentioned.

The older public health laws in the Australian Capital Territory, Queensland, Tasmania and New South Wales⁵ do not have these kinds of objectives addressing equity and access and the needs of particular communities, and do not specifically mention Aboriginal and Torres Strait Islander people.

Among State and Territory laws that govern health service delivery, only the South Australian *Health Care Act 2008* includes a principle about the health needs of Aboriginal and Torres Strait Islanders to be applied in connection with the operation and administration of the Act:

Aboriginal people and Torres Strait Islanders should be recognised as having a special heritage and the health system should, in interacting with Aboriginal people and Torres Strait Islanders, support values that respect their historical and contemporary cultures (Section 5(b)).

In the same Act, in an explanatory note in a section about management of hospitals, the specific needs of Aboriginal and Torres Strait Islander peoples are mentioned:

An incorporated hospital must be administered and managed on the basis that its services will address the health needs of the community but may, in so doing, focus on 1 or more areas or sections of the community if so determined by the Minister or the Chief Executive.

Note—It is recognised that some groups within the community should be able to access special or enhanced health services due to their special needs. Examples of these groups include veterans, Aboriginal people and Torres Strait Islanders (Section 30).

The *Health Act 1993* (ACT) is a law about health service delivery and includes the following as one of its objectives:

to guarantee equitable access to and participation in health services and to ensure that language and cultural differences are not barriers to such access or participation (Section 10(b)).

The Victorian *Health Services Act 1988* has similar criteria for public funding of agencies: ‘for making its services accessible to minority groups and disadvantaged people’ (Section 18(a)(iii)).

5 *Public Health Act 1997* (ACT), *Public Health Act 2005* (Qld), *Public Health Act 1997* (Tas.) and *Public Health Act 1991* (NSW).

The Queensland *Health Services Act 1991* has a definition of ‘parent’ for the purposes of an Aboriginal child or a Torres Strait Islander child (Section 61(3) and (4)).

The equivalent laws in the Northern Territory, Western Australia and New South Wales⁶ do not have objects, principles or similar mechanisms to establish a requirement to consider health inequalities, vulnerable communities or similar as found in the other Acts, nor do they specifically mention Aboriginal and Torres Strait Islander people.

Aboriginal Health Workers exist in all States and Territories, but only in the Northern Territory have they been registered prior to 2012 (via the *Health Practitioners Act 2004* (NT)). The Aboriginal Health Workers Board is a statutory body responsible for ensuring the public is protected through the regulation of Aboriginal Health Workers registered in the Northern Territory. However, a national board to register Aboriginal and Torres Strait Islander health workers has recently been established. In July 2012 the National Aboriginal and Torres Strait Islander Health Board of Australia will commence under the *Health Practitioner National Law Act 2009* and its regulations in participating jurisdictions (AHPRA 2011).

In summary, of the State and Territory laws that establish health governance, only South Australia specifically mentions the particular needs of Aboriginal and Torres Strait Islander peoples and enables stewardship and governance for Aboriginal and Torres Strait Islander health. The *South Australian Public Health Act 2011* and *Health Care Act 2008* are to be applied and interpreted based on principles that include consideration of the needs of Aboriginal and Torres Strait Islander people.

Victoria, Western Australia, the Australian Capital Territory and the Northern Territory establish objects or principles in either their public health laws or laws that define the relationship between government and providers of public and private health service providers. These objects or principles enable some consideration of the issues that might affect stewardship and governance for Aboriginal and Torres Strait Islander health, but do not specifically mention Aboriginal and Torres Strait Islander people.

Tasmania and Queensland neither mention Aboriginal and Torres Strait Islander people nor create objects and purposes, in either their public health laws or their health services laws, that require consideration of access in equity or the special needs of particular communities in their application.

Other laws

Anti-discrimination laws incorporate human rights principles that would apply to the application and implementation of health legislation and other legislation, providing a forum for complaint in the event of breaches. However, these protections, although welcome, are limited to redressing individual complaints and do not provide a structure for stewardship and governance for Aboriginal and Torres Strait Islander health.

6 *Hospitals Management Boards Act 2001* (NT), *Hospitals and Health Services Act 1927* (WA), *Health Administration Act 1982* (NSW) and *Private Health Facilities Act 2007* (NSW).

Some local government laws, particularly in the Northern Territory, address some local governance issues for rural and remote communities,⁷ but as the NHHRC notes, 53 per cent of Aboriginal and Torres Strait Islander people live in a major city or regional centre, with only 25 per cent living in remote parts of the country (NHHRC 2009:87). Further, such laws, although a welcome advance for some communities, offer nothing towards stewardship and governance for Aboriginal and Torres Strait Islander health across Australia.

Current legislative situation

There is very little specific recognition of the needs of Aboriginal and Torres Strait Islander peoples in any of Australia's nine jurisdictions. Where it exists, it generally fails to provide for a mechanism of input to decision making or implementation. This almost total lack of recognition in national and sub-national laws for the health needs of Aboriginal and Torres Strait Islander people leaves a weak or non-existent legislative structure on which to build stewardship and governance for Aboriginal and Torres Strait Islander health.

Of the 69 principal Acts administered by the Commonwealth Department of Health and Ageing (DoHA 2009), only three specifically refer to Aboriginal and Torres Strait Islander people⁸ and no reference creates responsibility for stewardship or governance. South Australia provides strong leadership among the States and Territories with its new *South Australian Public Health Act 2011*⁹ and its *Health Care Act 2008*, which establish objects and principles about health equity and access. Both Acts also include an object that specifically refers to the needs of Aboriginal and Torres Strait Islander people and that could be used to justify policy making, programming and financing decisions. These are progressive reforms. Although objectives can be found in some other recent health laws in State and Territory jurisdictions (creating obligations to assist communities with special needs and advancing equity and access),¹⁰ no other State or Territory law specifically mentions Aboriginal and Torres Strait Islander people in its public health law or health service delivery law. This is despite State and Territory health portfolios administering between 22 and 29 principal Acts each.¹¹

Among the approximately 250 principal Acts administered by the Commonwealth, State and Territory health portfolios, there is no Australian law or series of laws which, taken together, create a legislative structure to secure stewardship and governance for the health of Aboriginal and Torres Strait Islander people. Instead, the current configuration of laws creates a need to negotiate through a bewildering array of jurisdictions, laws, policies, criteria for funding, and funding streams through and within which accountability for health outcomes is diffused and muddled.

7 The *Local Government Act 1978* (NT) provides for Aboriginal Community Councils, of which 28 have been established in the Northern Territory. The Australian Law Reform Commission stated that the Community Government Scheme, as it is known, might provide a model for law and order powers to be given to certain communities in addition to their local government powers. See ALRC n.d.

8 *Aged Care Act 1997* (Cth), Chapter 2, Division 1, Section 11-3 and *National Health and Medical Research Council Act 1992* (Cth), Section 20(2)(d).

9 The Act has not yet come into operation.

10 *Public Health and Wellbeing Act 2008* (Vic.), *Public and Environmental Health Act 2011* (NT), *Public Health Bill* (WA).

11 Victoria (29), South Australia (23), Northern Territory (24), Queensland (26) and Australian Capital Territory (22). The other three (New South Wales, Western Australia and Tasmania) do not include lists of Acts administered by the portfolio on their websites.

This vacuum in governance persists despite reports, commentaries and calls for action (Stolen Generations Council 2011; Dwyer & Bell 2009; Anderson et al. 2006). Most recently, the National Health and Hospitals Reform Commission recommended the creation of a National Aboriginal and Torres Strait Islander Health Authority (NHHRC 2009), a recommendation that was not taken up by the Commonwealth Government. The recommendation was part of a broader idea for a Healthy Australia Accord, which would incorporate substantial structural reforms in the governance of the health system, including the establishment of the National Aboriginal and Torres Strait Islander Health Authority (NHHRC 2009). Despite this and many other well-informed calls for better stewardship and governance, the pace of law reform in this area has been glacial.

Governance vacuum—a subject of calls for reform

Recent reporting, commentary and academic literature point to frustration caused by this fragmentation and its effect on policy making and programming for Aboriginal and Torres Strait Islander health. For example, a recent Productivity Commission report noted that:

Poor government governance, such as a lack of coordination among agencies, duplication of services, failure to adapt to change, an unstable policy environment and ineffective processes, affect the governance of Indigenous organisations and outcomes for Indigenous people (SCRGSP 2011:690).

Ways of addressing systemic failures have been suggested by Aboriginal and Torres Strait Islander people for years:

...co-operation between governments and communities; ‘bottom up’ involvement in services and planning; sustained consistent government support; and good governance on both sides. This is also what the Productivity Commission (and almost everyone else) have found to work in Indigenous affairs. But these insights are almost always ignored the next time government announces a new policy (Dwyer & Bell 2009).

Laws—whether State, Territory or federal in origin—are neglectful in failing to create a legislative infrastructure to facilitate stewardship and governance for Aboriginal and Torres Strait Islander health.

In Chapter 3 of *A Healthier Future for All Australians: Final Report June 2009*, the NHHRC (2009) explores ‘Tackling major access and equity issues that affect health outcomes for people now’. A recommendation is made as follows:

to create a new National and Torres Strait Islander Health Authority (NATSIHA). This entity is to take all pooled funding that is now (and should be) spent on Aboriginal and Torres Strait Islander people and to actively commission the very best health services—effective, high quality, culturally appropriate and meeting the needs of Aboriginal and Torres Strait Islander people, their families and their communities. And we want this Authority to demand and hold all health services accountable for providing the right services for Aboriginal and Torres Strait Islander people (NHHRC 2009:87).

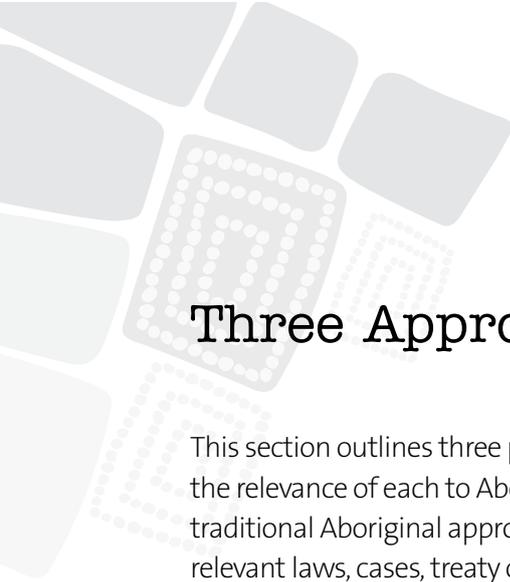
In relation to improving health outcomes of Aboriginal and Torres Strait Islander people, the NHHRC states clearly that:

Our first priority acknowledges the unacceptable health outcomes of Aboriginal and Torres Strait Islander people. To address this, we are recommending a radical change to how we take responsibility for improving the health of our first Australians. We want all the funding for Aboriginal and Torres Strait Islander people to be aggregated. We want a new National Aboriginal and Torres Strait Islander Health Authority to take this funding and actively purchase and commission the very best health services—services that are effective, high quality, culturally appropriate and meet the needs of Aboriginal and Torres Strait Islander people, their families and their communities (NHHRC 2009:3).

The Australian Government did not accept the recommendation. In a response to the NHHRC final report, it stated:

The Government does not support this recommendation. The Government will continue to work closely with the Indigenous health sector in an effort to close the gap in indigenous health outcomes. The Government will also continue to work with the Indigenous health sector in the monitoring and evaluation of the progress on the closing the gap measures. The Government also acknowledges that the ACCHS [Aboriginal Community Controlled Health Services] provide an effective model of culturally appropriate primary health care service delivery and will continue to play an important role into the future under the Government's reform to the health care system (Australian Government 2010:144).

To that end the government will work with the Aboriginal and Torres Strait Islander health sector on the implementation of primary health care reform (Australian Government 2010:128).



Three Approaches to Laws and Policy

This section outlines three possible ways of conceptualising laws and legal policy, and discusses the relevance of each to Aboriginal health and health care. It commences with consideration of traditional Aboriginal approaches to law, and their relevance to modern law. It then considers relevant laws, cases, treaty obligations and policies using three ways of conceptualising laws and legal policy: that is, a human rights approach, therapeutic jurisprudence and legal pluralism.

Traditional and modern law

Customs and traditions vary greatly among communities of Aboriginal and Torres Strait Islander people. The viewpoint of the elderly Ngarinyin described in Hannah Rachel Bell's (1998) book, although deriving from and focusing on a single community, is one example:

For elderly Ngarinyin... the future will only be sustainable if global consciousness shifts to awareness of what they call Two-Way thinking—the ways of ancient indigenous culture in sacred relationship with, and underpinning, the modern worldview (Bell 1998:21).

This viewpoint is useful in helping to illustrate the point that the customs, traditions and dreaming of Aboriginal and Torres Strait Islander people or communities create ways of looking at Country, people and community organisation that are very different from Western ways and are challenging to appreciate and accommodate in a Western legal tradition—a tradition that prefers laws recorded in precise written language from which emotion has been stripped.

How might Australian legal thinking, with all its limitations and its origins in the British legal system, try to grasp the challenge made by the elderly Ngarinyin? In the cold precise world of law, is it possible to use such ideas to influence and inspire some innovative thinking, which can have practical application in an approach to the construction of stewardship and governance structures for Aboriginal and Torres Strait Islander health and which is more resonant with the thinking, dreaming and customs of Australia's First Peoples?

Laws and legal systems are capable of change. Recent shifts in law as to the existence of Aboriginal customary laws, rules and forms of social organisation before the arrival of the British common law at colonisation and their survival after colonisation are evidenced by the majority view of Australia's highest legal authority, the High Court, in the case of *Mabo v. Queensland (No. 2)*.¹² Such shifts and the continuing national conversation about recognition of Aboriginal and Torres Strait Islander people in our Constitution encourage a glimmer of optimism about law reform.

¹² *Mabo v. Queensland (No. 2)* (1992) 175 CLR 1; hereafter, *Mabo*.

A human rights approach

How might human rights obligations and principles apply to stewardship and governance for health of Aboriginal and Torres Strait Islander people?

Australian jurisprudence remains a ‘prisoner of history’ because it is derived from the British common law, which arrived in Australia along with the settlers in 1788 (Mabo No 2.1992:12). It has also been interpreted as giving credence to rights of international law as they are presently understood (Mabo No 2.1992).

The *Mabo* case established that while the common law that was brought to Australia does not necessarily conform with international law, international law is a legitimate and important influence on the development of the common law, especially when international law declares the existence of universal human rights.

A common law doctrine founded upon unjust discrimination in the enjoyment of civil and political rights demands reconsideration (Mabo No 2 1992:22).

This statement was made in *Mabo* and refers to the doctrine of *terra nullius* and to the position argued in that case that, on settlement, the land in the entire continent of Australia vested in the King of England, leaving the Indigenous peoples dispossessed. *Mabo* established that a form of native title under customary law did survive British settlement and the arrival of the common law. Where such title has not been extinguished, it may still be recognised according to the laws and customs of Indigenous peoples (Mabo No 2.1992).

Reconsideration of the common law doctrine to enable the enjoyment of civil and political rights has broader application. Many human rights treaties and declarations ratified or adopted by Australia, if applied to the health needs of Aboriginal and Torres Strait Islander people, would assist in identifying the persistently poor health outcomes of Australia’s First Peoples as a human rights issue. Several treaty obligations directly or indirectly touch on the rights to health of populations and the right to enjoy civil and political rights without discrimination.

Acknowledging the poor health outcomes of Aboriginal and Torres Strait Islander people as a human rights issue is relevant to the issue of stewardship and governance for Aboriginal and Torres Strait Islander health (Aboriginal and Torres Strait Islander Social Justice Commissioner 2005). A human rights approach would justify special measures and the inclusion of Aboriginal and Torres Strait Islander Australian voices at every level of governance, would facilitate treaty making and partnerships in health governance and health service delivery, and would call for an approach that suits Aboriginal and Torres Strait Islander Australians whether they live a traditional lifestyle or in cities and regional centres with access to mainstream health facilities.

Australia’s human rights obligations

Efforts by the international community to codify human rights that might be accepted by all as universal culminated in the 1948 adoption by the United Nations General Assembly of the Universal Declaration of Human Rights. These rights have been further articulated in subsequent conventions. In 1966 the International Covenant on Civil and Political Rights (ICCPR) and the

International Covenant on Economic, Social and Cultural Rights were adopted by the General Assembly.¹³

The usefulness of a human rights approach was considered by the Aboriginal and Torres Strait Islander Social Justice Commissioner in the *Social Justice Report 2005*. The report noted the obligations on Australia under both the International Covenant on Economic, Social and Cultural Rights and the International Convention on the Rights of the Child in relation to Aboriginal and Torres Strait Islander health.

Both the *International Covenant on Economic, Social and Cultural Rights* (Article 12) and the *International Convention on the Rights of the Child* (Article 24) recognise the right of all people to the enjoyment of the highest attainable standard of health. By entering into these treaties, the Government has guaranteed the exercise of this right without discrimination.

The extent of inequality experienced by Aboriginal and Torres Strait Islander peoples indicates that they do not enjoy this and related rights in a non-discriminatory manner. The size of the inequality gap indicates the need for urgent attention to this issue. This has been acknowledged by successive governments in Australia (Aboriginal and Torres Strait Islander Social Justice Commission 2005:Ch.2).

The United Nations Declaration on the Rights of Indigenous Peoples

The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) was adopted by the United Nations General Assembly in September 2007. Mick Gooda, the current Aboriginal and Torres Strait Islander Social Justice Commissioner, welcomed the declaration with the following words:

As an international instrument, the Declaration provides a blueprint for Indigenous peoples and governments around the world, based on the principles of self-determination and participation, to respect the rights and roles of Indigenous peoples within society. It is the instrument that contains the minimum standards for the survival, dignity and well-being of Indigenous peoples all over the world (Australian Human Rights Commission 2010).

On 3 April 2009 the Hon. Jenny Macklin MP announced in parliament that Australia supported the declaration. In announcing the adoption of the Declaration on the Rights of Indigenous Peoples, she stated that 'While it is non-binding and does not affect existing Australian law, it sets important international principles for nations to aspire to' (Macklin 2009).

Despite the words of the Minister in a public statement that the Declaration on the Rights of Indigenous Peoples makes no difference to Australian law, this is not a definitive statement as to how the High Court may interpret the effect of government action in law in moving to support publicly a declaration it had once opposed. In her statement adopting the declaration, the Minister also affirmed that after voting against the declaration in 2007, 'Today, Australia changes its position. Today, Australia gives our support to the Declaration' (Macklin 2009).

¹³ Other treaties to which Australia has acceded and have relevance to Aboriginal and Torres Strait Islander people include: the International Convention on the Elimination of All Forms of Racial Discrimination; the Convention on the Elimination of All Forms of Discrimination Against Women; the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; the Convention on the Rights of the Child; and the Convention on the Rights of Persons with Disabilities.

The Australian Government has promised to be guided by the principles of the declaration. Its legal effect may be stronger than mere guidance, but law in this area is not settled.

Are ‘special provisions’ measures justified on human rights grounds or are they discriminatory?

The Australian Law Reform Commission (ALRC) recognised a tension between the principle of equality and non-discrimination and the need to make special provision, including special legal provision, for members of minority groups because of the distinct problems they face (ALRC 1986). The ALRC concluded that special measures for the recognition of Aboriginal customary laws will not be racially discriminatory and will not involve a denial of equality before the law or equal protection as those concepts are understood in comparable jurisdictions, if these measures:

- are reasonable responses to the special needs of those Aboriginal people affected by the proposals
- are generally accepted by them, and
- do not deprive individual Aborigines of basic human rights, or of access to the general legal system and its institutions (ALRC 1986:para.165).

The ALRC also thought that the question of obligations towards minorities (especially Indigenous minorities) needs to be distinguished from the question of preserving individual human rights (including those of minority groups) (ALRC 1986:para.170).

Constitutional recognition of Australia’s First Peoples

One concrete way to implement international human rights treaty obligations relevant to Aboriginal and Torres Strait Islander Australians is to recognise them in our Constitution. Reynolds, Howse and Beesley (2007:213) ask about the benefit of such recognition in a health context:

How might positive rights be relevant to Indigenous communities in Australia? We are a wealthy country and have the resources to provide a good level of health care for all of our citizens. More particularly, the deficits in Indigenous health are so great that a ‘rights based’ approach would demand more be spent on Indigenous health... A constitutional right to health would provide a forum for an applicant, representing an Indigenous community, to take the matter to court and to seek an order that his or her constitutional right was not being met.

Some limitations on a human rights approach

Experiences in the Pacific illustrate some of the limitations of a rights-based approach. There may be some cause for sensitivity and caution in confining policy justifications to human rights instruments as there may also be moves within Aboriginal and Torres Strait Islander communities to approach social organisation in ways that are not resonant with the Western style expression of rights.

ALRC considered the application of Australia’s human rights obligations in the absence of an Australian bill of rights in domestic law. It took the view that human rights conventions and international obligations may require some degree of recognition of customary law and traditions;

on the other hand, there may be aspects of customary law and traditions that may be said to contravene basic human rights. The consistency of a law or practice with basic human rights must depend on an examination of the particular issue in its context, and cannot be decided in the abstract (ALRC 1986:para.170).

Problems have been encountered with implementation of human rights treaties in countries where strong traditions of customary law and village-based community organisation do not always fit well into a rights-based framework.

One scholar described attempts by non-government organisations and government officials to incorporate Indigenous social institutions such as kinship systems and transnational models (e.g. women's shelters) and human rights ideas (e.g. safety from violence) in this manner: 'The result is a bricolage of elements in constantly shifting relation to one another made up of elements that do not necessarily fit together smoothly' (Merry 2006:135).

A rights-based approach strengthens arguments for recognition of Australia's First Peoples in the Constitution and for better stewardship and governance for Aboriginal and Torres Strait Islander health. Treaty obligations help give policy and legal legitimacy to broader demands for legal recognition of the right to health, involvement in decision making and policy making, and approaches more resonant with the culture of Aboriginal and Torres Strait Islander communities. The recent announcement of formal support from the Australian Government for the United Nations Declaration on the Rights of Indigenous Peoples is an encouraging step and is likely to provide further legitimacy to advocacy in this area. It is suggested, however, that care should be taken in singling out a particular approach to ensuring the nurturing of a community or communities, which may conceptualise community organisation and community responsibility quite differently from approaches described in the formal language of a bilateral treaty. It may be that a rights-based approach works best as one of a number of ways of justifying the need for better stewardship and governance for Aboriginal and Torres Strait Islander health.

Conclusions

A human rights approach gives weight to advocacy for a broad-based and holistic approach to stewardship and governance for Aboriginal and Torres Strait Islander health. Some measures that may be specifically justified using the rights in the various human rights instruments ratified by Australia and the Declaration on the Rights of Indigenous Peoples (now adopted) could include:

- consistent with the human rights approach, special provisions to advance Aboriginal and Torres Strait Islander health (Universal Declaration of Human Rights (ICCPR), United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP))
- the right to implement customary law approaches (UNDRIP)
- special approaches to remote health care and specific focus on health care needs of women in rural areas and for reproductive care (Convention on the Elimination of All Forms of Discrimination Against Women)

- acknowledgment that the health care needs of Aboriginal and Torres Strait Islander people may be the subject of special programs, which is justified on grounds that it is discriminatory for the health system to produce such different outcomes for different races (Universal Declaration of Human Rights)
- the right to involvement in decision making (UNDRIP)
- development of partnerships and treaties (UNDRIP)
- the right to culturally appropriate health services (ICCPR, UNDRIP)
- the right to enjoy the highest standards of physical and mental health (ICCPR)
- the right to recognition in the Constitution relevant in a broader sense and as the implementation of the right to health (ICCPR, UNDRIP).

Therapeutic jurisprudence

The field of therapeutic jurisprudence originated in the work of David Wexler and Bruce Winick. It is relatively recent and began in the field of mental health law, but has since expanded into many other areas of law including criminal law, family law, juvenile law, health law, preventive law, tort law, the law of evidence and the legal profession (Wexler 2011). Wexler and Winick describe therapeutic jurisprudence as:

an approach which seeks to assess the therapeutic and counter therapeutic consequences of law and how it is applied, and to effect legal change designed to increase the former and diminish the latter. It is a mental health approach to law that uses the tools of the behavioural sciences to assess the law's therapeutic impact, and when consistent with other important values, to reshape law and legal processes, in ways that can improve the psychological functioning and emotional wellbeing of those affected (Winick 2000).

The idea of law itself having positive or negative therapeutic consequences is echoed in recent commentary on the effect of social disadvantage, including that experienced under the law, as having a direct effect on the health of Aboriginal and Torres Strait Islander people. Such commentary sits well within a concept of therapeutic jurisprudence as it examines direct and indirect consequences of Australian laws on the health of Aboriginal and Torres Strait Islander people.

It is not possible, in our view, to understand the persistent poor health status of the original custodians of Australia since the time of European arrival and invasion, without situating this understanding within the history of dispossession, colonisation, failed attempts at assimilation, racism and denial of citizenship rights (Baum, Bentley & Anderson 2007:x).

At least two of these disadvantages — dispossession and denial of citizenship rights — are direct consequences of laws, while others are arguably exacerbated by current laws and legal structures. The same paper goes further in suggesting direct health consequences from legal structures; it raises the original official position of the British Government that the colony of Australia was *terra nullius* or 'land of no one':

For any people, the refusal to recognise occupation of land as a basic determinant of health would be crucial, but even more so for a people who had lived so closely to the land in a stable culture for thousands of years (Baum, Bentley & Anderson 2007:xi).

‘Cultural security’ is an example of a therapeutic principle that might be applied under a therapeutic jurisprudence approach. It could operate to justify legislation recognising the cultural contribution of Aboriginal and Torres Strait Islander people in the Constitution because of the importance of recognition in the context of its health consequences. This principle, that the construct and services of the health system should not compromise the cultural rights, views, values and expectations of indigenous peoples (Anderson et al. 2006:8) is an element of quality and equity in health care consistent with, for example, the Aboriginal and Torres Strait Islander Health Performance Framework (Australian Health Ministers Advisory Council 2011).

This concept is also consistent with the idea of therapeutic jurisprudence as an attempt to recognise the importance of the structures of the laws that establish the health system. The configuration of laws can have health consequences. When an approach is taken which is grounded in therapeutic jurisprudence, laws establishing the health system set out to achieve resonance with cultural values and processes rather than create discordance with the values and modes of social organisation of Aboriginal and Torres Strait Islander people and, therefore, be potentially, and inadvertently, destructive.

The Human Rights and Equal Opportunity Commission’s *Social Justice Report 2005* (Aboriginal and Torres Strait Islander Social Justice Commissioner 2005) put considerable emphasis on the role of social determinants of health, and stressed that land and culture are important to health and that racism is detrimental to health. A similar point was made in a paper on recognition of the rights of Indigenous people in Cambodia (Simbolon 2009).

Reynolds, Howse and Beesley (2007) argue that law can be seen as a determinant of Aboriginal and Torres Strait Islander health and, as such, arguments could be made for recognition of Australia’s First Peoples in the Constitution. The same conceptualisation also justifies other forms of recognition.

Therefore, in considering a framework for governance and leadership in Aboriginal and Torres Strait Islander health, the nature of proposed laws, including the extent to which they acknowledge the history, culture and social organisation of Aboriginal and Torres Strait Islander Australians, is itself worthy of consideration for its possible therapeutic effect. Such a conceptualisation justifies a form of governance that is holistic, includes Aboriginal and Torres Strait Islander decision making, and enables treaties, delegations and funding of existing Aboriginal and Torres Strait Islander organisations to deliver health services where possible.

Conclusions

Therapeutic jurisprudence in this context gives weight to advocacy for a broad-based and holistic approach to stewardship and governance for Aboriginal and Torres Strait Islander health and broader measures to acknowledge the contribution of Australia's First Peoples to the development of this country. Some measures that may be specifically justified using such an approach could include:

- acknowledgment in the Constitution of Aboriginal and Torres Strait Islander people as the first Australians and as custodians of an important source of culture and of law, which remains important today to all Australians
- acknowledgment in principles of health legislation of the holistic approach to health taken by Aboriginal and Torres Strait Islander people
- incorporation within public health laws of opportunities for customary approaches to public health education, health promotion and disease prevention in traditional communities where possible.

Legal pluralism

Legal pluralism may be described as the situation resulting from the existence of distinct laws or legal systems within a particular country, especially where that situation results from the transfer or introduction of one of the systems as an aspect of an introduced political system and culture (ALRC 1986:para.166).

Although writers may disagree on particular issues, there is agreement that there existed in traditional Aboriginal societies a body of rules, values and traditions, more or less clearly defined, which were accepted as establishing standards or procedures to be followed and upheld. Furthermore, these rules, values and traditions continue to exist, in various forms, today (ALRC 1986:para.99). Aboriginal customary law continues to exist alongside the common law, which came to this country at British settlement, giving Australia a pluralist legal system. The operation and acceptance of customary law in Australia is considerably weaker than that found in other countries in the Pacific region, which recognise customary law in their constitutions and embrace it in other laws and within their court systems (e.g. as in Papua New Guinea, the Solomon Islands and Vanuatu).

The Pacific provides many examples of pluralist legal systems in operation. It is a region in which pluralist legal orders or a multiplicity of forms of law might be found in virtually every country in the region (Forsyth 2009:36). As one commentator put it:

The existence of normative legal systems operating independently, or semi independently from the State, such as the *Kastom* system in Vanuatu, is an empirical reality for almost every decolonized country in the world (Forsyth 2009:29).

The ALRC asked the question:

whether the impact of the introduced culture and legal system, and the associated drastic changes in Aboriginal society, still permit measures for the recognition of Aboriginal customary laws. If they do, what form should such recognition now take? (ALRC 1986:5).

Legal pluralism enables two systems to exist side by side, one system even existing as part of the other as in the case of Papua New Guinea village courts, which apply custom and which are part of the broader court system and have an appellate jurisdiction in the District Court. *Mabo* recognised that some system of Indigenous land ownership continued to exist alongside the common law after colonisation.

What might recognition of the ongoing existence of Aboriginal customary law look like and what does it mean for stewardship and governance for Aboriginal and Torres Strait Islander health?

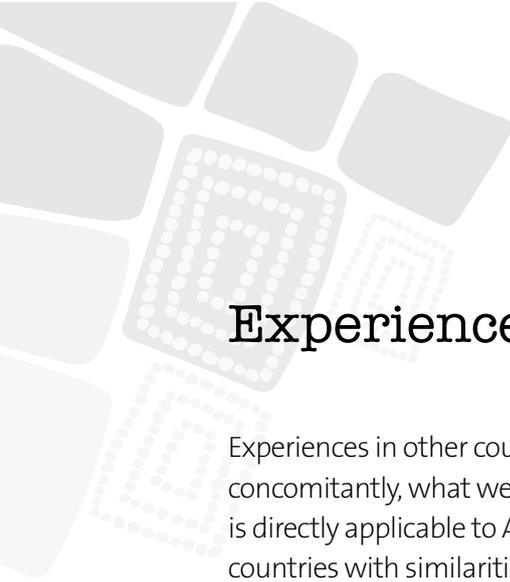
But it is also possible to take the view that Aboriginal customary laws include modern versions or developments, that they deal with ways of life and social ordering still followed by many traditionally oriented Aborigines today. Similarly, the notion of ‘recognition’ can be regarded in many different ways—narrowly, as extending only to the incorporation or enactment of particular rules (e.g. by way of codification), or widely, as covering a variety of methods recognition, reinforcement or accommodation of Aboriginal customs or traditions (ALRC 1986:para.86).

Legal pluralism would envisage a more flexible approach to governance that might incorporate approaches to protection and promotion of Aboriginal and Torres Strait Islander health, which embrace and use customary law where possible, either on its own or in combination with Western-style laws.

Conclusions

Legal pluralism in this context gives weight to acknowledgment that more than one source of law in Australia may be relevant to stewardship and governance for Aboriginal and Torres Strait Islander health. Some measures that may be specifically justified using this acknowledgment in many sources—but, in particular, *Mabo*, the ALRC and the Declaration on the Rights of Indigenous Peoples—include:

- constitutional recognition in the preamble:
 - » specific recognition of Aboriginal and Torres Strait Islander people as custodians of ancient customs, laws and dreaming, which enrich all Australians and which must be nurtured and protected
- constitutional recognition in the body of the Constitution:
 - » entrench the right to health and make specific reference to this right for Aboriginal and Torres Strait Islander people
 - » a treaty-making power
- powers in a Commonwealth law to acknowledge customary and community-based approaches to health promotion, health education and the prevention of diseases.



Experiences of other Countries

Experiences in other countries can help us consider what we might wish to achieve and, concomitantly, what we might wish to avoid in advocating a reform agenda. No foreign experience is directly applicable to Australian conditions, but an examination of the experiences of some countries with similarities in systems and history is a worthwhile exercise in an exploration of possible approaches within the Australian system. This section considers the experiences of Canada, the US and New Zealand, all of which have a history of settlement of a large foreign population in a country with long-existing Indigenous populations.

Canada

Canadian Aboriginal people make up 3.8 per cent of the total population of Canada (Human Resources and Skills Development Canada 2011). In 2002 a report was prepared arising from a Royal Commission into the Canadian health care system. One chapter was devoted to a new approach to Aboriginal health and it sets out some familiar issues (Romanow 2002).

The Commissioner reported that:

In fundamental terms there is a ‘disconnect’ between Aboriginal peoples and the rest of Canadian society, particularly when it comes to sharing many of the benefits of Canada’s healthcare system. There are at least five underlying reasons for this disconnect:

- Competing constitutional assumptions
- Fragmented funding for health services
- Inadequate access to health care services
- Poor health outcomes
- Different cultural and political influences (Romanow 2002:212).

The Canadian experience is, of course, different from that of Australia, but there are some interesting parallels. Views in Canada conflict about constitutional responsibility for Aboriginal health care and the Romanow (2002:212) report describes the result as ‘a confusing mix of federal, provincial and territorial programs and services as well as services provided directly by some Aboriginal communities’.

Romanow (2002:212) notes that, as a result, the Canadian federal government limits its responsibility to being ‘payer of last resort’. Aboriginal peoples see it differently and seek to link federal health programs to statutory or treaty obligations or, more broadly, to the trustee role of the federal government.

Another interesting parallel with the Australian position is that the Romanow report discovered a range of views about the best approach to system reform, but found a common thread in a consistent call for more active participation of Aboriginal peoples, communities and organisations in deciding what services are delivered and how.

The Commission on the Future of Health Care in Canada cited problems with ‘silos’ existing between health policy and other social policy areas such as education, housing or social services:

A remarkable primary healthcare model was hampered time and again by legal and administrative obstacles associated with jurisdiction, in particular, the designation of some funding as ‘health’ funding and some as ‘social services’ funding (Romanow 2002:221).

The commission took the view that better results could be achieved by sharing responsibilities rather than jealously guarding jurisdiction. It recommended several directions for change:

- consolidate funding from all sources and use the funds to support the creation of Aboriginal health partnerships to manage and organise health services for Aboriginal people and promote Aboriginal health
- establish a clear structure and mandate for Aboriginal health partnerships to use the finding to address specific health needs of their populations, improve access to all levels of health care services, recruit new Aboriginal health care providers, and increase training for non-Aboriginal healthcare providers
- ensure ongoing input from Aboriginal peoples into the direction and design of health care services in their communities.

One commentary suggests that the partnerships may work in a method similar to a regional health authority. They could serve as an organisation with a specific health goal, such as organising the public health and primary care for a community. The partnership would be granted federal funds to pursue these health goals in a manner that partnership executives agree upon. Aboriginal representation in the partnership assists in ensuring that these services fit with the cultural needs of the Aboriginal community. Partnerships would also interface with the existing health system to coordinate access to resources such as diagnostics and specialised care.

In an urban setting, the partnership could serve as a voluntary health organisation that coordinates access to specific health facilities such as primary care and diagnostics. The partnership would have similar representation from the Aboriginal community, ensuring that services provided in the urban environment are still sensitive to Aboriginal cultural and linguistic concerns. Partnerships are especially needed in urban settings due to the specific needs of urban Aboriginals for problems such as diabetes and addiction. Furthermore, partnerships may serve as an additional urban community organisation that interfaces with other such Aboriginal organisations to serve as activists for the socioeconomic status of Aboriginals.

An important point stressed by the Romanow report is that health care initiatives must be accountable towards the taxpayer and consumer. Aboriginal health is no different; partnerships must be closely monitored and their effects on health outcomes determined. Changes in policy may be necessitated as this is a new approach (e Notes n.d.).

Some ideas from the Canadian experience

Ideas from the Canadian experience that might have some application in the Australian context include:

- fragmentation of the levers of policy making, programming and funding creates confusion and a vacuum in governance
- lack of clarity about the meaning of responsibility in the Constitution adds to the general confusion and creates silos of disparate responsibility
- pooling of funds is desirable
- flexibility to use a number of different program approaches should be enabled in the legislation
- accountability is crucial
- Indigenous peoples must have a strong voice in all aspects of governance
- it is desirable to draft laws which enable flexibility to establish partnerships between government and Indigenous communities. These partnerships may supply funding for health service delivery where it is needed or may operate to link Indigenous communities back into the health system to supply broader support when needed. A model enabling Indigenous health service delivery in an environment of clear government responsibility and with sensitivity to cultural and language issues and accountability is of interest in the Australian context.

The United States

Native American Indians account for 1.5 per cent of the population of the United States (US Department of Commerce 2002). The history of US recognition of its Indigenous peoples differs from that of Australia in several important ways. Tribal governments were recognised as sovereign governments from the outset and treaties were entered with them. This appears to have sprung more from a desire to give a legal legitimacy to agreements to transfer land from Indian tribes, which would prevent other European nations with interest in land acquisition from contesting or objecting to the transaction (Miller 2006). The Supreme Court of the United States has likened these Indian treaties to contracts between two sovereign nations (Miller 2006). Ultimately, the US negotiated, signed and ratified almost 390 treaties with American Indian tribes.

The United States Constitution (Article 1, Section 8) states that only Congress has the power to regulate commerce with foreign nations, and among several States and with Indian tribes (US Constitution Online 2011). The United States Supreme Court has interpreted this as meaning that Congress has the sole right and power to regulate trade and affairs with the Indian tribes (Miller 2006).

As with the Australian Constitution and Australia's First Peoples, the United States Constitution specifically excludes Indian tribes from being counted for the purposes of determining representation rates in Congress, although an exception was made for those who paid tax. Most Indians did not become United States citizens until 1924 (Kappler 1929), when Congress passed

a law for this purpose. Uncertainty continued as to whether Indians were citizens of the various States. United States citizenship, when it came, was not universally welcomed by Indian tribes.

United States citizenship was just another way of absorbing us and destroying our customs and our government. How could these Europeans come over and tell us we were citizens in our country? We had our own citizenship. By its [the Citizenship Act of 1924] provisions all Indians were automatically made United States citizens whether they wanted to be so or not. This was a violation of our sovereignty. Our citizenship was in our nations (NebraskaStudies.org n.d.).

In enforcing sovereignty over the territory of the United States, the government also utilised the doctrine of 'discovery' (Miller 2006). This has some echoes of the doctrine of *terra nullius* in that a European country that first discovered a new area where Christian Europeans had not yet arrived could claim the territory as their own country,¹⁴ the underlying assumption being that it was legally acceptable to dispossess non-European Indigenous peoples.

The relationship between the early United States Government and Indian tribes included provision for health care. Treaties between the US Government and Indian tribes often involved provision of medical services, the services of physicians or the provision of hospitals for the care of Indian people (IHS 2011). Supreme Court cases (e.g. *Cherokee Nation v. Georgia (1831)*) specifically address the relationship between tribes, States and the federal government. Out of such cases, the guardian/ward relationship was created, which still exists today. Congress has legislative authority to appropriate funds specifically for the health care of Indian people.¹⁵

The Bureau of Indian Affairs is an agency of the federal government of the United States within the Department of the Interior whose responsibilities once included providing health care services to American Indians and Alaska Natives. In 1954 that function was legislatively transferred to the Department of Health and Human Services. It retains that function today and implements it via the Indian Health Service. In summary, the Indian Health Service is the principal federal health care provider and health advocate for Indian people, and its goal is to raise their health status to the highest possible level. It provides a health service delivery system for approximately 1.9 million American Indians and Alaska Natives who belong to 564 federally recognised tribes in 35 States.¹⁶

The National Indian Health Board is a not-for-profit, charitable organisation providing health care advocacy services. It facilitates tribal budget consultation and information and other services to all tribal governments.¹⁷ The National Indian Health Board presents the tribal perspective while monitoring, reporting on and responding to federal legislation and regulations.

14 *Johnson v. McIntosh*, 21 U.S. (8 Wheat) 543 (1823). See University of Tulsa n.d.

15 *Snyder Act of 1921* (25 USC 13) and the *Indian Health Care Improvement Act* (25 USC 1601) of 1976.

16 On its website, the Indian Health Service describes itself as follows:

The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally-recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. This relationship, established in 1787, is based on Article I, Section 8 of the Constitution, and has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders (IHS n.d.).

17 Section 501(c) of the United States Internal Revenue Code (26 U.S.C. § 501(c)), provides that 28 types of non-profit organisations are exempt from some federal income taxes. See IRS 2010.

Some ideas from the United States experience

The United States legal system provides better infrastructure for stewardship and governance for Indigenous peoples than the Australian system. Several elements exist in the US system that are not present in the Australian system including:

- a long-held acceptance of responsibility at the federal level and within the Indian Health Service to implement the service responsibly
- a federal law to enable financing and programming for Indian health
- the idea of an independent incorporated entity that undertakes advocacy, advice, monitoring of compliance with health planning and perhaps human rights obligations, which is of interest in the Australian context.

New Zealand

Fourteen per cent of New Zealanders are of Māori ethnicity (Statistics New Zealand 2002). The *New Zealand Constitution Act 1852*, like the Australian Constitution, was an Act of the Parliament of the United Kingdom that granted self-government to the colony of New Zealand. The Act remained in force as part of New Zealand's constitution until it was repealed by the *Constitution Act 1986*. The long title of the Act was 'An Act to Grant a Representative Constitution to the Colony of New Zealand'. It allowed for 'Māori districts' (Section 71) where Māori law and custom were to be preserved. However, this section was never implemented by the Crown. It was, however, used to justify claims of Māori self-governance during the 1870s and 1880s.

The Treaty of Waitangi was signed on 6 February 1840. It was essentially a treaty of cessation and affected a transfer of sovereignty from Māori to the British Crown (Orange 1987). The obligations agreed to by Māori in the treaty have largely been met; however, there is less agreement on the extent to which the Crown has matched these—whether or not mechanisms for Māori self-governance have been made and the level to which Māori interests have been protected (Kingi 2006).

The Treaty of Waitangi is not considered part of New Zealand domestic law, except where its principles are referred to in Acts of parliament. The Waitangi Tribunal has the exclusive right to determine the meaning of the treaty. The tribunal is a commission of inquiry created in 1975 to investigate alleged breaches of the treaty by the Crown. More than two thousand claims have been lodged with the tribunal, and a number of major settlements have been reached (NZ History Online 2011).

The *New Zealand Public Health and Disability Act 2000* has a population focus with an overall objective of improving the health of the population. One of its purposes is to reduce health disparities by improving the health outcomes of Māori and other population groups.

The overall aims of the Māori provisions of the Act are to:

- recognise and respect the Treaty of Waitangi
- ensure Māori are represented on District Health Boards to ensure they participate in and contribute to strategies for Māori health improvement

- protect gains already made and move forward to strengthen Māori provider and workforce development to improve mainstream service responsiveness to Māori and other populations.

The Act itself states that:

In order to recognise and respect the principles of the Treaty of Waitangi, and with a view to improving health outcomes for Māori, Part 3 provides for mechanisms to enable Māori to contribute to decision-making on, and to participate in the delivery of, health and disability services (Part 1, Clause 4).

The Act establishes a number of committees in Part 2, including a national Advisory Committee for Health and Disability. There is no statutory requirement for Māori on those committees, nor do the matters they consider specifically include matters relevant to Māori.

Part 3 has a requirement that the Minister, in appointing the District Health Boards, must endeavour to ensure that:

- Māori membership of the board is proportional to the number of Māori in the [District Health Board's] resident population, and
- in any event, there are at least two Māori members of the board.

The objectives of the Boards include:

- to reduce health disparities by improving health outcomes for Māori and other population groups
- to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders.

Part 3 also includes the following in the functions of the Boards:

- to establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement
- to continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori
- to provide relevant information to Māori for the purposes of the above paragraphs
- to regularly investigate, assess, and monitor the health status of its resident population, any factors that the [District Health Board] believes may adversely affect the health status of that population, and the needs of that population for services.

Some ideas from the New Zealand experience

It is important to note that the percentage of the Māori population is greater than the percentage of Australia's First Peoples to the remainder of the population. Further, New Zealand has only one national jurisdiction, which is much simpler than Australia's federal system, which effectively creates nine lawmaking jurisdictions across the Commonwealth, States and Territories. Recognising that New Zealand is free of some of the Australian complexities in lawmaking and funding, New Zealand has created an excellent legislative infrastructure that enables some important elements

of stewardship and governance, which are almost entirely absent from the Australian legislative infrastructure to provide stewardship and governance for Aboriginal and Torres Strait Islander people.

Without providing a carefully considered history of the establishment and implementation of the Treaty of Waitangi, it may still be said that it was not an entirely positive experience for Māori, and neglect of its obligations has arguably created significant resentment. Despite any negatives, its continued existence today as an enduring symbol of recognition and legal relationship with Māori since 1840 is a powerful symbol of legal existence and relevance for the Māori peoples, a symbol that is entirely lacking for Australia's First Peoples. Further, the existence of a tribunal to interpret the meaning of the treaty, and the ongoing obligation to fulfil the treaty obligations and its adoption into the Public Health and Disability Act, give a holistic approach to recognition of the Māori population and the placement of stewardship and governance for Indigenous health inside a bigger conceptualisation of Māori as a recognised people in law and in fact. This recognition provides a basis for good stewardship and governance and is sound from the perspective of human rights, therapeutic jurisprudence and legal pluralism.

It cannot be said that overall stewardship and governance is provided because the overarching committees created in the Public Health and Disability Act do not have overall stewardship and governance responsibility for Māori health, but there is no doubt that District Health Boards have such responsibility in every district. A specific objective of the Public Health and Disability Act to provide mechanisms to enable Māori to contribute to decision making on, and to participate in the delivery of, health and disability services could provide a useful model for objectives in Australian laws. The New Zealand experience provides some useful ideas about how the existence of constitutional and treaty recognition provides a platform on which stewardship and governance for health legislation may be built.

Conclusions

The Australian experience is acknowledged to be unique. Examining the experience of other countries that have also had to consider the legislative infrastructure enabling stewardship and governance for health of their Indigenous populations can, nonetheless, provide insights into systemic features that impede stewardship and governance and other systemic features that seem to enable or strengthen it. The experiences of Canada, the United States and New Zealand have helped to show that the recognition of the existence, particular needs and special contribution of Indigenous people in a country's constitution provides a basis for the creation of other laws to give effect to the Constitutional provisions in the area of health. This was found in the examples of New Zealand and the United States. The absence of such recognition, by contrast, in Canada contributes to confusion and a lack of effective mechanisms for stewardship and governance for the health of the Indigenous peoples of that country. This may have some application to the Australian context.



Three Options for Law Reform

There are a number of ways Australian law could be reformed to better address stewardship and governance for Aboriginal and Torres Strait Islander health. The ‘race’ power gives the Commonwealth power to legislate with respect to Aboriginal and Torres Strait Islander people, and the States and Territories have power to legislate with respect to health. One level of government or both together could address the issue in their laws. This paper does not recommend a particular approach, but does state that whatever approach is used, it must contain a number of elements necessary to achieve stewardship and good governance. These are set out in a checklist below.

Checklist for evaluation of legislative reform options

A checklist of elements that could be included in legislation intended to address stewardship and governance for Aboriginal and Torres Strait Islander health might be a useful starting point. Acknowledging that the Commonwealth, States and Territories enjoy sovereignty and have discretion to legislate within their own jurisdictions, it may be helpful to evaluate any reform option or combination of reform options as to how they address these important elements. The elements have all been derived from an exploration of the current configuration of laws affecting governance in Aboriginal and Torres Strait Islander health, recent reports, cases and commentaries considered in this paper, the position in some other countries and the three conceptualisations—a human rights approach, therapeutic jurisprudence and legal pluralism.

This paper acknowledges that while it is desirable that legislation intended to advance the health needs of Aboriginal and Torres Strait Islander people is needed, there are a number of ways that laws might be configured to achieve this policy objective. Such laws should include certain elements. Instead of proposing one approach to law reform, this paper puts forward a checklist against which existing laws or proposed law reform might be measured to establish whether they contain elements which will operate to address the health needs of Aboriginal and Torres Strait Islander people.

A checklist for evaluation of legislative reform options might include:

- constitutional recognition of Australia’s First Peoples to provide a basis for stewardship and governance for health as has proved useful in both the US and New Zealand (its absence has been noted as giving rise to confusion and disagreement about responsibility in Canada); it is also consistent with human rights obligations in the ICCPR and the Declaration on the Rights of Indigenous Peoples and with therapeutic jurisprudence
- establishment of governance arrangements that bring together the levers for policy making, programming and financing to one responsible ministry or entity
- clarity in responsibility for policy making, planning, programming and service delivery
- capacity and resources of the responsible authority for efficient implementation
- a clear source of funding and preferably aggregated funding

- that objectives of the law and principles used for interpretation and implementation of the law include:
 - » participation of Aboriginal and Torres Strait Islander people in all aspects of governance
 - » recognition that Aboriginal and Torres Strait Islander people have a holistic approach to health and this should be reflected in health policy making and programming
 - » delivery of health programs and services in a culturally sensitive way
 - » a statement of intention that the Act is consistent with and seeks to positively implement treaty obligations, in particular International Covenant on Economic, Social and Cultural Rights and the Declaration on the Rights of Indigenous Peoples
- a flexible range of financing and partnering arrangements such as treaties, contracts, partnerships, delegations and financing (in whole or in part) of existing programs
- sufficient flexibility in governance arrangements to enable a range of approaches to service delivery including, but not limited to, direct service delivery, financing of health services delivered specifically for Aboriginal and Torres Strait Islander people or appropriate services through mainstream providers
- where possible, legislative approaches that respect or even incorporate customary approaches to community organisation and social responsibility
- a requirement for data collection to support health planning for Aboriginal and Torres Strait Islander people; this should also include power to make regulations or codes or protocols about information collection in a culturally sensitive manner; it might also include mandatory reporting of certain data where there is a policy need to do so
- advice to government on health policy implications of broader national debates such as the current national debate about the inclusion of Australia's First Peoples in our Constitution and in other legislation such as laws that recognise customary laws, anti-discrimination laws and laws to establish Aboriginal and Torres Strait Islander community governance structures
- recognition of the role played by traditional medicine practitioners in Aboriginal and Torres Strait Islander communities.

Option 1: Constitutional change

There is an opportunity to advocate for recognition of Aboriginal and Torres Strait Islander people in the Constitution based on a health perspective that better stewardship and governance may be built on a platform of legislative recognition. The experiences of New Zealand and the United States show that the presence of such constitutional recognition makes recognition in health legislation easier. The lack of such recognition in the Canadian Constitution has been identified in an authoritative report on the Canadian health system (Romanow 2002) as causing confusion in identifying responsibility for the health of the Indigenous peoples.

There is further opportunity to advocate for constitutional reform to recognise Australia's First Peoples based on human rights obligations in the ICCPR and the Declaration on the Rights of Indigenous Peoples (although this might not be legally binding in Australia).

Such recognition is also justified based on a therapeutic jurisprudence argument that legal invisibility, which began with settlement, was compounded at federation and entrenched in the Constitution and not adequately addressed by the 1967 referendum and amendment.

Recognition might include:

- in the preamble:
 - » specific recognition of Aboriginal and Torres Strait Islander people as custodians of ancient customs, laws and dreaming, which enrich all Australians and which must be nurtured and protected
- in the body of the Constitution:
 - » entrenchment of the right to health and specific reference to this right for Aboriginal and Torres Strait Islander people
 - » a treaty-making power.

Option 2: Commonwealth law

As initially drafted, section 51(xxvi) of the Constitution empowered the parliament to make laws with respect to ‘The people of any race, *other than the aboriginal race in any State*, for whom it is deemed necessary to make special laws’. The Australian people voted at the 1967 referendum to delete the words in italics.

This power enables the Commonwealth to pass a law to protect and promote the health of Aboriginal and Torres Strait Islander people. Such a special measure would be justified on human rights grounds and would not be discriminatory.

A Commonwealth Act might establish government responsibility for the following functions (these might be most easily carried out by a standalone agency with the requisite skills, experience and qualifications):

- undertake policy making, programming and financing in Aboriginal and Torres Strait Islander health
- introduce principles by which all Commonwealth health legislation must be interpreted and administered with regard to promotion of Aboriginal and Torres Strait Islander health and prevention of disease:
 - » recognise the special health needs of Aboriginal and Torres Strait Islander people giving rise to the need for both special programs and appropriately designed responses to these needs within mainstream programs
 - » provide culturally safe health services in mainstream services and services specially designed for Aboriginal and Torres Strait Islander people
 - » refer to and implement the right to the highest possible standard of health in ICCPR and some of the rights in the UNDRIP
 - » require involvement of Aboriginal and Torres Strait Islander people at all levels of decision making

- » recognise the importance of traditional medicine—consider negative licensing of traditional medical practitioners (Negative licensing is a legislative mechanism in use in New South Wales to provide some form of regulation for unregistered health practitioners.)
- establish responsibility for implementation of the Act (some of the following are alternative approaches):
 - » a health committee or board responsible for advising the Minister on all matters relevant to the promotion of Aboriginal and Torres Strait Islander health and the prevention of disease
 - » appoint a Chief Indigenous Health Officer to report to the board/committee and to take responsibility for planning, policy making and issuing of warnings where relevant or necessary; responsible for coordination of service delivery and application of principles in the National Health Act
 - » enable establishment of a health authority to receive all funding for Aboriginal and Torres Strait Islander health and take responsibility for policy making, programming etc. (similar to NHHRC recommendation)
- create specific data collection and reporting obligations for Aboriginal and Torres Strait Islander health
- create power to enter treaties and partnerships or to delegate responsibilities under the Act to Aboriginal and Torres Strait Islander communities or health services
- create a mechanism for monitoring provision of health services for compliance with the Act:
 - » A useful model may be that of existing community visitors under health services legislation. The office of the Aboriginal and Torres Strait Islander health visitor may be established to undertake monitoring of the operation of health services provided to Aboriginal and Torres Strait Islander people for consistency with principles included in legislation to advance the health needs of Australia’s First Peoples.

Advantages

A constitutional power already exists to enable such a law. A Commonwealth law is the only mechanism to achieve a nationwide law establishing clear responsibility for stewardship and governance. The law would have nationwide effect. Clear responsibilities and accountabilities make it easier to identify successes and failures to achieve what has been mandated.

Barriers

This option would require a commitment by the federal government to pass a law and then to implement it. Recent rejection of the NHHRC recommendation suggests a reluctance to take such action.

Option 3: A uniform national approach

Under this approach, laws could be enacted to engage more closely with public health functions and health service delivery functions within States or Territories. It would use the same list of elements as those in Option 2, but would be developed into a law appropriate for operation and implementation at State and Territory level. It could be passed in one State jurisdiction and then incorporated by reference into the laws of all the others. This is the mechanism used to create nationally uniform health practitioner registration law (AHPRA 2011).

Advantages

This option would establish a uniform approach to enable cooperative and complementary legislative infrastructure nationwide. It would be able to cover health service delivery at State and Territory level.

Barriers

This option is more difficult politically and administratively. It requires agreement of the application of a State and Territory law and all jurisdictions would have to agree and to pass the law. It would also require considerable work on deciding how the law would interact with existing State and Territory laws on public health and health service delivery, and the operation of existing mechanisms such as complaints mechanisms, health visitors etc.

It also misses the opportunity for the Commonwealth to take the lead on what is manifestly a national issue and there is existing Commonwealth power to address it: i.e. the establishment of stewardship and governance for health of members of the Aboriginal and Torres Strait Islander population who live in every State and Territory in Australia.

Model provisions for adoption into public health and health services legislation

Model legislative text could be developed in consultation with Commonwealth, State and Territory stakeholders to cover a range of issues relevant to State and Territory health legislation. It would be possible to provide several examples of legislative text to address issues of stewardship and governance for Aboriginal and Torres Strait Islander health, together with explanations of their purpose and how they might operate within a State or Territory health law.

Model legislative text might be endorsed by an appropriate body or bodies with acknowledged understanding and expertise in Aboriginal and Torres Strait Islander health and largely governed by Aboriginal and Torres Strait Islander people. The following areas might be covered:

- objectives (including health outcome improvement) and principles in the manner of the South Australian Public Health Act and Health Care Act
- specific measures for introduction into health complaints legislation

- allocation of responsibility for stewardship and governance for Aboriginal and Torres Strait Islander health to a particular entity or individual with statutory responsibility, such as a Chief Executive of a Ministry of Health or a Chief Health Officer, if such a policy was agreed upon
- data collection, including any necessary protocols
- a requirement for participation of Aboriginal and Torres Strait Islander people in decision making in entities such as boards, advisory committees, etc.
- introduction of a national administrative entity given responsibility for stewardship and governance for Aboriginal and Torres Strait Islander health and the granting of powers to monitor implementation of the State or Territory law for compliance with principles/objectives.

The use of the legislative text and its adaptation into State or Territory health laws and any consequential amendments is left up to the individual jurisdictions.

Advantages

This option is useful in creating a softer, less politically and legally complicated cooperative approach that recognises difference in the political willingness of jurisdictions to attempt to address the issues of stewardship and governance for Aboriginal and Torres Strait Islander health. The legislative text would be developed in a collaborative manner and could then be implemented by each jurisdiction at a time politically and administratively convenient to each jurisdiction. Administratively, it is relatively simple, cooperative and respectful of State sovereignty.

Barriers

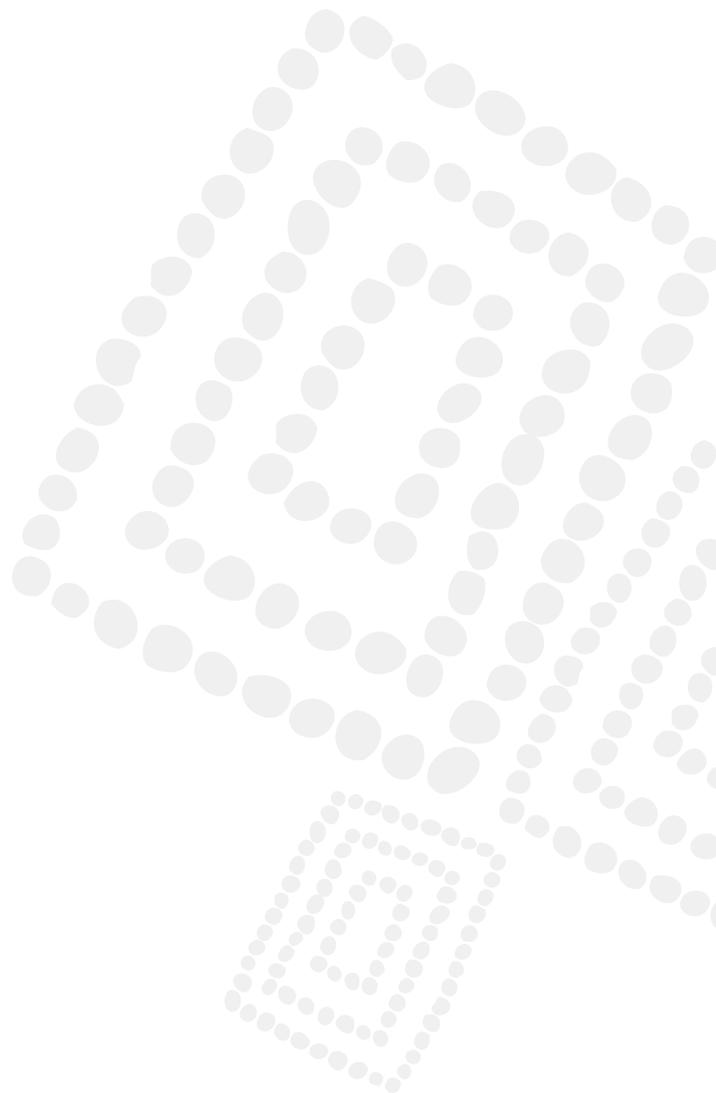
This option, although helpful in identifying ways to better recognise some issues relating to Aboriginal and Torres Strait Islander health in various State and Territory laws, is unlikely to be able to offer much in respect of stewardship and governance. The cooperative and optional nature of the approach means that it is respectful of State and Territory sovereignty, but largely ineffective in achieving national leadership or national mechanisms. Drafting styles, political expediency and the pressure of other government work could mean that the resulting legislation may be quite different in each jurisdiction. There is also a risk that a considerable period of time may elapse between the development of the legislative text and the passage of any legislation to implement it in each jurisdiction. Further, there is no mechanism to ensure continuity of the arrangements achieved. The cross-jurisdictional networks that may have been established are likely to break down over time with personnel changes. The goodwill and momentum necessary to develop and implement the policy and subsequent support for ongoing cooperation is generally lost.

Comments on the options

It would be quite possible and quite logical to consider more than one option or to rearrange the options to better suit a preferred policy approach.

For example, the checklist of elements in laws to establish stewardship and governance for Aboriginal and Torres Strait Islander health may be used to critique existing laws and followed by one of the other options for a legislative approach depending on how jurisdictions fared against the list.

The options are intended to provide a spectrum of possible approaches and are a starting point for consideration. They are not exhaustive. They may be used like building blocks. They can be dismantled and reassembled in a different form or other pieces may be added to suit new ideas.





Conclusion

The legal document that created Australia as a nation specifically excluded Australia's First Peoples from being counted and from being the subject of Commonwealth laws. A movement seeking recognition for Australia's First Peoples in our Constitution is currently gaining momentum and progressive reform may come soon. The United States and New Zealand, which took early steps towards recognition of their Indigenous peoples in their constitutions and in treaties, have laws today that better enable coherent national approaches to stewardship and governance for Indigenous health. Canada has recognised that constitutional uncertainty about responsibility for Indigenous health affects stewardship and governance and is reviewing and reforming its health system and governance arrangements.

These system examples are not without flaws, but they show that legal recognition provides a structure on which better governance may be built. A lack of recognition in law provides no structure and no foundation for something better. Many credible voices—both Aboriginal and Torres Strait Islander and others—have identified the lack of stewardship and governance as an impediment to better policy making and programming for Aboriginal and Torres Strait Islander health in this country. Law reform can create structures that help to support national stewardship and governance, yet only a niggardly handful of the 250 principal Acts administered by the nine health portfolios of the Commonwealth, States and Territories even mention Aboriginal and Torres Strait Islander people, let alone provide a framework for national stewardship and governance.

Continued inaction condemns us to persist in seeking stewardship and governance for Aboriginal and Torres Strait Islander health amidst a bewildering profusion of programs, policies and funding streams and to negotiate through constant political bickering. Continued inaction fails to provide a foundation on which stewardship and governance may be built and arguably breaches a number of our legally binding human rights obligations.

Australian jurisprudence need not continue to be a 'prisoner of history' in failing to recognise Aboriginal and Torres Strait Islander people in health laws, and in failing to provide a legislative structure on which stewardship and governance for Aboriginal and Torres Strait Islander health may be constructed. Legal invisibility of Australia's First Peoples was an ugly beginning for their engagement with British common law and it continues to have ugly consequences. To paraphrase former Prime Minister Paul Keating, the solution begins with the act of recognition.

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