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Indigenous Health and Human Rights

Abstract

‘Closing the Gap in Indigenous Disadvantage’ and the Northern Territory Emergency Response or ‘Intervention’ are policies that highlight the significant intellectual distance between Australia’s rhetorical public support for human rights and its routine willingness to set these aside in relation to Indigenous health. Yet, there does remain political possibility and space for the incorporation of human rights precepts into domestic policy arrangements. This article sets these out, uses them to evaluate contemporary policies, and to propose alternative philosophical premises to support the development of a more substantive human rights framework for the conduct of Indigenous health policy. It does these things by juxtaposing human rights with the politics of indigeneity to contextualise Indigenous claims in liberal democratic thought, and to bring conceptual clarity to an intellectually inconsistent policy environment.

Introduction

In 2005 the Aboriginal and Torres Strait Islander Social Justice Commissioner proposed a human rights approach to ‘closing the gap in Indigenous disadvantage’. In 2008 the Council of Australian Governments (COAG) formally accepted the Commissioner’s ‘ambitious, yet realistic’ goal (Calma 2005) of closing the life expectancy differential between Indigenous and other Australians of 11.5 years for men and 9.7 years for women (ABS 2011). ‘Closing the Gap’ was developed in an alliance of common aspiration with civil actors such as Oxfam and a number of Indigenous professional health associations.

‘Closing the Gap’s relationship to human rights and health is paradoxical. On the one hand it sets out a number of goals to improve Indigenous health outcomes and is consistent with ‘the right to health analytical framework’ developed to assist states to give effect to the universal right to the highest attainable standard of health, and which is discussed later in this article

(Hunt et al., 2009). However, as this article argues, its goals have not always been set with regard to ‘active and informed [indigenous] participation’ and there remains evidence that health policy, more generally, proceeds without sufficient attention to ‘non-discrimination’ and cultural ‘acceptability’ as further characteristics of the framework (Hunt et al., 2009).

‘Closing the Gap’ sits alongside, and is compromised by the Northern Territory Emergency Response or ‘Intervention’, which an independent Review Board found was explicit in its disregard for non-discriminatory and culturally cognisant policy development and implementation (Yu et al 2008). The Intervention was a Commonwealth policy response to widespread sexual abuse in a number of Northern Territory Indigenous communities. It was developed without the engagement of the communities and required the suspension of the *Racial Discrimination Act 1975* to enable measures such as the sequestering of welfare payments and compulsory health checks of community children (Yu et al 2008).

Together, ‘Closing the Gap’ and the Intervention constitute the two most significant contemporary Indigenous public policies and demonstrate the significant intellectual distance between Australia’s rhetorical public support for human rights and its routine willingness to set these aside in relation to Indigenous health. Yet, there does remain political possibility and space for the incorporation of human rights precepts into domestic policy arrangements. This article sets these out, uses them to evaluate contemporary policies, and to propose alternative philosophical premises to support the development of a more substantive human rights framework for the conduct of Indigenous health policy. It does these things by juxtaposing human rights with the politics of indigeneity (Maaka and Fleras 2005, O’Sullivan 2007, Shaw 2008) to contextualise Indigenous claims in liberal democratic thought, and to bring conceptual clarity to an intellectually inconsistent policy environment.

Human Rights and the Politics of Indigeneity

Universal human rights are not politically useful, on their own, as a normatively just framework for improving the health status of Indigenous peoples. However, when juxtaposed with the politics of indigeneity they help to express Indigenous claims in prevailing liberal democratic context and provide a coherent body of political thought to support political activism and provide Indigenous policy with the ‘conceptual clarity... [necessarily] associated with the normative content and scope of the right to health’ (Gay 2008, 34). Such clarity includes attention to history, prejudice and political inequality as determinants of health. Attending to these, among health’s wider determinants, provides promising ground for establishing connections between theoretical precepts and policy practice. A normative and principled framework for thinking about the rights and responsibilities of Indigenous citizens is then established in domains such as education, housing and the labour market. Public policy requires ways of thinking about how the particular circumstances of Indigenous peoples, including extant rights of indigeneity, might shape or differentiate Indigenous citizenship.

Further, human rights and indigeneity together respond to the proposition that for Indigenous peoples, the relationship between politics and health transcends simple questions of resource allocation. The politics of indigeneity expresses the relationship, as a more complex one, concerned with the distribution of political authority. It seeks political space for cultural maintenance and self-determination, and gives local specificity and context to general rights to ensure that these are not ‘lost or rendered opaque in discussions of distributive justice’ (Iverson et al, 2000, 10). For example, indigeneity’s concern for Indigenous political participation as peoples, to complement individual participation, requires a re-balancing of the political order from one where subjugation and domination are the inevitable outcome of one culture asserting itself as rightly providing the exclusive basis for public administration, to one that allows Indigenous people to participate in wider society with reference to their own values and

aspirations. This means that political rights are claimed, not on the basis of material need, or even as restitutive justice, but on the basis of ‘ancestral occupation’ (Fleras 2000, 129). In short, the politics of indigeneity resists the notion that neo-colonialism ought to constrain and limit the construction of political relationships that allow people ‘to live together differently’ in the one national polity (Maaka and Fleras 2005). It ‘emphasises the right to be different in some senses and the same in others – the opportunity to live in the modern world while... preserving one’s ancient cultural heritage’ (Fleras and Elliot 1996 in O’Sullivan 2007, 106).

A dual or two-tiered citizenship where Indigenous peoples simultaneously assume rights and responsibilities as members of the one national polity and as members of their own tribal nations is one way of constructing citizenship to respect difference, acknowledge self-determination and broaden responsibility for human rights beyond just the state to recognise that the terms of citizenship, from which stems the practical nature of political rights cannot reasonably be imposed on Indigenous peoples any further than colonization has unalterably established. A two-tiered citizenship would be concerned, particularly, with the cultural and economic rights of Indigenous people, as well as those of a deliberative nature. This view of the politics of indigeneity is consistent with the *Declaration on the Rights of Indigenous Peoples* and the ways in which it privileges Indigenous, over state, agency.

Institutions such as the Aboriginal Congress and Aboriginal Community Controlled Health Organizations (ACCHOs) are among the Indigenous civil bodies contributing to self-determination to recognise that from a human rights perspective ‘the building of effective social and civil institutions that express the values and beliefs of the community’ (Yu et al 2008) is important, and justified by the *Bangkok Charter’s* proposition that:

well organized and empowered communities are highly effective in determining their own health, and are capable of making governments and the private sector accountable for the health consequences of their policies and practices (United Nations 2006).

At the same time, Indigenous people's health entitlements are codified by a human rights framework that provides moral, legal and political principles to guide policy development. Human rights extend to the broader determinants of health such as the right to deliberate in public affairs, to receive schooling in ways that recognise culture and language, and to have Indigenous communities' distinct economic imperatives respected. The politics of indigeneity reflects efforts 'to create legitimate authorities – sovereignties within and across spatial, temporal and discursive conditions that may be at odds with those that have enabled modern state sovereignty' (Shaw 2008, 5).

However, inconsistent approaches to policy, and uncertainty about the ways in which Indigenous peoples ought to be allowed to practice their theoretically equal citizenship mean that Australia's commitment to universal human rights is often more rhetorical than substantive, preventing it from joining 'a growing consensus that... the right to health has a core content that imposes immediate obligations upon states. That core content mandates state adherence to the fundamental principles of non-discrimination and participation' (Gay 2008, 34). Therefore, it is important by way of contrast, to note the complimentary significance of domestic instruments such as the Treaty of Waitangi in New Zealand, which helps to explain greater Maori deliberative engagement in health policy as the outcome of a stronger theoretical convergence between indigeneity and liberal democratic citizenship (O'Sullivan 2007). The Treaty makes human rights more easily justiciable in New Zealand courts and has helped to shape domestic conceptions of justice in ways that are not as indifferent to the specific needs and claims that Indigenous people place before the state (O'Sullivan 2008).

Human Rights in Ideological Context

Ideological inconsistency is Indigenous health policy's distinguishing characteristic. The Commonwealth's most recent *National Mental Health Policy* (2008) does, for example,

recognise Indigenous people's distinctive rights to status and culture, self-determination and the land' (p. 7). Its alignment with the human right to health's insistence on cultural 'acceptability' (CESCR 2000, Hunt et al 2009) is reflected in the policy's insistence that: 'Every attempt should be made to provide service in a way that is culturally safe. The special rights of Indigenous Australians must be respected and there should be no tolerance of discrimination or racism in service environments' (p. 13). However, the translation of these general principles into meaningful policy outcomes is inconsistent and contested with, for example, most Indigenous people claiming to have experienced racism in the health system (Paradies et al. 2008). These data alone suggest that while Australian governments have taken incremental steps to improve Indigenous health, the measures fail the human rights test of 'suitability' and 'adequacy' (United Nations 2006), and show that: 'Health outcomes offer a good measure of social and political processes' (Pham et al 2010, 100).

Indigenous people constitute just 2% of the national population and have no guaranteed representation at any level of the political system and there is generally little electoral incentive for parliamentary candidates to attend to their concerns. Although Robbins (2010) takes an alternative, more positive perspective, it remains one that admits the significance of deliberative inclusivity to successful policy outcomes:

Politicians would like to do the right thing, but cannot because policy is not sufficiently based on knowledge of actual problems. The rationality behind policy then fails because politics has no realistic view of the nature or magnitude of a problem... the concomitant argument is that valid knowledge is in fact available, and it is among citizens that it is found (p. 512).

Exclusivity is a reflection of Indigenous affairs' deeply contested nature. Indeed, Indigenous affairs illustrates, more strongly than any other policy domain, the ways in which public policy is 'an arbiter of political conflict and... a discipline responsible for shaping societal affairs' (Nabatchi et al., 2011, 129). 'Closing the Gap' and the 'Intervention', discussed later in this article, are examples that demonstrate policy conflict's ideological underpinnings and also the

absence of conceptual clarity that a human rights approach might help to address. They are examples of the distribution of policy resources and authority not being politically neutral, and not necessarily responsive to relative need in the ways that the state's obligation to 'respect, protect and fulfil' the human right to health might imagine (Hunt et al 2009).

Persistent inequality is illustrated by the fact that while there have been recent improvements in some determinants of good health, others remain as overt markers of policy failure: for example, overcrowded housing, relatively low incomes, relatively high rates of imprisonment, child abuse and neglect, risky levels of tobacco and alcohol consumption, substance abuse and the prevalence of obesity (Australian Health Ministers' Advisory Council 2006); indicators reflective of the observation that: 'The right to health is closely related to and dependent upon the realization of other human rights' (CESCR 2000, 14).

Contemporary international law, with its emphasis on the Indigenous right to self-determination, provides a political counter-balance to the narrower post-colonial discourses which have traditionally not given adequate consideration to the conditions which would allow Indigenous Australians to maximise self-determining responsibility for their own health and its social determinants. It is not surprising, then, that UN Special Rapporteurs have noted Australia does not, as a matter of course, extend the same human rights to Indigenous peoples that it extends to other citizens. Successive UN reports on Australian Indigenous policy draw attention to ideological inconsistencies and the absence of meaningful connections between policy goals and outcomes.

In 2009 the Special Rapporteur on the Situation of Human Rights and Fundamental Freedoms of Indigenous Peoples commended Australia's apology to the stolen generations, endorsement of the *Declaration on the Rights of Indigenous Peoples* (2007) and commitment to closing the gap in Indigenous disadvantage. However, the Special Rapporteur noted weaknesses in policy co-ordination, inattention to advancing self-determination, and that 'a

lack of adequate cultural adaptation in the delivery of health services continues to represent a barrier to the effective enjoyment of the right to health for Indigenous peoples' (Anaya 2010, 34).

The UN has also found instances of policy failure as the outcome of inequitable resource distribution. For example, in 2005, it observed 'malnutrition and under-nutrition' among Indigenous children, compared with 'over-nutrition... and obesity at [the] national level' (UN 2005, 47). Its Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (Grover 2010) contrasted the poor quality of health service provision to Indigenous people with the 'excellent' services provided to other citizens, and 'regretted' the absence of any formal domestic recognition of the human right to health (Grover 2010, 7), even though Australia has ratified instruments such as the *International Convention on the Elimination of All Forms of Racial Discrimination* (1965), which obliges signatories to

undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law' because 'the existence of racial barriers is repugnant to the ideals of any human society (United Nations 1965).

One of the ways in which Australia has pursued this objective is by seeking United Nations' advice 'on ways to ensure a greater role for Indigenous women in decision-making' (Commonwealth of Australia 2011). The obtuse assumption that the views of Indigenous women themselves provide insufficient guidance is demonstrative of Australia's general unease with Indigenous engagement in the policy process, and by extension the argument that 'by establishing equal liberties, robustly equal opportunity, a fair distribution of resources, and support for our self-respect – the basics of Rawlsian justice – we would go a long way toward eliminating the most important injustices in health outcomes' (Daniels 2001, 6). It is in this context that human rights discourse provides indigeneity with a way of contextualising and

expressing itself in liberal political theory, and with recourse to international law, as a morally important site of appeal against the state's inattentiveness to Indigenous policy expectations. Together, indigeneity and human rights propose principled policy coherence to a political order traditionally distinguished by unease with cultural pluralism and theoretically exclusive approaches to democratic equality.

'Closing the Gap in Indigenous Disadvantage' and the 'Northern Territory Emergency Response'

Contemporary policy measures such as 'Closing the Gap' and the 'Intervention' illustrate further the ways in which domestic health policy proceeds without the conceptual clarity that an application of human rights might provide. Neither principles of non-discrimination nor participation distinguish the Intervention. Indeed, the Intervention 'diminished its own effectiveness through its failure to engage constructively with the Aboriginal people it was intended to help' (Yu et al. 2008). It was marked by numerous instances of discrimination and institutional disregard for participatory principles (Yu et al 2008). It provided conditional attention to human rights on the one hand, and disregard for them, on the other (Lloyd et al. 2010).

The report into child sexual abuse that precipitated the Intervention showed deep and sustained bureaucratic inability to uphold physical safety as a most fundamental human right, and under the Intervention itself sexual abuse treatment services remained inadequate (Yu et al. 2008). Further, those human rights to which the Intervention did attend were ones to which the Indigenous people had an established expectation as rights of citizenship, for example: permanent police stations and good quality housing, health and education. By way of specific illustration, in 2008, the Intervention was reviewed by a Commonwealth Government appointed Board which was told by the Territory Government that the Intervention's measures to respond to school truancy were problematic because 'the anticipated increase in attendance'

may be beyond the system's capacity to manage (Yu et al. 2008). The Government's 'benign and understated language' (Yu et al. 2008) illustrated the kind of policy failure that a more robust conception of citizenship might eliminate. So, too, might a 'recalibration' of the terms of association between governments and Indigenous peoples 'to the principle of racial equality and respect for the human rights of all Australians' (Yu et al. 2008). Policy might then purposefully proceed on assumptions of Indigenous people's agency and acceptance 'not as problems, but positively and distinctively' (Yu et al. 2008). Similar philosophical positions have prevented the meaningful policy application of human rights principles as the Aboriginal and Torres Strait Islander Social Justice Commissioner imagined in his advocacy of measures to close the gap in Indigenous disadvantage.

'Closing the Gaps' was a New Zealand policy programme applied to Maori disadvantage in 2000 and a term used by the World Health Organization (2008) to advocate broadly focussed public policies to eliminate disadvantage by 'tackl[ing] the inequitable distribution of power, money and resources'. In Australia, the Social Justice Commissioner affirmed 'five integrated requirements' of a human rights approach to health. Although these were benign at surface level, they actually reflected a radical departure from established policy practice, and were: a commitment to addressing Indigenous disadvantage in health, the collection of suitable data to inform policy making and allow evaluation, setting benchmarks against which policy ought to be evaluated, improving inter-government co-ordination and ensuring Indigenous participation in the policy process (Calma 2005). The Commissioner argued that developments over the last ten years, including greater co-ordination in service delivery, have established a foundation from which to realize these goals (Calma 2005), yet the requirement that public health strategies ought to proceed 'on the basis of epidemiological evidence' (CESCR 2000) remains elusive because as Lea (2008) explains the policy process itself is not sufficiently well informed to insist on an 'exact correlation between rhetoric and reality' (p. xv). Indeed, in 2008,

developments in the Northern Territory led to polic-makers being advised that: ‘We have new information systems being put in place but it will still take a few years for community-level data to be easily available’ (Lea 2008 p. 118).

While data are essential, ‘Closing the Gap’s’ solely statistical measures of policy progress are, on their own, profoundly limiting and isolated from a ‘complete’ conception of justice; one that is able to order all the claims that can arise (or are likely to in practice)’ (Rawls 1999 p. 115), which is preliminary to addressing inequality. For example, claims to education, housing, employment, land and culture are all important determinants of health and require attention to challenge the underlying philosophical paradigm that positions Indigenous policy as a site of ‘misrecognition’ (Fraser 2003). Indeed, the importance of a rights based approach to Indigenous affairs is contextualized by the observation that ‘many of these disparities occur in areas that are considered to be unquestioned rights to all other Australians’ (Behrendt 2001, 850). However, ‘Closing the Gap’ does not consider the ‘substantial imbalance in power and control over the Indigenous affairs agenda... as the ‘true gap’ that must be addressed’ (Black and Richards 2009, p. 1). Nor does it exhibit what the Human Rights and Equal Opportunities Commission describes as the human rights approach’s principal policy strength: transcending ‘rhetorical acknowledgment’ of a problem and non-specific solutions (Calma 2005, 48).

The question then becomes one of what theoretical shifts human rights can promote to allow Australia to admit the United Nations’ Charter’s (1945) foundational assumption that

international law presupposes that there is a minimum substantive normatively inherent in the international legal order, a kind of foundation or floor, grounding the aspirations and effort of the international legal system and that the preservation of human life and health can be understood to comprise that floor (Howse and Teitel 2007, 10).

This theoretical position is expressed further in a man’s right to

a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or

other lack of livelihood in circumstances beyond his control (*Universal Declaration of Human Rights* Article 25: 1).

The just distribution of resources must be informed by what people actually want of the health system and of life itself. Policy makers must understand ‘what the most choiceworthy way of life is. As long as this is unclear the best regime must necessarily be unclear as well’ (Aristotle 1936). As the Chairman of the Australian Productivity Commission notes:

An integrated approach to government services, involving consultations with those at the ‘receiving end’, may not sound very radical... But it contrasts strongly with the silo-based, tops-down approaches of the past (Banks 2005 p. 3).

But, at the same time Langton (2011) cautions against ‘an approach that prioritises the political and cultural rights of Indigenous people above the kinds of life-enhancing circumstances that are necessary for them to participate in the economy and create wealth’ (p. 1). She points out that improvements in Indigenous health requires community leadership often impeded by dysfunction and continuing ‘tragedy’: ‘It might be the suicide, it might be the fatal car accident, it might be the death of the twenty-year old from heart disease, because of diet, failure to thrive, lots of grog... petrol’ (Rogers in Langton 2008, 15). These instances of social breakdown explain Sutton’s (2005) caution against ‘the politicization of health’, and its tendency to propose colonialism as the sole factor explaining the Indigenous health differential. He argues that ‘the disease of politicisation’ reduces ‘a serious medical, social and cultural issue to the politics of voice’ (p. 2). Alternatively, ‘political voice’ or Fraser’s (2003) ‘politics of presence’ are, in fact, essential elements of political capacity and provide avenues for the plural expression of ideas. They allow policy makers to look to the foundational guidance that human rights provides in relation to participation (CESCR 2000, Hunt et al 2009), before conceptualizing a view of citizenship as agency. Indeed, as Sutton himself admits, attributing partial responsibility for ill-health to cultural practices or personal responsibility is not

necessarily ascribing moral responsibility in ‘victim-blaming’ fashion. It is an appeal to people’s capacity to make personal choices commensurate with good health.

Human Rights: an alternative policy framework

Human rights provide Indigenous people with a normative language and legal framework for thinking about the universal right to health in their own context, and in pursuit of their own aspirations. They are drawn together as a 10 point ‘right to health analytical framework’ (Hunt et al., 2009) that provides Indigenous peoples with a means of articulating their political aspirations and a moral framework for justifying their claims in common with all peoples. The 10 points encompass and address:

national and international human rights laws, norms and standards... resource constraints and progressive realization... obligations of immediate effect, freedoms and entitlements, availability, accessibility and quality... [the obligation on states to} respect, protect and fulfil human rights... non-discrimination, equality and vulnerability... active and informed participation... international assistance and co-operation... mentoring and accountability (Hunt et al. 2009 pp. 338-339).

The 10 point analytical framework sets aside conditional Indigenous citizenship by making a fundamental appeal to humanity as the basis of an aspiration to good health. They remove health from ‘the domain of charity or largesse’ (London and Schneide 2011) and, in Indigenous context, from the often emotionally and prejudicially charged domestic environment to one given considered international authority.

The *Declaration on the Rights of Indigenous Peoples* (2007) is a recent and significant addition to the body of human rights precepts available to support Indigenous aspirations. Australia’s endorsement of the *Declaration* adds moral urgency and philosophical context to Indigenous health and adds to the international legal instruments requiring states to achieve minimum international standards in housing, education, employment and access to food as determinants of health. It affirms Indigenous entitlement to all of the human rights available to others and claims that:

Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right (United Nations 2007).

The Declaration broadens capacity for human rights and indigeneity to contribute collectively to ‘an account of justice’ required to ‘help determine which inequalities are unjust and which are tolerable’ (Daniels et al. 1999, 216).

The right to health has broad systemic implications such as those outlined in the *Declaration of Alma-Ata* (1978) which proposes integrating medical, public health and human rights imperatives. The *Ottawa Charter* outlines the ‘fundamental conditions and resources for health’ as ‘peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity’ (World Health Organization 1986). Further: ‘To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment’ (World Health Organization 1986). Further still, the UN Millennium Development Goals (2000) provide perspectives on the multi-sectoral nature of health as a universal human right. The Goals are to ‘eradicate extreme poverty and hunger, achieve universal primary education, promote gender equality and empower women, reduce child mortality, improve maternal health, combat HIV/AIDS, malaria and other diseases, ensure environmental sustainability, [and] develop a Global Partnership for Development (United Nations, 2000).

These universal material conditions of a just social order are not, as a matter of course, available to all people, and the United Nations’ response is to urge states ‘to take concerted positive steps to ensure respect for all human rights and fundamental freedoms of Indigenous people, on the basis of equality and non-discrimination’ (United Nations 1993). Indeed, the *Vienna Declaration* positioned human rights and fundamental freedoms as ‘the first responsibility of governments’ and is ‘widely regarded’ as an international ‘consensus on the moral primacy of human rights over other public interests’ (Gagnon and Lamont 2011, 195).

For Indigenous peoples these are realized with reference to culture and self-determination over the design, delivery and control of health services, but also with reference to procedural rights such as the right to deliberate at every level of the political process to ensure that human rights do not become submerged in an assimilationist narrative where shared humanity is privileged in ways that do not admit colonialism's on-going negative impact on Indigenous people. The right to deliberate is set out in Article 18 of the *Declaration on the Rights of Indigenous People*:

Indigenous peoples have the right to participate in decision-making in matters which would affect their rights, through representatives chosen by themselves in accordance with their own procedures, as well as to maintain and develop their own Indigenous decision-making institutions (United Nations 2007).

The right is expanded on in Article 19 which requires states to engage Indigenous people in decision making processes and obtain their informed consent before adopting policy measures impacting on them. The implications are explained in the requirement that:

Indigenous peoples have the right to maintain and develop their political, economic and social systems or institutions, to be secure in the enjoyment of their own means of subsistence and development, and to engage freely in all their traditional and other economic activities (United Nations 2007, Article 20).

Inclusive and substantive deliberative arrangements challenge liberal democratic citizenship's prevailing character to suggest 'an authentic devolution of power within and beyond the health sector, with a transfer of planning and decision-making capacities... to the individuals and communities' (Yamin 2008). Fraser (2003) describes this as 'participatory parity' which assumes that 'the distribution of resources allows participants 'independence and voice' where 'institutionalized patterns of cultural value express equal respect for all participants and ensure equal opportunity for achieving social esteem' (p. 36). Procedural fairness in decision making is essential to setting aside 'misrecognition' 'constituted by *institutionalized patterns of cultural value* in ways that prevent one from participating as a peer in social life' (Fraser 2003, 30).

Participating as a peer is deeper than the shared right to vote, petition a health funding agency or access a health service. Instead, 'participatory parity' is concerned with just 'terms of association' which potentially strengthen the link between policy formulation and implementation (Iverson 2002), by insisting on inclusive deliberative arrangements. By way of contrast with Australia, inclusivity is an increasingly distinguishing feature of the New Zealand health policy environment where Maori involvement in District Health Boards aimed at 'improving the health outcomes of Maori and other population groups' (*New Zealand Public Health and Disability Act 2000*), reflect state provision of deliberative opportunity.

Inclusive deliberative arrangements challenge the prevailing nature of liberal democratic citizenship and confirm the Indigenous person's right to deliberate is secured through 'an authentic devolution of power within and beyond the health sector, with a transfer of planning and decision-making capacities to the individuals and communities served' (Yamin 2008, 13). However, given the context of Indigenous exclusion it is significant to propose that: 'From a normative perspective, governments are in democratic deficit when political arrangements fail the expectation that participation should elicit government responsiveness' (Warren 2009, 1).

Inclusivity is possible through a form of postcolonial liberalism concerned with 'articulating a space within liberal democracies and liberal thought in which these Aboriginal perspectives and philosophies can not only be heard, but given equal opportunity to shape (and reshape) the forms of power and government acting on them' (Iverson 2002, 1). So a political order interested in much more than 'closing' the statistical 'gap' in Indigenous disadvantage is imagined. For Indigenous peoples it is not sufficient to propose that 'the principal added value of a rights framework lies precisely in identifying individuals as claims-holders and States and other actors as duty bearers that can be held to account for their discharge of legal, and not merely moral, obligations' (Yamin 2008, 1).

Culture is among Indigenous health policy's more significant points of contention. It challenges the liberal tendency to 'obscure the ways in which apparently universal claims about justice or reasonableness in fact harbor particular presumptions about the relative worth of different... ways of life (Iverson 2002, p. 47). As Iverson (2002) explains it:

Liberal pluralism is not pluralistic enough. It often underestimates the kinds of difference it encounters, especially with regard to Indigenous forms of life, and it slides over the extent to which the political identities it presupposes fix institutional arrangements and distributive outcomes in particular ways, and the need for these presuppositions to be open to contestation and re-negotiation (p. 48).

'Closing the Gap' is an example. It is compromised by weak association with the 'right to culture', and its conceptualisation of disadvantage as the product of cultural deficit. For example, Carter et al (2009) similarly found that assumptions of deficit were routinely made to set aside culture in cancer treatment policy. Rather than locating policy in positive cultural terms, they found a tendency to describe Indigenous peoples as an 'intrinsically risky group' who had 'not enough knowledge' to make decisions commensurate with good health:

cancer policy can construct the identity of subcultures within communities... at present many such policies talk about subcultures only when they are deemed hazardous while allowing 'mainstream' cultures to remain invisible, and that models for alternative policy practices exist (Carter et al, 2009).

Carter et al. (2009) provide examples of attitudes to cancer treatment reflecting policy preferences for an assimilationist narrative which contextualize citizenship as giving equal rights to all, provided those rights can be expressed for Indigenous and minority populations on the assumption that

You, like the rest of us, are free by virtue of the fact that we are ruling ourselves in common and are not being ruled by some agency that need take no account of us. Your freedom consists in the fact that you have a guaranteed voice in the sovereign, that you can be heard, and that you have some part in making the decision. You enjoy this freedom by virtue of a law that franchises all of us, and so we enjoy this together. Your freedom is realized and defended by this law, and this whether or not you win or lose in any particular decision. This law defines a community of those whose freedom it realizes and defends together. It defines a collective agency, a people, whose acting together by the law preserves their freedom (Taylor 1999, 267).

Alternatively, human rights' universality means that they should propose standards that transcend domestic cultural and political circumstances. In this way, the rights of Indigenous citizenship reasonably extend to access to medical treatment with reference to one's own cultural values and expectations.

Indigenous expectations transcend distributive fairness in resource allocation to concern self-determining capacity in other areas that impact on health. For example, Sanders (2008) discusses the centrality of property rights to Indigenous peoples whose material dispossession remains among those determinants of ill-health that are routinely noted in international human rights instruments (CESCR 2000).

Pearson (2001) places the relationship among economic imperatives, health and human into pragmatic context by noting that: 'For people who participate in the economy, ill-health is only a minor consideration during their first seven or eight decades' (p. 17). The United Nations' Committee on Economic, Social and Cultural Rights notes the dependent relationship between employment and health as a human right (CESCR 2000) to suggest the importance of Indigenous economic development as a constituent of the human right to health.

Conclusion

Human rights contextualise and lend international political authority to Indigenous policy claims. The elements of health policy that the politics of indigeneity might require are properly understood as human rights; for example, in relation to the rights to deliberate and to expect cultural consideration in policy development and implementation. Human rights are responsive to the complex relationships among politics, ideology and health policy to provide Indigenous people with a particular way of challenging the political process to admit their deliberative participation, and respond to those cultural and economic determinants of health that are the product of colonial relationships with the state.

They offer conceptual clarity to a policy environment of sustained failure by proposing a broader appreciation of the liberal meaning of equal citizenship. The human rights framework's analytical potential is evident in the ways it exposes the limitations of 'Closing the Gap in Indigenous Disadvantage' and the 'Northern Territory Emergency Response', as Australia's two most significant contemporary Indigenous policy measures. The practical distance between Australia's rhetorical support for human rights and these policy initiatives helps to explain sustained policy failure in Indigenous health and highlights policy's deeply ideological character which, in turn, limits the construction of principled and informed measures equipped to improve health outcomes.

Prevailing domestic ideology diminishes policy makers' capacity to consider the ways in which human rights might guide the construction of inclusive, culturally cognisant policy, attentive to the determinants of Indigenous health. The United Nations itself has identified Australian policy failure in these terms.

A human rights approach might also provide a theoretical rationale for the establishment of just 'terms of association' between governments and Indigenous people as preliminary to reasoned and successful policy able to 'close the rhetorical' gap between stated government objectives and ideologically driven policy practice.

Human rights law provides a normative language and legal framework for thinking about the right to health, while United Nations' monitoring committees and accountability measures emphasise Australia's human rights commitments to its Indigenous peoples and its internationally sanctioned obligations to protect and fulfil these commitments. Australia's acceptance of the *Declaration on the Rights of Indigenous Peoples*, gives added authority to Indigenous claims to inclusion in a policy process informed by cultural imperatives and the unique context in which the determinants of health exist.

Human rights, therefore, add to the arguments in indigeneity for a dual or two-tiered Indigenous citizenship as one way of giving effect to the Indigenous right to self-determination, and responding to Australian liberalism's particular difficulty with cultural pluralism. This broader construction of citizenship recognises that Indigenous concerns transcend distributive justice as an important, but incomplete, source of philosophical guidance to policy-makers.

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