

Legally invisible: stewardship for Aboriginal and Torres Strait Islander health

Genevieve Howse,¹ Judith Dwyer²

Australian Aboriginal and Torres Strait Islander people die younger and carry a higher burden of disease than the general Australian population, with an average life expectancy gap of about 10 years.¹ The seriousness of the 'health gap' for Aboriginal people is universally acknowledged in policy and public debate, but progress has been slow, and implementation of policy and programs is often seen to be unsuccessful, although there is progress in some important areas (e.g. reduction in infant mortality).¹

Community-based NGOs – the Aboriginal Community-Controlled Health Organisations (ACCHOs) – provide a major share of primary health care for Aboriginal people (estimated at between one-third and one-half of the Aboriginal population)² and are generally recognised as a successful component of the health system. However, there is also widespread concern about the effectiveness of current governance and stewardship arrangements, both by government and in the ACCHO sector.³

Why focus on stewardship and governance?

National stewardship for health has been defined as "the careful and responsible management of the wellbeing of the population"⁴ and is the responsibility of government. In embracing stewardship of the health system, the responsible ministry of health must ensure the health sector is properly governed at national and sub-national levels based on government

Abstract

Objectives: The need to improve access to good health care for Aboriginal and Torres Strait Islander people has been the subject of policy debate for decades, but progress is hampered by complex policy and administrative arrangements and lack of clarity about the responsibilities of governments. This study aimed to identify the current legal basis of those responsibilities and define options available to Australian governments to enact enduring responsibility for Aboriginal health care.

Methods: This study used a framework for public health law research and conducted a mapping study to examine the current legal underpinnings for stewardship and governance for Aboriginal health and health care. More than 200 pieces of health legislation were analysed in the context of the common and statutory law and health policy goals.

Results: Very little specific recognition of the needs of Aboriginal people was found, and nothing that creates responsibility for stewardship and governance. The continuing absence of a legislative framework to address and protect Aboriginal health can be traced back to the founding doctrine of *terra nullius* (unoccupied land).

Conclusions: We considered the results applying both a human rights perspective and the perspective of therapeutic jurisprudence. We suggest that national law for health stewardship would provide a strong foundation for progress, and should itself be based on recognition of Australia's First Peoples in the Australian Constitution, as is currently proposed.

Key words: Aboriginal health care, stewardship, health law, constitutional recognition

policy, legislated functions and duties, and applicable domestic and international standards and values.

In broad terms, governance can be defined as the "means adopted by a society to promote collective action and deliver collective solutions in pursuit of common goals"⁵ 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 meaningful

participation of non-government actors in ongoing decision making is supported.

In a federal system, where law-making and governance responsibilities are split between three levels of government (federal, state and local), statutory responsibility for governance creates the basis for accountability. The absence of statutory responsibility for governance enables those who might be accountable to shift blame for lack of action or for system failures to other levels of government or to other ministries with relevant portfolio responsibility.

1. Public Health, La Trobe University, Victoria

2. Department of Health Care Management, South Australia

Correspondence to: Professor Judith Dwyer, Department of Health Care Management, Flinders University School of Medicine, GPO Box 2100, Adelaide 5000, South Australia; e-mail: Judith.dwyer@flinders.edu.au

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Sound governance also enables coherent observation of the efficacy of the system as a whole and of the use of system-wide mechanisms such as data collection, surveillance, monitoring, financing, planning, policy making and programming.

While the underlying causes of 'the health gap' are largely social, economic and political/cultural, the health system can play a leading role in addressing the health effects of these broad social determinants.⁶ There is a growing body of evidence that Aboriginal people enjoy less than optimal access to care and less than optimal quality of care.⁷ Aboriginal people were formally excluded from the mainstream health system in several jurisdictions during the 19th and early-mid 20th centuries,⁸ and their access to services remains compromised in many ways. Lower screening rates and poorer prevention of complications for Aboriginal patients than for the general population have been documented in national health data, along with higher numbers of potentially preventable hospitalisations.^{7,9} Although emergency department visits and hospitalisation rates for Aboriginal people are relatively higher, procedure rates are lower. Waiting times for surgery are longer than for non-Aboriginal patients, and nearly double for some types of surgery.^{7,10}

Experiences of shaming, misunderstanding and stereotyping make engagement with the health system less effective than it can and should be.¹¹⁻¹³ Aboriginal patients sometimes receive care that is ineffective, insensitive or inappropriate.¹⁴ Language and interpersonal communication breakdown across the cultural divide leads to difficulty in assessing symptoms, reaching an accurate diagnosis and providing effective care.^{12,15-17}

There is also evidence that access for Aboriginal patients is compromised by barriers that affect them differentially.⁷ These include resources for travel and accommodation; availability of supportive or rehabilitation care, such as cardiac rehabilitation;¹⁸ and continuity of care across different health and support services.¹⁹

This evidence suggests strongly that action is needed to improve access to and quality of care for Aboriginal people, and that the causes of the documented differentials lie at least partly in the policy and program settings of the health system. A recent study of the experiences of public hospital staff in providing care to Aboriginal patients

from rural and remote areas found that while some staff are energetic and creative in tailoring their care to the needs of this group of patients, they do so in the absence of operational policies and programs to authorise and guide such action, and experience some discomfort in the effort to reconcile their actions with prevailing norms.²⁰

The funding and regulation of primary health care for Aboriginal people also provide cause for concern about the effectiveness of stewardship and governance. These problems are well-documented, and include arrangements that are fragmented and complex, short- to medium-term, with excessive administrative and reporting requirements.^{21,22} This situation contrasts with the mainstream health system, where essential basic care is either provided directly by government or funded through long-term fee-for-service arrangements (which bring their own bureaucratic burden). The cost and efficiency problems caused by the complex contractual environment for Aboriginal services are also well documented.^{23,24} The major national funding agency for Aboriginal-specific primary health care, the Department of Health, has made significant progress towards reducing complexity, but the overlapping roles of multiple funders remain problematic. One consequence is that funding for equitable access to PHC is not feasible (since no single agency has control – or even an overview – of the decisions of multiple funders).

Legal recognition

Establishing a legal basis for 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 inertia caused by current fragmentation of laws and administrative responsibilities in relation to their health and health care.

The legal relationship between the Commonwealth of Australia (including its predecessor colonial governments) and Australia's First Peoples began with a failure to recognise their rights and accommodate their needs, under the doctrine of terra nullius (land belonging to no-one). Subjects of a 'settled' colony became British subjects at settlement and only British common law applied.

Since settlement, the progress of law-making that recognises Australia's First Peoples and is sensitive to their particular needs 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 population legally invisible to the Commonwealth Government. It took until 1967 for the Constitution to be changed by referendum to enable the government to make laws for Aboriginal people and include them in the census.

Terra nullius was disposed of by the High Court in the *Mabo v. Queensland (No. 2)* (1992) 175 CLR judgment of 1992. In recent years, four of eight jurisdictions (in which more than 70% of the total and Indigenous populations live: NSW, Queensland, Victoria and South Australia) have inserted recognition clauses into the body or preamble of their constitutions.

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

Some local government laws, particularly in the Northern Territory, address some local governance issues for rural and remote communities,²⁵ but such arrangements apply only to a small proportion of the Aboriginal population and offer nothing towards stewardship and governance for Aboriginal and Torres Strait Islander health across Australia.

Australia's health policy and system

Responsibility for health care in Australia is divided between two levels of government. The Constitution allocates some limited powers to the Commonwealth 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.² As the National Health and Hospitals Reform Commission notes:

*[the two levels of government] have different approaches to funding, different relationships with health service providers, and different responsibilities for various parts of health care. The two levels of government also have different capacities to meet the cost of services from their own revenue.*²

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 health in general, and for Aboriginal and Torres Strait Islander health in particular.

The development of a health system for Aboriginal and Torres Strait Islander people post-contact was confused and piecemeal, with the Commonwealth only really becoming engaged with Aboriginal affairs after the 1967 referendum. Radical administrative change to the existing arrangements was suggested by the National Health and Hospitals Reform Commission,² in the form of a National Aboriginal and Torres Strait Islander Health Authority that would hold all funding for Aboriginal health and “actively purchase and commission the very best health services...”. But this recommendation was promptly rejected by the government, which opted instead to ‘continue to work closely with the Indigenous health sector in an effort to close the gap in Indigenous health outcomes.’²⁶

Recent commentary and academic literature point to the frustration caused by the current fragmentation and its effects on policy making and programming for Aboriginal 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.*²⁷

There appears to be a broad consensus among observers of the policy process about ways of addressing systemic failures, summed up by the former chair of the Productivity Commission as having four elements:

co-operation between governments and communities; ‘bottom up’ involvement in services and planning; sustained, consistent government support; and good governance on both sides.²⁸ However, while these ideas are almost always supported in principle by government policy-makers, they have not been effectively implemented in practice.²²

Governments do not always fulfil all statutory obligations, and statutory obligations do not always result in legal or administrative accountability. However, recognition in law is powerful. Even when laws do not create absolute obligations for governments, legislative duties and functions are the focus of public service departments and agencies. Ministers and secretaries must report compliance and progress against them. Agencies’ recurrent funding is appropriated 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.²⁹

This study examined existing Australian laws allocating responsibility for health in order to assess their adequacy to support system-wide stewardship and good governance for Aboriginal health.

Methods

We used the framework of public health law research for this study.^{30,31} This framework guides the study of laws and legal practices and their (potential) outputs – changes in environments and behaviours that ultimately lead to changes in population health. In the typology of public health law research put forward by Wagenaar et al,³⁰ this study is a mapping study.

A search was conducted to identify all national and jurisdictional health law extant in December 2011, using publicly available information on government websites. For seven of nine jurisdictions, (the Commonwealth, Victoria, South Australia, Northern Territory, New South Wales, Queensland and the Australian Capital Territory), all Acts administered by health portfolios are listed on the portfolio website, enabling complete ascertainment. For the other two jurisdictions (Western Australia and Tasmania), hand searching was conducted examining lists of laws on publicly available websites that compile Australian laws and identifying those commonly administered by the health portfolio. While completeness

cannot be assured, it is highly unlikely that substantially relevant Acts were overlooked. Each Act was examined to identify whether Aboriginal health was explicitly mentioned; and whether the Act could be seen to contribute to the development of a basis for stewardship and governance for Aboriginal health.

Based on this analysis, we considered options for strengthening the legal basis for stewardship and governance of Aboriginal health, with reference to relevant international comparators.

For the purposes of this paper, we have focused on the ways in which modern Australian law could address stewardship and governance for Aboriginal health. In doing so, we nevertheless recognise that Indigenous traditional law proceeds from a radically different basis,³² and that legal pluralism is a necessary condition in post-colonial societies.

Results

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. Of 69 principal Acts administered by the Commonwealth Department of Health and Ageing,³³ three specifically refer to Aboriginal and Torres Strait Islander people: *Aged Care Act 1997* (Cth), Chapter 2, Division 1, Section 11-3; *National Health and Medical Research Council Act 1992* (Cth), Section 20(2)(d); and *National Health Practitioner Registration National Law Act 2009* (Cth), Part 5 Division 1 Section 31 (1); Division 10 Section 113(3); and Part 10 Division 3 Section 222(2). None create responsibility for stewardship or governance.

Of 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. The few instances of specific recognition of the needs of Aboriginal peoples generally fail to provide for a mechanism of input to decision making or implementation. Thus, among an estimated 269 principal Acts administered by Australia’s nine health portfolios, there is no Australian law or series of laws that, 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.

South Australia provides leadership among the states and territories with its *South Australian Public Health Act 2011* and *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.

Objectives can be found in some other recent state and territory health laws – *Public Health and Wellbeing Act 2008 (Vic.)*, *Public and Environmental Health Act 2011 (NT)*, *Public Health Bill (WA)* – that create obligations to assist communities with special needs and to advance equity and access. However, neither these nor any other state or territory health law specifically mentions Aboriginal people, despite state and territory health portfolios administering between 20 and 31 principal Acts each. Victoria, Western Australia, the

Australian Capital Territory and the Northern Territory establish objects or principles in either their public health or health service laws that enable some consideration of the issues that might affect stewardship and governance for Aboriginal health, but do not specifically mention Aboriginal people. Tasmania and Queensland neither mention Aboriginal and Torres Strait Islander people nor create objects and purposes, in either their public health or health service laws, that require consideration of inequity in access to care or the special needs of particular communities.

The situation for each jurisdiction is summarised in Table 1.

This vacuum in governance persists, and despite reports, commentaries and calls for action for better stewardship and governance,³⁴⁻³⁶ the pace of law reform in this area has been slow.

Discussion

The virtually complete absence of legislated attention to the need to improve Aboriginal health and health care and to allocate systemic responsibility for doing so shows up a stark gap at odds with universal recognition of the importance of reducing

Aboriginal health inequity. In the historical context of the colonisation of Australia, the pervading legislative silence on Aboriginal health can logically be seen as a long-term effect of the *terra nullius* doctrine; and more proximately of the way that the Constitution was shaped at Federation (dealing with Australia's First Peoples only to exclude them from both national law and the census) and the enduring impact of this history on public policy generally.

Thus the mediators, or the current public health laws that might create a legislative infrastructure for governance in Aboriginal and Torres Strait Islander health, are almost completely silent and create no legal basis for accountability. The outputs, which would be changes in environments and behaviours that ultimately lead to changes in population health, are similarly robbed of substance.

Comparison with countries that have similar legal systems and colonisation histories, and ongoing problems arising from dispossession, discrimination, exclusion and relatively poor indigenous health, is instructive. Several researchers have compared the health of Indigenous peoples in Australia with the situation in Canada, the US and New Zealand. These analyses were reviewed by the Australian Institute of Health Welfare, which concluded that comparisons of the mortality gap are unreliable due to significant differences in the data collections. They conclude that the longevity gap in Australia is larger than in New Zealand; and that comparison with Canada and the US is not feasible.³⁷ What is clear is that the legal invisibility of Australia's First Peoples is not matched in the comparator countries. Table 2 summarises the legal basis for health care for indigenous peoples in the four countries.

The experiences of Canada, the United States and New Zealand add weight to the view that 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.

The potential role of legislation

From a health perspective, the question of why any population group's health should be the subject of legislation arises, particularly given Australia's universalist and relatively equitable approach to health care. However, the importance of legislation to health and health care is made clear by the very

Table 1: Summary of legal provisions for governance of Aboriginal health.

| Jurisdiction | Health Acts | Mention | Provision for particular responsibility for Aboriginal health | Provision for Participation |
|-------------------|-------------|--|--|---|
| Commonwealth | 69 | 1. Aged Care Act 1997 2. National Health and Medical Research Council Act 1992 3. Health Practitioners National Law Act | Provision for NATSIH Board to govern registration of Aboriginal Health Workers | NHMRC Act requires 1 member with expertise in Aboriginal health |
| ACT | 22 | 0 | | |
| NSW | 31 | 0 | | |
| NT | 24 | Public and Environmental Health Act 2011 – No mention but apparent intention to apply particular public health protection to Aboriginal communities (S3, b), c) Health Practitioners Act 2004 – registers AHWs (superseded) | | |
| Queensland | 26 | Health Services Act 1991 – definition of 'parent' for Aboriginal child (S61 (3), (4)) | | |
| South Australia | 23 | Public Health Act 2011 Health Care Act 2008 | Yes, in objects in both Acts | |
| Victoria | 29 | 0 | | |
| Tasmania | 25 | 0 | | |
| Western Australia | 20 | 0 | | |
| TOTAL | 269 | 8 | 3 | 1 |

existence of more than 260 pieces of health legislation nationally, addressing a vast array of particular and general health issues, from the allocation of administrative and programming responsibility across state and territory health systems to laws about the needs of people with disabilities and the need to ensure safe food and water, to the roles of governments, the private sector and the non-government sector in operating health systems and providing safe health care.

Two lenses through which to examine the legal vacuum in laws about stewardship and governance

International treaties and their attendant obligations provide a relevant perspective. Australia has ratified the International Convention on Economic, Social and Cultural Rights and the International Convention on the Rights of the Child. Both these treaties impose obligations on Australia at international law to progressively realise the rights of all Australians to the highest attainable standard of health free of discrimination. Australia has also adopted the International Convention on the Rights of Indigenous Peoples, which “while it is non-binding and does not affect existing Australian law, it sets important international principles for nations to aspire to”.³⁸

Australia's commitment to these conventions brings 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”.²⁹ 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 population.

The second perspective is therapeutic jurisprudence, a relatively recent concept first applied in the field of mental health law, and 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 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.*³⁹

The idea of law itself having positive or negative therapeutic consequences is echoed in recent commentary on social disadvantage, including that experienced under the law, as having a direct effect on the health of Aboriginal and Torres Strait Islander peoples, for example:

*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.*³⁶

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.

Using therapeutic jurisprudence as a lens through which to examine laws creating stewardship and governance for Aboriginal and Torres Strait Islander health, the lack of recognition and allocation of responsibility may itself have negative therapeutic consequences. The same concept applies to the history of *terra nullius* and the early lack of recognition in the Constitution, the law from which all other laws are made and from which every part of our Westminster system draws its power. From this perspective, recognition

Table 2: International comparison of legal basis for indigenous health care.

CANADA: Local treaties negotiated following European arrivals. Royal Proclamation of 1763 aimed to stabilise British holdings, and established some regulation and protection for First Nations and Inuit communities. Indian Act (1867) established formal relationships between the Federal Government and First Nations and Inuit communities. The Romanow report described responsibilities for indigenous health care as ‘a confusing mix of federal, provincial and territorial programs and services as well as services provided directly by some aboriginal communities.’^{a(p212)} The Romanow report also reported a consistent call for more active participation of aboriginal peoples in communities. Over the past 20 years, responsibility for provision of primary health care has largely transferred to local community governance in discrete First Nations and Inuit communities; with urban dwelling indigenous people mostly relying on the mainstream health system.

US: Tribal governments formally recognised as sovereign governments and almost 390 treaties were made, perhaps mainly to legitimise transfer of land from Indian tribes.^b The doctrine of ‘discovery’ was used in the US to justify dispossession (Johnson v. M’Intosh, 21 U.S. [8 Wheat] 543 [1823]).^c Most Indians did not become US citizens until 1924.^d

Congress has long had legislative authority to appropriate funds specifically for the health care of Indian people (Snyder Act of 1921 [25 USC 13] and the Indian Health Care Improvement Act [25 USC 1601] of 1976). Responsibility for Indigenous health care transferred in 1954 to the Department of Health and Human Services, which established the Indian Health Service, the principal federal health care provider and health advocate for Indian people (serving 1.9 million people in 35 states). The National Indian Health Board is a representative body that monitors, reports on and responds to federal legislation and regulations.

NEW ZEALAND: The Treaty of Waitangi (1840) effected a transfer of sovereignty from Māori to the British Crown;^e and created obligations on the Crown to enable mechanisms for Māori self-governance and to protect Māori interests.^f

Improving health outcomes for Māori and other population groups is stated as one purpose of the NZ Public Health and Disability Act 2000. The relevant provisions recognise the Treaty; ensure Māori representation on District Health Boards and other ways of contributing to decision-making (Part 1, Cl 4).

AUSTRALIA: No treaties or formal agreements exist. Foundations in doctrine of *terra nullius*. This was overturned by Mabo decision and partly overcome by land rights legislation in the 1990s. Citizenship granted to Aboriginal people in 1940s. National law made possible by constitutional change in 1967. There is no specific legislative basis for policy or action on Aboriginal health.

Footnotes:

a. Romanow RJ. *Building on Values: The Future of Health Care in Canada* [Internet]. Saskatoon (CAN): Commission on the Future of Health Care in Canada; 2001 [cited 2011 Jun 7]. Available from: <http://dsp-psd.pwgsc.gc.ca/Collection/CP32-85-2002E.pdf>

b. Miller RJ. *American Indians and the United States Constitution* [Internet]. Portland (OR): Lewis and Clark Law School; 2006 [cited 2015 Mar 25]. Available from: www.flashpointmag.com/amindus.htm

c. Gallagher EJ. Johnson and Graham's Lessee v. William M'Intosh. In: *Literature of Justification Supreme Court*. Bethlehem (PA): Lehigh University; 2003 [cited 2011 Jun 20]. Available from: www.utulsa.edu/law/classes/rice/ussct_cases/JOHNSON_V_MCINTOSH_1823.HTM

d. Kappler CJ. Part 4: Indian citizenship. In: *Indian Affairs: Laws and Treaties*. Washington (DC): Government Printing Office; 1929 [cited 2011 Jun 20]. Available from: http://digital.library.okstate.edu/kappler/vol4/html_files/v4p1165.html

e. Orange C. *The Treaty of Waitangi*. Wellington (NZ): Port Nicholson Press; 1987.

f. Kingi Te KR. *The Treaty of Waitangi and Maori Health*. Palmerston North (NZ): Massey University; 2006 [cited 2015 Mar 26]. Available from: www.massey.ac.nz/massey/fms/Te%20Mata%200%20Te%20Tau/Publications%20-%20Te%20Kani/T%20Kingi%20Treaty_of_Waitangi_Maori_Health1.pdf?95BAA6D4A43BA51CFB9589A7660869D

in the Constitution and in laws directly addressing governance and stewardship can address the present governance vacuum but may also have, in themselves, therapeutic consequences.

Options for a legal basis for stewardship and governance for Aboriginal health

In the light of our results, the important question is how best to establish a legal basis for stewardship and governance for Aboriginal health policy, programs and services; one that will enable improvements in health care and health outcomes. We suggest that the following criteria should be applied to the evaluation of options:

1. Is there allocation of overall government stewardship responsibility for Indigenous health?
2. Will there be consolidation/less fragmentation of government funding and regulation of health care for Indigenous people?
3. Is participation by Indigenous people built in?

We also suggest that the most effective option has two elements – constitutional recognition and national law.

Constitutional recognition is needed

Constitutional recognition of Australia's First Peoples will provide a basis for stewardship and governance for health, as has proved useful in both the US and New Zealand. It is also consistent with human rights obligations in the ICCPR and the Declaration on the Rights of Indigenous Peoples, and with therapeutic jurisprudence.

The absence of recognition of Australia's First Peoples in the Constitution is acknowledged as problematic by all major parties and the majority of the Australian population are supportive of change.⁴⁰ A referendum is to be held in the near future, in accordance with the provisions of the *Aboriginal and Torres Strait Islander Peoples Recognition Act 2013* (No. 18, 2013). We suggest that among many important outcomes, constitutional recognition will provide a genuine opportunity to address the legal invisibility of Aboriginal health by establishing a viable foundation on which health law can be built.

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, involving both national and state/territory governments. However it is done, we suggest that any law purporting to enable good governance for Aboriginal health would need to bring together the levers for policy making, programming and financing to one responsible ministry or entity. It should be clear about allocation of responsibility for policy making, planning, programming and service delivery. It should be supported by clear source/s of funding – preferably, aggregated funding – and include objectives and principles that enable participation of Aboriginal and Torres Strait Islander people in all aspects of governance.

The Commonwealth has the power 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 could establish government responsibility for policy, programming and financing; include recognition of the need for culturally safe care; and incorporate arrangements for active engagement of Aboriginal people at all levels of decision-making. It could also address the role of traditional medicine, and enable agreement-making with Aboriginal communities and organisations for health care provision.⁴¹ A Commonwealth law is the only mechanism to achieve nationwide effect and establish clear responsibility for stewardship and governance. A practical alternative would be to adopt a uniform national approach through the enactment of matching laws in all states and territories. 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.⁴²

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. However, this option is more difficult politically and administratively. It requires

agreement to 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 for which there is existing Commonwealth power, i.e. the establishment of stewardship and governance for the health of members of the Aboriginal and Torres Strait Islander population who live in every state and territory in Australia.

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. 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.

While the doctrine of *terra nullius* and the legal invisibility it conferred on Aboriginal people is slowly shifting, the lack of recognition in Australian law generally means that approaches to governance and stewardship in Aboriginal and Torres Strait Islander health lack a basis of recognition and rights in Australian law. Such recognition has been shown to provide a basis for law-making in health in other comparable countries.

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.

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