The Right to Health of Indigenous peoples in the Industrialized World: A Research Agenda

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The international community has made great strides in developing a coherent body of international human rights law principles. Far less attention, however, has been focused on the extent to which such principles have been implemented within countries and the processes involved in their implementation. This is particularly evident in relation to economic, social, and cultural rights, not least within wealthy nations. It is often overlooked that most wealthy countries include minority populations that suffer from poor standards of living by any comparison. Such minority populations include Indigenous peoples in Australia, Canada, New Zealand, and the United States. These populations still experience relatively poor standards of living, including in the area of health.[1]

Australia, Canada, and New Zealand are parties to the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Rights of the Child (CRC), and the Convention on the Elimination of Discrimination Against Women (CEDAW), and all four countries are parties to the Convention on the Elimination of Racial Discrimination (CERD). These treaties incorporate elements of the right to the highest attainable standard of health.[2] These countries are also parties to the International Covenant on Civil and Political Rights (ICCPR), which in-

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cludes a non-discrimination provision that can arguably be extended to health-related services.[3] Yet, the extent to which the right to health of Indigenous peoples in these countries has been implemented, and the ways in which international human rights law principles are engaged with in formulating domestic law and policy on Indigenous health, remain under-assessed.

This comment introduces a research agenda for assessing the implementation of the right to health of these populations and also considers the potential relevance of international human rights law to the development of domestic law and policy on Indigenous health. The purpose of articulating a broader research agenda, such as the one proposed here, is to enhance understanding of the processes of and factors affecting the implementation of the right to health of Indigenous peoples in wealthy countries with a view to the ultimate aim of improving the health status of Indigenous peoples in the industrialized world.

Assessing Implementation: A Research Agenda

Most research into the domestic implementation of international human rights law can be characterized in one of two ways. Studies by legal scholars tend to focus on formal elements of implementation, such as the incorporation of international human rights principles into domestic constitutional and statutory law or the justiciability of human rights.[4] Researchers working in the development field and those writing in the political science field tend to focus on the statistical measurement of human rights enjoyment.[5] Though both approaches are important to understanding human rights implementation, there is also a need for broader, cross-sectoral analyses that qualitatively examine the processes, actors, and conditions affecting implementation.[6] Here we consider the beginnings of such an approach, broadly situated within the discipline of socio-legal studies.

The domestic implementation of international law includes both "formal" and "substantive" implementation. Formal implementation involves the legal processes of incorporating the principles of an international agreement into the domestic legal system to give effect to the agreement domestically. In countries such as Australia, Canada, and New

Zealand, the provisions of an international agreement may have no direct legal effect domestically until this process takes place, even if the agreement has been ratified.[7] Approaches that focus on statistical indicators of health status may overlook this important aspect of implementation.

Substantive implementation, often inadequately considered by legal scholars, is the means by which the provisions of an international agreement, as ideally reflected in domestic legal standards via formal implementation, are operationalized through their incorporation into government policies, decisions, and actions.[8] Substantive implementation should also include the transparent and participatory development and review of such policies, with these procedural and review elements forming an important part of a state's obligations to respect, protect, and fulfill human rights, including the right to health.

Finally, a socio-legal approach suggests that full implementation involves the internalization of international law norms by government officials, civil society, and ultimately, the wider public. By this understanding, success in terms of implementation occurs where "human rights standards are accepted as authoritative by national institutions and officials in such manner that their practical actions and decisions are in compliance with them."[9] Implementation thus becomes a matter of degree, even as "full implementation" is an ideal that cannot occur completely. We can nonetheless attempt to study the extent to which, and how, implementation is actually occurring.

Such a conceptualization of implementation points to the need for a broad approach to assessing implementation in any given context, an approach which should, in its practical application, include the involvement of Indigenous peoples themselves. In considering the right to health of Indigenous peoples in the industrialized world, analysis across three areas — the legal system, the policy sector, and civil society — is relevant. The approach proposed here incorporates consideration of qualitative notions of norm internalization as well as quantitative notions of the statistical measurement of human rights enjoyment.

In the first area of analysis, the legal system, key processes for review include constitutional and statutory

amendments, judicial consideration of right to health concepts, and state-reporting activities to UN human rights treaty bodies and other accounting mechanisms relevant to the right to health of Indigenous peoples. Analysis in this sector would appear to equate with Paul Hunt's notion of "structural indicators." One of three types of "rights-based approach to health indicators" identified by Hunt, structural indicators address "whether or not key structures and mechanisms that are necessary for, or conducive to, the realization of the right to health, are in place."[10] According to Hunt, such indicators are "often (but not always) framed as a question generating a yes/no answer," such as whether a state has ratified international conventions that recognize the right to health and whether domestic laws and policies have been adopted that explicitly protect the right.[11]

In fact, simple "yes or no" questions regarding the structural framework within which a right is, or is not, recognized are not likely on their own to be sufficient. Elements of the right to health may be "indirectly" implemented even where a country has not formally incorporated the relevant international agreements. In Canada, for example, the non-discrimination provisions of the Canadian Charter of Rights and Freedoms have been found by the Supreme Court to be applicable in the context of health care services.[12] This idea of indirect implementation is particularly relevant to an analysis of the right to health of Indigenous peoples in Australia and Canada, where federalism contributes to the legal and administrative complexity of implementing the right to health of Indigenous peoples. This is because the federal governments retain constitutional authority over the administration of Indigenous affairs, while the state and provincial governments have primary responsibility for the administration of health affairs.[13]

Often, a government may refer to instances of indirect implementation in its reports to the UN human rights treaty bodies and in interactions with other national and international accountability mechanisms. This evidences an awareness of the ways in which judicial and statutory developments that do not explicitly mention a particular right, or that were not originally created for the express purpose of protecting a particular right, may nonetheless contribute to

the fulfillment of the state's international human rights obligations. It may even be that, through the "discursive processes of argumentation and persuasion" involved in reporting to national and international accountability mechanisms, a state may begin to view the substance of an action of indirect implementation as a matter of obligation, rather than simply governmental discretion, thereby slowly internalizing the right to health norms.[14] In attempting to analyze such issues of norm internalization as relevant to the health of Indigenous peoples in this and the policy and civil society sectors, a range of research methods may be necessary, including archival and textual analysis, surveying, participant observation, and interviewing. Socio-legal and international relations literature on social norms can also provide useful analytical tools for considering the degree of norm internalization and the notion of "indirect" implementation.

The second area of analysis is that of the policy sector, where government actions to develop, implement, and review domestic policy on human rights and Indigenous health must be considered. Similar to the idea of indirect implementation in the legal system, inquiry in this sector should extend beyond an examination of explicit references to international human rights law to consider the extent to which elements of the right to health are substantively reflected in policies and bureaucratic activities. A particular public health measure relevant to Indigenous health, for example, might incorporate key components of the right to health even in the absence of any explicit reference to the right itself. Additional factors to consider here include the role of bureaucratic decision-making, the coordination of activities across departments and levels of government, and bureaucratic awareness and acceptance of international human rights norms. As with the legal system, such an analysis may require multiple research methods such as documentary reviews and interviews with key informants.

It is also relevant to consider statistical indicators of health status, since these remain an important aspect of measuring individual and population level enjoyment of the right to health. Such indicators relate to Sofia Gruskin's idea of accountability and equate directly with Hunt's notion of "outcome indicators."[15] Clearly, data should be disaggregated on

the basis of Indigenousness and non-Indigenousness, but, where possible and appropriate, it should be further disaggregated by gender, age, urban/rural location, and socio-economic status.[16] Data should compare progress over time and should include the following, at a minimum: life expectancy; birth weight; rate of infant mortality; chief causes of death, disease, and illness rates; and prevalence of health risk factors, such as smoking, obesity, and substance abuse. Consideration should also be given to statistical indicators of *access* to quality health services within each country, given the impact of such access on health status, and to other economic and social indicators in light of the growing recognition that "economic and social disadvantage tends to equate with poorer health than [does] higher economic and social status, even where access to quality health services" is good.[17] This is particularly applicable to the Indigenous populations of the industrialized world, where Indigenous peoples fare poorly across the spectrum of social and economic indicators, including in the areas of employment, income, housing and water access, education levels, and incarceration rates.

Where possible, the application of statistical indicators should also include an analysis of total health expenditure per capita on a disaggregated basis. The underlying tenet of the right to health is not that an individual should or can be perfectly healthy; rather, that he or she should have the best opportunity of being such in light of national circumstances.[18] The significant gap between Indigenous and non-Indigenous health in these countries suggests that a higher amount of per capita funding should be directed towards Indigenous-specific health programs as compared with health programs aimed at the population as a whole or at other national sub-groups. In this context, the human rights law concepts of non-discrimination and equality indicate that such a *differential* approach to per capita health expenditure is necessary in order to move towards parity of health outcomes.

As noted by the Aboriginal and Torres Strait Islander Social Justice Commissioner in Australia, "reducing people and their experiences to percentages and numbers is problematic," and the literature on the use and limitations of statistical indicators in measuring human rights enjoyment is growing.[19] A particular concern in the context of Indigenous

health is that the collection of disaggregated data on Indigenous peoples remains disjointed and incomplete due in part to remoteness and accessibility issues, the complex federal political structure in all but New Zealand, the role of self-identification in the classification of Indigenousness, and the history of institutionalized discrimination against Indigenous peoples in each country. If used with commentary, however, or, as suggested here, within a wider, qualitative study of implementation, statistical indicators can provide a worthwhile picture of inequalities between Indigenous and non-Indigenous populations.[20] Statistical indicators relating to Indigenous health should also be placed within the context of any nationally defined benchmarks that exist for measuring economic and social progress. This is an important way of contextualizing statistical data. Furthermore, the very development and application of national benchmarks by a state may reflect the "review" aspect of substantive implementation referred to earlier.

The third and final area of analysis is civil society action, incorporating the media, nongovernmental organizations, and the general public. Potentially overlooked by purely legal analyses of human rights implementation, these actions may play an important role in the domestic implementation of international human rights law in at least three ways: 1) lobbying and advocacy, 2) monitoring and reporting on state compliance, and 3) incorporating human rights law concepts into the delivery of services.[21] The latter is particularly relevant with regard to the administration of Indigenous health in the industrialized world because community-controlled organizations are often involved in the direct provision of primary health care services in Indigenous communities.

Various issues are relevant to an analysis of civil society: the representation of human rights norms and issues in the national media; the nature and extent to which human rights norms are employed by civil society organizations active in the area of Indigenous health; and acceptance of international human rights law concepts by the general public. Also of importance is the extent to which international human rights norms are internalized by Indigenous communities themselves, and the extent to which notions of the right to health, and Indigenous control over health services, are connected to

wider struggles for Indigenous self-determination. Reasons for any absence of reliance upon international human rights norms could include the following: 1) the view that such individualistic norms are not applicable to some communal Indigenous contexts; 2) lack of awareness about the content and applicability of international law; or 3) the view that appeals to alternative, domestically-founded entitlements may provide greater possibilities for encouraging change.[22]

General issues that might need to be addressed in the future development of a research agenda include the methodological gap that may exist between monitoring health itself and monitoring the right to health, and investigating the possibility of a conceptual distinction between a rights-based approach and a right-to-health-based approach. More specifically, it will be necessary to consider the incorporation of Indigenous viewpoints into the research agenda itself.

Relevance of the Right to Health to Indigenous Health in Australia, Canada, New Zealand, and the United States

There are at least five related ways in which implementation of the right to health within these countries may be relevant to the development of law and policy on Indigenous health and therefore to Indigenous health itself. First, the conceptualization of Indigenous health in terms of the right of Indigenous peoples to the highest attainable standard of health allows for a broader approach to Indigenous health that acknowledges the historic and ongoing impact of human rights violations on the health status of Indigenous peoples. The Committee on Economic, Social and Cultural Rights and the UN Special Rapporteur on the Right to Health have both emphasized the interconnectedness between the right to health and the fulfillment of other human rights, such as rights to an adequate standard of living, education, and water, and the right to be free from discrimination.[23] This understanding of health is vital in the Indigenous context where addressing ongoing dispossession and institutional racism is key to tackling poor health status.

Second, appeals to the right to health may provide possibilities for stronger protection of Indigenous health in law. This involves a conceptualization of Indigenous health in terms of

state *obligations* rather than as merely policy decisions regarding social welfare and resource allocation. While sound policies are vital, a legal framework that explicitly recognizes the right of Indigenous peoples to health could provide greater certainty and consistency in the administration of Indigenous health care, as well as greater possibilities for the resolution of disputes regarding inadequate or inappropriate health services.[24] The former is especially relevant here because a long-term approach to addressing Indigenous health is key, requiring politicians to think beyond three- or four-year election cycles.

Related to the latter issue of resolving disputes is a third factor — that of assessing outcomes and ensuring accountability. A focus on the right to health encourages consideration of the substantive effects of government policies and programs. There is also a procedural element associated with assessing outcomes, that being a focus on data collection, which, until recently, has been very poor in the Indigenous health context in all these countries but New Zealand.[25]

The fourth possibility for affecting the administration of Indigenous health care equates with the second of Gruskin's three frameworks for bringing together approaches to public health and human rights — that of advocacy.[26] Domestically, appealing to human rights may be an important tool for encouraging change. Internationally, the UN monitoring procedures, in particular the reporting requirements relevant to Indigenous health under ICESCR, CRC, CEDAW, and CERD, provide an added level of pressure.

Finally, an emphasis on human rights may inform policy development and implementation at a practical level, including the development and implementation of nongovernmental programs. This is arguably where much of the conceptual and practical work is currently taking place.[27] Based on consideration of the provisions of General Comment 14 of the Committee on Economic, Social, and Cultural Rights to Indigenous health, such an approach would include, at the very least: 1) greater involvement of Indigenous peoples in decision-making processes that affect them; 2) greater control over the administration of Indigenous health programs; 3) emphasis on culturally appropriate services; 4) recognition of traditional healing methods; 5) emphasis on the social determinants of health; 6) coordination of policies across de-

partments and levels of government; and 7) emphasis on equality in the provision of health services.[28] This fifth element arguably equates more with a "rights-based approach" to health, as compared with a "right to health approach," a potential distinction recently touched upon by UN Special Rapporteur, Paul Hunt, and one that requires further scholarly attention.[29]

Ultimately, if the principles of international human rights law are to achieve their underlying aims, it is vital that the extent to and ways in which such rights are being implemented domestically is better understood.[30] This is no more evident than in the case of the right to health of marginalized populations in the industrialized world, such as Indigenous peoples in Australia, Canada, New Zealand, and the United States. Only in this way can the international community build upon the solid work achieved in developing human rights law in the 20th century.

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2. Referred to throughout as the "right to health." International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200 (XXI), UN GAOR, 21st Sess., Supp. No. 16, at 49, UN Doc. A/6316 (1966) Article 12; Convention on the Rights of the Child, G.A. Res. 44/25, UN GAOR, 44th Sess., Supp. No. 49, at 166, UN Doc. A/44/25 (1989) Article 24; Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180, UN GAOR, 34th Sess., Supp. No. 46, at 193, UN Doc. A/34/46 (1979) Articles 11.1(f), 12, 14.2(b); Convention on the Elimination of All Forms of Racial Discrimination, G.A. Res. 2106A (XX) (1965) Article 5(e)(iv).

3. Article 26, International Covenant on Civil and Political Rights, G.A. Res. 2200 (XXI), UN GAOR, 21st Sess., Supp. No. 16, at 49, UN Doc. A/6316 (1966).

4. D. Galligan, and D. Sandler, "Implementing Human Rights," in S. Halliday and P. Schmidt (eds), *Human Rights Brought Home: Socio-Legal Studies of Human Rights in the National Context* (London: Hart, 2004), p. 25; P. Schmidt, and S. Halliday, "Introduction: Socio-Legal Perspectives on Human Rights in the National Context" in *Human Rights Brought Home*: p. 3. See, for example, B. Conforti and F. Francioni (eds), *Enforcing*

International Human Rights Law in Domestic Courts (The Hague: Martinus Nijhoff, 1997); C. Harland, "The Status of the International Covenant on Civil and Political Rights (ICCPR) in the Domestic Law of State Parties: An Initial Global Survey through UN Human Rights Committee Documents," *Human Rights Quarterly* 22/1 (2000): pp. 187–260.

5. See, for example, O. Hathaway, "Do Human Rights Treaties Make a Difference?" *Yale Law Journal* 111 (2001–2002): pp. 1935–2042.

6. There have been some studies that have employed a more qualitative approach to human rights implementation. See for example, T. Risse and S. Ropp (eds), *The Power of Human Rights: International Norms and Domestic Change* (Cambridge, UK: Cambridge University Press, 1999).

7. In classic international law theory, a "monist" state is one that approaches international and national law as comprising a single legal system, such that, when the state ratifies an international law agreement, its provisions automatically carry the force of law domestically. In a "dualist" state, domestic legislation must be passed before the provisions of the international agreement directly enter the national legal system. Whether a state is monist, dualist, or some combination of the two, depends upon its domestic constitutional and legal arrangements. E. Denza, "The Relationship between International and National Law," in M. D. Evans (ed), *International Law* (Oxford: Oxford University Press, 2003): p. 421; V. Leary, "International Labour Conventions and National Law," cited in H. J. Steiner and P. Alston, *International Human Rights in Context: Law, Politics and Morals* (Oxford: Oxford University Press, 2000, 2nd ed.): pp. 999–1001.

8. Galligan and Sandler (see note 4): p. 24.

9. Ibid. p. 29.

10. "Process indicators" measure "programmes, activities and interventions," while "outcome indicators" measure "the impact of programmes, activities and interventions on health status and related issues." Paul Hunt, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. E/CN.4/2006/48 (2006): paras. 55–56.

11. Ibid. para. 54.

12. See, for example, *Eldridge* v *British Columbia (Attorney-General)* (1997) 3 SCR 624.

13. For Australia, see Constitution of Australia, sections 51 (xxiiiA), 51 (xxix). For Canada, see Constitution Act, 1867, 91(24) 92(16).

14. See the work of Risse and Ropp (note 6) on socialization processes that may assist a state in internalizing international human rights norms.

15. Sofia Gruskin identifies three frameworks for bringing together activities in the fields of human rights and public health — the "law and policy framework," the "advocacy framework" and the "programmatic framework." S. Gruskin, "Is There a Government in the Cockpit: A Passenger's Perspective on Global Public Health: The Role of Human Rights," *Temple Law Review* 77 (2004): pp. 327–30.

16. See Paul Hunt's discussion of the need for and sensitivities of disaggregated health indicators. Hunt (see note 10): para. 49.

17. Australasia Economics, *Key Social and Economic Indicators for Indigenous Australia: A Comparative Analysis* (a study prepared for the

Office of Aboriginal and Torres Strait Islander Affairs (Canberra: April, 2004). Available at http://www.oipc.gov.au/publications/KeyIndicatorsReport/.

18. Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. No. E/C.12/200/4 (2000): paras. 8, 9.

19. Australian Human Rights and Equal Opportunity Commission, *A Statistical Overview of Aboriginal and Torres Strait Islander Peoples in Australia* (Sydney: May 2005). Available at http://www.hreoc.gov.au/social_justice/statistics/.

20. Ibid.

21. See Gruskin's discussion of advocacy and programmatic activities. Gruskin (see note 15): pp. 328–30.

22. These ideas derive from interviews conducted for the author's doctoral research. A more collective approach to the rights of Indigenous peoples has often been emphasized. See, for example, the Draft United Nations Declaration on Rights of Indigenous Peoples, UN Doc. E/CN.4/Sub.2/1994/2/Add.1 (1994).

23. General Comment 14 (see note 18): para. 4; Paul Hunt, Report submitted by the Special Rapporteur on The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, UN Doc. E/CN.4/2003/58 (2003), para. 8.

24. The existence of laws equates with formal implementation or structural indicators, while the adjudication of such laws moves into the area of substantive implementation.

25. Regarding these second and third factors, see Gruskin's discussion of the law and policy framework. Gruskin (see note 15): p. 328.

26. Gruskin (see note 15): pp. 328–9.

27. Hunt (see note 10).

28. Committee on Economic, Social and Cultural Rights (see note 18): para. 43.

29. P. Hunt, Keynote Address, Lessons Learned from Rights Based Approaches to Health, Atlanta: Emory University, April 14–16, 2005.

30. Ibid.