Indigenous health: power, politics and citizenship

by

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Acknowledgements

For Joey

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Acknowledgements

INTRODUCTION[1]

This book begins with the simple but compelling observation that Indigenous health is distinguished by a median age of death approximately 20 years less than that of the non-indigenous population (Australian Bureau of Statistics, 2009), and Australia is unique among comparable neo-colonial societies in failing to reduce a differential (Oxfam Australia, 2007), that is principally explained by the number of indigenous people who die prematurely, but from causes that are preventable (Australian Bureau of Statistics, 2009). Between 2001 and 2005, cardiovascular conditions were the most common explanation for the death rates of both men and women, and were higher than the expected 'age cause-specific' rates for non-indigenous people (3% and 2.7%, respectively). For men, injuries (2.9% higher), cancers (1.5%), respiratory diseases (4.3%), and nutritional and metabolic diseases (7.5%) were the next most common causes of death (Australian Bureau of Statistics, 2009). For women, cancers (1.6%), nutritional and metabolic (10.1%) and respiratory diseases (3.6%) most commonly account for the differential (Australian Bureau of Statistics, 2009).

Indigenous Australians are twice as likely as others to have asthma. They have a greater incidence of ear diseases and hearing loss by a ratio of 1:3. Their burden of heart and circulatory diseases exceeds that of other Australians by a ratio of 1:2 (Australian Bureau of Statistics, 2013) and they are one and a half times more likely to die from cardio-vascular diseases (Collins at al., 2009). In parts of Australia, 26 percent of the Indigenous population suffers diabetes: a

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[1] This book develops and expands on work previously published, in different form, as O'Sullivan, D. 'Indigenous Health and Human Rights'. *Australian Journal of Human Rights*, Vol. 18(2) 2012, pp.1-20. O'Sullivan, D. 'Indigenous Health Policy and the Politics of 'Democratic Exclusion' or self determination'? *Journal of Australian Indigenous Issues* Vol. 16(1) 2013, pp. 38; O'Sullivan, D. 'Justice, Culture and the Political Determinants of Indigenous Australian Health'. *Ethnicities* Available at http://etn.sagepub.com/content/early/recent doi:10.1177/1468796811432697, published 3 January 2012.

prevalence rate six times that of the general population (World Health Organization, 2010). It is not surprising, then, that indigenous Australians are half as likely as other citizens 'to have reported excellent or very good health' in a survey conducted by the Australian Bureau of Statistics in 2013 (Australian Bureau of Statistics, 2013). Nor is it surprising, given history's role as a determinant of health, that McDonald et al (2013) describe indigenous public policy history as 'confusing, disappointing, reactive and ad hoc' (p. 2), while Gooda (2005) describes it as distinguished by 'Contradiction, Confusion and Ironies' because

> as a difficult cross-cultural policy arena and the moral cause celebre of Australian nationhood, indigenous affairs goes through generational cycles. Approaches to indigenous affairs that are pursued confidently at one point in time become seen after 30 or 40 years as having failed to develop to expectations (Sanders and Hunt, 2010, p. 222).

Confusion, contradiction and ironies because although relative indigenous ill-health has been well canvassed from clinical perspectives, health and its determinants, including colonisation itself are also matters of philosophy and justice. It then becomes essential to ask: 'what recourses exist in political theory for thinking about the possibilities of a non-colonial relation between indigenous and non-indigenous peoples' (Tully, 2000, p. 50)? As the Director of the Cape York Institute for Policy and Leadership, Noel Pearson (2011), puts it: 'Aboriginal policy will never prosper if the Leviathan is not restrained in its cage, and self-determining humans seeking a better life are once again free to roam the continent'. Further overarching political questions are how should indigenous peoples be involved in policy-making and what role should culture play in service delivery? These questions are important, simply because political values influence people's opportunities to influence the burden of disease. They influence a society's acceptance of ethnic discrepancies in health outcomes and the extent to which inclusive and substantive deliberative agency is admitted into the policy process.

This book proposes that while these differemces properly attract serious clinical concern, they are also explained and reasonably addressed as the outcome of considered political values, aspirations and arrangements. The argument is developed from the conceptual foundations laid in the book's first two chapters. That foundation allows Chapter Three to explore the ways in which liberal democratic political arrangements exclude indigenous peoples from substantive deliberative engagement in the policy process, before setting out an argument in liberal theory for considered political inclusion as preliminary to improved health outcomes for indigenous peoples. Chapter Four shows how political values and aspirations influence the work of health professionals who as 'street level' bureaucrats (Lipsky, 1980) can become policy's 'public face'. Chapter Five examines relationships among human rights, health and liberal democracy before Chapter Six develops arguments about the construction of citizenship and its meaning for people's opportunities for good health. It asks what it actually means, in real terms, for an indigenous person to be an equal citizen of the Commonwealth. Chapters Seven and Eight then draw on Amartya Sen (1999) and Martha Nussbaum's (1987, 2003) capabilities approach to development to bring human rights and citizenship from the abstract to the practical. The Chapters examine the capabilities approach's potential to allow indigenous peoples to frame for themselves the substantive meaning of self-determination as a right at international law (United Nations, 2007). Self-determination remains important, even though it is a right that has been the subject of deep controversy in Australian political discourse, both in terms of its moral legitimacy and practical efficacy.

It was in 1967 that amendments to the Commonwealth Constitution allowed the Commonwealth Government to enter the indigenous policy domain. A series of incremental steps towards more inclusive and culturally cognisant indigenous policy have since occurred.

Yet, on the other hand, there remain significant intellectual contests among policy actors over the terms of indigenous peoples' belonging to the liberal state. Contrasts between relatively better indigenous health in jurisdictions such as Canada and New Zealand where opportunities for self-determination are more broadly admitted into public policy arrangements illuminates these tensions. the contrasts show Australia's standing as a jurisdiction where more significant and sustained improvements might reasonably have been made. They further suggest that poor indigenous health is neither inevitable nor immutable and that there is, perhaps, political space to think more broadly about liberal political possibilities so that constraints and conditions on indigenous citizenship might be removed in favour of greater accommodation of difference and indigenous democratic engagement in the policy process. Indeed, equal deliberative capacity is a mark of equal moral worth.

Health outcomes are influenced by relationships among health, education, housing, and employment. These relationships are the subject of an extensive literature broadly described as the 'social determinants' of health. The book accepts these relationships, but shows their inherently political, not simply 'social' character. The distribution is preliminary to a full appreciation of the ways in which these determinants of health are influenced by prevailing conceptions of justice, democracy and citizenship, which makes health policy, itself, the outcome of contested political values. Indigenous actors such as the National Congress of Australia's First Peoples recognise these relationships in their accounts of self-determination to reflect, again, the importance of politics to equal opportunities for good health. Considered political decisions across health policy and its determinants reveal the ways in which public authority is distributed inequitably based on decisions that are, in fact, judgments about the purpose of political activity and the justice of collective indigenous participation in the policy process.

Political and administrative decisions also influence the cultural responsiveness of public institutions and create space for political values about relationships between health and culture to influence policy outcomes. The ways in which societies share public authority is an indication of their conceptions of justice and willingness to function as inclusive political communities. Yet, there is recourse within liberal political theory, juxtaposed with the politics of indigeneity, for securing indigenous people's substantive democratic engagement, including participation at every stage of the health policy process.

Australia can draw policy lessons from New Zealand on the indigenization of policy making, representative participation and recognition of relationships between health and culture. In these ways, one can complement distributive arguments for particular attention to indigenous health with reparative positions that address relationships between colonial history and health. At the same time, contemporary political exclusivity is challenged by arguments for 'participatory parity' as a matter of democratic legitimacy and moral urgency to accept that group recognition is preliminary to fair political outcomes. It is only on account of their indigeneity that individual members of the group have been affected by colonialism's necessarily exploitative logic. Injustice has occurred in specific contexts peculiar to the group, which means that general appeals to principles of egalitarian justice will be insufficient to protect indigenous people's individual liberties and opportunities to share in the 'good life'. Culture, first occupancy and claims that reparative principles ought to inform policy development add to the political nature of the determinants of indigenous health and are reasonably integrated into policy frameworks concerned with indigenous peoples' health and well-being.

It is significant that it is only since 1973 that the Commonwealth has systematically attended to indigenous health. It is only since the 1990s that jurisprudential and political developments

began to expose racism's ingrained policy presence, and subsequently suggest policy developments towards a more inclusive conception of the ways in which common citizenship might be exercised. However, a constraining consideration is policy actors' conflicting positions on indigenous belonging to the one liberal polity which creates a policy environment of intellectual tensions, contradictions and inconsistencies that hinder the emergence of clear and broadly understood accounts of indigenous peoples' reasonable expectations of the health system. Yet, from the debates that have occurred over time one can still find political space for theoretical ideas of participatory parity, recognition and relational justice to combine to create a coherent and defensible alternative account of liberal democratic possibilities consistent with indigenous aspirations to self-determination.

Self-determination was practised in limited form from the early 1970s until the 1990s when the Howard Government (1996-2007) drew on failings in the concept's practical application by the Aboriginal and Torres Strait Islander Commission (ATSIC) to discredit its philosophical propriety and practical worth. Self-determination's justification as an aspiration that indigenous people might pursue through their own culturally-grounded institutions was similarly questioned. However, for indigenous peoples self-determination remains central to their identities as distinct 'peoples' with political rights and aspirations that cannot be subsumed into a state prescribed understanding of liberal democratic citizenship.

Self-determination represents a particular view of the proper terms of indigenous belonging to the liberal state and challenges the prevailing proposition that public sovereignty resides only with state institutions. Instead, it proposes that indigenous peoples might reasonably enjoy a particular share in public authority through relative and relational autonomy with the state.

Self-determination embodies a series of rights codified in the United Nations' *Universal Declaration on the Rights of Indigenous Peoples* (2007), which Australia accepted in 2009. In practical health policy terms, the right to self-determination is claimed and expressed through entities such as the National Congress of Australia's First Peoples, Aboriginal Community Controlled Health Organisations and a number of indigenous professional associations. Self-determination also finds expression through indigenous deliberation at various levels of public administration to counter liberalism's tendency to marginalise minority voices and establish public policy objectives that privilege 'sameness' over cultural difference. For example, it was only through reviews *after* the implementation of 'Closing the Gap in Indigenous Disadvantage' and the 'Northern Territory Emergency Response' (the Intervention), as the two most significant measures in contemporary indigenous health policy, that substantive opportunities were created for indigenous engagement in their development.

Reparative justice is also important in health policy because so much in contemporary indigenous disadvantage is the product of a succession of public policies of intended negative consequence. The 'stolen generations' policy under which colonial, then state governments, removed indigenous children from their families between the late nineteenth century and early 1970s is a significant example. It suggests that reparation is required to restore balance and integrity to political relationships and to the ways in which the system, itself, deals with contemporary disadvantage.

Self-determination expresses the politics of indigeneity's purpose of contesting the theoretical presumptions of democratic exclusion and proposing political relationships that admit extant rights of first occupancy. The politics of indigeneity is a developing theory of justice grounded in the presumption that indigenous belonging to the state is properly crafted with reference to self-

defined aspirations, including cultural perceptions of what constitutes good health, and substantive deliberative equality in national affairs. these presumptions are complemented by the argument that there ought to be political space for independent indigenous entities to exercise authority over their own affairs. The politics of indigeneity's emphasis on group rights as preliminary to individual liberty is among its more significant arguments; it challenges the prevailing liberal order to consider its purposes and procedures more broadly and inclusively.

Closing the Gap and the Intervention most graphically expose the tension between inclusive and exclusive accounts of liberal democracy. The contrast is especially apparent when these policies are compared with measures grounded in firmer conceptions of relational justice. For example, such principles influence the *Cultural Respect Framework* (2004), *National Mental Health Policy 2008* (2009) and the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* (2013). Participatory parity, recognition and self-determination are also evident in these policy measures to show liberal democracy's capacity to admit, in limited ways, the propriety of differentiated approaches to public policy. The contrast stresses health policy's profoundly political character and that, for indigenous peoples, it cannot be concerned only with the egalitarian objective of 'closing gaps'. While the egalitarian objective is an important one, its tendency, when pursued in isolation from other policy imperatives is to position indigenous peoples in deficit and stereotypical terms to confine policy ambition to achieving a particular statistical profile.

Political tensions over what indigenous peoples might reasonably expect of the health system are played out, in a particular way, through the work of the front-line health worker, or street level bureaucrat (Lipsky, 1980). Health workers' personal political values influence their work, within the bureaucracy, as they are often positioned to constrain or transcend official policy

objectives. The extent to which they might do either is influenced by multiple and potentially conflicting professional loyalties: to the patient, the profession, the state, and perhaps above all, to personal conceptions of indigenous people and their legitimate expectations of the health system. Politics, then, complements knowledge and skill as determinants of professional agency and rather than being a Weberian 'iron cage' (Weber, 1958) the bureaucracy becomes a site of considerable professional discretion. The absence of intellectual clarity and consistency, in the policy process itself, also broadens the scope for bureaucratic discretion to either undermine policy efficacy or transcend it with reference to more fully developed conceptions of health work as an instrument of social justice. However, professional agency's importance is not absolute and it is never just the combination of personal skill and philosophical disposition that influences people's opportunities for high-quality healthcare.

Workplace cultures influence street level work and need to be examined as one seeks an explanation for the distance between indigenous and professional institutional cultures. Workplace cultures reflect broader political values to demonstrate, once again, the contribution that politics makes to people's opportunities for good health, as a universal human right.

The principal connection between indigeneity and human rights is that together they provide ways of arguing for a deeper relationship between politics and health than one concerned simply with resource allocation. Human rights affirm cultural aspirations and the right to self-determination as measures that cannot be subsumed beneath a general concern for distributive equality.

The absence of domestic human rights instruments, such as the Treaty of Waitangi in New Zealand, coupled with Australia's long history of discrimination against indigenous peoples makes recourse to an internationally recognised liberal account of reasonable political

expectations especially important as the success that indigenous claims might enjoy depends on the extent to which they can be framed in liberal terms. A consistent liberal theory of what the right to health care actually means, in practical terms, is preliminary to challenging the intellectual inconsistency that continues to pervade the indigenous health policy environment and undermine measures intended to increase indigenous people's opportunities for good health. Human rights standards codify the moral, legal and political principles of indigenous peoples' reasonable health entitlements. They also provide international and independent benchmarks against which to measure political opportunities and the underlying moral values that allow inequality and discrimination to persist. They help to explain policy failure and promote values of equality and human dignity as among indigenous peoples' reasonable public policy expectations. Human rights provide useful analytical tools for assessing policy possibilities and limitations.

Human rights affirm access to the full, substantive and uncontested rights of liberal democratic citizenship, expressed most significantly and succinctly by the Aboriginal and Torres Strait Islander Social Justice Commissioner in his 'five integrated requirements' of a human rights approach to health policy. While these requirements may seem fair and reasonable, their significance is actually in their radical inconsistency with prevailing practices. The five requirements are: addressing indigenous disadvantage in health, evidence-based policy development and evaluation, evaluation against established benchmarks, co-ordination and cooperation among governments and indigenous engagement in the policy process (Calma, 2008). These aspirations are consistent with Australia's acceptance of the United Nations' *Universal Declaration on the Rights of Indigenous Peoples* (2007) and a series of other health-related human rights instruments to which Australia has acceded, for example: *Charter of the*

United Nations (1945), the *International Convention on the Elimination of All Forms of Racial Discrimination* (1965) the *Declaration of Alma-ata* (1978), the *Ottawa Charter for Health Promotion* (1986), *Vienna Declaration and Programme of Action* (1993) and the *Bangkok Charter for Health Promotion in a Globalized World* (2005).

Although citizenship does not, on its own, provide simple solutions to relative indigenous ill-health its construction does reflect political values and contribute to the institutional arrangements that constrain or encourage opportunities for good health. Therefore, it provides an instructive set of theoretical propositions for examining both policy failure and policy possibilities. Indeed, it is its potential to empower or constrain that makes citizenship a contested concept. One of the ways in which citizenship might complement the political possibilities sought by the politics of indigeneity is through its construction and practice in differentiated or two-tiered terms. Differentiated citizenship extends to indigenous peoples the same rights and privileges that citizenship provides to all others, but it does so in preferred cultural contexts and in recognition of the proposition that indigenous peoples may wish to participate in national political affairs collectively as well as individually and with reference to their particular socio-political and historical circumstances. At the same time, they may wish to participate in the affairs of their own nations in ways that permit the retention, development and utilisation of traditional political structures in pursuit of the self-defined collective good. In this sense, the collective good might be distinguished by land rights, effective education, access to traditional resources and the ability to define and pursue health and well-being according to personal values and aspirations. So there is scope for liberal theories of citizenship to transcend the concept's traditional unresponsiveness to just terms of indigenous belonging to the modern liberal democratic state. There is scope for citizenship to transcend its own tendency to diminish

indigenous political voice by setting aside a purely undifferentiated codification of the rights, responsibilities, opportunities and limits that stem from membership of the one polity. The ways in which citizenship is constructed sets the terms of public policy's capacity to deal with claims beyond distributive justice in the allocation of public resources, especially those claims to a particular distribution of political authority that recognises rights arising from first occupancy and that are owed as restitution for instances of injustice against indigenous peoples.

One of the most persistent indigenous objections to the contemporary construction of citizenship is its encouragement of passive welfare, whereas an 'active' citizenship beyond the welfare state is an essential consideration for policy concerned with enhancing indigenous people's health and well-being. Passive welfare arises from the positioning of people as simply materially poor and, therefore, deserving the attention of the benevolent state as a policy end in itself. A fuller conception of citizenship might respond to the structural causes of material poverty and alienation from education and the labour market as the primary determinants of material well-being. It might also admit relationships between good health and access to culture and economic security as rights of indigeneity. The location of such rights, within a broader politics of indigeneity, means that for citizenship to acquire substantive meaning for indigenous peoples it must be a more far reaching concept than simple access to the welfare state. The welfare state enhances neither personal nor collective agency, which are both important determinants of health, and foundational rights of indigeneity.

Differentiated accounts of citizenship, coupled with arguments at human rights law, are among the more recent responses to sustained indigenous ill-health. However, the discourses of human rights and citizenship are often couched in abstract terms. Their practical applications and ability to contribute to people's substantive capacities to make choices commensurate with good health

are enhanced by a capabilities approach to development (Sen, 1999 and Nussbaum (1987, 2003), which is a contemporary application of Aristotle's concern for human flourishing (Aristotle, 1988). It is well juxtaposed with the politics of indigeneity to provide ways of thinking about what indigenous people mean, exactly, when making a claim to self-determination.

Capabilities is a counter-colonial approach to development as its claims to essentialist universal freedoms are necessarily preliminary to any individual or group's capacity to make choices consistent with what they, *themselves*, value. Its concern is for public policies that enable people to maximise personal agency, which means that justice must be measured through the opportunities that people have (inputs) rather than what they choose to do with their endowments (outputs). From these concerns, it is possible to develop a politics of indigeneity that protects, but also transcends, rights to resources and culturally contextualised deliberative opportunities. The freedom 'to function well' (Nussbaum, 1987, p. 20) depends on the application of a series of universal human rights including the right to life, opportunities for good health, protection from violence, opportunities for substantive political expression and the political space to reason about what is good and desirable, the right to live in free association with whomever one chooses, and control over the environment in which one lives (Nussbaum, 2003). While these rights must be practised in a world of profound inequality they are, unquestionably, the rights that actually give people the capacity to challenge inequality. Nussbaum (1987, 2003) extends indigeneity's concern for a 'particular' distribution of power and authority to suggest the political imperative to think more broadly about the constituents of freedom and the essential pre-conditions for and of freedom.

The health system, itself, is an important contributor to physical and mental well-being as determinants of broad capabilities. Its efficacy for *all* not merely *some* of its users is an important

question that makes the functioning of the health system not just a clinical concern but one that must also be considered as a matter of moral and political philosophy. Good health is preliminary to the 'human flourishing' that Aristotle positions among the ultimate purposes of politics (Aristotle, 1988).

The capabilities approach to development is one that the Cape York Institute applies in its policy development and is one that is consistent with a cautious but growing tendency for group rights to be admitted into national policy discourses. The Cape York Institute's particular interest is in the idea that capabilities are the antithesis of the passive welfare to which many indigenous policy actors (Pearson, Langton, Anderson and Price, for example) ascribe responsibility for the social dysfunction that contributes to relative ill-health.

Rather than passivity, Pearson (2007) argues that people ought to have access to systems and structures that 'enable' them to do things of personal value as essential marks of their humanity. In this way, Pearson demonstrates capabilities as self-determination and positions them as essential to a practical and substantive politics of indigeneity. Pearson tests the boundaries of liberal possibilities to show that, although it embodies significant constraints, the liberal political order is not one that always and necessarily rejects cultural plurality and can admit the universal essentialist rights that Nussbaum (2003) proposes as rights without which full human being itself is impossible. It is significant, then, that a Lowitja Institute for Indigenous Health Research (2014) examination of future research needs in indigenous health outlined two different but 'plausible' directions that Australia might take into 2030. The direction that is ultimately taken will depend, at least partly, on the policy aspirations that indigenous peoples have the political freedom to pursue. 'On the one hand, we could live in a future where there is significant improvement in the health and wellbeing of our communities, within an Australia which

recognises and values the diversity of Aboriginal and Torres Strait Islander ways of life' (Brands, 2014). Under this scenario the Institute's Chairperson, Pat Anderson, outlined self-determination's ideal appearance by 2030:

- True reconciliation – treaty, constitutional recognition, resulting in an Australian society in which Aboriginal and Torres Strait Islander people and cultures have pride of place
- Real community control in our community controlled sector
- Significant improvement in health outcomes and life expectancy
- Real cultural equity, no racism
- Aboriginal knowledge would be part of mainstream, part of the norm. 'Nunga streaming' not 'mainstreaming'
- Aboriginal models of health would be brought to the fore and privileged; for example, spirituality
- Education/employment/informed choices/control
- Diversity and difference would be celebrated
- Seamless integration of Aboriginal values, would become part of the landscape
- There would be no 'othering'
- There would be Aboriginal representation at all levels of government and society
- Aboriginal people would be influencing decisions, across all dimensions of society
- On a broader scale across society we would have a broader approach, it wouldn't just be about money, there would be a return to values and ethics (individual and community), less focus on consumerism and capitalism, and sustainable and ecological ways of living (Anderson, 2014).

The project imagines that under these conditions a representative indigenous woman, in 2030, would be one who:

- Reaches 29 years in full health
- Has higher education qualifications; is technically, socially and culturally savvy
- Mentally and socially in touch with community and family
- Non-smoker, good BMI, no drinking problem
- Stable relationship
- Has choice and control over fertility, childcare and employment
- World-aware but with a sense of individual purpose
- Well travelled/global visions
- Economically independent
- Grounded in mixed cultures
- Builds on family history for positive outcomes (Brands, 2014, pp. 12-13).

Anderson (2014) continues that: 'On the other hand, we can imagine an Australia which turns its back on diversity, which increases the divide between rich and poor, and which sees little or no

real improvement in the health and wellbeing of its First Peoples'. Indigenous society would then

be distinguished by

- Negative political change: ultra conservative governments, back to the future, all the worst political nightmares come true
- Ramifications will include:
  decrease of Aboriginal organisations (in the worst case, Aboriginal organisations are dissolved)
  Aboriginal health funding cut
  mainstreaming of health, privatisation of health, acute care driven
  decrease in primary health care, promotion, prevention
  the health gap will widen
  child health would decrease for many reasons
  more negative impacts on social determinants of health
  incease in incarceration, marginalization, political control, disempowerment, suicide, decrease in wellbeing (Brands, 2014, p. 12).

The report argues that under these conditions a representative indigenous woman, in 2030, would

be one whose life was distinguished by:

- Family breakdown/violence
- Abusive relationship
- School dropout
- Substance abuse
- Imprisonment
- Housing crisis
- Children at risk/Social service involvement
- Stress/mental illness
- Chronic disease
- Premature death
- Her family and community deeply affected by her loss (Brands, 2014, p. 13)

Clinical capabilities and practices will be among the variables contributing to which of these, or

any other appearances, indigenous policy may assume by 2030. Yet so, too, will political values

underpin the constructions and practices of liberal democratic citizenship and its influences on

indigenous people's opportunities for good health as they, themselves, define it.

The ideological foundations of indigenous health policy

Introduction

Political values and group capacity to influence the burden of disease are among the essential variables that help to explain relative indigenous ill-health. Similarly, a community's preparedness to accept ethnic discrepancies in health outcomes is a mark of its conceptions of justice, and the values it holds about citizenship and social inclusion. This is especially so as health policy transcends physical and mental wellbeing to affect social equity, educational and economic opportunities, and the general capacity to exercise personal self-determination. Therefore, policy solutions to sustained Indigenous ill health rest on a revised underlying philosophical paradigm, in which human rights cannot be diminished, and in which broadened conceptions of liberal citizenship are juxtaposed with the politics of indigeneity (described in Chapters Five and Six) to promote theories of justice capable of defining the 'duties of institutions and actors in reducing inequalities' (Ruger 2004, p. 1092). In particular, it is argued that policy ought to transcend individual rights to, and need for, healthcare towards a model which is based on broader and more inclusive conceptions of justice, cognizant of the Indigenous right to self-determination and deliberative engagement in the policy process. If power imbalances, policy inertia and dysfunctional political relationships help to explain sustained policy failure, it follows that poor Indigenous health is neither inevitable nor immutable.

Health in ideological context

The contemporary indigenous policy environment is one of perpetual uncertainty, distinguished by evolving, yet always confused and contested policy rationale. Sanders and Hunt (2010) argue that the current policy fashion is one that draws upon 'responsibility sharing,

partnership and a whole-of-government approach… to disparage what has gone before' (p. 222) and create, rather than mediate debate about who and what is responsible for indigenous peoples ill-health. For example, from perspectives that privilege individual responsibility over self-determination as if the two were mutually exclusive, one could support the libertarian argument that 'society has no obligation of justice (as opposed to charity) to provide the poor with what they are missing' (Daniels et al., 1999, p. 226) on the grounds of established relationships between group ill health and propensity to engage in risky behaviours. There would, then, be no grounds for the substantive reconceptualisation of what it means, in health policy terms, for an indigenous person to share common citizenship with other members of the liberal democratic Australian community. Alternatively, relative Indigenous ill health's universality cautions against a 'victim blaming' policy response and suggests that one ought to consider the argument that 'it is not credible to suggest that one of the wealthiest nations of the world cannot solve a health crisis affecting less than 3% of its citizens' (Calma, 2007).

Relative Indigenous ill health is an outcome of relationships between ideology and history, as well as an outcome of the philosophical paradigms through which societies make policy and conduct their political affairs. Across the Americas,

> the present epidemiological profile of indigenous populations is associated with high poverty indices, unemployment, illiteracy, migration, exclusion from the mainstream society, lack of land and territory, destruction of the ecosystem, alteration of the dynamic of life, and unmet basic needs (Pan American Health Organization, 2003).

Canadian studies have reinforced the same theme, in finding that economic marginalization, trauma, violence and racism inhibit diabetes control among Aboriginal communities (Iwasaki et al., 2004) and that 'diabetes as a recent phenomenon is directly attributed to changes from past to present' (Sunday et al., 2001, p. 76). However, in spite of the policy problem's universality, Australia remains unique among comparable post-colonial societies in failing to make relative

and substantive improvements. For example, the most recent data indicate a New Zealand Maori/non-Maori life expectancy differential of 7.3 years (Statistics New Zealand, 2013), while native Canadian life expectancy is 5-6 years less than that of the total Canadian population (Garner et al., 2010). There are instructive policy lessons on which Australia might draw from these and other international authorities. For example, the World Bank proposes a nexus between citizenship and development by advancing investment in household capacity to improve health and incomes, raising the quality of schooling and a primary care focus on immunization, nutritional deficiencies and the control and treatment of communicable diseases. Diversity and competition in the delivery of health services is also promoted to make these strategies simultaneously consistent with Australia's prevailing liberal political disposition and the self-determining objectives of the politics of indigeneity (World Bank, 1993).

New Zealand's relatively better indigenous health is principally explained by policy paradigms more attentive to the role of culture in health care and more willing to countenance specific forms of indigenous participation in policy-making. For example, the public health system's administration by District Health Boards (DHBs) proceeds with the requirement that Maori representation on the Boards is at least proportionate to their share of the district's population (*New Zealand Public Health and Disability Act 2000*). While not providing policy panaceas for good health these measures are important because they show that even as it is contested there is still a politically established view that liberal democracy is not affronted by systemic recognition of difference. Nor is it necessarily affronted by recognition of the cultural precepts and political aspirations of a group of citizens whose democratic expectations are conditioned by colonial experiences.

Contemporary New Zealand politics are distinguished by values and practices (Maaka and Fleras, 2005; O'Sullivan, 2007) that confront the state's assumption of exclusive sovereignty in favour of a political philosophy allowing all citizens to contribute to the development of the national community. Notwithstanding these significant policy measures, institutional racism does remain in the New Zealand health system. Good intentions do not, on their own, eliminate racism (Came, 2014) because as the Maori party co-leader and Associate Minister for Social Development, Tariana Turia, put it:

> Over the years, the findings have been conclusive. Maori receive fewer referrals and diagnostic tests, and less effective treatment plans from their doctors than do non-Maori patients. It goes further. Maori are interviewed for less time and are offered far fewer opportunities for treatment. They are prescribed fewer secondary services such as physiotherapy, chiropractors and rehabilitation. And worst of all in too many cases Maori are either blamed for their plight or the professionals treat them in such a way as to presume they have a natural inclination towards the various illness (Turia, 2013b).

Nevertheless, the fact that a Maori person is in a position to make these observations, as a Minister of the Crown, provides an instructive contrast with Australia, where indigenous membership of a Federal Cabinet has not occurred in the nation's 113 year history. The bigger question, still, is as the Minister asked in a speech to the Australia New Zealand School of Government:

> Whether it be either side of the Tasman, perhaps that is the ultimate challenge - how do we ensure that our respective peoples do indeed shape their destiny? Whose voices are being heard? What peoples are represented in the advice that you put forward (Turia, 2013a)?

Turia's question invites a broad framework for thinking about liberal political possibilities, based perhaps on the fundamental questions Benhabib (2002) raises about democratic inclusivity and responsiveness:

> Does democracy rest on homogenizing models of identity? What does the body of the 'body politic' look like? Can the ideal of universal citizenship accommodate difference?

What institutional cultural, representational channels are there for the expression of difference? How much difference is compatible with the ideal of the rule of law under fair and equal conditions (p. 5)?

It is in the ways that it thinks about these questions that contemporary Indigenous health policy exposes a tension between equality through sameness and difference through considered choice. Rowse (2002) explains the tension as 'found in two competing visions of 'reconciliation'. One vision would eliminate 'difference', while the other would 'enact and enshrine the different ways that Indigenous and non-Indigenous Australians belong to Australia' (p. 2), where the state might seek re-engagement with indigenous peoples on terms that are more reflective of their common citizenship (Sullivan, 2011)

Sullivan supposes values that are, in fact, applied inconsistently and occur alongside policies distinguished by the presumption of conditional citizenship, to show the ideological tension in which policy occurs. The tension is summarized as between liberal egalitarianism and indigenous calls for a human rights based approach to health, with self-determination and deliberative opportunity important constituents. For example, in 2013, the newly appointed Prime Minister, Tony Abbott, established a Prime Minister's Indigenous Advisory Council. Its 'Terms of Reference' set out important policy objectives intended to better the lives of Indigenous peoples but, at the same time, the Council is not intended to be representative and is not required to make public its advice to the Prime Minister. Nor, is it clear that it is supported by a secretariat with the capacity to assist in the development of policy advice or that there is public sector ability to evaluate the longer term efficacy of that advice. Its 'Terms of Reference' require focus on:

1. improving school attendance and educational attainment
2. creating lasting employment opportunities in the real economy
3. reviewing land ownership and other drivers of economic development
4. preserving Aboriginal and Torres Strait Islander cultures

5. building reconciliation and creating a new partnership between black and white Australians
6. empowering Aboriginal and Torres Strait Islander communities, including through more flexible and outcome-focussed programme design and delivery
7. building the capacity of communities, service providers and governments
8. promoting better evaluation to inform government decision-making
9. supporting greater shared responsibility and reducing dependence on government within Aboriginal and Torres Strait Islander communities
10. achieving constitutional recognition of Aboriginal and Torres Strait Islander people (Department of Prime Minister and Cabinet, 2013).

Within two weeks of the Council's first meeting in December 2013, its Chairman Warren Mindine's criticism of a policy measure to reduce public funding to a National Family Violence Prevention and Legal Service Programme foreshadowed an on-going conflict that is likely to arise between the cost of policy measures to advance the Council's Terms of Reference and the fiscal prudence to which the Abbott Government (2013 -) and by late 2013, the Government had established a National Commission of Audit to review government revenue and expenditure in the interest of balancing the Commonwealth's Budget and it remains unclear what impact these measured will have on indigenous health.

Political values and group capacity to influence the burden of disease will be essential policy considerations, in the evaluations of the Audit Commission's recommendations and other new measures impacting on indigenous health, especially as health policy transcends physical and mental wellbeing to affect social equity, educational and economic opportunities, and the general capacity to exercise personal self-determination. It is in this context that cultural pluralism 'throws up considerable challenges for the ways in which we conceptualise freedom, equality and justice' (Little, 2003, p. 23). Indeed, deliberative procedures and consequent policy decisions influence Indigenous people's access to the 'good life' (Aristotle, 1988) and propensity to enjoy good health. Policy focus on the 'good life' is culturally located and relative to political possibilities.

Equal opportunity for good health is a mark of equal moral worth; just as comparable access to the highest achievable level of health care distinguishes equal citizenship and protects access to political, economic and social liberties. As a matter of distributive justice, public administration should, then, allow each person the same political space to engage with others as peers, with the same political 'voice' to demand that public institutions provide cultural respect and group recognition as pre-conditions for individual social equity. A further philosophical rationale for public health policy is that 'by keeping people close to normal functioning, healthcare preserves… the ability to participate in the political, social, and economic life of their society. It sustains them as fully participating citizens – normal collaborators and competitors – in all spheres of social life' (Daniels, 2001, p. 3). In this respect, the relationship between health and employment is especially important as, for example, both unemployment and unsatisfactory employment are established determinants of ill-health (Berkham and Kawachi, 2000, Dollard and Winefield 2002, Harris and Harris, 2009). The Australasian Faculty of Occupational and Environmental Medicine and the Royal Australasian College of Physicians' observation that: 'Work is generally good for health and wellbeing' is made with an understanding of the political factors that influence peoples' experiences of work and ability to secure its full benefits for themselves.

- Work must be safe so far as is reasonably practicable.
- Work is an effective means of reducing poverty and social exclusion, including that faced by indigenous populations and other currently disadvantaged groups. With appropriate support, many of those who have the potential to work, but are not currently working because of economic or social inequalities, illness or acquired or congenital disability, can access the benefits of work.
- Work practices, workplace culture, work-life balance, injury management programs and relationships within workplaces are key determinates, not only of whether people feel valued and supported in their work roles, but also of individual health, wellbeing and productivity.
- Individuals seeking to enter the workforce for the first time, seeking reemployment or attempting to return to work after a period of injury or illness, face a complex situation with

many variables. Good outcomes are more likely when individuals understand the health benefits of work, and are empowered to take responsibility for their own situation.

• Health professionals exert a significant influence on work Australian Bureau of absences and work disability, particularly in relation to medical sickness certification practices. This influence provides health professionals with many opportunities for patient advocacy, which includes, but is not limited to, recognition of the health benefits of work (The Australasian Faculty of Occupational and Environmental Medicine and the Royal Australasian College of Physicians Royal Australasian College of Physicians, 2011).

Relationships between racism and employment opportunities are also important (Gray et al., 2012) and show that suspicion of difference remains influential even if sharply contested and at odds with 'The principle [of indigeneity which also] goes beyond cultural recognition to claim a special place for indigenous peoples in the life of the nation' (Durie, 2008, p. 370). From this perspective, Indigenous health policy has implications beyond the simple objective of meeting a 'need' for public services. Indeed, if contemporary public policy ought to consider the implications of historic breaches of the rights of Indigenous peoples, it is intellectually, if not politically, a short step to recognising the contemporary relevance of a rights-based discourse to public policy. In other words, how should Indigenous people, as a means of democratic participation, be involved in policy-making and what role ought culture play in service delivery? Ought efforts be made to juxtapose the politics of indigeneity with liberal political theory so that '[t]he goals of remedialism' may be transcended rather than simply 'balanced' (Kowal, 2008, p. 346)?

Social-determinants and the politics of health

Constraints on indigenous Australians' capacity for good health raise questions about public decisions in housing, education, economic, environmental and labour market policy. The social

determinants of health are important and, as the National Congress of Australia's First Peoples[2] argues, they should necessarily be incorporated into health policy (The National Congress of Australia's First Peoples, 2013). However, the description of these variables as purely social determinants can misleadingly overshadow their inherently political character.

The National Congress is among those indigenous policy actors to argue that health policy requires more far reaching political assessments to transcend the purely 'social' construction of the determinants of health that the World Health Organization (WHO) popularised in 2005 when it established a Commission on Social Determinants of Health. While the 'social determinants' discourse does attend to political considerations it requires, as an essential complement, deeper and explicit consideration of the philosophical and ideological factors that influence policy processes and decisions.

The determinants of ill-health include inherently political phenomenon evident, for example, in the Congress' reference to the *Alma Ata Declaration* to give international authority to its argument that: 'the holistic definition of health incorporates broader issues of social justice, well-being and equity as key attributes of health for Aboriginal peoples' (The National Congress of Australia's First Peoples, 2013). The *Declaration* provides governments with a rationale for responding to the expectation that their: 'responsibility is not to make people healthy but to provide equal opportunities to be healthy, and develop an effective health system that is available, accessible, acceptable and of sufficient quality' (The National Congress of Australia's First Peoples, 2013). The National Congress' expectation is premised on policy transcending individual rights to healthcare to admit a model grounded in self-determination and strengthening

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[2] The National Congress of Australia's First Peoples is a national representative body of indigenous peoples.

Indigenous deliberative capacity. Indeed, WHOs (2013) own definition illustrates the ways in which the term 'social' is, on its own, a misleading descriptor.

> The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.

WHOs argument for the health system's policy 'collaboration with other areas of government' (WHO, 2013) is supported by the *Rio Political Declaration on the Social Determinants of Health* (WHO, 2011) to illustrate the need for analytical breadth beyond the 'social'. Venkatapuram and Marmot (2009) also contextualise the social determinants to show their political character, while Anderson et. al's (2007) edited collection, *Beyond Bandaids*, explores relationships between health and education (Bell, et al., Askell-Williams, et al.), poverty (Walter), community development (Campbell et al.) and labour market participation (Lowry and Moskos).

 The collection's explicit attention to governance (Sullivan and Oliver) and constitutional rights (Reynolds et al) concern overtly political, rather than social determinants. The 'confusion at the interface of indigenous and non Indigenous governance' positions politics as a very specific and immediate concern as

> the governance instruments in place affect how aboriginal groups may be communicated with, how research projects can be managed with consent, and how compliance with good health practice can be encouraged and monitored. Perhaps less obviously, good governance leads to relative community harmony and a sense of wellbeing, and thus both to the conditions for better health and receptiveness to health programs (Sullivan and Oliver, 2007, p. 181).

For the National Congress, political values and practices are part of (not extraneous to) the complex social system, and sustained policy failure across the wider determinants of health points to the explanatory potential of political and administrative decisions. The Northern Territory Auditor-General's recent partial attribution of poor indigenous housing to these

variables (Auditor-General for the Northern Territory, 2010) is illustrative, and could partially justify the additional Prime Ministerial oversight of indigenous housing policy that might be achieved through the amalgamation of the National Policy Commission on Indigenous Housing with the Prime Minister's Indigenous Advisory Council (Abbott, 2013). While this particular administrative arrangement may diminish indigenous political voices in the area of housing policy, specifically, it may allow stronger policy integration between domains such as housing and health where outcomes in each impact on the other, even as the deliberative deficiency might reasonably be remedied as part of the new administrative structure.

Along with poor and overcrowded housing, the most significant 'social' determinants of health include indigenous over-representation in detention and the overtly political imperative for 'an honest and frank appraisal' of the 'intolerable incidence of [systemic] racism' that indigenous peoples report (National Congress of Australia's First Peoples, 2013). Institutional racism refers to 'a pattern of differential access to material resources and power determined by race, [which] advantages one sector of the population while disadvantaging another' (Came, et al., 2013, p. i). Greater willingness to acknowledge its existence may reduce its pervasiveness and impact on policy development.

Indeed, Paradies (2006) estimates that personal racism in the public health system has affected as many as 79 percent of the Indigenous Australian population (Paradies, 2006). In 2009, when 70 percent of Indigenous school-aged children in a South Australian study failed a standard hearing test, and 30 percent suffered perforated eardrums, a 'lack of power in our communities and a lack of engagement with us by governments' was offered as a local community explanation (National Aboriginal Community Controlled Health Organization, 2009). Whether or not objectively and demonstrably true, this kind of expression does explain

people's sense of political invisibility and vulnerability, and their perceived incapacity to exercise the rights of liberal democratic citizenship, especially the right to challenge discriminatory practices and policies, which is significant because as the Commonwealth Government, itself, has noted:

> Aboriginal and Torres Strait Islander people who have experienced discrimination are more likely to have high levels of psychological distress, to drink alcohol at harmful levels and to take illicit substances than those who haved not. They are also less likely to trust the police, their local school, their doctor or their local hospital (Commonwealth of Australia, 2012).

Professional resistance to admitting the relationship between cultural imperatives and treatment outcomes further establishes race and racism among the political determinants of health. Paradies et al's (2013) proposed meta-analysis of racism as a determinant of health will investigate increasing epidemiological evidence for the proposition that there are 'strong associations between self-reported racism and poor health outcomes across diverse minority groups in developed countries' (p. 1). Racism raises perceptions of 'invisibility' and 'vulnerability' and its presence is supported by the claim that there is greater indigenous propensity, on the grounds of negative stereotyping to be denied public hospital treatment for acute drug and alcohol conditions (Talmeta et. al., 2009). In practical, political terms, the question then becomes: 'how can the state deliver human services which are congruent with, rather than destructive of, the most valued features of Aboriginal social organization (Rowse, 1996, p. xv)?

These questions are important because equal opportunity for good health and access to the highest achievable level of health care distinguishes equal citizenship and protects access to political, economic and social liberties (Daniels, 1981). As a matter of distributive justice, public administration should, then, allow each person the same political space to engage with others as peers, with the same political 'voice' to demand that public institutions provide cultural respect

and group recognition as pre-conditions for individual social equity. A consequent rationale for public health policy is that:

> . . . by keeping people close to normal functioning, healthcare preserves for people the ability to participate in the political, social, and economic life of their society. It sustains them as fully participating citizens – normal collaborators and competitors – in all spheres of social life. . . (Daniels, 2001, p. 3).

Trachoma's continued prevalence among some indigenous communities illustrates public policy failing to provide equitable access to good health. Trachoma is a poverty related eye disease with endemic rates in 50 percent of Australia's very remote communities. Its persistence reflects the depth of policy failure in Indigenous health, especially as it is only since 2006 that the Commonwealth Department of Health and Ageing has collected data on its prevalence. It was only in 2009 that the Commonwealth budgeted $58.3 million over four years for a comprehensive plan to reduce the incidence of this, and other, chronic eye and ear diseases (University of Melbourne, 2009).

Treating the disease that has been eliminated from every first-world jurisdiction but Australia, is a pressing clinical imperative, but in the context of uncertain public expenditure it emphasizes health policy as an important political concern inviting a theoretical account of what indigenous people might fairly expect from the public health system, through perhaps, 'a theory of health-care needs [that] must come to grips with two widely held judgements: that there is something especially important about health care and that some kinds of health care are more important than others' (Daniels, 1981, p. 147).

Political arrangements influence people's capacity to function as best they can. It is a well-developed principle in political philosophy that the best arrangement is that which is conducive to anyone being able to live a 'flourishing life' (Aristotle, 1988), which suggests that neo-colonial societies ought to develop frameworks for thinking about the fair distribution of

resources and the state's role in maximizing personal agency so that the international tests of 'objectiveness, reasonableness, necessity, and proportionality' can be applied to the distribution of public authority (Xanthaki, 2008, p. 282).

Just as it has diminished personal agency, public policy has the means to improve individual capacity 'to function well if one so chooses' (Nussbaum, 1987, p. 20) and to differentiate 'achievement' from the 'freedom to achieve' (Ruger, 2006b, p. 288). The idea that public policy ought to focus on personal 'freedom to achieve' recognizes that the 'good life' is both culturally located and relative to political possibilities; a point that Schmidt (2009) makes through the argument that, rather than attempting to apportion personal blame for ill health, solidarity requires attention to its underlying causes. Acts and omissions of governments have compromised indigenous access to the determinants of health, and solidarity should 'guide us in determining questions around access to treatment, and, generally, prompt us to provide it' (Schmidt, 2009, p. 27).

Even if the balance of responsibility rests with the individual, the remaining contributing variables establish grounds for public attention, and show that, while inequalities can sometimes be just, the necessary conditions do not apply in the present context. For example, differences in income, which is a determinant of health, are legitimate if they are 'attached to positions and offices open to all' (Rawls, 1971, p. 53). Income inequalities can also arise from unjust determinants for which Rawls does not account; for example, relationships between land alienation and economic capacity, inadequate schooling and access to the primary labour market. It is significant, then, that data from 2011 affirmed the relationship between education and incomes, with indigenous graduate incomes being 2.91 times greater than those of indigenous people who had left school without completing a Year 12 qualification (Biddle, 2013). While

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Indigenous incomes increased between the 2006 and 2011 census', so too did non-indigenous incomes, meaning that in 2011 average indigenous incomes had fallen from 74% to 72% of the non-indigenous (Biddle, 2013).

  Public acceptance of indigenous claims, in justice, is also historically contextualized. British settlement in New Zealand, as well as in parts of Canada and the Unites States of America, is distinguished from the Australian context by the negotiation of treaties, such as the Treaty of Waitangi, with the indigenous populations to set settlement's terms and conditions and to secure at least the appearance of moral legitimacy for the colonial project. Although these treaties tended to be one sided and principally a British political strategy to secure authority until such time as they could obtain it by force (Markus, 1994), they have assumed long-term and unintended moral, jurisprudential and political authority which indigenous peoples have, in modern times, been able to draw upon to claim extant political rights from the state. However, just as treaties have had formative influence over the ways in which some post-colonial jurisdictions understand the rights of indigenous peoples, the Absenceof an instrument of comparable jurisprudential significance in Australia means that Australians are generally more cautious about accepting rights-based notions of indigeneity as either a legitimate or pragmatic framework for policy development. Indeed, it was its rejection of indigenous rights as a legal construct that explained the Howard Government's (1996–2007) 'practical reconciliation', which it distinguished from alternative rights-based policy ideas. The prevailing rationale was that indigenous people had no further or differentiated rights to political participation than those available to them as Australian citizens, and that previous attempts at self-determination had failed to deliver improved policy outcomes (Sanders, 2004). However, there is still space within

Australian political discourse for conceptions of liberal justice to contribute to growing but cautious public support for plurality and indigeneity as legitimate policy considerations.

Health and personal responsibility

Personal responsibility assumes that people have the capability to make informed choices commensurate with good health.

> If many people in a cultural group or class behave similarly, there may also be factors at work that reduce how voluntary their behaviour is and how much responsibility we should ascribe to them for it. The analysis thus leaves us with the unresolved complexity of these judgments about responsibility and, as a result, with disagreements about fairness (Daniels et al. 1999: 25–26).

While in the present context, it is true that ill health is often the outcome of poor lifestyle choices, it is a misrepresentation of the breadth of its contributing variables to argue that illnesses are only unfortunate, rather than unjust, because nobody else has actually caused them (Engelhardt, 1986).

The disproportionate burden that history places on indigenous people's health transcends the unfortunate, and addressing that burden from reparative as well as distributive perspectives acknowledges the original contributing injustices. The extent to which this occurs is an outcome of a community's conceptions of justice. For example, mental health may not be more worthy of public funding, in its own right, than treating sporting injuries acquired through bad luck, but the fact that the prevalence of mental ill health is significant among indigenous people precisely because of the considered policy positions of governments means that it has a unique moral relevance and a particular call on public resources. One perspective from the discipline of psychiatry holds that 'Aboriginal mental health cannot be separated from its historical context' as 'the intergenerational transmission of trauma . . . socio-cultural dislocation . . . [and] high rates

of grief and loss' (Rege, 2009, p. 98) continue to account for disproportionate distributions of the burden of disease.

Framing health policy in reparative terms is an 'an acknowledgement on the part of the transgressor that what he is doing is required of him because of his prior error' (Boxill, 1972: 118). Therefore, the ways in which societies ration health resources is a guide to their broader conceptions of justice and how they view the unequal and arbitrary outcomes of the 'natural lottery' (Rawls, 1971, p. 15).

Deeply political questions are, then, raised about the human right to 'the highest attainable standard of health' (World Health Organization, 2010), the nature and expression of citizenship, and the ways in which non-clinical factors shape opportunities for good health. They are questions that concern the place Indigenous peoples reasonably hold in the political life of the state, and the impact of prevailing liberal democratic tendencies to diminish minority voices. These questions call for an examination of relationships between health and the just distribution of public authority, the purpose of political activity, equal political participation and cultural responsiveness in the provision of health services. These conditions are preliminary to reducing cross-cultural inequities in the burden of disease, as it is ideology rather than government inattention *per se*, that helps to explain Australia's relative policy failure in Indigenous health.

Ideology sets pragmatism aside so that new policy solutions are 'rare and the windows of opportunity that make them possible [do] not stay open for long' (Baum et al., 2013), partly because 'issues that don't lend themselves to simplistic analysis and presentation are unlikely to find an audience' (Bridges and Davis, 1998, p. 46). As it was put to Baum et al (2013) by one former health minister:

> the inertia was the problem. I mean, I was very strongly committed to the community health, health prevention, education approach. I fully identified with the people who said 'Why aren't

we getting more money in this area?' but again, of course, you've had 50,100 years of the hospitals getting most of the money and how do you in fact divert some of that money away from the hospital system into community care, preventative stuff and so on? Not easy unless you can identify more money, additional money, which your colleagues may or may not give you, which can then go into prevention (p. 143).

Contemporary public policy responds to a very recent history of officially sanctioned discrimination and political inequality (Attwood, 2005). Indeed, the conditional nature that continues to distinguish Indigenous citizenship is an outcome of historical legacy, which positions history itself as a determinant of agency. For example, for much of the twentieth century, children removed from their families and people compelled under 'protective' legislation to reside on mission stations surrendered personal control over as simple, but far-reaching factors as diet (Dodson and Wilson, 1997). Indeed, in 1934, a Royal Commissioner's Report on a 'native settlement' in Western Australia noted that in relation to food:

> there is much room for improvement. Powdered milk for children is obviously useless but 56 cases are consumed in a month. No vegetables are grown at the settlement and a totally inadequate supply is imported. Tinned vegetables (so called) are in the same category as powdered milk. There is an insufficiency of meat and, if such articles as fruit and eggs were occasionally supplied, fewer children would go to the hospital. This view is supported by the Doctor and the nursing sister (Mosely, 1934).

Nutritionally deficient rations displaced traditional low fat, low carbohydrate foods, meaning that diet emerges from 'history and social structures, representing aspects of identity and social relations' (Foley, 2005, p. 25) to partially explain why certain diet-related cancers, cardio-vascular and metabolic diseases increasingly account for premature Indigenous deaths (Vos et al, 2009).

The widespread belief during the first half of the twentieth century that Indigenous populations were becoming extinct meant that there was no influential demand for long-term policy planning. Thus, even by 1957, the Director-General of Commonwealth Health was able to argue that: 'the major health problem at this time was the protection of the organized European community from

the heavy incidence of infection in the native population camps in its vicinity and employed as domestics in its households' (Cook in Couzos and Murray, 1999, p. 5). While the Director-General argued for the 'training of selected natives as hygiene instructors and supervisors with the intention that they shall return to their tribes and there impart the lessons learned to their own people in their own language' (Cook in Couzos and Murray, 1999, p. 5), the second Menzies Government (1949-1966) used the constitutional barrier to the Commonwealth acting for the benefit of Indigenous people to reject this, as well as more substantive and less paternalistic policy interventions (Couzos and Murray, 1999, p. 5), leaving Cook free to argue that indigenous people are 'the natural host of endemic disease by which successful white settlement is gravely menaced' (Cook in Anderson, 2013). He continued in a vane consistent with the general presumptions of the state Aboriginal Protection Acts in force at the time:

> It is... impossible for the hygienist...to...safeguard the health of the white community... unless he has full powers over the native population, not only in regard to treatment for apparent ailment, but also in relation to hygiene, community life, migration and dispersion through the white community (Cook in Anderson, 2013).

It was not until 1973, after the removal of the constitutional impediment to Commonwealth engagement in Indigenous affairs that the first long-term national Indigenous health strategy was established (Australian Indigenous Health*InfoNet*, 2010) and by 2014, the prevailing policy paradigm has shifted to one that is no longer concerned with the 'welfare and life of the white man' alone (Breinl, 1911, p. 525). However, the impact of land alienation, sub-standard educational opportunities, and labor market discrimination continue to constrain Indigenous opportunities to make personal decisions commensurate with good health (Dodson and Wilson, 1997). These political determinants mean that life expectancy differentials are not always 'inevitable' (Marmot 2005, p. 1099) but, at least partially, the outcome of considered policy choices.

The removal of day-to-day social controls under protective policies, that made way for limited self-determination during the 1970s, has still not been universally replaced with access to the fuller distinguishing possibilities of an egalitarian, stable and cohesive society: the primary labor market, effective education, quality housing, diets and sanitation (Attwood, 2005). Ill health then remains both a cause and an outcome of political disempowerment, as the ideals of liberal citizenship were extended to Indigenous peoples without due consideration for the substantive rights, obligations and opportunities that allow citizenship to transcend simple legal status. Nevertheless, contemporary Australian public policy no longer officially or overtly questions the common humanity between Indigenous and non-Indigenous Australians.

Since the 1990s, the legal, political and human frailties of racism have become more systematically, precisely and definitely exposed. The *Mabo* (1992) and *Wik* (1996) decisions of the High Court, the *Report of the Royal Commission into Indigenous Deaths in Custody* (1991) and the *Bringing them Home Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* (Dodson and Wilson, 1997) reshaped the public narrative to create space for further incremental policy developments, but not for the philosophical shift required to imagine relationships among needs, rights and development as preliminary to Indigenous communities' substantive exercise of liberal citizenship. The once dominant assimilationist narrative encapsulated in a Liberal party election campaign theme song, as recently as 1988 'son you're Australian… that's enough for anyone to be' does not automatically resonate with a public willing to admit policy attention to indigenous peoples (Rowse and Goot, 2007) and in 1992 the Prime Minister, Paul Keating, reflected the shifting public mood in a speech to the indigenous community of Redfern:

It begins, I think, with the act of recognition. Recognition that it was we who did the dispossessing. We took the traditional lands and smashed the traditional way of life.We brought

the disasters.The alcohol.We committed the murders. We took the children from their mothers. We practised discrimination and exclusion... We failed to ask - how would I feel if this were done to me (Keating, 1992)?

Yet, at the same time, the large body of evidence suggesting ways of improving Indigenous health outcomes exists in a policy environment in which 'evidence alone' is unlikely to convince the public of the paradigm shift required to affect significant and sustainable change (Couzos and Murray, 1999, p. 32). Indeed, 'the extent to which Aboriginal people really are permitted to define their own vision of the good life and require other Australians to let them live it' (Clarke, 2006, p. 122) has been sharply contested. This is, perhaps, why Pat Anderson, Chair of the Lowitja Institute proposed three elements of 'respect' as preliminary to improved health outcomes. These elements reflect respect's inherent political character.

> The first is respect for rights - positive change must be built upon the recognition of our rights as people and as First Nations. The second is respect for the evidence - rights alone are not enough, they need to be combined with what we know works. The last is respect for each other we need to Close the Gap in respect between Aboriginal and non-Aboriginal Australia, so that we are seen not just as a 'problem' that needs 'solving' but where our unique cultures, histories and abilities are recognised and welcomed (Anderson, 2012).

Anderson followed with the remark that:

> What really interests me is the unequal relationship between our First Nations and the nation state in Australia – a persistent and fundamental inequality that we are yet to resolve or even properly address (Anderson, 2012).

It is to this end that in a report to indigenous allied health Australia, Neumayer (2013) proposes a fundamental change in the nature of the indigenous health public 'conversation' to one that is focused on 'strengthening a rights-based holistic approach' to ensure 'a positive sense of cultural identity and… Innovative and dynamic approaches and processes towards health programs and policies' (p. ii). Policy can then position peoples as agents, not helpless victims, who are properly only subjects of a benevolent state because it is from the position of victimhood that helplessness becomes entrenched and ill-health and its determinants become more difficult to address.

Conclusion

Luck and personal responsibility may contribute to ill-health, but political arrangements, too, influence people's capacity to make choices commensurate with good health and reflect ideas about the just distribution of material resources and political authority. Yet policy tension arises over the extent to which indigenous peoples might enjoy the rights of self-determination, and the extent to which liberal citizenship might accommodate difference. Although paternalism no longer provides public policy's unquestioned theoretical basis, and public values are becoming increasingly more sympathetic to indigenous aspirations and general well-being, it is shown throughout this book that policies grounded in liberal egalitarianism do not attend to cultural considerations, nor challenge the power imbalances that inhibit indigenous opportunities for good health. Instead, scope for policy reform arises if 'the institutions and culture of liberal democracies are sufficiently complex, supple, and decentred so as to allow the expression of difference without fracturing the identity of the body politic or subverting existing forms of political sovereignty' (Benhabib, 1996, p. 5). Similarly: 'Good indigenous affairs public policy – if Australia is ever to achieve it – will be based on a self-conscious awareness of competing principles and of the tendency towards generational revolutions in this difficult cross-cultural and highly morally charged policy arena' (Sanders and Hunt, 2010, p. 235).

CHAPTER TWO

Values and health policy

Introduction

The tensions, contradictions and inconsistencies that pervade contemporary Indigenous health policy are grounded in the philosophical positions that policy actors take on the nature and conditions of Indigenous belonging to the liberal democratic state. Contrasting theoretical contradictions that distingush and confuse the policy environment show that participatory parity, recognition and relational justice can combine to create a theoretically defensible and substantive framework for thinking about self-determination as an alternative to democratic exclusion as the ascendant influence over public institutional and administrative arrangements. The argument presumes that just relationships require a politics of recognition that admits Indigenous peoples as distinct political communities whose extant rights are affirmed at international law and include the rights to deliberate in public affairs, to have their cultures respected in dealings with the state, and to function independently of the state in areas such as health.

Until 1967[3] Indigenous public policy was unapologetically exclusive. Its aim was to eliminate racial difference so that an homogenous white Australia could prevail.[4] However, since that time, pervasive intellectual inconsistencies and policy contradictions have distinguished the Commonwealth's attempts to provide philosophical rationale to its Indigenous affairs policy. In health, policy design is heavily influenced by philosophical positions on the Indigenous claim to self-determination, contrasted with the proposition that their enjoyment of individual political

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[3] In 1967 the Commonwealth Constitution was amended to allow the Commonwealth to make laws for Indigenous people.

[4] From the late nineteenth century each of the colonies (later states) enacted legislation to restrict Indigenous freedoms in ways that prevented substantive membership of the wider community. See Attwood, B., 2005, *Telling the truth about Aboriginal history* (Allen & Unwin Academic) for full details.

rights, is all that common citizenship might reasonably provide (Waldron, 2002). The tension can be summarised as one concerning the nature of Indigenous belonging to the nation state where it is, on balance, democratic exclusion and political misrecognition that assume greater influence, even though examples of alternative culturally cognisant policy measures are also available.

Self-determination

Indigenous health policy's contemporary intellectual setting is partly a product of the ways in which recent Australian history has positioned self-determination and its consequent political rights. Self-determination was accepted as a legitimate political objective by the Whitlam Government (1972-1975) and is, in short, 'a search for domestic public policy arrangements which recognise the distinct minority nationalism of indigenous people while also drawing them into a single larger nation state' (Sanders, 2002, p. 16). In doing so, it made a particular statement about the terms and conditions on which Indigenous peoples belong to the modern liberal democratic state. It challenged conventional liberal notions of exclusive state sovereignty in favour of ideas that are recognisant of extant indigenous political rights and the right to substantive deliberative engagement in public decision-making as peoples, as well as citizens of the liberal state. It compliments liberal citizenship to allow shared political authority and the exercise of indigenous determined political, social, cultural and economic priorities. It is not a philosophy of political isolation but one of relative and relational autonomy with the state (Maaka and Fleras, 2005). Dodson (1994) argues that:

> Time and again indigenous peoples expressed the view that the right to self-determination is the pillar on which all other rights rest. It is of such profound nature that the integrity of all other rights depends on its observance. We [indigenous peoples] hold that it is a right that has operated since time immemorial amongst our people, but it is the right that is at the centre of the abuses we have suffered in the face of invasion and colonisation. The dominant theme of our lives since colonisation has been that we have been deprived of the very basic right to

determine our future, to choose how we would live, to follow our own laws. When you understand that, you understand why the right to self-determination is at the heart of our aspirations (p. 44).

The right to self-determination is one that has been admitted at international law well before Australia's ratification of the United Nations' *Declaration on the Rights of Indigenous Peoples* in 2009. Tully (2000) explains that in 1975 the International Court of Justice upheld the right to self-determination on the grounds that:

> The structure and form of government and whether a people are said to be at a lower level of civilisation are not valid criteria for determining if the inhabitants have rights, such as the right to self-determination. The relevant consideration is if they have social and political organisations (p. 54).

The opportunity to maintain and develop such organisations then becomes important, and the Aboriginal Community Controlled Health Organisation, Aboriginal Medical Services and National Congress of Australia's First Peoples are modern embodiments of the concept, while the Australian Indigenous Doctors' Association (AIDA) proposes self-determination's centrality to health initiatives. It argues that contemporary expressions of self-determination in health policy require attention to

- Land, culture and connectedness;
- A strength-based, healing approach, which incorporates kinship care and builds on the resilience of Aboriginal and Torres Strait Islander people;
- Genuine partnership with Indigenous people;
- Learn[ing] from existing good practice in Indigenous health;
- Valu[ing] existing Indigenous health expertise and engag [ing] the Indigenous health workforce (Australian Indigenous Doctors' Association, 2008).

The Cape York Health Council's aim *'*to support Cape York communities' own solutions to live long healthy lives, strengthening our culture and regaining our spirit' is a simple but significant expression of the kind of citizenship that self-determination presumes (Apunipima Cape York Health Council, 2010). This view parallels Durie's (2005) argument that:

Indigenous peoples do not always see their destinies locked into the wisdom of the state, especially if their sovereignty has been appropriated by other powers and their experiences of state control have been marred by dispossession and deculturation (p. 163).

It is in this sense that Indigenous members of the Northern Territory's present conservative government (2012 -) understand self-determination. In his first speech to the Northern Territory Legislative Assembly, Francis Kurrupuwu remarked that:

Traditional Aboriginal law and culture must become a partner with white man's law and culture so our people can maintain their respect and dignity. Far too much dependency on government has taken away our freedom to make decisions which benefit our people. It is not possible for public servants who live in Canberra or Darwin to manage our lives. We have to do this ourselves, in partnership with non-Aboriginal people. We do not want to be looked after by government from a long way away (Kurrupuwu, 2012).

Larissa Lee similarly argued the point:

My people are thinking people; they have dreams like all Australians. They look across our vast lands and they see potential for economic development while maintaining our traditional practices (Lee, 2012).

In 2013, Nova Peris, the first indigenous woman elected to the Commonwealth Parliament told the Senate that:

within every one of us, lies the ability to reach deep inside ourselves and draw upon our inherited strength that our ancestors have given us. There lies a spirit that needs to be awakened (Peris, 2013).

Warren Mudine, Chair of the Prime Minister's Indigenous Advisory Council, has called

on all of us to do what needs to be done to smash through the socio-economic ills of Indigenous peoples... Indigenous people can and should take the lead on this. Because without the leadership of Indigenous people, governments may struggle to find the courage to do what needs to be done to deal with the elephants in the room (Mundine, 2013).

Yet, the Howard Government's (1996-2007) dismissive attitude to the concept, and aspiration of self-determination, through its abolition of the Aboriginal and Torres Strait Islander Commission

(ATSIC) in 2005 has left an intellectual legacy of uncertainty about self-determination's legitimacy and pragmatic utility.

 ATSIC was established by the Hawke Government (1983-1991), in 1989, as an acceptance of the general principle of self-determination. ATSICs legal obligations included ensuring 'maximum participation of Aboriginal persons and Torres Straight Islanders in the formulation of government policies that affect them'. The Commission was required to promote 'the development of self-management and self-sufficiency' which was 'a radical departure from previous policy' (Robbins 2010, p. 266) and exposed the depth of political division on 'the exercise of sovereignty within a nation and whether racially differentiated political institutions are intrinsically divisive and detrimental to national social cohesion' (Robbins 2010, p. 258).

  ATSIC replaced the Aboriginal Development Commission and Department of Aboriginal Affairs. It was 'often criticized as being ad hoc, [and] driven by a crisis mentality' (Smith, 1993). It was established amidst suspicion of an indigenous organisation's capacity to function transparently and with appropriate accountability. At the same time there were contradictory expectations that ATSIC would 'put 'power back into the hands of Aboriginal and Torres Strait Islander peoples' (O'Donoghue, 1992, p. 5) as, according to law, it was established to

> ensure the maximum participation of indigenous people in the formulation and implementation of government policies affecting them; to promote the development of self-determination and self sufficiency; further their economic, social and cultural development; ensure coordination of policies which affect them at all levels of government (*Aboriginal and Torres Strait Islander Commission Act 1989*, section 3).

These broad self-determining objectives were compromised by ideological contestation over the term 'maximum participation'. For the Howard Government (1996-2007), resistance to a broader liberal construction allowing common citizenship to be expressed in different ways was a defining point of principle. The Government did not accept ATSICs claim to serve as its

principal indigenous affairs policy adviser. Instead, the role was fulfilled by an especially established Office of Indigenous Policy with a staff of 42; just two of whom were indigenous (Ivanitz, 2000). ATSICs exclusion from responsibility for areas in which profound indigenous disadvantage continued also limited its agency. Yet in popular discourse, ATSIC was at fault, and government, not ATSIC policy failures, in areas such as health were used to justify its abolition (Ivanitz, 2000).

ATSICs abolition was a statement of resistance to the dispersal of sovereignty, which is significant because sovereignty's dispersal is differentiated citizenship's underlying purpose.

> Through language that is as moral as it is political and legal, Indigenous people are attaching a unique interpretation of the term sovereignty. It includes concepts such as representative government and democracy, the recognition of cultural distinctiveness and notions of the freedom of the individual that are embodied in liberalism. These claims take place by seeking a new relationship with the Australian state as increased self-government and autonomy, not through the creation of a new country (Behrendt 2003, pp. 101-2).

In stark contrast, it was for the Prime Minister, a matter of deep ideological conviction that:

> Aboriginal affairs has to be addressed within the concept of a single, undivided nation of which all Australians, whether indigenous Australians or other Australians, are treated equally, governed by a common set of laws to which all of us are equally accountable and governed by a set of common values and common principles as Australian citizens… We are one people and one nation, with one future (Howard 1995).

However, the proposition that differentiated citizenship is just and pragmatically warranted proceeds on the assumption that a 'single nation' would necessarily be divided because such a nation cannot, in fact, treat people 'equally'. Nor would such a nation's appeal to 'common values and common principles' be capable of transcending a very general sense of commonality and as political opportunities are significant determinants of health (Marmot et al., 2008) which means that one must evaluate political arrangements for their contributions to freedom (Sen, 1999),

Nevertheless, Howard's minister responsible for Indigenous Affairs, Amanda Vanstone, maintained that self-determination meant 'different standards' and had 'short-changed indigenous people'. Instead, she proposed the authoritarian coercion of Shared Responsibility Agreements (SRAs), which demonstrated a philosophical change of much greater significance than just the alleged corruption that constituted the government's official rationale for dis-establishing the Commission. For example, the Agreement between the Mulan community (Western Australia) and the Commonwealth and state governments was that children would wash their faces twice daily in return for two Commonwealth-provided petrol bowsers [pumps] and access to trachoma screening and treatment. The minister, ironically, defended the Agreement as an example of self-determination: 'A community gets what it wants – a petrol bowser ... and the kids get better health outcomes. Who could complain about that (Vanstone 2004)? Alternatively, the policy was one of making the child's human right to health conditional on parental behavior in a way that was not similarly required in other communities, and that did not recognize that the state's health legislation already required the provision of these services as rights of citizenship (Couzos and Murray, 2009).

Similarly, the Secretary of the Department of Prime Minister and Cabinet explained to a Senate Select Committee that SRAs might, for example, 'involve combating domestic violence, improving attendance at school [as well as] trying to deal with the awful disease of trachoma' (The Senate, 2005). Yet citizens generally take for granted the right of protection from domestic violence, and insisting on the social imperative to attend school is reasonably and ordinarily the business of the state. The Select Committee itself remained unconvinced

that clear distinction has been made between what is a fundamental right and what is a discretionary benefit. It remains a nebulous issue, subject very much to individual government

officer/agency judgements, and with the subsequent potential for variance in interpretation (The Senate, 2005).

Simple factors such as not washing one's face or choosing to consume liquor over fresh fruit and vegetables may be among the causes of ill health, but human rights to sanitation, clean water, housing, education, and health facilities are further explanatory variables, suggesting that a fuller conceptualization of Indigenous citizenship as capacity <u>and</u> entitlements may provide a stronger foundation for policy development.

SRAs demonstrated that a public re-conceptualization of what it means for Indigenous people to enjoy common national citizenship was required as an essential prelude to the creation of a more just and effective policy paradigm. The extent to which this has and has not occurred is assessed throughout this book, which proceeds on the understanding that access to healthcare ought to be based on human equality, not the acceptance of specified hygienic practices not equally demanded of other citizens.

Health services may well have an educative dimension emphasizing personal responsibility, but to make health care dependent on behaving in certain ways, for just one racial group, compromises the system's capacity to fulfil what Daniels (2003) describes as one of its principal purposes; to help people 'function as free and equal citizens' (p. 15). Implicit in this view, is a relationship between health and political equality that makes health more than just an abstract policy concern; but a matter of moral philosophy and a measure of how society treats the implications of common humanity. Indeed, in extending a general theory of capability to health (developed in Chapters Seven and Eight), Ruger (2010) argues that, by protecting the conditions that allow people to make lifestyle choices consistent with good health, one establishes the conceptual foundation for 'finding a balance between paternalism and autonomy' (p. 41).

However, self-determination's positive cultural and political differentiation of Indigenous peoples was inconsistent with Howard's observation that:

> the experiment in separate representation, elected representation, for Indigenous people has been a failure… [and] arrangements will be established to ensure that there is a major policy role for the Minister for Indigenous Affairs [as opposed to Indigenous peoples themselves] (Howard in Brett, 2005, p. 25).

In 2009, the Rudd Government (2007-2010) reversed Australia's initial opposition to the United Nations' *Universal Declaration on the Rights of Indigenous Peoples*. However, it is not evident that the *Declaration's* principles are given sufficient authority to alter Indigenous public policy's prevailing direction, as democratic exclusion allows national political affairs to be arranged on the medieval assumption that a majority is 'more likely to be substantively right than a minority' (Mansbridge, 1996). The *Declaration* holds that

> Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, Indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions (United Nations, 2007, p. 23).

Democratic Exclusion

While the establishment, in 2011, of an alternative elected body to represent Indigenous perspectives to governments provides a political voice, it is not yet one of sufficient authority to give Indigenous peoples guaranteed, genuine and sustained influence in the policy process. It does not have the political capacity to counter democratic exclusion's pervasive influence on contemporary Indigenous public policy. Nor can it counter the ways that democratic exclusion conditions the terms of Indigenous people's access to public services in ways that result in systemic disrespect for their cultures, customs and priorities. Among democratic exclusion's

practical outcomes, acknowledged by the Commonwealth itself, are examples of 'what doesn't work' in indigenous health:

- One size fits all' approaches. For example, residential treatment for alcohol and other drugs dependency is generally not more effective than non-residential treatment. However, evidence indicates that residential treatment is more effective for clients with more severe deterioration, less social stability and high relapse risk. As these are characteristics of many Indigenous clients, residential treatment may be most appropriate.
- Lack of collaboration and poor access to services. For example, successful interventions require the integration of health services to provide continuity of care, community involvement and local leadership in health-care delivery and culturally appropriate mainstream services. These steps help to ensure the suitability and availability of services, which can thereby improve access by Indigenous Australians.
- External authorities imposing change and reporting requirements. For example, a review of evidence from seven rigorously evaluated programs that linked school attendance with welfare payments in the United States found that sanction-only programs have a negligible effect on attendance, but that case management was the most critical variable.
- Interventions without local Indigenous community control and culturally appropriate adaptation. For example, evidence indicated external imposition of 'local dry area bans' (where consumption of alcohol is prohibited within a set distance of licensed premises) was ineffective and only served to move the site of public drinking, often to areas where the risk of harm was greater.
- Short-term, one-off funding, piecemeal interventions, provision of services in isolation and failure to develop Indigenous capacity to provide services. For example, a one-off health assessment with community feedback and an increase in health service use was unlikely to produce long-term health benefits and improvements. An ongoing focus on community development and sustained population health intervention are needed (Al-Yamin and Higgins, 2011, p. 3).

Among other considerations democratic exclusion occurs through '*institutionalised patterns of cultural value*' (Fraser in Fraser and Honneth, 2003, p. 30) that exclude some citizens from substantive engagement in the political process. One 'amusing if the issues weren't so serious' example provided by the Chairman of the Productivity Commission involved Indigenous children adopting the practice of petrol sniffing so that they could obtain the benefits of a program established to counter the problem. 'That this might happen no doubt would not have occurred to any of us in Canberra, but it may well have occurred to some of the elders in the

community if they had asked' (Banks, 2009, p. 6). This is an illustration of democratic exclusion through misrecognition or relational injustice.

Shaw (2008) explains Indigenous democratic exclusion with reference to Hobbes' account of sovereignty.

> The structure of sovereignty that Hobbes produces is enabled and authorized through the production of a shared ontological ground, and identity. This identity, in turn, rests upon the necessary exclusion of Indigenous peoples at several different levels, not least through the explicit marking of Indigenous peoples as "different" as "Other". What is more crucial in determining the character of contemporary Indigenous politics, however, is that Hobbes renders the construction of this exclusionary identity, the process through which authority is produced and guaranteed, as pre-political, as necessary and natural rather than contingent and violent (p. 9).

Hobbes' is an ideologically bound perspective leading some modern policy actors to legitimise the measurement of policy success with reference only to the closing of easily described statistically meausurable 'gaps' on the grounds that Indigenous people's claims on the state are ones belonging to them only as members of a single homogenous polity (Shaw, 2008). Indigenous 'belonging' is accepted in this liberal account of justice, but only as an individual whose 'belonging' is 'inextricably tied to white possession' (Moreton-Robinson, 2003, p. 137), and whose 'whiteness' is the 'definitive marker of citizenship' (Moreton-Robinson, 2004, p. 79), and definitive point of comparison in the description of Indigenous health and well-being.

Waldron's (2002) supersession thesis provides a detailed account of the view that individual liberal citizenship is sufficient to provide just political conditions for Indigenous peoples even if there have been instances of injustice against them in the past. The proposition is that a theory of justice, based on citizenship, can be established to supersede historic transgressions and focus on fair and reasonable contemporary relations among citizens and between the state and citizens.

The argument proceeds as though colonisation was a single event 'done' to people at a particular instant with the injustice becoming politically unimportant with time. It holds that supersession, itself, creates the conditions for relational justice to emerge by virtue of common citizenship. There is consequently no need for a conception of justice that is 'able to order all the claims that can arise' (Rawls, 1999, p 115) because the liberal democratic electoral process always and necessarily answers the consequent question of: 'Who shall decide between... appeals to conflicting principles of justice' (Mill, 2007, p. 54)? From this perspective, the principles of universal egalitarian justice are sufficient to protect the needs and rights of all peoples. Waldorn proposes that the argument holds regardless of any injustices that may have previously been occasioned by one group over another, and that universal egalitarianism is sufficient to establish a just political order on the basis of a 'principle of proximity,' where 'people have a paramount duty to come to terms with, and to deal justly with, those with whom they are, in Kant's phrase, 'unavoidably side by side' in a given territory, irrespective of cultural or national affinity' (Waldron, 2002, p. 30). For Waldron, this view holds even if one concedes that past acts may have contributed to disadvantage, on the grounds that injustice is superseded by later events, and may have even left the once aggrieved party in a better position. However, elsewhere Kant recognises self-determination as a right of peoples (Klausen, 2014) to suggest that a 'rightful condition' is not one in which indigenous peoples must 'proceed' with others, against their wishes, into a state of assimilated homogeneity. Indeed, a single polity can accommodate difference in the ways that indigenous policy actors consistently propose. Among the justifications for difference in liberal political theory is that:

Dismissing others' norms out of hand, or refusing to engage them seriously, or giving up easily and declaring stalemate quickly all negate the cosmopolitan spirit of the proximity principle because such actions deny that one must inevitably share with others the circumstances of living… Another group's social practices are just as much a "repository of human wisdom as

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one's own, and cosmopolitan moral responsibility demands that each person try to enrich her own parochial claims by entertaining these alternate sources of wisdom and modifying one's practices in light of others' persuasive standards of conduct (Klausen, 2014, p. 37).

This means that political values and practices ought to be fluid, responsive to those of others and capable of considering justice not as a static and abslute aspiration but as one that is relative to circumstances and the particular demands that previous relationships with other peoples require. In other words, there is a justification for policies that transcend distributive justice and attend to reparative demands, the right to particular shares in political authority and to rights of first occupancy. Nevertheless, as the modern Australian state comprises many peoples living 'side by side' principles of justice and political practice are required to set out the terms of living together differently (Maaka and Fleras, 2005) to support Aristotle's 'human flourishing' as an essential purpose of political activity (Aristotle, 1988). Further, it is simply inconsistent with indigenous experience to argue that 'we should not assume that thoughts about one's culture – whether they are thoughts about its distinctiveness or anything else – loom very large in one's own involvement in the cultural life of one's community' (Waldron, 2000, p. 233). In common with indigenous populations throughout the world indigenous Australians consistently and vociferously claim cultural recognition within the health system as preliminary to improved outcomes. Chapter Eight's discussion of measures that actually work in indigenous health illustrate culture's centrality to indigenous expectations of how the health system ought to function. There is also a significant '*practical* importance *now* of a judgement that injustice occurred in the past' (Waldron, 1992, p. 4) because colonial injustices are not single acts but ones of ongoing consequence and often of considered repetition. It is for these, among other reasons, that the present distribution of the burden of disease is unjust.

Injustice is not a single event overridden by some subsequent positive engagements with the neo-colonial society. Indeed, the 'causal connection' between Indigenous dispossession and contemporary social, political and economic disadvantage 'is structural or systematic rather than traceable to individual unjust acts' (Patton, 2005, p. 264).

Indigenous peoples' general marginalization from public power and authority diminishes personal capacity to resist inequities in the burden of disease, to suggest that the liberal society ought to recognize history as a determinant of political agency, and admit group rights as preliminary to liberalism's capacity to protect the Indigenous person's individual liberty. Access to culture, language and identity are integral to Indigenous people's exercise of both individual and collective citizenship, and are fundamental to a particular Indigenous share in the sovereign authority of the nation state, as the cultural foundations of the past are the basis of Indigenous 'participatory parity' and capacity to set forward looking political priorities. For these reasons, an equitable health policy cannot be grounded in Waldron's view that 'the general duty of a government to do justice to all people living in a territory is [not] trumped by any special duty it owes to those of the inhabitants who can claim Indigenous descent' (Waldron, 2002). In short, egalitarianism alone cannot provide an adequate theory for the just distribution of public power and authority. Broader perceptions of Indigenous peoples' citizenship or place in the political community are instead required, in recognizance of relationships among history, culture and prevailing political values as determinants of health. To this end, the distinction between liberal egalitarian sameness and human rights (discussed in Chapter 5) is also important if policy is to be framed more widely than as a technical process aimed at addressing 'need' for better services.

Health and justice

Their minority status, the general absence of secure economic bases and, for many Indigenous people, isolation from the principal sites of political power add to the claim for group-specific measures to ensure access to impartial public institutions, even as the causal relationship between the acts and omissions of governments and contemporary indigenous ill-health, adds to the justifications for policy to transcend purely clinical responses and equal per capita expenditure on indigenous people to become an instrument of reparative justice.

Reeparative justice privileges equal human dignity over charitable obligations to the poor as a public policy foundation. It provides grounds to challenge Verdeja's (2008) assumption that a:

> Lack of conceptual clarity about what exactly reparations are for – are they meant to return victims to the status quo and, serve as a moral repudiation of the past, enable once-oppressed groups to achieve self-actualization, or something else? – has meant that reparations programs risk becoming normatively confused and practically ineffective (p. 208).

Reparative justice recognises that health policy's fuller purpose is to preserve human dignity and maximise opportunity for social participation. Positioning health policy within a wider politics of reparation gives substantive significance to the formal parliamentary apology in 2008 to the indigenous people who were forcibly removed from their families during the twentieth century, and provides a sense of moral urgency to improving indigenous health outcomes. In that apology the Prime Minister, Kevin Rudd, remarked

> The time has now come for the nation to turn a new page in Australia's history by righting the wrongs of the past and so moving forward with confidence to the future.
> We apologise for the laws and policies of successive Parliaments and governments that have inflicted profound grief, suffering and loss on these our fellow Australians. We apologise especially for the removal of Aboriginal and Torres Strait Islander children from their families, their communities and their country (Rudd, 2008).

Apologies contextualize reparation's moral purpose. In line with an increasing number of international examples, the apology to Australia's stolen generations applies a Christian theology of reconciliation to a secular political context. Both theologically and politically, 'sorrow' is preliminary to just public relationships and the universal exercise of political freedoms. Sorrow, through the reconciliation movement that was politically prominent during the 1990s, has positioned reparative justice as a potential contributor to indigenous–state relationships and helps to establish who should offer reparation to whom and for what.

A reparative approach could help to reduce the 'power gap' that Pholi et al. (2009) identify as essential to improved policy outcomes and counter more simplistic conceptions of distributive justice, holding, as Kymlicka (1996) explains, that indigeneity, like ethnicity, is a matter only of private concern. One ought to be free to live according to preferred cultural norms in one's own home, but in the public sphere democratic equality requires institutional homogeneity and public policies indifferent to group identity. There is, perhaps, a fear that the politics of indigeneity is concerned with granting public privilege to some groups over others. However, as Benhabib (2002) argues, 'struggles for recognition . . . are really efforts to negate the status of ''otherness'' insofar as otherness is taken to entail disrespect, domination and inequality' (p. 8). At the same time, the politics of indigeneity is concerned with recognition to protect the positive characteristics of 'otherness' and to ensure that indigenous people are able to bring these characteristics into the policy process. The very concept of 'otherness' is deeply political because:

> Whether in the psyche of the individual or in the imagined community of a nation, it is very difficult to accept the ''other'' as deeply different while recognizing his/her fundamental human equality and dignity. I argue that the task of democratic equality is to create impartial institutions in the public sphere and civil society where this struggle for the recognition of

cultural differences and the contestation for cultural narratives can take place without domination (Benhabib 2002, p. 8).

For Fraser (2003), group recognition is an essential requirement of justice:

It is unjust that some individuals and groups are denied the status of full partners in social interaction simply as a consequence of institutionalised patterns of cultural value in whose construction they have not equally participated and which disparage their distinctive characteristics (Fraser and Honneth, 2003, p. 29).

In other words, in the absence of a treaty or some other form of negotiated British settlement, indigenous people were not involved in setting the terms of colonial engagement. They are now required to seek health and health care through institutions whose patterns of operation affect them in disadvantageous ways by functioning exclusively and by according normative privilege to the preferences and practices of other cultural groups. Indeed: 'Recent research indicates that a primary barrier to engagement in mental health services for Indigenous people lies in the failure of services to be able to acknowledge and work within traditional methods of resolving mental health problems' (Westerman, 2004, p. 93). Whereas, in contrast, studies in Australia, New Zealand and the United States have found culturally targeted social media campaigns more effective than generic ones in reducing tobacco consumption among indigenous communities (Gould, et al, 2012).

Racism is a significant and tangible expression of a system that operates exclusively, and a participant in Kelly et al's (2011) study made the point in this way:

When I got back here, there was no one to help me learn to walk… I went to the physio, but they seemed a bit racist or something. I went to see them and they said, 'what are you doing here?' Well, I thought it was a bit obvious. She said she was too busy. I didn't like her attitude so I didn't go back. Now I have my gopher to get around town, but I would still like to learn to walk again. There is someone else who is helping me, but they are leaving for six months soon. I don't know if they will be replaced or not. I have a frame that I need to use, but I need someone to help me with it. You need someone to start you off (p. 31).

It is significant, then, that culturally respectful health services lead to improved access to primary health care [which] has been found to have had significant impact on indigenous people's health outcomes (Donato and Segal, 2013, p. 233), and is therefore an important determinant of health.

  Rawls (1971) proposes a theory of justice as fairness containing 'principles that give a plausible account of the fair distribution of those determinants' of health (Daniels, 2001, p.2). Although Rawls did not place health among his primary goods, Daniels argues that his account of justice is relevant to health care because it protects equal liberties and access to public services and provides a rationale against race - or class based disadvantages (Daniels, 2001, p. 2). It is an account of justice that has society's 'basic structure' as its 'primary subject' and that protects minority interests by assuming that each 'person possesses an inviolability . . . that even the welfare of society as a whole cannot override' (Rawls, 1971, p. 3). Its concern for equal liberty is based on the proposition that 'justice denies that the loss of freedom for some is made right by a greater good shared by others' (Rawls, 1971, pp. 3–4). When political arrangements are made with at least some concession to these principles, it becomes more likely that power will be distributed in ways that allow people to participate more equitably in policy decisions. It is relational justice that is concerned with the terms of association between Indigenous peoples and the state. Relational justice establishes the necessary conditions for fair political and administrative relationships between the post-settler state and its Indigenous peoples. It legitimises deliberative democratic principles to presume protection against the 'tyranny of the majority' and creates a case for administrative arrangements that actually work in Indigenous health, in Indigenous terms. The public funding of ACCHOs is an incremental step towards recognition, which occurs as the outcome of relational justice. Indeed, Indigenous peoples'

aspirations are reflected in a policy approach distinguished from more exclusive liberal perspectives by its reference to principles of inclusion and self-determination, such as that emphasised by the National Indigenous Doctors' Association, whose policy interventions have included the argument that:

> Aboriginal and Torres Strait Islander people have rights conferred by international laws and agreements that requires Australian Governments of all levels to ensure access and attainment of health and wellbeing outcomes (NAIDA, 2013).

The National Aboriginal Community Controlled Health Organisation gives practical application to this philosophical presumption in its *Strategic Plan 2011-2014*. The Plan's objectives are to:

1. Shape the national reform of Aboriginal health.
2. Promote and support high performance and best practice models of culturally appropriate and comprehensive primary health care.
3. Promote research that will build evidence-informed best practice in Aboriginal health policy and service delivery (NACCHO, 2011, p. 7).

NACCHO will measure its success in relation to the first Strategic Direction by evaluating the extent to which governments allow it to be involved in decisions about health service funding, management and monitoring. The general policy recognition accorded to the Aboriginal Community Controlled Health Sector is a further evaluative measure (NACCHO, 2011, p. 8). These measures are consistent with the presumption, in relational justice, that public administrative arrangements must better allow the different tiers of government to make timely and efficient responses to the multi-faceted determinants of Indigenous ill-health. It assumes that Indigenous claims on the state

> are not only about compensation or reparations, but also about the terms of association between them and the colonial state. The injustice of expropriation of Aboriginal lands, for example, is not only about the dispossession of property, or the violation of negative rights of non-interference, but a violation or denial of just terms of association (Ivison, 2002, p. 100).

In the present context, such terms of human association are preliminary to the human flourishing that Aristotle explains as the end of political activity (Aristotle, 1988).

The capacity to flourish is an essential public policy concern and it is the responsibility of the political order to see that everybody may share in the good life (Aristotle, 1988). The question then becomes one of which political philosophy would most reasonably and substantively extend 'happiness' to the greatest number of indigenous people, given that happiness must at least take 'into account the determination of indigenous peoples to retain their own distinctive cultural identity, avoid assimilation and exercise a degree of autonomy' (Durie, 2008, p. 370). For example, culture is a determinant of health and the extent to which it reasonably influences public policy is an inescapably political question. Further:

> In developing a theory of justice, we should treat access to one's culture as something that people can be expected to want whatever their more particular conception of the good. Leaving one's culture, while possible, is best seen as renouncing something to which one is reasonably entitled. This is a claim, not about the limits of human possibility, but about reasonable expectations (Kymlicka, 1995, p. 86).

From this perspective, the politics of indigeneity's principal concern for recognition of prior sovereignty requires, in practice, that attention is paid to the demonstrable 'need' for a more effective, culturally cognizant and broadly focused public policy.

The politics of indigeneity, health, and deliberative capacity

The politics of indigeneity is a rights based discourse concerned with the extant rights of first occupancy, including land and resource rights and opportunities for particular shares in the national sovereignty of the settler states that have emerged over indigenous territories. The particular sovereign share that the politics of indigeneity asserts is concerned with indigenous peoples' enjoyment of collective identities and authority over cultural, social and economic affairs. For example rights to deliberative agency, government by representative government and

full but differentiated or two-tiered citizenship where indigenous peoples enjoy all the rights and opportunities of membership of the nation-state, complemented by full access to their traditional communities and the opportunity to participate in national affairs as indigenous peoples, rather than as peoples properly assimilated into the normative customs and values of the post-settler society (Maaka and Fleras, 2005; O'Sullivan, 2007 and Shaw, 2008). It is, as Shaw (2008) points out, 'an attempt to come to terms with how discourses and practices of sovereingnty still set the conditions under which Indigenous – and other forms of "marginal" politics occur at all' (Shaw, 2008). It is a politics of inclusion with implications for health policy, and an internationally developing theory of justice used by indigenous peoples to craft the terms of belonging to the nation state with reference to their own aspirations. Unlike, Waldron's (2000, 2002), the politics of indigeneity's understanding of self-determination as a necessarily relative and relational aspiration means that it reconcile political independence, on the one hand, with engagement with others as members of a common polity. It is a relational politics that evolves in response to the changing political values and priorities of the neo-colonial societies with which it engages. Its responses to inequality occur through a particular lens concerned with rights as important on their own account, but also as preliminary to the capacity to exercise authority in relation to their own affairs. It is not simply a claim to recognition, but to inherent rights constrained, but not extinguished, by the political authority of the neo-colonial state.

It is a discourse of both resistance and transformation most recently and substantively expressed through the United Nations' *Universal Declaration on the Rights of Indigenous Peoples* (2007). It constitutes 'a fundamental challenge to the prevailing social and political order' requiring colonial ideas about political arrangements, authority and power to make way for political spaces of indigenous autonomy (Fleras, 2000), but through its engagement with

normative liberal ideas can make the liberal order more flexible in its thinking about the rights that indigenous peoples claim.

Indigeneity proposes that individual liberties are dependent on group rights. It maintains that political participation is reasonably the concern of peoples as well as individuals, with no one culture providing the normative foundation for the conduct of public affairs (O'Sullivan, 2007). Indigeneity is rights-based rather than needs-based politics, transcending distributive concern for what is owed to the most economically disadvantaged. Maaka and Fleras (2005) have argued that, in New Zealand as well as in Canadian contexts, there is a 'sharply etched' distinction between 'needs' and 'rights' as a public policy rationale because 'a needs discourse is concerned with reducing disadvantage by removing discriminatory barriers. By contrast, a rights-based discourse focuses on the particular claims to rightful entitlements' (Maaka and Fleras, 2005, p. 139). It allows people to think about public policy development in ways that consider the demands of egalitarian distributive justice, but take further perspectives still to reject the proposition that public policy's duty extends only to considering indigenous needs as the needs of poor people (Maaka and Fleras, 2005; O'Sullivan, 2007 and Shaw, 2008). Instead there is, first and foremost, a right to belong to the modern state with reference to contemporary self-defined aspirations. For indigenous peoples, these may extend beyond physical and mental well-being to a conception of health concerned with the social, emotional and cultural welfare of the whole community (National Aboriginal Health Strategy Working Party, 1989). The National Aboriginal and Islander Health Organisation (the predecessor organization to NACCHO) defined health in a way that continues to influence policy aspirations after its acceptance into the *National Aboriginal Health Strategy* in 1989. Health

means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total well-being of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life (National Aboriginal Health Strategy Working Party, 1989).

The politics of indigeneity necessarily proposes group rights, especially the right to culture, as ways in which the neo-colonial state can extend the principles of liberty and freedom to *all* its citizens, *all* of whom ought to enjoy the capacity to engage in the development of public policies, especially those of immediate relevance to themselves. In other words, liberal freedom is not acultural, and indigeneity is not a simple claim to material equality (O'Sullivan, 2008) because as Kant (1970) puts it:

No one can or ought to decide what the highest degree may be at which mankind may have to stop progressing, and hence how wide a gap may still of necessity remain between the idea and its execution. For this will depend on freedom, which can transcend any limit we care to impose (p. 191).

The politics of indigeneity's challenge is to secure liberation *within* the state; recognizing that liberation *from* the state is constrained not only by exaggerated non-Indigenous insecurities about territorial integrity, but also by pragmatic acceptance that self-determination can only ever emerge as an outcome of interdependent co-operation. The political imperative becomes one of working out a principled framework for living together differently (Maaka and Fleras, 2005). However, living together differently does demand the recognition of history as a determinant of both political agency and capacity to make decisions associated with good health. In this context, as well as in the assertion of extant political rights, it ought not surprise or appear unreasonable that contemporary Indigenous claims to specific political authority are collectively expressed within sovereignty discourses, as 'the conditions under which and the practices through which authority is constituted and legitimated, and what these constitutions and legitimations enable

and disable' (Shaw, 2008, p. 1). It is instructive to health policy because it provides a theoretical context for examining the 'moral disagreement about the nature of health care as a social good, about what sort of special importance, if any, attaches to it' and shows that 'disagreement on this question is tied to other fundamental disagreements about what distributions of social goods are just' (Daniels, 1982, pp. 52-53). Indeed, 'different approaches to defining equity of access to healthcare ultimately depend on different underlying accounts of the kind of social good health care is, and on appeals to different principles of distributive justice' (Daniels, 1982, p. 76). The politics of indigeneity draws principles of restitutive and restorative justice into the policy equation as indigenous health policy demands reference to self-determination and deliberately inclusive conceptions of citizenship.

Indigeneity contributes to a theory of justice presuming that collective rights, arising from first occupancy, are grounds for distinct and particular expressions of citizenship. The principal intended outcome of a reconfigured sovereignty would be to shift Indigenous politics and its most pressing policy concerns from the margins to the national mainstream, as Indigenous peoples are increasingly able to assert shares in public power and authority. For example, it is the Central Australian Aboriginal Congress' view that:

> The recognition of sovereignty rights does not have to diminish the legitimacy of the National Government, [but through] the exercising of our cultural practices and through the establishment of our community-controlled organizations, such as Congress we daily express this sovereignty and our right to self-determination (Central Australian Aboriginal Congress, 2002).

Fraser's politics of 'participatory parity' rationalizes this objective in liberal terms (Fraser, 2003), as 'reasonable' opportunities for public participation arise when administrative arrangements permit each person equal opportunity to participate and engage with other citizens as peers. Each individual can then reasonably claim the political space to enjoy 'independence'

and 'voice' including, Fraser argues, the 'voice' to demand group recognition and cultural respect from public institutions, as preliminary to individual opportunities for social equity (Fraser, 2003, p. 36).

The Pan-American Health Organisation (PAHO) proposes indicators of 'recognition' as: administrative responsiveness, access to health services, inter-sectoral co-operation, targeted interventions and the 'harmonization' of 'Indigenous' and state health systems as a means of recognition and respect, and as a mark of 'the extent to which governments are meeting the health needs of Indigenous people' (PAHO, 1993). Organisations such as PAHO give international authority to recognition as a precursor to participatory parity and promote 'the participation of leaders and representatives of Indigenous peoples and their communities in the formulation of health policies and strategies' (PAHO, 1993).

> we must move beyond a liberal individualist theory toward an inter-subjective theory of recognition that takes seriously how symbolic wrongs can inflict damage, while maintaining a critical lens on material wrongs as well (Verdeja, 2008, p. 210)

Participatory parity, as politics of recognition (Mansbridge, 1996), provides promising ground for re-thinking the ways in which Indigenous health policy is conceptualised, designed and implemented. It recognises that good health is preliminary to full Indigenous democratic participation and 'makes a distinct but limited contribution to the protection of equality of opportunity' (Daniels, 2001, p 2).

> Specifically, by keeping people close to normal functioning, healthcare preserves for people the ability to participate in the political, social, and economic life of their society. It sustains them as fully participating citizens—normal collaborators and competitors—in all spheres of social life. (Daniels, 2001, p. 2)

Therefore, 'the appropriate principle of distributive justice for regulating the design of a healthcare system is a principle protecting equality of opportunity' (Daniels, 2001, p.2).

'Participatory parity' is concerned with equitable deliberative opportunity and finds intellectual alignment with the politics of indigeneity's interest in the nature, legitimacy and distribution of power (Maaka and Fleras, 2005; O'Sullivan, 2007). One can consider these political concerns with reference to Aristotle's argument that governments ought 'to distribute sufficient goods, services and conditions to achieve human functioning, while respecting human dignity by giving individuals the freedom to choose the life they want to lead' (Ruger, 2010, p. 46). Therefore, the best political arrangements are those that bring 'the people as close to good functioning as their natural circumstances permit' (Aristotle, 1988), which Nussbaum (1987) notes is a task 'aimed at producing capabilities... it aims not simply at the allotment of commodities, but at making people able to function in certain human ways...' (p. 1). To this end, the equitable sharing of financial resources remains a constituent of justice, but there are additional ideological and procedural variables that need to be brought into account to satisfy the 'condition of fairness as the appropriate principle to govern the distribution of healthcare' (Daniels, 2001, p. 27). The political and philosophical question then becomes one of what 'institutional, cultural and representational channels are there for the expression of difference? How much difference is compatible with the ideal of the rule of law under fair and equal conditions' (Benhabib, 1996, p. 5)? In other words, how might the political order articulate

> a space within liberal democracies and liberal thought in which... 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 (Ivison, 2002, p. 1).

The principal political obstacle to thinking about Indigenous policy in these terms is the ideological one supposing that liberalism's individual rights cannot logically be expressed in common with others. An alternative argument is that everybody ought to be included in the political life of the state. No one group should always and necessarily find itself on the losing

side' and if liberal democracy is to 'offer protection against the misuse of political power, it must make group rights an important concern of the political system itself' (O'Sullivan, 2011, p. 87).

Fraser's (2003) 'participatory parity' is an analytically instructive concept for thinking about just political relationships and can be aligned with Daniels' (2001) argument that health is special because it is preliminary to substantive access to the 'good life'. It provides ways of assessing the political values informing policy proposals and, in particular, identifying proposals that are likely to be injurious to indigenous peoples' political opportunities. Equitable political participation does not assure a just distribution of the burden of disease, but it does mitigate against policies that perpetuate disadvantage. Procedural fairness in public decision-making also provides ways of determining the relative justice of conflicting demands on the state. Its association with relational justice responds to a 'violation or denial of just terms of association' (Ivison, 2002, p. 100), which envisages political relationships of democratic equality that might, for example, extend to the development of a health system recognisant of Indigenous knowledge and value systems, where one's place in the political order contributes to opportunities to live the 'good life'. Participation also provides protection against what Mill (11869) has called:

> The tyranny of the prevailing opinion and feeling [and]; against the tendency of society to impose, by other means than civil penalties, its own ideas and practices as rules of conduct on those who dissent from them; to fetter the development, and, if possible, prevent the formation, of any individuality not in harmony with its ways, and compel all characters to fashion themselves upon the model of its own.

Participatory democracy affirms the reasonable expectation that public health policies focus more sharply and unapologetically on indigenous peoples' historically and politically shaped needs and expectations. For example, it is inadequate to propose that an equal per capita distribution of public funding makes health expenditure just. Health policy's fuller purpose is to preserve human dignity and maximize opportunity for social participation. Resources are simply

a means to an end, bearing no intrinsic value of their own. It is health care's ends that make it morally important (Daniels, 2001, p. 2) and that establish outcomes as the essential test of a just public policy.

Political participation is usually correlated with wealth (Daniels et al., 1999, p. 27), which is in turn correlated with good health. The right to political participation is grounded in Aristotle's conception of justice, which makes it reasonable for governments to assume 'responsibility for developing individual capabilities for participation and deliberation' as 'a constitutive part of public policy' (Ruger, 2006b, p. 292). In reference to Sen (1999), Ruger goes on to explain that participation is both 'instrumental and constitutive' (Ruger, 2006b, p. 298) of a just policy process. Participation is instrumental because 'informed and unregimented formation of our values requires openness of communication and arguments . . .' and constitutive because public debate is 'crucial to the formation of values and priorities' (Sen in Ruger, 2006, p. 298). For these reasons, one can admit the New Zealand Maori right to elect their own members to parliament as one which particularly enhances deliberative capacity. Guaranteed and, in practice, proportionate indigenous parliamentary representation is a conditional and qualified, yet still substantive, illustration of democratic participation which directly affects New Zealand's indigenous health policy environment. Maori claims are certainly constrained and mediated by a subordinate relationship with the state, but political significance remains attached to the Maori position as peoples whose cultures and occupation of the land pre-date the entrenchment of colonial government. Therefore, intellectual convergence with the politics of indigeneity may suggest ways of thinking about how liberal societies might recognise and respond to the rights that indigenous peoples claim and the expectations that they might have of the state, including aspirations to self-determination. The choice between isolable self-determination and western

measured equality is, then, a mischaracterization of political possibilities. It misrepresents what indigenous peoples, themselves, routinely understand as self-determination and conceptualise as meaningful equality, which means that Kawal (2008) is not necessarily correct to argue that self-determination is politically vulnerable because: 'reconciling the innate difference of indigenous people with the universalism of the liberal state will always be a provisional, ambiguous, and uncertain process' (Kowal, 2008, p. 345).

 While some might object to plural political recognition (Little, 2003), broader conceptions of liberalism mean that it may not, in fact, be necessary to 'move beyond the liberal paradigm' in responding to cultural plurality, as Little (2003) proposes. Indigenous peoples may find it more productive and pragmatic to examine what recourses exist within liberal theory itself for thinking about the claims that they wish to make against the state (Tully, 2000). Liberalism, then, would reduce the possibility of 'blind[ing] itself' to its own partiality in the eyes of non-liberal groups' (Little, 2003) to assert that 'discourses of difference and multiculturalism are part of the liberal tradition' (Little, 2003). Liberalism is, then, equipped to make distinct contributions to debates about what indigenous peoples might reasonably claim against the state and several responses emerge to Little's (2003) question of why non-liberal societies would accept Rawls' proposition that they would wish to contribute 'to an overlapping consensus' on the institutions and processes of government that are 'established on liberal territory' (p. 25). Finding congruence between indigeneity and liberalism is pragmatically useful in its potential to provide a way of integrating universal rights of liberal concern with the particular, and geo-politically contextualized, concerns of indigenous peoples. Indigeneity proposes that individual liberties are dependent on group rights. It maintains that political participation is reasonably the concern of peoples as well as individuals, with no one culture providing the normative foundation for the

conduct of public affairs (O'Sullivan, 2007). It is the intellectual contest over these ideas that principally influence the directions that indigenous health policy takes and that determine the contribution that politics makes to indigenous peoples' opportunities to enjoy good health.

Conclusion

The genuine contestation of ideas, which deliberative democracy presumes, depends on broad political engagement. In its absence, parliamentary democracy struggles to challenge 'bureaucratic path dependency' (Altman, 2009, p. 6) to prevent consideration of alternative theoretical and cultural perspectives. In contrast, inclusive policy arrangements provide self-determination with substantive meaning to allow Indigenous people to develop ways of thinking about 'belonging' as equal members of the nation state where cultural imperatives and deliberative entitlements are recognized through 'relationships of non-dominance involving interdependent people who work through differences in a non-coercive spirit of relative yet relational autonomy' (Fleras, 2000, p. 113). Potential then arises to transform the nature of indigenous political engagement so that an extant right to self-determination over Indigenous affairs can be articulated.

CHAPTER THREE

Democratic exclusion or deliberative inclusion?

Introduction

The Northern Territory Emergency Response (Intervention) and 'Closing the Gap' in Indigenous Disadvantage are the two most significant policy measures in contemporary Indigenous health. They have been widely, but certainly not universally, cited as examples of democratic exclusion (refs) to stand in philosophical contrast with the principles of cultural respect that distinguish certain other indigenous health policy initiatives such as the *National Mental Health Policy 2008*, the Australian Health Ministers' Advisory Council's *Cultural Respect Framework* (2004), the *National Aboriginal and Torres Strait Islander Health Plan* (2013) and the public funding of Aboriginal Community Controlled Health Organizations (ACCHOs). These alternatives are based on relational justice, and ability to admit into policy discourse, principles of participatory parity, (Fraser in Fraser and Honneth: 2003), recognition and self-determination (Alfredsson, 1996; Anaya, 2000; Daes, 1996). Relational justice between governments and Indigenous peoples then allows 'a critical reinterpretation of... [the] nation's history' (Verdeja, 2008, p. 209) to emerge to admit Indigenous peoples, their priorities and cultures into national political discourse.

The contrast between democratic exclusion and political misrecognition on the one hand, and recognition, self-determination and relational justice on the other is an instructive one that sets out relationships between political values and policy practice. The contrast between Closing the Gap and the Intervention, and deliberative inclusion, shows the prevailing liberal paradigm's capacity to admit routinely a more respectful approach to Indigenous health policy should it so choose. However, both policies were initially developed without meaningful deliberative

engagement or regard for Indigenous values and priorities. Neither was supported by strong evidence about what ought to provide the immediate policy focus to confirm an indigenous view that evaluative policy research is 'ad hoc' (Brands et al, 2014) to suggest that there is no consistent systemic capacity for robust evidentially based policy evaluation which is, itself, an outcome of political misrecognition. The failure to engage Indigenous peoples in the policy process means that rather than being underpinned by 'a commitment to stronger engagement with Indigenous communities' (Gillard, 2011), these policies are undermined by mutual mistrust as 'serious engagement with Indigenous politics might disrupt established thinking about politics, and open new political spaces' (Shaw, 2008, p. 9). However, and on the other hand, it remains that by 2014 more serious efforts at engagement have occurred to show that although the politics of exclusion still retains influence, contemporary liberalism is increasingly revealing its potential for greater alignment with the politics of indigeneity and its interests and aspirations.

'Closing the Gap in Indigenous Disadvantage'

'Closing the Gap' is a policy measure intended to close statistically measurable gaps between indigenous and other Australian citizens across six inter-related policy areas: early childhood, schooling, health, economic participation, healthy homes, safe communities, governance and leadership (Macklin, 2008, p. 8). Closing the Gap's initial development was distinguished by relational injustice, even as its substantive policy objectives were concerned with improving Indigenous well-being and were developments from goals initially placed on the national policy agenda by Indigenous policy actors.

'Closing the Gap' describes a series of objectives developed by the Aboriginal and Torres Strait Islander Social Justice Commissioner and advanced in association with Oxfam and the National Aboriginal Community Controlled Health Organisation (2007). It was endorsed by the National

Indigenous Doctors' Association, Congress of Aboriginal and Torres Strait Islander Nurses, and the Indigenous Dentists' Association because it was based on human rights precepts related to, but still distinct from the government measure of similar name. It was similarly related to 'Closing the Gaps', a New Zealand policy program applied to statistically measurable Maori disadvantage in 2000, and 'Closing the Gap', a term used by the World Health Organization (2008) to advocate broadly focused public policies to eliminate disadvantage by 'tackl[ing] the inequitable distribution of power, money and resources'. So it was in 2008 that the Council of Australian Governments (COAG) formally accepted the Commissioner's 'ambitious, yet realistic' goal of closing the life expectancy differential — 11.5 years for men and 9.7 years for women— between Indigenous and other Australians. The specific objectives agreed among the Commonwealth, state and territory governments were:

(a) to close the gap in life expectancy within a generation;
(b) to halve the gap in mortality rates for Indigenous children under five within a decade;
(c) to ensure all Indigenous four years olds in remote communities have access to early
    childhood education within five years;
(d) to halve the gap in reading, writing and numeracy achievements for Indigenous children
    within a decade;
(e) to halve the gap for Indigenous students in year 12 attainment or equivalent attainment
    rates by 2020; and
(f) to halve the gap in employment outcomes between Indigenous and non-Indigenous
    Australians within a decade (Council of Australian Governments, 2008, p. 3).

However, these objectives were pursued in a form that emphasised sameness as the outcome of belonging, and presumed that principles of egalitarian distributive justice were sufficient to meet indigenous peoples' just citizenship claims. Like the 'Intervention', it acceded to indigenous deliberative engagement only after the initial policy implementation phases. Closing the Gap's distributive objectives are constrained by inattention to indigenous populations' 'diversity and difference' (Altman, 2009), leading to the argument that there is scope for 'political epidemiology' to counter considerations of 'health as apolitical' (Gil-Gonzalez *et al*. 2009, p.

278). One could then 'conduct more realistic research and evaluation, better anticipate opportunities and constraints on governmental action and design more effective policies and programs' (Oliver et al., 2006, p. 195). In complementary fashion, Altman (2009) proposes policies of both equality *and* difference so that homogenisation is not the likely policy outcome, while Kymlicka and Norman (1994) argue that 'attempts to create a fairer society will flounder if citizens are chronically intolerant of difference and generally lacking in what Rawls calls a sense of justice' (p. 360).

While Closing the Gap's overarching goals do 'not necessarily reflect the human-rights based approach of the [Indigenous] Close the Gap campaign' (National Aboriginal Community Controlled Health Organisation, 2013, p. 2), the Rudd, Gillard and Rudd Governments (2007-2013) enjoyed bi-partisan support for their principal national indigenous policy measure. 'It is a measure that has helped to improve child mortality rates, and the incidence of smoking'. It has contributed to more effective chronic disease management, but in 2014 the Prime Minister has conceded that

> there's almost no progress in closing the life expectancy gap between Aboriginal and other Australians – which is still about a decade. There's been very little improvement towards halving the gap in reading, writing and numeracy. And indigenous employment has, if anything, slipped backwards over the past few years. We are not on track to achieve the more important and meaningful targets (Abbott, 2014).

'Closing the Gap's early implementation reflected an obtuseness in official attitudes to indigenous people and their place, as citizens, in the national policy process. This argument is fully developed in Chapter Six. However, at this point, it is instructive to consider that while the National Congress of Australia's First Peoples (2013) argued for the policy's importance it also proposed that its focus on 'closing' easily measurable statistical 'gaps' in health and other social outcomes is insufficient, because for Indigenous peoples 'health is complex and multifaceted and

includes the physical health of individuals, social and emotional health, and the wellbeing of whole communities' (National Congress of Australia's First Peoples, 2013). Further, the policy's on-going funding is uncertain (Gooda, 2013), and its distributive focus occurs in isolation from broader culturally defined characteristics of good health and social inclusion (Altman et al., 2008). More broadly, Indigenous imagining of what it takes to enjoy a good life is likely to include land rights and related religious freedoms to complement 'Closing the Gap's integrated concern for better quality housing, education, and employment opportunities as determinants of health (Marmot, 2005). Physical and 'culturally safe' access to health services (Liaw et al., 2011) are likely to be similarly important as cultural imperatives might demand, for example, systemic recognition that:

> Health to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity (Calma, 2005).

A policy focus on eliminating statistical differentials alone is an approach that 'pathologises Indigenous disadvantage by defining it in relational terms... to standards that are constructed according to distinct non-Indigenous cultural values.' Policy thus helps to establish a 'power narrative of Indigenous policy failure' (Altman, 2009, p. 43), meaning that it cannot respond to the deeper theoretical proposition that if reparation is owed when one's rights have been unreasonably transgressed then there is an Indigenous claim to public policies marked by flexibility, choice and self-determination, through guaranteed deliberative engagement in the policy process. In short, 'statistical equality' has become a simple but profoundly limiting 'short-hand' for what is reasonable and attainable. 'Closing the Gap's' focus on average national life expectancy does not confront the substantive issue of extremely low life expectancy in some

communities such as the Tiwi Islands, Wadeye, and Palm Island where male life expectancies range between 46 and 50 years (Hudson, 2010). The necessary corollary is that there are Indigenous men elsewhere whose life expectancies equal or even exceed those of all Australian men, meaning that a 'whole population' focus is misdirected. Incomplete demographic information provides surface level representations of Indigenous peoples (Atkinson, et al., 2010). However, these representations are unduly influential because they establish 'the way in which [Indigenous peoples] are made 'legible' to the state (Taylor, 2009, p. 121) in an environment where 'statistical equality' summarises public policy ambition.

'Closing the Gap' proceeded without regard for democratic inclusion as preliminary to good health, to create an intellectual vacuum filled by stereotypical assumptions and the positioning of 'Aboriginality' as itself a contributing risk factor. For example, Carter et al. (2009) found that policy approaches to cancer treatment negatively framed Indigenous peoples and cultures as 'intrinsically risky'. Positioning people in deficit terms is inconsistent with human equality and dignity (Benhabib, 1996) and allows discriminatory procedures to acquire normative privilege do that negatively framed, stereotypically influenced, clinical advice can follow to restrict the quality of some people's engagement with public services. The further significance of displacing evidence with stereotypical assumptions in policy formation, more broadly, is that evidence can 'condition the political environment in which... judgments' (Banks, 2009, p. 5) are made to facilitate policy success. On the other hand, limited or mis-information diminishes evaluative potential, and a recent *Overcoming Indigenous Disadvantage* report (2011) on progress towards 'Closing the Gap' noted that data were not available to measure changes for one third of the indicators of progress that the Council of Australian Governments (COAG) had established (COAG, 2008). In short, there were no means of quantifying the policy's efficacy. While the

'Closing the Gap' objectives 'are useful for macro-policy settings,' their deeper utility depends on the simultaneous engagement of 'ethnographically informed data that account for the intercultural world in which many Indigenous people exist and operate' (Taylor, 2009, p. 115). Such information is required to make sense of the 'demography of disadvantage' (p. 121).

'Closing the Gap's' distributive focus occurs in isolation from broader culturally defined characteristics of good health. Its focus is not on the full measures of social exclusion (Altman et al., 2008), and the policy functions in the absence of adequate data collection and statistical reporting systems (Australian Institute of Health and Welfare, 2010). 'Closing the gap' is not on its own 'a novel or particularly promising approach', especially as it is guided by assumptions of human deficit, and 'illustrates a substantial imbalance in power and control over the indigenous affairs agenda . . . which is the ''gap'' that must be addressed for the health and wellbeing of Indigenous Australians to improve' (Pholi et al., 2009, p. 1). However, more importantly from a philosophical perspective, statistical equality alone reduces indigenous aspirations to a 'practical' politics of 'need'. Extant rights to land, language and culture are superseded, and their relationship to good health is set aside as 'need' is positioned as the only obligation that citizenship puts upon the state. In this sense, 'practical reconciliation' and its principles, which remain evident in 'closing the gap', can be understood in relation to Taylor's (1999) theoretical articulation of democratic exclusion:

> 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 (p. 267).

The health system's previously integral role in the separation of Indigenous children from their families also helps to explain Indigenous 'fear' and thus exclusion from the system (Shahid et al., 2009, p. 579). One participant in Shahid et al's study noted the relationship between history and Indigenous attitudes to the health system:

> There were instances when Aboriginal people had to wait on the veranda, sit on the veranda outside the surgery while all the white people were seen to. Aboriginal people would sit there for whole day and wait . . . Even if it was freezing cold . . . *Urban female family member.*

Other interviewees provided contemporary insights into why Indigenous peoples might discharge themselves from hospital against medical advice at 13 times the rate of non-Indigenous people (Australian Institute of Health and Welfare, 2009), while Dwyer et al (2011) identified poor communication between hospital staff and indigenous patients as a likely explanatory variable:

> when my sister was in hospital they didn't want a lot of people there—because there was a lot of blackfellas coming in and out—I said, well, this is the only way that's going to bring her back to us… if she hears her people, her mob, she'll come home. Well, [one nurse] she didn't want the people there. She said, 'only you'. I said, not only me. That's all her cousins, they're like her sisters and brothers, you've got to let them in, if you don't she'll only get worse. Let them in, she'll be home next week… and sure enough, she was too.

On the other hand there are indigenous perceptions that the systemic tendency to discharge patients early, for financial rather than clinical reasons, may be applied in discriminatory fashion:

> they knew my baby was premature and the birth weight wasn't up. Why they didn't keep me in then?… they said, 'oh, he's still not putting on weight', and they still end up sending me back here, you know, why they send me back… the midwife from here told me they don't usually send babies back that way (they knew my baby was premature and the birth weight wasn't up. Why they didn't keep me in then?… they said, 'oh, he's still not putting on weight', and they still end up sending me back here, you know, why they send me back… the midwife from here told me they don't usually send babies back that way (Dwyer, et al. 2011 p. 30).

Yet, Dwyer et al. (2001) also found instances of effective and culturally respectful practices:

> The actual service in the hospital is really good. I couldn't fault it. The staff were fantastic and did their job very well. There was the same level of care and respect shown for all families there. Our experience has been very positive. We didn't encounter anything negative based on being Aboriginal. You have your radar on when you go somewhere new, and there was

nothing to detect... There are posters there, things around that are culturally inclusive. You can see yourself as a patient within the system. Aboriginality is acknowledged and it looks like it is respected. These signposts make a huge difference (p. 8),

and

The [Aboriginal health service GP] is really mindful of our needs. She is really busy and everything, but she makes time to talk about things and follow through. She explains things really well. With the medication she tells me why, what it does, not just taking it and not knowing. If you get the right help, you can get through... What we need is friendly people, with friendly processes. The specialists in Adelaide are not friendly, but the [rural and remote] mental health people... were better... There was a teleconference with the doctors in Adelaide, I chatted with her for a half an hour and discussed all sorts of things... We are pretty shy people, not right out there, it is a huge thing for us. Speaking to us makes a huge difference. Talking in terms that we can understand is much better (Dwyer, et al. 2011, p. 11).

Dwyer et al's (2011) further examples are consistent with Carter et al's (2009) attribution of New Zealand's relative policy success in Maori cancer treatment to a paradigm that sees culture positively and as an important context from which to establish clinical practices. While the Australian policy documents referred to 'knowledge gaps', New Zealand's were guided by 'Maori ways of being and knowing, explicitly positing that these had value in NZ society' (Carter et. al 2009, p. 1453). While stereotypes may persist in New Zealand, and Maori health is poor relative to other New Zealanders, it remains that stereotypes rather than evidence about relationships between culture and well-being are more significant in Australian policy discourses.

Carter et al's finding is not an original one; its significance is to confirm that inattention to robust and comprehensive policy evidence prevails. Therefore, there remains political space for a principled normative conception of justice to evaluate and codify Indigenous rights in the ways that public services are received.

The Northern Territory Emergency Response (the Intervention)

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* (Cth) to enable measures such as the sequestering of welfare payments and compulsory health checks of community children (Yu et al., 2008). In 2008, an independent review board found that the Intervention was explicit in its disregard for non-discriminatory and culturally cognisant policy development and implementation (Yu et al., 2008).

The 'Intervention' reflects an ideological disposition that helps to explain why remedial solutions to a 'problem' prevail when policy objectives may, instead, suggest a significant paradigm shift, as 'the state looks to bring about order, but simultaneously overlooks its role in creating chaos' (Altman, 2009, p. 14). For example, the 'Intervention's' official rationale is that the Northern Territory Government's inadequate response to a commissioned report on the widespread sexual abuse of children in the Territory required Commonwealth intervention to protect these children through measures such as compulsory health checks, greater policing and the enforcement of school attendance. Schooling and access to policing are widely held citizenship rights, yet protecting Indigenous children from violence was apparently possible only by way of removing their communities from the protective measures of the *Racial Discrimination Act 1975*.[5] The 'Intervention' relied on military personnel to stabilise these communities and protect their residents from deep-seated violence. However, the communities themselves were not engaged in the policy development process, which included the compulsory

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[5] For example, discriminatory sequestering of welfare payments would have contravened the Act which was suspended to allow the 'Intervention' to proceed.

medical examination of *all* children and the sequestering of welfare payments to *all* beneficiaries. Individual circumstances were not investigated to establish the irresponsible use of welfare payments; it was sufficient to be an Indigenous member of a designated Northern Territory community (Yu et. al., 2008). Therefore the innocent were victimized and the guilty in other parts of the Commonwealth left free to continue their neglect. The conditional nature of Indigenous citizenship was explicit as race, not personal irresponsibility, was the policy criteria. One sees, then, how public policy is readily formed on the ascription of negative social traits to Indigenous peoples by virtue of group membership.

Further instances of policy failure emerged from the Intervention's Child Health Check program. A total of 10,605 children came to the program's attention between July 2007 and June 2009, 97 percent of whom required treatment for conditions with 'fairly high to reasonable recovery rates' (Australian Institute of Health and Welfare, 2009), suggesting that sustained access to services ought to be an immediate and ongoing policy priority. Indeed, improving service quality's inclusion among the Department of Health and Ageing's policy responsibilities admits that relatively poor Indigenous health outcomes, across a range of indicators, could be partly explained by inter-ethnic discrepancies in service quality (Department of Health and Ageing, 2013).

Although not explicitly in the context of health policy the Abbot Government (2013-) has, to this end, indicated an intention to streamline and simplify service delivery across a number of policy domains by combining the responsibilities of 26 existing service delivery programmes to form just 5 more sharply focused and better integrated programmes (Scullion, 22 January 2014). The measure's success remains to be evaluated and its efficacy will be influenced by the extent to which proposed reductions in public expenditure effect these programmes. However, it does

remain that the policy intent of simplicity in the provision of public services to indigenous peoples and in the contractual arrangements between the government and indigenous service providers is one for which National Aboriginal Community Controlled Health Organisations, and other indigenous policy actors, have long argued (see Chapter Seven).

A further consideration in the efficacy of any indigenous policy measure is that contemporary policy exposes a tension between equality, through sameness, and difference, through considered choice. Rowse (2002) argues that these differences are 'found in two competing visions of 'reconciliation'. One vision would eliminate 'difference', while the other would 'enact and enshrine the different ways that Indigenous and non-Indigenous Australians belonged to Australia' (p. 2). Yet, inadequate access to specialist health professionals (Aboriginal Medical Services Alliance Northern Territory, 2009) and the recurrence of easily treatable diseases (Australian Institute of Health and Welfare, 2009) indicates that Indigenous child health, for example, remains in an historic policy vacuum, highlighting the incongruence between policy rhetoric and budgetary priorities. Indeed, Altman (2009) asks whether the Intervention shows that Indigenous affairs policy has not evolved beyond the assimilationist paradigm officially abandoned in the 1970s?

An alternative policy position is that the need for a response to political disempowerment must consider that disempowerment is, itself, perpetuated by the social dysfunction that both Pearson (2000) and Langton (2008) raise as determinants of Indigenous ill-health. Both these Indigenous policy actors argue the significance of confronting social dysfunction to improving Indigenous capacity for personal responsibility. As Langton (2008) puts it

> To expect that people who reel from one traumatic event to another can enjoy the much-lauded Aboriginal 'rights to self-determination' while their own community and the larger society repeatedly fail them is an indulgent fantasy (p. 15).

Pearson's (2000) more detailed assessment of social dysfunction is that:

> Of course racism, dispossession and trauma are ultimately the explanations for our precarious situation as a people. But the point is: they do not explain our recent, rapid and almost total social breakdown. If we build our ideology and base our plan of action on our justified bitterness about what has happened to us we will not be able to claim our place in the modern economy, because our current social dysfunction is caused by the artificial economy of our communities and by the corrupting nature of passive welfare (p. 151).

Sutton (2009) proposes that prior to the Intervention 'the abusers of children, women and the elderly in so many of these ghettoes had had a long, easy run… He argues for 'the personal to be more highly valued in this arena and to be defended against the claims and inroads of the collective, the corporate, the racial, the legal, the governmental' (p. 12). However, in making his criticism of the 'politicisation of disease' (p. 9), Sutton diminishes the importance of political participation and community decision-making in critical areas he apparently separates from 'politics':

> domestic sanitation and personal hygiene, housing density, diet, the care of children and the elderly, gender relationships, alcohol and drug use, conflict resolution, the social acceptability of violence… and attitudes to making changes in health related behavior (p. 12).

While these are determinants of health over which individuals have significant personal control, it is misleading to understand them in isolation from broader socio-political and economic considerations because to do so is, as Sutton himself points out, to miscalculate the limits to human agency and the reasonable expectation of 'women and others' [in dysfunctional and violent communities] that the state will be 'on their side' (p. 9).

Health, culture and deliberation

In 2008, an independent Review Board found that discrimination and the failure to consider Indigenous cultural imperatives were central to the Intervention's development and implementation (Yu et al 2008), and were responsible for an acute Indigenous sense of exclusion

from the policy process (Calma, 2008). The 'Intervention' was 'not based on a consideration of current evidence about what works in Indigenous communities' (Northern Territory Emergency Response Review Board, 2008). Indeed, one of the Northern Territory Government's responses to the report that precipitated the Intervention was the establishment of a 5 member 'Outreach Service' to develop a work programme necessarily limited by its grounding in 'little research about effective therapeutic approaches for Aboriginal people'.

> There was one visit by a counsellor when the abuse was first disclosed but there had been no follow-up either with the girl, her family or the community. Whether the service was discontinued due to higher priority needs or because the family was assessed as no longer requiring the service is unclear. The fact that the family doesn't know why the service ceased shows poor communication and lack of clarity about service delivery limitations and expectations (Northern Territory Emergency Response Review Board, 2008).

Recognising culture in health care illustrates what Kymlica (1996) explains as giving all people the same option to 'live and work in their own culture' as other members of the community (p. 109). The United Nation's *Declaration on the Rights of Indigenous Peoples* (2007) expresses the right as one allowing people 'to promote, develop and maintain their institutional structures and their distinctive customs, spirituality, traditions, procedures, [and] practices' (United Nations: 2007, 34). From this authoritative perspective at international law, excluding culture from the policy process sets aside its significance to human identity and social capacity to function well (Nussbaum, 1987, p. 2). Yet, there are, in fact, numerous examples of cultural recognition to provide models for more widespread policy attention to Indigenous health and deliberative engagement. One example is Wilson's (2009) summary of Aboriginal women's expectations of antenatal care which found that people wanted personal agency to be fostered and that there were simple and inexpensive measures proposed to improve health equality: protection from violence, culturally respectful familial engagement in antenatal care, relationships of trust and respect with the health provider and the accessibility of safe transport to and from health care facilities.

Lee et al's (1994) discussion of an Indigenous community initiated health and nutrition project, managed through 'traditional power structures' is a further example, while d'Espaignet et al's (2003) evaluation of a number of tobacco reduction programmes found culturally cognisant and community controlled interventions were preferred, while Hoy et al (2003) described the characteristics of a programme responsible for preventing 13 deaths from renal disease as 'a strong sense of community ownership and control, a non-judgemental, non-authoritarian style and respect for competing personal and community perspectives and priorities' (p. 183).

Durie's (2003) argument from the New Zealand Maori context highlights the significance of culture in establishing the measures against which policy ought to be assessed.

> Maori progress, whether in commerce, education, or science, could not be accomplished without taking cognisance of Maori values and the realities of modern Maori experience. In other words, Maori development was not solely about making economic progress or reducing state obligations towards Maori; it was also about being able to retain a Maori identity and formulate development according to Maori aspirations (p. 304)

It is with reference to measures of success, conceptualised in Indigenous terms, that there is potential for the evolution of new paradigms responsive to the arguments in procedural justice that democratic deficit occurs when some citizens lack proportionate opportunity to participate in public decision making. To this end, a NSW Health Policy Directive (NSW Health, 2007), issued in 2007, suggested a noteworthy admission of the propriety of Indigenous deliberative engagement in policy making

> An Aboriginal Health Impact Statement Declaration... will accompany new policies and proposals for major health policies and programs submitted for Executive or Ministerial approval. This will ensure that the health needs and interests of Aboriginal people have been considered, and where relevant, appropriately incorporated into health policies (p. 5).

Further, the *National Mental Health Policy 2008* acknowledged Australia's

> Indigenous heritage and the unique contribution of Indigenous people's culture and heritage to our society. Furthermore it recognises Indigenous people's distinctive rights to status and culture, self-determination and the land. It acknowledges that this recognition and identity is

fundamental to the well-being of Indigenous Australians. It recognises that mutual resolve, respect and responsibility are required to close the gap on Indigenous disadvantage and to improve mental health and well-being (Commonwealth of Australia, 2009).

In 2004, the Australian Health Ministers' Advisory Council adopted a *Cultural Respect Framework* to inform systemic engagement with Indigenous peoples. The *Framework* acknowledged that Indigenous ill-health is often avoidable and that 'cultural respect' is a precept that ought to help to remove some of the barriers that continue to restrict… access to an equitable, quality health system' (Australian Health Ministers' Advisory Council, 2004, p. 3). In other policy literature, the Australian Health Ministers' Advisory Council's noted 'connectedness to country, land and history, culture and identity; resilience; leadership; structure and routine; feeling safe; [and] vitality' (Australian Institute of Health and Welfare, 2011) as indicators of a broader possible Indigenous interpretation of the 'good life'. In turn, effect might be given to the view of the Intervention Review Board that policy ought to be developed on the presumptions of:

- genuine engagement with communities in talking about, developing and implementing policies
- active and well-supported Indigenous led decision making in program design
- bottom-up approaches that kniy together local knowledge within a national framework
- local and region-specific programs that are tailored to the needs of particular communities rather than one size fits all approaches
- investment in and financial support for local Indigenous leadership
- long-term investment in strengthening communities at a local level to decide and manage their own lives
- programs and policy approaches that are geared towards long-term achievements
- real investment of dollars and people based on need and ongoing support for programs that work
- regular and independant public evaluation of government programs and policies to make sure we learn from mistakes and successes
- cooperative approaches by state, Federal and local governments and their agencies which reduce the burden of duplication and red tape on community organisations (NTER Review Board, 2008).

It is through the development of these kinds of polices and their underlying theoretical precepts that public policy might admit that it is a fundamental change in relationships that will provide practical responses to the arguments in political theory for bringing self-determination, relational justice, recognition and cultural respect into health policy consideration. Indeed, as the Review Board argued, relationships between governments and Indigenous peoples 'must be recalibrated to the principle of racial equality and respect for the human rights of all Australia citizens' and that relationships of trust require 'effective social and civil institutions that express the values and beliefs of the community' (Yu et al., 2008). However, Government indifference towards a human rights based approach to Indigenous health policy (discussed in Chapter Five) helps to explain the absence of substantive and systematic Indigenous engagement in policy development. The Aboriginal and Torres Strait Islander Social Justice Commissioner has endorsed the findings of the Intervention Review as

> spot on in identifying... [its] fundamental flaw of the intervention when they state in their report that: 'There is intense hurt and anger at being isolated on the basis of race and subjected to collective measures that would never be applied to other Australians. The Intervention was received with a sense of betrayal and disbelief. Resistance to its imposition undercut the potential effectiveness of its substantive measures'. Measures that deny people basic dignity will never work. As the NT Review report notes, it is this singular problem that has undermined the effectiveness of the intervention and has broken down the trust and relationship between government and Indigenous peoples across the Territory (Calma, 2008).

A useful response, in procedural justice, could, then, be to establish a conceptual rationale for 'active and informed [indigenous] participation' to ensure 'non-discrimination' and cultural 'acceptability' (Hunter and Jordan, 2009) in the policy process. Indeed, tentative steps to these ends have been taken in recent Commonwealth concessions to more inclusive political arrangements.

In 2013, the Commonwealth revised its National Aboriginal and Torres Strait Islander Health Plan to make limited, but important, concessions to active citizenship. The Plan was endorsed by

the Australian Medical Association (2013) as one that 'should be a catalyst for a new era of unprecedented coordination'. It was the first comprehensive Commonwealth response to indigenous criticisms of 'Closing the Gap', which brings participation and accountability together 'in a conception of rights' that 'strengthens the status of citizens from that of beneficiaries of development to its rightful and legitimate claimants' (Gaventa, 2002, p. 2).

The Plan removes Closing the Gap's underlying state centred rationale by positioning itself as the product of 'a collaborative effort after extensive consultation with Aboriginal and Torres Strait Islander people and their representatives' (Commonwealth of Australia, 2013, p. 1). The justice of indigenous deliberative engagement was accepted and sustained indigenous lobbying for evidence based policy development was admitted, as the Plan proposed 'an evidence-based policy framework to guide policies and programs to improve Aboriginal and Torres Strait Islander health over the next decade until 2023' (Commonwealth of Australia, 2013).

The Plan's overarching principles respond to sustained indigenous lobbying for: 'health equality and a human rights approach, Aboriginal and Torres Strait Islander community control and engagement, partnership and accountability' (Commonwealth of Australia, 2013, p. 7). Its aim, to create a health system 'free of racism and inequality' is a significant aspirational goal consistent with an inclusive conception of citizenship. It gives substantive effect to the Commonwealth's Overcoming Indigenous Disadvantage strategy, which although criticised for being 'very limited in its recognition of differences in Indigenous cultures and aspirations' (Hunter and Jordan, 2009, p. 11), does imagine 'a society where Aboriginal and Torres Strait Islander peoples… enjoy a similar standard of living to that of other Australians, without losing their cultural identity' (Steering Committee for the Review of Government Service Provision, in

Jordan *et al*. 2010, p. 5). It continues to propose that indigenous peoples' lives ought to be distinguished by:

1. Safe, healthy and supportive family environments with strong communities and cultural identity;
2. Positive child development and prevention of violence, crime and self-harm; and
3. Improved wealth creation and economic sustainability for individuals, families and communities (Steering Committee for the Review of Government Service Provision in Jordan et al. 2010, p. 5).

To these ends

The Australian Government's vision of a socially inclusive society is one in which all Australians feel valued and have the opportunity to participate fully in the life of our society. Achieving this vision means that all Australians will have the resources, opportunities and capability to learn, work, engage in the community and have a voice (Commonwealth of Australia, 2013).

Recognition is a precursor to participatory parity. It may justify distributive measures, but it is a theoretically and practically deeper construct concerned with the possibility that the inequitable distribution of resources is grounded in the considered systemic exclusion of some groups of people from the policy process. Individually focussed liberal egalitarianism is therefore ill-equipped to respond to the fundamental reason for some people's inability to access the same level of resources and care that may be available to others. Indeed, if it is as Behrendt (2001) puts it, that Indigenous policy is distinguished by discriminatory practices that are not occasioned against other groups of people, the admission of group rights into policy consideration becomes a requirement of equal opportunity. Recognising group rights is further defensible because injustices against Indigenous people almost always occur on the grounds of group membership.

Conclusion

If it is true that liberal political theory was developed to determine how societies should admit religious plurality, it ought to be able to rationalize ethnic diversity and the political implications

of some citizens' claim that certain rights arise from membership of an indigenous group. As Kant (1970) has observed:

> Men have different views on the empirical end of happiness, and what it consists of, so that as far as happiness is concerned, their will cannot be brought under any common principle, nor thus under an external law harmonizing with the freedom of everyone (Kant 1970, p. 73–74).

Closing the Gap and the Intervention, are policies that highlight the significant intellectual distance between Australia's rhetorical public support for human rights and its routine willingness to set aside these rights in relation to Indigenous health. 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 in giving effect to the universal right to the highest attainable standard of health, which is discussed later in this Chapter (Hunter and Jordan, 2009). However, like the Intervention, which depends on racial discrimination for its implementation, Closing the Gap's 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 (Hunter and Jordan, 2009).

CHAPTER FOUR

Power, Politics and the Street Level Bureaucrat

Introduction

Ideology is important at every level of the policy process, and it is at the 'street level' point of implementation that workers' personal philosophies are played out and contested with profound influence on the ways in which indigenous people perceive and experience government policy. Indeed,

> public policy is not best understood as made in legislatures or top-floor suites of high-ranking administrators, because in important ways it is actually made in the crowded offices and daily encounters of street-level workers (Lipsky, 1980, p. xii).

Street level workers (for example doctors, nurses and dentists) are guided by personal political values in the ways that they prioritise their work and make decisions about the care that will be available to particular patients. The possibilty that street level workers make decisions with reference to stereotypical or prejudiced judgements about Indigenous peoples makes their bureaucratic discretion a point of particular significance. Alternatively, their capacity to work on the assumption that they have the professional agency and moral duty to make a substantive contribution to improving Indigenous health outcomes positions their work in the context of social justice. As the Royal Australian and New Zealand College of Psychiatrists notes in its 'Principles and Guidelines for Aboriginal and Torres Strait Islander Mental Health:

> Health professionals and scientists have considerable influence in the creation of stereotypes and over their eventual abandonment. At times, health professionals have contributed to the development of pejorative and disempowering stereotypes of Aboriginal and Torres Strait Islander people. On the other hand, health professionals have considerable influence over the beliefs and practices of the wider community and can make great contributions to breaking down prejudice and unfair practices. Psychiatrists have an important part to play in the removal of prejudice from all mental health services and the encouragement of Indigenous community efforts to improve mental health and social and emotional well being (Royal Australian and New Zealand College of Psychiatrists, 2009).

The street level worker is, then, drawn into the politics of public policy and policy activism, where ideology sits alongside professional knowldge and skills as determinants of Indigenous health outcomes.

Inconsistent and contested appreciations of the nature of Indigenous citizenship and the terms of Indigenous belonging to the modern liberal democratic state means that Indigenous health policy is itelf theoretically underconceptualised and therefore a site of practical confusion at each level of the policy process. In this context, the Indigenous health street level workforce is able to challenge the Weberian (1958) account of bureaucracy as a controlling 'iron cage' to create space for considerable discretion in the ways that street level workers implememt Indigenous health policy. The level of time and care devoted to any one patient is a matter of discretion, yet as one health worker in Kowanko et al's (2011) study explained, the way in which that discretion is exercised can be significant to the patient:

> it does take time… to get that rapport as well… I sat there for three hours one day, just getting a client to respond really. Like, it was a great session but out of that three hours there was about an hour and half hiding under her hat and whatever, but, by the end of it we've got such a great rapport. … so, to get her care planned to the point of getting it signed off, probably a six hour journey. You know. It's very time consuming (pp. 19-20).

Professional responsibilities mean that street level workers may be guided by philosophically coherent positions and conceptions of social justice requiring them, sometimes, to contest prevailing policy paradigms. For example, the Medical Board of Australia (2009) proposes that: 'Good medical practice involves using your expertise and influence to protect and advance the health and wellbeing of individual patients, communities and populations' (p. 17). Professional skill and autonomy can, then, become powerful instruments of resistance and foundations for the construction of alternative ways of thinking about Indigenous peoples, their place in the political

community and the consequent expectations they might reasonably hold of the public health system.

Street level discretion, agency and ideology

Street level workers' capacity to influence occurs because policy is 'rarely applied directly to the external world, but is mediated through other institutions and actors' (Hudson, 1989, p. 42). Admitting the significance of street level discretion and agency is preliminary to a broad understanding of the political determinants of Indigenous health, especially as the clinician, as street level worker, influences who and what is treated and with what level of care (Lipsky, 1980). Understanding the role of health workers in the policy process is integral to appreciating the political factors that shape policy outcomes.

Agency combines the professional capacity to make a difference to health outcomes with a complementary philosophical commitment. It contrasts with the view that ill-health can be explained only with reference to deficiencies in the individual and community. Deficit accounts of ill-health set aside variables such as the interpersonal relationships between practitioner and patient and discount the wider complexities of systemic access including racism, cultural dissonance between the Indigenous person and clinical setting and the acceptance of cultural imperatives into treatment regimes (Paradies et al., 2008).

Although street level work is most effective when guided by a political philosophy that privileges professional agency, it can be difficult to work with agency when professional duties are performed in a highly contested yet theoretically under conceptualised policy environment, where the ability to treat an Indigenous patient with neither fear nor favour is a relatively recent

right and expectation.[6] At one level, the bureaucracy is instructed to operate in ways that do not discriminate, but in practice there are certain measures and modes of operation that are inherently discriminatory and are, themselves, determinants of sustained Indigenous ill-health (NTER Review Board, 2008). The suspension of the *Racial Discrimination Act 2005* to allow the Intervention to proceed is an example, and bureaucratic discretion in the administration of the Intervention's income management arrangements has been especially discriminatory (Bielefeld, 2012). However, in this context, bureaucratic failure may be as much the outcome of failures in democratic governance as the outcome of the inept or even discriminatory exercise of discretion. Failures in democratic governance occur when decision making arrangements do not admit the proposition that the citizen is 'he who has power to take part in the deliberative or judicial administration of any state' (Aristotle in Hindess, 2000). Greater deliberative capacity would provide Indigenous peoples, themselves, with better opportunities to confront bureaucratic inertia, challenge street level prejudice and establish what they might reasonably expect from the public health system.

The ideological inconsistencies that pervade Indigenous health policy reflect Lea's (2008) description of a fragmented, intellectually disjointed state, functioning in this way because the state itself 'does not have a conscience, misanthropic or otherwise; there is no singular architect, no authorial centre for the institutional ability to engender self-replicating practices. It is a dynamic that exceeds individual actors' (Lea, 2008, p. 16). As Lea (2008) continues, the 'point about the bureaucratic emanations' of the state is that 'such emanations have a magical relationship to the worlds that they simplify, distort and describe. Exact correlation between

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[6] See for example Dodson, M. and Wilson, R. (1997), 'Bringing them home: Report of the national inquiry into the separation of Aboriginal and Torres Strait Islander children from their families', *Human Rights and Equal Opportunity Commission, Sydney*.

'rhetoric and reality' is not required' (p. xv), especially in the context of street level work being constrained by the absence of substantive data on particular community needs. For example, in 2008, policy-makers in the Northern Territory were 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 avaliable' (p. 118).

The street level worker's role in adding to or detracting from health inequality is, then, an illustration of Weber's conceptualisation of inequality as an outcome of values and group memberships, just as it is an outcome of economic considerations (Marmot, 2005). As Hupe and Hill (2007) observe

> Since most of the activities of street-level bureaucrats are multi-faceted, some bits will be structured where others are not. The institutional context helps determine that structuring. The implication for practice is that there are some important political choices, not only about what to structure and how to structure it, but also, about who should be in control … (p. 296).

Indeed, the complexities of bureaucratic power means that even well-considered and broadly endorsed policy measures can fail, with the health system then perpetuating disadvantage (Marmot, 2005). For example, the street level bureaucrat's professional agency can be compromised and confused by the role's multiple accountabilities: to the patient, the bureaucracy, the profession, and personal conceptions of justice. Indeed, it is the practitioner's ideological disposition that rationalises and negotiates these multiple accountabilities, that must be managed in a context where workers unavoidably present themselves as the public face of government. The reality of '*being the state*' (Lea, 2008, p. 9) means that street level workers must, individually and with the guidance of their own philosophical dispositions, mediate the logical inconsistencies that pervade the formal expressions of public policy. Therefore, the street

level bureaucracy is 'a complex socio-cultural domain with its own passions and inanities, pains and pleasures, complicities and truths, mysticism and magic' (Lea, 2008, p. 10).

Political and moral conceptions of social justice are also relevant to the street-level workers' sense of agency and responsibility, and there is an argument that discretion ought to be exercised in support of socially just and altruistic goals (Maynard-Moody et. al., 1990). Indeed, the capacity to use the resources at their disposal to provide services beyond personal contractual obligations makes street-level influence 'a pre-requisite for justice' just as much as it is a potential 'source of considerable abuse' (Maynard-Moody et. al., 1990, p. 833). Further, the bureacracy's collective capacity to effect change depends on promoting personal agency through the institutional conceptualisation of goals that are congruent with specific, culturally acceptable policy priorities, relevant to the needs and aspirations of a particular community.

However, it is still ideology that provides the motivation to support or undermine particular policies and practices. Ideology rationalises the decisions that people make about the levels and quality of professional attention that individuals will receive, and its influential capacity is enhanced when the regulations governing policy implementation do not always make sense to the street-level worker in the context of an immediate problem they are trying to resolve.

> Workers in one agency admitted to deceiving STH [the South Australian Government's Street-to-Home programme] about whether they were working with particular clients. STH were sometimes informed that a particular client was not receiving a service, if the worker thought that STH may offer the client better resources than their agency could (Talbot et. al., 2010, p. 45).

Yet Bacchi and Eveline (2006) argue the cetrality of street level contributions to the resolution of policy problems, and point to the importance of transparent policy making in establishing street-level understandings of a policy objective.

The testing of selected… frameworks 'on the ground' revealed that such frameworks are not static; rather, they are malleable and subject to continual political pressures, reflecting the changing contexts in which they operate (2006, p. 62).

Uncertainty is among the public policy environment's distinguishing characteristics. It is an environment where change is usually incremental, but where the possibility of rapid and unexpected development also exists. In this context, personal agency is important, but there also remain significant systemic barriers to the individual worker's capacity to effect improvements in health outcomes. The broader policy environment can be constraining and the inevitable tendency to 'fall back on answers conceptualised in terms of their own agency' (Lea, 2008, p. 15) can inhibit the individual's critical reflection on the broad philosophical context in which policy occurs.

Political values account for the ways in which decisions are made about the rationing of public resources and the claims that Indigenous peoples make on the health system. Institutional workplace cultures also influence street level decisions about service delivery to show, as Sullivan (2008) found, a fundamental cultural and physical distance between Indigenous communities and bureaucratic communities, such that 'Aboriginal people become symbolic capital in patterns of action determined by the bureacratic imagination' (p. 127). Sullivan's description is one that has long distinguished Indigenous policy. Historically, governments have used the public service to position the Indigenous person beyond citizenship and the legacy of street-level health bureaucrats as essential agents in discriminatory policies, such as the removal of Indigenous children from their families, which helps to account for Indigenous wariness of health workers as well as the system itself. Indeed, Jamieson et al.'s (2008) research in South Australia found people who

felt that historical legacy impacted on the oral health of community members, through continued practices of being told what to do, where to live and what oral health services were available to them. Participants perceived they had little power over their oral health or oral health care decisions (p. 52).

Street-level bureaucrats' perceived unfriendliness, inflexibility and intolerance also impedes Indigenous access to health services, and locates street level workers and their professional activities within a 'sociocultural and political context' where racism is commonly experienced (Cutcliffe, 2004, Paradies, 2007 and Paradies et al., 2008), even as many health workers bear no conscuious ill-will towards Indigenous peoples, and as Lea (2008) demonstrates, are motivated by a well-developed passionately held sense of social justice. One health worker in the Pilbara region of Western Australia told Walker et al. (2012) that:

> We can do all the cultural awareness training in the world, but we are not Aboriginal and cannot understand everything. We need to be able to offer what is needed (p. 432).

Alternatively, as one health professional put it to Dwyer et al (2011):

> A really difficult thing for me, being a white male in a foreign environment, is having any possibility of communicating with a shy woman with poor English, possibly, who comes from a totally different cultural background… I just have to say that I really don't… communicate very well with the women and that just is a fact of life' (p. 10)

explaining, perhaps, why: 'Generally speaking, these women don't ask for anything, and much to their detriment at times I think' (Dwyer, et al., 2011, p.11). Nevertheless, racism does occur at levels suggesting that the generally attentive view that contemporary professional associations (discussed later in the Chapter) show towards Indigenous aspirations are contested among their memberships. Officially sanctioned professional Codes of Ethics may not actually determine workplace practice**. This is because as well as allowing flexibility and responsiveness in service delivery, discretion also allows prejudiced accounts of Indigenous citizenship and stereotypically

grounded positions to become, in effect, the public policies that are implemented at the street level (Lipsky, 1980).

Stereotypical assumptions cannot be set aside by bureaucratic directive. They can retain pervasive influence even where institutional cultures mean that attitudes of negative consequence to Indigenous people can only be subtly expressed. Discretion is thus a paradoxical influence that 'promotes flexibility and innovation, yet allows indifference and abuse' (Maynard-Moody et. al., 1990, p. 833). Therefore, service delivery decisions can constitute a 'moral judgment and statement about [a person's] social worth' (Hasenfeld, 1992, p. 5). The capacity to subvert the position that all citizens ought to enjoy the same quality of health care reflects the 'dilemma of discretion' (Maynard-Moody et. al., 1990, p. 833) that occurs when individuals neglect aspects of their work that they dislike, find difficult or philosophically objectionable.

The street level worker and the politics of public policy

Indigenous public policy's deeply contested ideological nature explains why the policy process reinforces discriminatory values in some respects and counters them in others. Indigenous policy is distinguished by constant change as the state struggles to develop a consistent philosophical position on the Indigenous citizens' place within the national polity. Policy changes can alter the tenor of public debate and the positioning of Indigenous peoples vis-à-vis the policy process. For example, philosophical confusion and intellectual inconsistency on the matter of common Indigenous citizenship and the terms of their 'belonging' to the modern liberal democratic state shapes and constrains policy possibilities. On the one hand, Weber's 'iron cage' directs street level workers to implement culturally respectful policies responsive to Indigenous experiences and priorities such as the *National Mental Health Policy 2008*, the public funding of Aboriginal Community Controlled Health Organizations (ACCHOs) and the

Australian Health Ministers' Advisory Council's *Cultural Respect Framework* (2004), which was established to guide the development and delivery of health services to Indigenous peoples. The intention of these policies was to use bureaucratic authority to impose requirements on health workers that would, ideally, give substantive recognition to relationships between culture and well-being. However, and on the other hand, the Northern Territory Emergency Response (Intervention), which added significantly to Indigenous mistrust of the state (Yu wt al.,, 2008), which is discussed in Chapter Three, rests on exclusive accounts of Indigenous citizenship, where common membership of the same polity is not interpreted to allow substantive deliberative engagement in policy development (NTER Review Board, 2008).

The power to influence public discourse is important and Indigenous peoples' limited collective deliberative capacity diminishes scope for democratic accountability. So it seems, then, that present arrangements sometimes proceed on the basis that there is neither an argument in justice nor a pragmatic imperative to engage Indigenous peoples to give effect to the presumptions of the United Nations' *Declaration on the Rights of Indigenous Peoples* that they ought to be able to state their expectations of the public health system in ways that are congruent with their own customs, values and aspirations (United Nations, 2007). In contrast, indigenous democratic exclusion casts the aboriginal person as an antropological artefact who is 'never where an actual Aboriginal subject stands and speaks' (Povinelli, 1999, p. 34).

Democratic exclusion disturbs the theoretical attractiveness of the proposition that: 'Street-level bureaucrats do have legitimate claims to power based on their expertise, but this power claim does not have the same moral quality as claims based on powers bestowed by a sovereign citzenry' (Matland, 1995, p. 11). In simple terms, Indigenous people's admission into the 'sovereign citizenry' is contested and conditional, as policy measures such as the Intervention

demonstrate. Prevailing liberal accounts of sovereignty make access to decision making processes conditional on deliberating in ways that require acceptance of dominant cultural practices and framing political aspirations in the language of non-Indigenous political concepts because the unacknowledged '"client" of aboriginal development… is the non-Indigenous voter and the political class that is responsive to them' (Sullivan, 2009, p. 62).

An alternative account of sovereignty is a shared one (Maaka and Fleras 2005; O'Sullivan 2007; Shaw 2008) intended, among other objectives, to re-frame the political context of public policy so that it is both universal and differentiated' (Fleras, 1999, p 183). Fleras' alternative account of liberal democratic justice for indigenous peoples is one that is intended to grant them the greatest possible autonomy over their own affairs, potentially through existing bodies such as Aboriginal Community Controlled Health Organisations, as a way of 'mainstreaming indigeneity' to reflect 'moves towards participatory governance, but also... a commitment to indigenous models of self-determining autonomy' (Maaka and Fleras, 2009, p. 1). The implication for street level bureaucrats is that a rights based discourse requires the distinct conceptualization of Indigenous communities for policy purposes, and recognition that 'culture counts' in service delivery. Bishop and Glyn's *Culture Counts* (1999) examines the theme in a New Zealand Maori educational context, and the comparison positions the point as a universal one where culture's effective relevance to service delivery is, in effect, determined by the street level worker whose work is influenced by a personal sense of agency so that the bureaucratic ideal of public service can, if one chooses, recognize that ideology precedes the exercise of discretion. In Australia, ACCHOs show that relationships between policy and practice are culturally contextualized and that the distinction between what is inside and outside the government is narrowing.

The 'contracting out' of street-level responsibilities changes the power relationship between governments and street level professionals. It means that there is no immediate employment relationship to provide the state with direct control over people's work. The lines of accountability are blurred as these workers' salaries may be paid from public money, and their work regulated by legislation and public policy imperatives. Yet, they are formally employees of an agency with an overt commitment to self-determination. In this sense, the policy process' 'layers of relations... involves a succession of struggles for control over action' (Hupe and Hill, 2007, p. 295) when, for example, work is contracted to ACCHOs.

Self-determination is grounded in differentiated citizenship, discussed in Chapter Six, which presumes Indigenous delberative engagement of the sort explicitly prevented by the Northern Territory 'Intervention'. Limiting Indigenous policy participation and therefore the overall distribution of political power was among the Intervention's essential bureaucratic objectives (Yu et al., 2008), and one of the outcomes was that rather than providing the interface between government and citizens the front-line workers' role, that the army assumed, became one of restricting access to policy influence.

Procedurally, the Intervention was the antithesis of Shergold's (2009) model for more 'open structures' of governance because as the former Secretary of the Department of Prime Minister and Cabinet noted, open governance requires

> shifts of power. Decision-making needs to be less bureaucratic and more citizen-centric. That requires far more flexible organisational structures and delivery systems and more collaborative leadership cultures. It demands that governments embrace social innovation and that public services are willing to manage the risks that inevitably accompany it. It needs to be recognised that too much 'accountability', too much public service process and too much 'professional' expertise kill creativity (p. 15).

Shergold's hope that Australia might 'develop as a participatory society' (p. 1) remains an elusive goal for Indigenous citizens because as Shergold (2009) himself, notes:

Trust and engagement are the twin pillars of a participation society. In their absence, the ties that bind – the networks of 'social capital' that underpin civility, respect for others and a collective sense of mutual responsibility – are loosened (p. 1).

There is a philosophical incongruence between positioning 'mutual responsibility' as a guiding paradigm and concurrent policy decisions that are injurious to the maintenance of trust and engagement. The Intervention confirmed indigenous peoples' place in a discourse of 'disadvantage' and qualified citizenship. While the army did bring significant resources to the Northern Territory (Lea, 2008), it also brought a command structure more easily able to constrain bureaucratic discretion, as the military health worker's professional agency is conditioned by the obligation to subservience. The outcome was to diminish opportunity for professional capture by co-opting the military to perform street level work, with the soldier's responsibility to military hierarchical authority meaning that tight ministerial and managerial control of the workforce could proceed.

Scope for street-level influence is also diminished as normative practices shift towards more managerialist, discretion-limiting, civilian administrative arrangements. While street-level workers can be well placed to assess policy efficacy their influential capacity can be constrained by public management theory's resistance to 'provider capture', and while individual workers may aim to make a positive difference in the lives of others 'bureaucratic control systems' impact negatively on individual motivation (Paarlberg and Lavigna, 2010, p. 710) as accountability is conceptualized in these terms: 'accountability of the minister to the public, accountability of public servants to the minister, and accountability of Indigenous people to white Australia in general' (Sullivan, 2009, p. 58).

Street level work and policy activism

In spite of the personal and systemic constraints on professional agency it remains that street level workers' complex, highly skilled, and professionally autonomous policy contributions allow their agency to be used to advance alternatives to government policy priorities. Weber's 'ideal' bureaucratic 'type' where occupational expertise is conditioned by systemic rules and regulations (Germov, 2005) is therefore challenged. Indeed, professional autonomy positions Weber's (1958) conceptualisation of the bureaucracy as an 'iron cage' of control in a continuously evolving tension with people whose philosophically guided professional priorities can conflict with prevailing state paradigms and their attendant 'contradictions and resource limitations' (Wells, 1997, p. 333) at the points of policy delivery. Professional agency is enhanced when street-level workers account for relationships between personal political values and policy outcomes. One of the ways in which they do this is through their professional associations which are not, themselves, impeded by the bureaucratic obligations that may constrain their members' individual agency. Professional associations do not have bureaucratic loyalties, but they can respond to Giles' (2009) argument that the ideological disposition of street level workers is, itself, among the determinants of Indigenous health, with positive as well as negative potential. For example, in the field of social work, she explains that:

> By paying greater attention to the details of the relationship between social factors and physical and mental health, these present both challenges to current social work practices and opportunities for the profession to continue to advance, in collaboration with related professions, common goals of reductions in poverty, the alleviation of oppression and enhanced social equality; that is, the development in each practitioner of a health equality imagination that inspires action (p. 530).

Giles (2009) continues to propose that the explicit politicization of the social work profession to respond to 'discrimination and injustice' (p. 530) is a reasonable professional responsibility

that draws ideology, professionalism and political activism together to pursue substantive Indigenous rights. Her view is supported by health care's growing international acceptance as a human right, embodied in the Constitution of the World Health Organization (World Health Organization, 1946) among other international legal instruments.[7] Certainly, the Australian Association of Social Workers' Code of Ethics (2010) emphasises 'respect for human dignity and worth' on the basis that 'each person has a right to wellbeing, self-fulfilment and self-determination, consistent with the rights and culture of others' (p. 12). The medical practitioners' and nurses' codes are grounded in similar conceptions of social justice. For example, the Australian Medical Association (2004) Code precludes denying treatment 'because of a judgment based on discrimination', while the nursing Code requires that care is provided with 'just and due consideration' for 'ethnicity, culture, gender, spiritual values, sexuality, disability, age, economic, social or health status, or any other grounds' and that: 'Nurses respect and uphold the rights of Australian indigenous peoples' (Australian Nursing Council, 2002). These professional obligations give effect to the United Nations' *Declaration on the Rights of Indigenous Peoples*' (2007) insistence that:

> Indigenous peoples have the right to the full enjoyment, as a collective or as individuals, of all human rights and fundamental freedoms as recognized in the Charter of the United Nations, the Universal Declaration of Human Rights and international human rights law (Article 1)

and that

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[7] The Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination Against Women, the Convention on the Elimination of All Forms of Racial Discrimination, and the Convention on the Rights of the Child.

Indigenous peoples and individuals are free and equal to all other peoples and individuals and have the right to be free from any kind of discrimination, in the exercise of their rights, in particular that based on their indigenous origin or identity (Article 2).

In admitting these international positions professional bodies are, in fact, challenging the policy process' conditioning of Indigenous citizenship, and contributing to the mainstreaming of indigeneity as an alternative way of reducing the dissonance between policy-makers and Indigenous people (Maaka and Fleras, 2009). Professional associations can function as political lobby groups with capacity to engage in public debates even to re-define policy problems. For example, the AMAs annual 'report card' on Indigenous health combines professional expertise with 'street level' experience to make proposals and critiques that challenge government policy's philosophical presumptions and add to the complexities that governments experience in maintaining control of the Indigenous affairs policy agenda. The bureaucracy's 'power to direct any individual or section is attenuated by the subordinates' power to resist, resile or reinterpret' (Sullivan, 2008, p 138), which can be done indirectly through professional associations. For example, in 2007, a Government review of Shared Responsibility Agreements (SRAs)[8] found that:

Most communities appear in the main to be very supporitve.. [of the Agreements] and the… process. There is consistent positive feedback that this new way of working is very consistent with Indigenous customs, community traditions and values regarding working together, community and family obligations, and reciprocity (Department of Families, Communities and Indigenous Affairs, 2007).

The AMAs contrasting argument that the government's position was paternalistic and lacking in 'respect and equality' (AMA) was based on a fundamentally different philosophical position on the meaning of Indigenous citizenship, while the Australian Indigenous Doctors' Association's

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[8] Shared Responsibility Agreements were introduced by the Howard Government (1996-2007) to make Indigenous access to certain public services conditional on meeting specified 'mutual responsibilities' to the state.

critique of the Northern Territory Emergency Response (Intervention) argued that the Intervention 'overlooked the centrality of human dignity to health' (AIDA and Centre for Health Equity Training, Research and Evaluation, University of New South Wales, 2010).

The street-level bureaucrat's capacity to effect change can counter inadequacies, or even philosophical indifference, in policy design. In Canada and New Zealand, for example, policy environments more conducive to Indigenous self-determination provide greater scope for Indigenous health workers to work for the benefit of their own communities. In these jurisdictions, community controlled health services operate in policy environments where limited self-determination is uncontested and where a culturally competent workforce is admitted, practically and substantively as well as rhetorically, as preliminary to significant impact on health outcomes. As the associate Minister of Health and Maori party co-leader, Tariana Turia, put it to the University of Otago, Faculty of Medicine:

> Training and recruiting culturally competent staff to work with Maori is also vital if we expect Maori to use health services and if we expect that Maori health and well-being will improve. The Maori Health Committee of the Medical Council has championed the vision that cultural competence must be a core competency for physicians and paediatricians and that clinical competence requires cultural competence. In other words cultural competence cannot be separated from clinical competence in achieving best Maori health outcomes (Turia, 2013).

'Transformational leaders' are thus able to 'influence followers by elevating their goals beyond their own self-interest' to counter the bureaucratic development of health policy in the absence of 'a compelling vision' (Paarlberg and Lavigna, 2010, p. 711) of what ought to be achieved and to what end. In an overall sense, the street level worker's capacity to influence Indigenous health outcomes can be of negative consequence. However, where professional agency and ideological disposition suggest that street level work requires policy activism, there is scope for professional health workers to make significant contributions to improved health outcomes at the point of policy delivery.

Conclusion

The ways in which street level health workers exercise bureaucratic discretion and professional agency is among the political determinants of relative Indigenous ill-health. The ideologically contested nature of the Indigenous affairs policy environment means that there is considerable space for street level work to be carried out with reference to workers' own philsophical preferencs and priorities. State efforts to direct street level work in the Weberian sense are compromised by its conflicting policy objectives, which means that the street level worker's personal political values have increased opportunity to find their own intellectual space to influence the nature and quality of the care that is available to Indigenous peoples.

For many people the street level worker *is* the state. Their discretion and agency *becomes* government policy and the possibility that they might make decisions based on stereotypical assumptions about Indigenous peoples, grounded in deficit accounts of their relative ill-health, illustrates the significance of their role as policy actors. However, it is just as illustrative of street level capacity to influence, to admit that a philosophical commitment to social justice positions street level workers and their professional associations to make significant contributions to effective public policy capable of providing improved health outcomes to Indigenous peoples. In making choices about the ways in which they will use their professional skills, street level workers are taking a position on the contested understandings of the nature of Indigenous citizenship and the terms of Indigenous belonging to the nation state. Theoretical debates on these questions have implications for what Indigenous peoples might reasonably expect from the pubublic health system and *inter alia* from those who work within it.

The street level health worker is, then, a policy activist with considerable capacity to interpret, promote, resist or contribute to alternative policy paradigms from those sanctioned by governments.

CHAPTER FIVE

Human Rights

Introduction

Indigenous public policy is routinely critiqued for its inconsistencies with prevailing human rights standards. Indeed, the stolen generations policy was only able to proceed through a conscious setting aside of normative human rights and, by way of further example, the tension between indigenous health policy actors and the Council of Australian Governments (COAG) over the Closing the Gap policy is principally an intellectual contest over the relevance of human rights to indigenous political aspirations, in general, and specifically to indigenous expectations of the health system. Similarly, objections to the Northern Territory Intervention are not objections to its concern for protecting women and children from violence, but to its presumption that these protections depend, perversely, on authoritarian controls and racially discriminatory policy implementation. However, there is an alternative argument that advances in indigenous health and well-being require the unconditional and unconstrained acceptance of international human rights standards into contemporary policy discourse. These standards are not politically useful, on their own, as a normatively just framework for improving Indigenous peoples' health status, but when juxtaposed with the politics of indigeneity, inclusive citizenship (Chapter Six) and complemented by a capabilities approach to development (Chapters Seven and Eight) they help to express Indigenous claims in prevailing liberal democratic context and to 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, p. 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.

Human rights and the politics of indigeneity

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' (Ivison, Patton and Sanders 2000, p. 10). For example, indigeneity's concern for Indigenous political participation by 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, p. 129). In short, the politics of indigeneity resists the notion that neocolonialism 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, p. 106).

A dual or two-tiered citizenship (developed in Chapter Six) 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 colonisation has unalterably established. A two-tiered citizenship would be concerned, particularly, with the cultural and economic rights of Indigenous peoples, 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* (2007) and the ways in which it privileges Indigenous, over state, agency.

Institutions such as the Aboriginal Congress and Aboriginal Community Controlled Health Organisations (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 (World Health Organisation, 2005).

At the same time, Indigenous peoples' 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 rights 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, p. 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, p. 34). Therefore, it is important, by way of contrast, to note the complementary 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 among Indigenous health policy's distinguishing characteristics. The Commonwealth's most recent National Mental Health Policy, for example, 'recognises Indigenous people's distinctive rights to status and culture, self-determination and the land'

(Commonwealth of Australia, 2009, p. 7). Its alignment with cultural 'acceptability', within the human right to health (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' (Commonwealth of Australia, 2008, p. 13). However, the translation of these general principles into meaningful policy outcomes is inconsistent and contested — for example, most Indigenous people claim 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, '[h]ealth outcomes [remain]… a good measure of social and political processes' (Pham, Vinck and Weinstein 2010, p. 100).

Indigenous people constitute just 2% of the national population and have no guaranteed representation at any level of the political system. There is generally little electoral incentive for parliamentary candidates to attend to their concerns. Although Robbins (2010) takes an alternative and 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 the deeply contested nature of Indigenous affairs. 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, p. 129). Closing the Gap and the Intervention, discussed

later in this article, are examples that demonstrate the ideological underpinnings of policy conflict 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 being 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., p. 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 (Commonwealth of Australia, 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, p. 14).

Contemporary international law, with its emphasis on the Indigenous right to self-determination, provides a political counterbalance to the narrower postcolonial discourses that traditionally have not given adequate consideration to the conditions that 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 that 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, its endorsement of the *Declaration on the Rights of Indigenous Peoples*, and its commitment to closing the gap in Indigenous disadvantage. However, the Special Rapporteur noted weaknesses in policy coordination, 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, p. 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' (CRC, 2005, p. 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, p. 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' (Article 5), because 'the existence of racial barriers is repugnant to the ideals of any human society' (preamble).

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, p. 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 and the Intervention

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. Principles of neither 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.

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 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 Northern 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 the agency and acceptance of Indigenous people '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.

The Commissioner affirmed 'five integrated requirements' of a human rights approach to health. Although these were benign at the surface level, they actually reflected a radical departure from established policy practice. The five requirements 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 coordination; and ensuring Indigenous participation in the policy process (Calma, 2005). The Commissioner argued that developments over the last 10 years,

including greater coordination in service delivery, have established a foundation from which to realise 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 explains, the policy process itself is not sufficiently well informed to insist on an 'exact correlation between rhetoric and reality' (Lea, 2008, p. xv). Indeed, in 2008 developments in the Northern Territory led to policy makers being advised that '[w]e have new information systems being put in place but it will still take a few years for community-level data to be easily avaliable' (Lea, 2008, p. 118). While data are essential, the solely statistical measures of policy progress for Closing the Gap 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 contextualised by the observation that 'many of these disparities occur in areas that are considered to be unquestioned rights to all other Australians' (Behrendt, 2001, p. 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' (Pholi, et al., 2009, p. 1). Nor does it exhibit what the Human Rights and Equal Opportunity Commission (now the Australian Human Rights Commission) described as the principal policy strength of the human rights approach: transcending 'rhetorical acknowledgment' of a problem and non-specific solutions (Calma, 2005, p. 48). The question

then becomes one of what theoretical shifts human rights can promote to allow Australia to admit the foundational assumption of the *United Nations' Charter* (1945) 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 Article 25 of the Universal Declaration of Human Rights:

> Everyone has the 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.

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 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' (Langton, 2011, p. 1). She points out that improvements in Indigenous health require community leadership, which is 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 2006, p. 160). These instances of social breakdown explain Sutton's 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' (Sutton, 2009, 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 conceptualising 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; a concept that is discussed in depth in Chapters Seven and Eight.

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. 338–39).

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. It removes health

from 'the domain of charity or largesse' (London and Schneider, 2012) and, in an Indigenous context, from the often emotionally and prejudicially charged domestic environment to one given considered international authority.

The *Universal 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.

The D*eclaratio*n 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, p. 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 for Health Promotion* (1986) outlines the 'fundamental conditions and resources for health' as 'peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity'. Further, '[t]o 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' (*Ottawa Charter*, 1986). Further still, the UN Millennium Development Goals (2000) provide

perspectives on the multi-sectoral nature of health as a universal human right. The eight 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.

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' (*Vienna Declaration and Programme of Action*, 1993). Indeed, the *Vienna Declaration* positioned human rights and fundamental freedoms as 'the first responsibility of governments', being 'widely regarded' as an international 'consensus on the moral primacy of human rights over other public interests' (Gagnon and Labonte, 2011, p. 195). For Indigenous peoples, these are realised 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 in which shared humanity is privileged in ways that do not admit colonialism's ongoing 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.

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 Article 20 with 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.

Inclusive and substantive deliberative arrangements challenge the prevailing character of liberal democratic citizenship 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, p. 13). Fraser describes this as 'participatory parity' that 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' (Fraser 2003, p. 36). Procedural fairness in decision making is essential to setting aside 'misrecognition', which is 'constituted by *institutionalized patterns of cultural value* in ways that prevent one from participating as a peer in social life' (Fraser, 2003, p. 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' that potentially strengthen the link between policy formulation and implementation (Ivison, p. 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, in which 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. Boards are required to

include Maori representatives and to improve Maori health outcomes (s. 3), while s. 23 requires

Boards to

> (d) to establish and maintain processes to enable Maori to participate in, and contribute to, strategies for Maori health improvement:
> (e) to continue to foster the development of Maori capacity for participating in the health and disability sector and for providing for the needs of Maori
> (f) to provide relevant information to Maori for the purposes of paragraphs (d) and (e):

Inclusive deliberative arrangements challenge the prevailing nature of liberal democratic citizenship and confirm that 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, p. 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, p. 1).

Inclusivity is possible through a form of postcolonial liberalism that is 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' (Ivison, 2002, p. 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, p. 1).

Culture is among the more significant points of contention in Indigenous health policy. 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' (Ivison, 2002, p. 47). As Ivison explains:

> 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 (Ivison, 2002, 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, as it was mentioned in Chapter Three, 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' that 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, p. 1453).

Carter et al. (2009) provide examples of attitudes to cancer treatment that reflect policy preferences for an assimilationist narrative that contextualises citizenship as giving equal rights to all, provided that those rights can be expressed without particular regard for indigenous minority populations. Alternatively, the universality of human rights 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 places the relationships among economic imperatives, health and human rights into pragmatic context by noting that '[f]or people who participate in the economy, ill-health is only a minor consideration during their first seven or eight decades' (Pearson, 2001, 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 to 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 analytical potential of the human rights framework 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 the policy's deeply ideological character — which, in turn, limits the construction of principled and informed measures equipped to improve health outcomes. These examples of domestic ideology diminishing 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 of responding to the particular difficulty that Australian liberalism has 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.

CHAPTER SIX

Citizenship

Introduction

Complex and multifaceted historical, political, cultural and sociological variables explain the life expectancy differential between indigenous and other Australians. Citizenship provides neither a theoretical nor practical policy panacea for the complexities that distinguish indigenous health policy, but it does provide an instructive theoretical framework for thinking about alternatives to prevailing unsuccessful policy arrangements. In particular, one might consider a differentiated or two-tiered model of citizenship to rationalise indigenous political claims and aspirations within a liberal paradigm so that health policy might be constructed to reflect indigenous people's substantive enjoyment of the same rights and privileges of all citizens, but in preferred cultural context and in cognisance of particular socio-political and historical circumstances.

Citizenship provides an informative analytical lens to describe and explain policy measures and their possible contributions to health differentials, even as from an indigenous perspective, citizenship may be under conceptualised, unresponsive and ill-equipped to respond to history's impact on the terms of indigenous 'belonging' to the modern liberal state. These are the limits on agency that universal, undifferentiated citizenship can impose by diminishing indigenous political voice and deliberative capacity with reference to their own needs and aspirations. Instead, public policies that transcend the goals of distributive justice are required to respond to the underlying values and power relationships inherent to Australia's neo-colonial context, where there is logical inconsistency in the expectation that indigenous peoples' accept undifferentiated citizenship when they have never been asked to consent to the transfer of political authority from

themselves to the modern state. The absence of consent contextualises indigenous claims to political recognition (Robbins, 2010) and provides an underlying explanation for uniform citizenship's incapacity to provide equal opportunities to *all* peoples. Yet, just how differently indigenous peoples need to be treated for citizenship to acquire substantive meaning in the exercise of rights, obligations and opportunities is contested, and is an important concern in liberal theory's application to contemporary indigenous health policy.

Citizenship needs to be conceptualised to provide scope for indigenous peoples to work out what they want from the health system and claim it in an ordered, systematic and meaningful fashion. To this end, the politics of Indigeneity rationalises a 'two-tiered' or 'differentiated' construction of liberal citizenship to allow Indigenous people to claim the same rights and privileges that all citizens enjoy, but in preferred cultural context and in cognisance of particular socio-political and historical circumstances, to include the promotion of active democratic participation. The second tier of citizenship is a complementary one involving membership of one's indigenous nation.

The Chapter compares and evaluates examples of contemporary indigenous health policy with reference to conceptions of citizenship before proposing active indigenous citizenship 'beyond the welfare state' as an important expression of the concept, but one that still falls short of the possibilities that differentiation allows in Canada and New Zealand, for example, where the indigenous populations enjoy relatively better health.

Citizenship

The Commonwealth Constitution was amended in 1967 to allow the Federal Government to make laws for indigenous people and count their numbers in national population census'. Although the referendum was not the event that extended citizenship to indigenous people it

assumed that 'mantle' because it helped to give substance to what had previously been an 'empty category' (Chesterman and Galligan, 1997). It ensured protectionism's discontinuance as an official policy goal and was a catalyst for assimilationist policies' gradual discrediting. However, it simultaneously legitimised the neo-colonial state (MacDonald and Muldoon, 2006) to ensure that citizenship's terms are contested, sometimes conditional, exclusively framed and passively experienced. The legal extension of substantive citizenship rights was not absolute as prevailing political understandings of the concept determine what it means, in practical terms, to be a member of a common community.

Although indigenous peoples are not 'powerless victims' (Rowse 1998), they are not collectively, in practical terms, 'equal citizens' of a liberal egalitarian democracy, with equal opportunities for substantive political participation, which is important because:

> In the absence of a Philosopher King who reads transcendent normative verities, the only ground for a claim that a policy or decision is just is that it has been arrived at by a public which has truly promoted the free expression of all (Young, 1989, p. 263).

Participation is a necessary constituent of citizenship because through participation people can promote and defend their individual and collective interests and contribute to the development of shared national interests. If citizenship is to acquire substantive meaning for indigenous peoples it needs to draw contrasting perspectives together to provide a coherent and just account of the rights and responsibilities that stem from 'belonging' to the nation state. The purpose of citizenship can, then, be realised by reconciling the liberal concern for the individual with indigeneity's concern for group aspirations and a particular share in national sovereignty.

Citizenship can separately or simultaneously dominate, or empower (Isin, 2009), and is neither abstract, nor politically neutral. Its construction is the product of considered political choices including, perhaps, the exclusion of some people from substantive democratic liberties. Its

meaning evolves with political values and with the changing ways in which societies re-balance competing political demands and people's shifting expectations of the state.

Citizenship is ideally the outcome of politically negotiated consensus 'rooted in a continual re-negotiation of the political forms of the body politic as a whole' (Cornwall et al. 2011, p. 27). However, the idea of 'societal consensus' necessarily pre-supposes just deliberative processes and relational justice between the most and the least powerful, whose perspectives are best accommodated through the conscious acceptance that citizenship is properly concerned with particular as well as general claims about the nature of belonging and perspectives of the common good. Indeed, it is doubtful that a truly objective general perspective of the common good can actually exist. A general perspective is obscured as citizenship resides 'in a multiplicity of spaces, across different experiences of democracy', which transcends the allegedly 'static binaries of state/civil society, universal/particular, individual/society' to allow 'a fuller and more nuanced understanding of citizenship precisely because it is able to attend to the contingencies of everyday life' (Cornwall *et al*. 2011, p. 27).

Ideological presumptions are prior to policy development and the sharply contested nature of citizenship itself means that successful public policy ought to 'be based on a self-conscious awareness of competing principles' (Sanders and Hunt, 2010, p. 235). In this way, policy can concern itself with what it actually means to be a citizen; does citizenship imply universal rights, can it admit differentiated claims of first occupancy, can it be structured to mitigate against colonialism's impact on indigenous political agency? Can rights be conditional on people behaving in prescribed ways? It is on these questions that Australian politics remains profoundly confused. As this Chapter will show, contemporary public policy simultaneously answers each in

the affirmative as well as in the negative, even as it admits that: 'Racism is not rare and it is not harmless' (*The Australian* 27 July 2013).

Differentiated Citizenship

Policy development routinely proceeds on the assumption of the moral propriety and practical efficacy of undifferentiated liberal egalitarian justice. Alternatively, there is an argument that neo colonial conceptions of justice are well removed from the Rawlsian ideal that:

> In the original position, the principles of justice are decided upon by free and equal citizens who do not know their own social status, class position, psychological tendencies, endowments of natural abilities or even their own beliefs about what is good (Hunter and Jordan, 2009, p. 7).

There are strands of indigenous political thought that seek to align this liberal position with the politics of indigeneity to propose differentiated two-tiered citizenship as a concept of considerable significance in health, among other policy domains.

Differentiated citizenship 'is a radical development in citizenship theory' (Kymlica and Norman, 1994, p. 370), while the politics of indigeneity intends a particular conceptualisation of citizenship where indigenous people are positioned, not as disadvantaged individuals deserving the benevolence of the welfare state, but as peoples whose cultures and political rights are not absolutely and fully extinguished by the colonial deprivation of sovereignty. The politics of indigeneity does not, ordinarily, challenge the existence of the Australian state, but it does challenge one culture's positioning of itself as providing the sole normative basis for the conduct of public affairs. It ordinarily claims self-determination as a relative and relational, rather than isolationist concept, and proceeds on the rejection of 'domination and subjugation as the foundation of political order' (O'Sullivan, 2007, p. 7). The politics of indigeneity is concerned with rights that predate citizenship, itself, but that seek to shape its contemporary form and practice to ensure indigenous deliberative agency in public decisions and the greatest possible

level of independent authority over their own affairs (O'Sullivan, 2007). From this perspective, rights to culture and particular political authority provides the terms of indigenous 'belonging' to the liberal state *and* to their own communities with different, but complementary, rights and obligations arising from each.

Differentiated citizenship contests the notion of sovereignty residing in a single Leviathan-like entity. It responds to the idea that sovereignty is, in fact, widely dispersed and shared among the different tiers of government, government agencies and the various civil bodies that practice indigenous self-determination. Its principal justification is that citizenship, itself, is experienced differently.

Citizenship of an indigenous nation may be distinguished by land rights, effective and culturally cognisant education and the capacity to use traditional natural resources for economic as well as cultural purposes and to define health and well-being in one's own terms and to receive health services in those terms. In respect of primary health care the National Aboriginal Health Strategy Working Party (1989) accepted the World Health Organisation's (1978) advocacy of:

Essential health care based on practical, scientifically sound, socially and culturally acceptable methods and technology made universally accessible to individuals and families in the communities in which they live through their full participation at every stage of development in the spirit of self-reliance and self-determination.

A construction of citizenship reflecting these principles could develop with reference to the National Congress of Australia's First Peoples' (2013) understanding of relationships among culture, self-determination and health:

Health for Aboriginal and Torres Strait Islander people focuses not only on physical health but also encompasses spiritual, cultural, emotional and social wellbeing. Health is more than the absence of sickness; it is the relationship with family and community, providing a sense of belonging and a connectedness with the environment (p. 4).

Differentiated citizenship is concerned with 'attachment' as well as welfare entitlements (Kymlica and Norman, 1994, p. 2). Attachment describes the geopolitical character of claims to cultural cognisance in health care, and Dockery's (2011) analysis of the 2008 National Aboriginal and Torres Strait Islander Social Survey found positive correlations between land and culture and general well-being to suggest that differentiated citizenship profitably allows the expression of universal rights in geopolitical and historically conditioned circumstances, and to show that political principles cannot, therefore, be developed on the assumption of an already just society (Young, 1989). A just society presumes these culturally contextualised rights to sit alongside the substantive recognition of indigenous peoples as members of the political community with, among other considerations, the same opportunities for deliberative engagement that other citizens enjoy. Deliberative agency ought to position indigenous peoples as 'part of the [policy] solution, not a gathering of problematic and pathologically failing individuals or helpless victims in the grip of economic and historical forces beyond their control' (Brannan et al., 2006, p. 996).

The extent to which citizenship is, and ought to be a differentiated right is not broadly accepted in public policy discourse, and its general acceptability depends on its capacity to remain, obviously and coherently, within a liberal framework. It is also significant that a political theory grounded in individual liberty cannot admit state paternalism or the exclusion from decision making processes that assimilationist policies necessarily require.

The argument that differentiation precludes citizenship itself from serving as 'a device to cultivate a sense of community and common sense of purpose' (Heater, 1990, p. 295) overlooks the possibility that in its undifferentiated and universal form citizenship has actually acted

against the 'ideal of community and common sense of purpose', because it does not admit that *all* people, not just *some* people, must be involved in negotiating those aspirations.

Undifferentiated citizenship cannot admit the depth of the indigenous claim to self-determination. Its failure to accept distinct indigenous identities (MacDonald and Muldoon, 2006) is why its broad and multifaceted significance to health is distinguished by complexity and contestability. It is in this context that Kickbusch (2005) provides only an aspirational, rather than substantive, description of the citizen as one who acts

> as an individual who takes care of her own health, as a consumer in the health market place, as a patient in the health care system, as a voter on health care issues, and as a social actor together with others in NGOs and social movements (p. 101).

As a statement of aspiration, the description is one that sets out some of the missing constituents of indigenous deliberative agency. It suggests some of the ways in which debates about health policy are necessarily debates about citizenship, concerned with 'inclusion and exclusion' as well as 'values and social justice' (Kickbusch, 2005). If 'the key value remains the empowerment of the citizen and the acceptance of health as a public good' it follows that:

> The healthy society needs the active involvement of citizens, patients' organisations, health literate consumers and social movements in order to avoid the increased privatisation of risk and to counteract the establishment of health as only a market value (Kickbusch 2005, p. 102).

These are among the justifications for the expression of citizenship in cultural context and with reference to indigenous peoples' neo-colonial political positioning vis-à-vis the state. They constitute the justifications for the proposition that the political integrity of the nation state does not require cultural homogeneity, nor homogeneity in the form and expression of political relationships.

Citizenship and Policy

Closing the Gap in Indigenous Disadvantage and the Northern Territory Emergency Response (the 'Intervention') are the most important contemporary Indigenous health policy measures. Their underlying philosophical presumptions are state-centred and reflect an exclusive account of indigenous citizenship, where indigenous peoples' deliberative capacity is constrained.

In contrast, measures such as Overcoming Indigenous Disadvantage (Banks, 2009), the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (2003), and the *National Aboriginal and Torres Strait Islander Health Pan* (2013) show self-determination's residual influence on indigenous health policy and provide scope for extending self-determination's possibilities through differentiated two-tiered models of citizenship, where indigenous people are simultaneously members of the nation state and members of their own political communities with complementary, but different, rights and obligations arising from each.

Self-determination replaced assimilation as official government policy from the 1970s, which meant that, at least officially, substantive citizenship was no longer dependent on the acceptance of a state approved 'white' lifestyle (Attwood 2005). Various models of self-determination have since been adopted and rejected, but it was always a limited and conditional understanding that assumed policy influence.

The most significant institutional expression of differentiated citizenship, through self-determination, was the Aboriginal and Torres Strait Islander Commission (ATSIC) established in 1990 and abolished in 2005 partly due to allegations of corruption among Commissioners, but also because of the Prime Minister, John Howard's view, that measures of this kind create national 'fragmentation' (Howard, 1995). However, Parliamentary apology to the stolen

generations, moved by the new Prime Minister, Kevin Rudd, in 2008, marked a turning point in government policy thinking (discussed in Chapter), and was an important statement in favour of a more inclusive citizenship, where differentiation provides one way of integrating 'substance' with the 'symbolism' that the apology advanced. As Rudd put it 'our challenge for the future' requires the development of a 'bridge based on… real respect' and 'a new partnership' between indigenous and other citizens (Rudd, 2008).

Moses (2011) argues that most indigenous people interpreted the apology as fundamentally changing the nature of their 'belonging' to the nation state: 'the indigenous sense of participating in the Australian national story as respected equals now seemed palpable' (p. 155), and attempts to frame post apology debates in terms of a 'resistance/co-option dichotomy' misrepresented the political options open to Indigenous peoples (Moses, 2011, p. 145), whose political arguments 'transcend' the 'dichotomy' by challenging 'mainstream liberalism, in particular, to account for difference beyond platitudes about toleration' (Moses, 2011, p. 146) and to accept that it is unjust that equal universal citizenship has not translated into equal political rights and opportunities, nor has it provided indigenous peoples with equal capacity for good health, as health policy is influenced not just by scientific possibility or fiscal capacity, but by political acceptability (Moses, 2011). Indeed, with the passage of almost 6 years since the apology, the extension of the 'Intervention' and the time taken to admit indigenous views into the Closing the Gap policy, one finds that the claim to differentiated citizenship remains polarised. However, the debate is certainly not settled and the search for new and more effective ways of drawing indigenous perspectives and aspirations into policy debates remains important.

The impact of policy's failure to differentiate is that public services and measures of success are not always targeted to the needs and aspirations of a particular community, which is

important because both internationally, and domestically, indigenous peoples maintain that opportunities for good health include access to culture and economic security, not as benevolent state indulgences, but as rights that inhere from indigeneity itself. The argument draws authority from the United Nations' *Declaration on the Rights of Indigenous Peoples*, which recognises:

> the urgent need to respect and promote the inherent rights of indigenous peoples which derive from their political, economic and social structures and from their cultures, spiritual traditions, histories and philosophies, especially their rights to their lands, territories and resources (United Nations, 2007).

History, too, is among the variables that explain contemporary political agency, so it is a matter of justice, for public policy and its underlying political arrangements to consider ways of bringing greater balance to the political relationships between indigenous peoples and the state.

The claim to a more balanced division of political authority means that indigenous political claims cannot be satisfied by the argument that 'the fullest expression of citizenship requires a liberal democratic welfare state' (Kymlica and Norman, 1994, p. 354). Indeed, 'social and political rights associated with TH Marshall's (1950) classic account of citizenship speaks very little to the realities faced by growing numbers of the world's population' (Nyers, 2004, p. 203).

The welfare state's concern for needs based entitlements does not attend to the differentiated political factors that create 'need'. Nor does it recognise that welfare entitlements do not, themselves, enhance personal agency or the capacity to challenge the circumstances that have created material need. Indeed, there are strong indigenous arguments (Anderson, 2012; Langton, 2008, 2011; Pearson, 2000, 2005) to support Barry's (1990) observation that while welfare keeps people from poverty, it does not promote active citizenship, which is important for the concept to serve a transformative function and especially significant for indigenous people whose unemployment rate of 17.2% is slightly more than three times the non-indigenous rate of 5.5%. The indigenous populations' age structure contributes to there being a further 44.1% (compared

with 23.6% of the non-indigenous population) of the indigenous population neither working nor seeking work (Australian Bureau of Statistics, 2013).

The level of indigenous non-engagement in the labour market indicates that the system has not, in fact, ensured that every person feels full inclusion in a common society (Kymlica and Norman, 1994). Yet, full inclusion is inherent to the welfare state's general presumption that 'access by all citizens to comprehensive health care… [is] axiomatic to securing a basic degree of social inclusion, cohesion and equality' (Milewa, 2004, p. 240). Although problematic in the ways discussed in Chapter Three this overarching objective of 'Closing the Gap in Indigenous Disadvantage' is accepted by the Abbott Government, even if within two months of it assuming office NACCHO was beginning to query the Government's interest in complementing the objective with substantive policy measures (NACCHO, 2013).

Differentiated citizenship responds to 'the need to supplement (or replace) the passive acceptance of citizenship rights with the active exercise of citizenship responsibilities and virtues, including economic self-reliance, political participation, and even civility' (Kymlica and Norman, 1994, p. 355). Similarly, the former British Prime Minister, Tony Blair, promoted community involvement in health services as an 'active politics' justified on the grounds that 'if people feel they have no stake in society, they feel little responsibility towards it, and little inclination to work for its success' (Blair, 1996).

Rather than justifying only the passive receipt of liberal rights, citizenship constitutes

a common political identity of persons who might be engaged in many different communities and who have different conceptions of the good, but who accept submission to certain authoritative rules of conduct (Mouffe, 1992, p. 30).

Indigenous submission to these rules is not necessarily voluntary. However, their ideal political value is to provide a normative framework for protecting personal capacity to choose and pursue 'purposes of their own' (Mouffe, 1992, p. 31).

Citizenship is important to the politics of health because it makes assumptions about obligations and entitlements which are, in turn, influenced by the ways in which people are accepted as 'full members of a community' (Marshall, 1963). However, if citizenship's obligations include taking 'part in constructing and maintaining [the] community' (Meehan 1993, p. 177), administrative arrangements conducive to substantive community participation must prevail. In this context, the state's failure to confront passive welfare has created political space for indigenous actors to re-shape debates on the meaning of indigenous citizenship to give people opportunities for self-responsibility and deliberative engagement in policy development. For example, Pearson (2000, 2005) understands active indigenous citizenship as requiring participation in the 'real economy' as an opportunity that is not routinely available to indigenous Australians which, in turn, compromises the concept's intended universality.

Alison Anderson, an indigenous former Minister in the Northern Territory government makes the same argument. For Anderson (2012), the absence of personal agency

is something else that shows what it means to be Indigenous in the Northern Territory… It does not have to be that way, you can be different and still have choice and that means being different and strong, not different and weak.

Anderson's aspirations require complex and comprehensive policy responses premised on a view of citizenship as capacity. However, capacity is inconsistent with the Intervention, which equates

Indigenous culture with Indigenous pathology - or, in other words, resolving the apparent tension between difference and equality by identifying difference as the cause of statistical inequality, dysfunction and disadvantage (Anderson, 2012).

One outcome of pathologising indigenous peoples in this way is social exclusion and alienation from the health system in response to 'two central tensions' in indigenous development: 'the tension between cultural differences and statistical equality, and the problem of marginalised identities' (Kowal and Paradies, 2010, p. 7). Public policy that positions 'Indigenous difference as the problem to be fixed' (Ingamells, 2010, p. 10) is relationally unjust as it denies people the opportunity to set their own aspirations and relies on the interpretation of citizenship as sameness. It helps to explain why 'it remains in the psyche of the Aboriginal people that mainstream services are only there for other people' (Taylor et al., 2010, p. 7).

'Closing the Gap' was founded on the same assumption of a tension between equality and difference, where the state 'looks for mainstream solutions to deeply entrenched non-mainstream problems… partly because it does not recognise colonial history and the sheer diversity of contemporary Indigenous circumstance' (Altman, 2009, p. 1). Altman (2009) continues that:

> Balancing the need for a framework based on equality and difference is currently beyond the capacity of the Australian state, where the dominance of the equality approach based on the liberal principles of individualism and unfettered economic growth is overpowering a subordinate culturalist discourse that values diverse life worlds and resistance to transformation and modernisation (p. 1).

In contrast, differentiated citizenship provides ways of thinking about equality *and* difference as compatible and achievable, so that: 'Through the principle of equivalence, a type of commonality is created that does not erase plurality and differences and that respects diverse forms of individuality' (Mouffe, 1992, p. 32), allowing one to consider 'theories of justice… centrally concerned with whether, how, and why persons should be treated differently from one another' (Okin, 1987, p. 42).

Indigeneity and Active Citizenship

Citizenship is a relational concept. It does not require shared appreciations of the common good. It simply requires agreement on the ways in which each might pursue his or her conception of the good so that one can still seek agreement on just terms of association and set aside the proposition that homogeneity is necessarily preferable to plurality.

Political arrangements to maximise indigenous peoples' authority over their own affairs are the basis of the 'personal sovereignty' that all people require to make choices consistent with good health. It is in this context that Aboriginal Community Health Organisations, the National Congress of Australia's First Peoples and indigenous professional bodies give indigenous civil society increasing policy significance, and new public management's policy prevalence in the field of public service delivery creates scope for private and civil actors to enter the indigenous market for primary health services not so much as 'shadow state' (Lake and Newman, 2002) organisations responding to the state's inattentiveness to duty, but as entities that express differentiated citizenship, as self-determination. In this sense, the 'shadow state' can be positively constructed as an indigenous one giving expression to a liberal theory of indigeneity, where although the state 'doubtless stands in an asymmetrical position of power vis-a-vis Indigenous groups' indigenous peoples are at least able to 'co-administer government schemes and are not just their passive objects' (Moses, 2011, p. 155). These benefits remain even as there are legitimate 'concerns about how the sector is supported, both to deliver services and to effectively engage as a strategic partner' (Marmot et al., 2010, p. 160).

Political 'voice' is the means through which people express their historically contextualised and culturally mediated political agency. However, although they are important, the measures described in this Chapter do not reflect the politics of indigeneity's full aspirations for political

voice through differentiated citizenship, to the same extent that occurs in other jurisdictions, where the politics of indigeneity's concern for the nature of indigenous belonging to the state, transcends even the arguments of the native Canadian scholar, Taiaiake Alfred, that the rights of indigeneity are the 'benefits accrued by indigenous peoples who have agreed to abandon their autonomy in order to enter the legal and political framework of the state' (Alfred, 1999, p. 140).

Indigenous Australians have never 'agreed to abandon their autonomy'. Their consent to the establishment of a colonial society was never sought. While there may well be pragmatic acceptance that there are limits on the extent to which autonomy can be reclaimed, that is not the same as acquiescence to neo-colonial authority. 'Entering the legal and political framework of the state' is not an accepted trade off for traditional authority but is a political strategy for claiming a share in the governance of the state, as the Canadian Nisga'a First Nation does by drawing 'heavily on the linkage in liberal theory between citizenship and the modern nation' (Blackburn 2009, p. 70) to explain the ways in which 'people simultaneously experience and claim differing sets of rights and forms of belonging' and to express the 'legal entitlement of particular groups to different rights in addition to individual rights' (Blackburn 2009, p. 66).

The Nisga'a nation uses the term citizenship 'purposefully to signal that they are not just one more element in Canada's multicultural mosaic.' The terms citizenship and nation are used as 'tools of identity and struggle in ways that have challenged the normative force of these concepts; they have also disrupted the relationship between citizenship, nationhood and sovereignty' (Blackburn 2009, p. 76) to develop ways of creating a particular indigenous share in national sovereignty. It is a theoretical construct developed to recognise distinctiveness and differentiation within a single state. The Nisga'a Treaty confirms self-government, including a representative Health Authority to provide primary health services, pharmaceuticals and medical

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and dental insurance (Nisga'a Valley Health Authority, 2013). The Treaty recognises Nisga'a people as a distinct political community within the Canadian state which, in practice, means that indigenous rights exist alongside national citizenship rights, with neither subservient to the other or at the exclusion of the other. Consequently, the state is no longer the sole source of political authority and state citizenship is no longer the only officially recognised form of political identity. Although not weakening traditional national sovereignty, these foundational principles give the Nisga'a nation the right to be 'different and apart' and thus enjoy independence on the one hand and, a distinct share in national sovereignty, on the other (Maaka and Fleras, 2005).

Differentiated New Zealand Maori citizenship recognises 'not only their status as citizens but also their status as tangata whenua or first peoples', because as MacDonald and Muldoon (2006) put it: 'Maori were not just an ethnic minority but signatories of a Treaty that acknowledged their prior ownership and sovereignty' (p. 214). Although there is no Treaty or instrument of similar domestic authority concerned with the rights of indigenous Australians, measures such as the United Nations' *Declaration on the Rights of Indigenous Peoples*, justify and help to develop a theoretical account of citizenship that is similarly recognisant of rights grounded in first occupancy (United Nations, 2007).

The bounds of liberal possibility are extended, when rather than connoting membership of a single national community, citizenship describes relationships among *all* members of the national polity, so that each is a 'deliberator' as Aristotle (1988) conceived it and 'becoming a citizen can mean 'adopting modes and forms of being an insider (assimilation, integration, incorporation), but equally it can mean challenging these modes and forms and thereby transforming them (identification, differentiation, recognition)' (Isin, 2009, p. 372). An outcome of the right to deliberate is the opportunity to be 'heard' in political discourse under

arrangements that presume and require that all participants are willing 'to listen seriously to a range of views which, given the diversity of liberal societies, will include ideas the listener is bound to find strange and even obnoxious' (Galston and Galston, 1991, p. 227).

Maori deliberative opportunity is provided by guaranteed representation in Parliament and on District Health Boards, a succession of Maori ministers in the health portfolio and the jurisprudential significance of the Treaty of Waitangi all support the argument that 'group representation is the best antidote to self-deceiving self-interest masked as an impartial or general interest' (Young, 1989, p. 229). Through such measures liberalism avoids the tendency to exclude in recognition of the argument that if the citizen is one who 'deliberates' (Aristotle 1936), the alternative is a 'radically incomplete and stunted being' (Oldfield, 1990, p. 187).

In New Zealand Maori parliamentary representation and ministerial appointments moderate the state's coercive capacity over Maori people because they ensure that policy priorities are set with significant Maori input. Maori parliamentary and ministerial representation also contributes to the Treaty of Waitangi having sufficient status to help conceptualize and contextualize the right to health care in ways that respond to Ruger's concern that giving effect to a human right to health care is compromised by difficulties 'in determining the scope and content of such a right' (Ruger, 2006, p. 312).

The Treaty of Waitangi is an agreement signed in 1840 between the British Crown and the Chiefs of the United Tribes of New Zealand. It legitimized the establishment of colonial government, while affirming certain Maori cultural, property and participatory rights. A succession of political and jurisprudential developments since the 1970s has confirmed its contemporary significance (Orange, 1987). It is, for example, noteworthy that in 'order to recognise and respect the principles of the Treaty of Waitangi', the *New Zealand Public Health*

and Disability Act 2000 'provides for mechanisms to enable Maori to contribute to decision-making on, and to participate in, the delivery of, health and disability services' (*New Zealand Public Health and Disability Act, 2000*, section 4). The Act assures Maori representation on District Health Boards and requires that they work with Maori communities to establish local priorities and report to parliament on their contributions to improvements in Maori health (*New Zealand Public Health and Disability Act 2000*), while in New South Wales which contains around one third of the indigenous Australian population and has the greatest number of indigenous residents of any Australian jurisdiction, there is no mandatory indigenous representation on Local Health District Boards. A review of health governance in 2011 did not address the constitution of these Boards and in her report to the Minister of Health, *Future Governance Arrangements for NSW Health*, the Director-General of Health did not include an indigenous entity among those listed as consulted for the review (NSW Health, 2011). Governance arrangements in New South Wales require Local Health District Boards to enter into service agreements with NSW Health and, by way of example, the Western NSW Board's 51 page agreement devotes just half a page to indigenous health and offers no account of how it will meet its two goals in this area of working 'collaboratively with the Ministry of Health, and Aboriginal Community Controlled Health Services to achieve the targets for "Closing the Gap" in Aboriginal Health' and to continuing to 'work towards achieving the target of 2.6% Aboriginal and Torres Strait Islander employment in the health system by 2015 (NSW Health, 2013, pp. 20-21).

In New Zealand, Maori are routinely represented on professional registration boards that are required to establish measures of cultural competence as part of their professional certification procedures (*Health Practitioners' Competence Assurance Act 2003*). Maori-established primary

health organizations are able to contract with District Health Boards to provide primary services, in similar fashion to the contractual relationships that ACCHOs enjoy with state funders in Australia. The assimilationist paradigm is consequently challenged and is consistent with Durie's (2008) proposal of 'pathways' for the realization of Maori health goals, to create space for the exercise of self-determination in health care alongside the proposition that the state ought to take more culturally responsive approaches to health service delivery. The right to culture is an essential claim of the politics of indigeneity. If culture is a determinant of health there emerges a multidimensional case for reducing the cultural dissonance between health providers and indigenous patients. In 2010, the New Zealand government began implementing Whanau Ora (family well-being) as a comprehensive policy measure to integrate the provision of government services to Maori families in ways that are consistent with cultural values and priorities. Whanau Ora is a policy initiative of the Maori Party, a junior partner in the coalition government, which addresses relationships between culture, economic security and political participation as determinants of health and broader well-being. The relationships implicit in the policy goals are that:

- The role of whaanau [families] as agents for promoting healthy lifestyles are to be endorsed and supported.
- Full whanau participation in society is to be recognized as a right of citizenship.
- Confident whanau participation in te ao Maori [the Maori world] is to be encouraged as a pathway towards Whanau Ora.
- Economic planning for whanau aim to generate levels of security and wealth that will offer certainty for current and future generations (Ministry of Social Development, 2010, p. 48).

New Zealand's policy process, which allows the philosophical paradigm implicit in Whanau Ora to command significance, means that it comes much closer than Australia to reflecting the ideal that:

> Those who hold different conceptions of justice can, then, still agree that institutions are just when no arbitrary distinctions are made between persons in the assigning of basic rights and duties and when the rules determine a proper balance between competing claims to the advantages of social life (Rawls, 1971, p. 5).

This ideal indicates the philosophical breadth required to support the development of a culturally respectful health system involving indigenous people in setting priorities and determining and allocating public budgets, which is justified because 'the capability of persons to determine and justify their own actions, with their ability to determine among alternative political programmes' is the 'core of the modern liberal democratic project' (Held, 1995, p. 149). Conversely, exclusive political arrangements diminish indigenous opportunities for substantive policy engagement, and the idea that a citizen is one who participates in public deliberation (Aristotle, 1988) is compromised.

Conclusion

Citizenship provides an instructive lens for thinking about the political variables that help to explain indigenous Australian relative ill-health. It helps to describe, explain and respond to the nature of indigenous 'belonging' to the neo-colonial liberal democratic state. The terms of 'belonging', in fact, describe citizenship's limits, conditions and opportunities and constitute a significant philosophical influence on how, why and by whom particular policies are developed and implemented. Citizenship is concerned with deliberative opportunity which means that it transcends the access to the welfare state that has often been the extent of its substantive meaning for indigenous Australians.

Citizenship's unresponsiveness to the rights and aspirations that indigenous peoples claim is principally explained by the concept's universal and undifferentiated character, yet there is scope within liberal political thought for differentiation of a kind that would allow indigenous people to claim an active and substantive citizenship where policy could develop with greater attention to

social values and priorities, and with greater responsiveness to the particular and immediate needs of a given community.

CHAPTER SEVEN

Capabilities and Freedom

Introduction

Relative ill-health requires far-reaching, complex and multifaceted policy responses. Theories and instruments of international human rights, and differentiated accounts of citizenship, are among those that have helped to shape responsive policy discourses. However, developing these often abstract rights into people's substantive capacities to make meaningful choices about how they will live and make decisions commensurate with good health benefits from the incorporation of Sen (1999) and Nussbaum's (1987, 2003) capabilities approach to development. Nussbaum develops the capabilities approach with reference to Aristotle's (1936) concern for 'human flourishing' – an interpretation of human capabilities that can be juxtaposed with the politics of indigeneity to propose capabilities as self-determination. The capabilities approach provides a framework for thinking about the fair distribution of resources and the state's role in maximising personal agency. Just as it has diminished personal agency, public policy has the means to improve individual capacity to function well (Nussbaum, 1987). The capability view helps to mediate conflicting claims by differentiating 'achievement' from the 'freedom to achieve' (Ruger, 2006b, p. 288), and by incorporating into the politics of indigeneity a politics of responsibility that 'enacts powers (versus rights) of sustainable self-determination' and that makes 'indigenous communities the central [policy] focus' (Corntassel, 2008, p. 122). However, exercising the politics of responsibility requires effective policy development supported by robust and verifiable policy implementation and evaluative data that show the scope that exists for health to contribute to people's broad capabilities. The capabilities approach to development is most concerned, then, with the necessary 'inputs' into a life that one has reason to value being

justly distributed, rather than being concerned with equality of outputs *per se*. Its utility is in the guiding essentialist or universal principles that it provides to all people. However, in insisting that these principles are to be applied by people to satisfy what they, *themselves* value, the capabilities approach is necessarily counter-colonial to provide a useful framework for thinking about the substantive and practical meaning of the right to self-determination and the human rights discourse from which that right emerges.

The capabilities' approach's universality and essentialist character is especially important in the indigenous Australian context where it has been drawn on by female policy actors to contest increasing levels of violence and to emphasise personal safety as among the human rights that are not as strongly protected as justice requires, and which undermine and relate to further capabilities in education and employment, as significant determinants of health. A universal account of human capabilities of the sort that Nussbaum (ref) proposes would also have protected indigenous children from removal from their families under the stolen generations' policy. This particular argument is developed to show the significance of allowing a capabilities approach to influence contemporary notions of self-determination, especially self-determination as personal agency.

Capabilities

The concept of capabilities as self-determination admits that the political right to self-determination requires certain essentialist or universal capabilities to be operationalised, so that people have political agency based on a distribution of resources and authority concerned with equal opportunities to make substantive and meaningful choices, rather than just an egalitarian concern for equality of outcomes. The presumption is that outcomes will be just if they are the result of people being able, in practical terms, to make choices that they have reason to value.

Nussbaum's development of Aristotle's 'human flourishing' adds to the politics of indigeneity's capacity to frame its objectives in terms that transcend rights to resources and culturally contextualised deliberative agency. Resources and substantive political participation are necessary but insufficient conditions for sustainable freedom. Capabilities contextualise indigeneity by focussing specifically on the '*freedom* to achieve' (Sen, 1999, p. 75).

The capabilities approach provides a framework for thinking about the fair distribution of resources and the state's role in maximising personal agency. Just as it has diminished personal agency, public policy has the means to improve individual capacity 'to function well if one so chooses' (Nussbaum, 1987, p. 20).

The argument presumes that while rights are preliminary to transformative capabilities, they do not have those attributes *in* and *of* themselves. Instead, it is capabilities, especially capabilities of responsibility, which position the politics of indigeneity to 'de-center the state from discussions of indigenous political, social, economic and cultural mobilisation' (Corntassel, 2008, p. 124). The National Congress of Australia's First Peoples is an example. Although established by the state, the body's subscription based membership potentially provides it with a financial base from which to provide an independent and representative indigenous political voice. The capabilities approach to development proposes that it is not so much peoples' choices that are morally significant, but the range of realistically available choices, especially those of greatest personal value. The capacity to exercise responsibility is the underlying objective that provides the capabilities approach and the politics of indigeneity with common intellectual aspirations and the basis for crafting a liberal account of the ways in which societies might admit indigenous cultures and aspirations, for people's enjoyment of lives that they have reason to value.

Removing the obstacles to lives of value means that people must be able to claim substantive political space to work out what it is, exactly, that they value and acquire capabilities to realise their aspirations. The importance of evaluating political systems and institutions in terms of their contributions to substantive freedoms (Sen, 1999) is that 'our opportunities and prospects depend crucially on what institutions exist and how they function' (Sen, 1999, p. 142). In particular, political empowerment, inclusion and voice are important determinants of health (Marmot, 2008).

In thinking about peoples' claims to live lives of personal value, the capabilities approach proceeds from Rawls' primary goods to which all people are entitled (Rawls, 1971). However, as Nussbaum (1997) explains, Rawls' list of entitlements is inadequate because resources alone do not provide 'a space within which to answer questions about who is better off and who is worse off' (p. 284). Nor do they provide a space to consider the distribution of political authority to complement egalitarian justice's distributive material concerns. While prevailing liberal political arrangements certainly constrain indigenous opportunities in many respects, they do provide scope for the politics of indigeneity to imagine arrangements based on differentiated or two-tiered constructions of citizenship where capabilities are more readily expressed.

Self-determination includes capabilities in the creation and exercise of the political space to take responsibility for one's own health and its determinants, and to claim the freedom to make choices leading to a life that one has reason to value. Intrinsic motivation is important, but capabilities are also the product of personal power vis-a-vis external influences. The responsibility to consume a nutritious diet is conditioned by the affordability of suitable foods. The responsibility to find employment is conditioned by educational preparedness for work and the presence of functioning markets. The responsibility to follow medical advice in response to

ill-health is conditioned by treatments' accessibility and affordability. The responsibility to deliberate in public policy formation is conditioned by relative political standing.

  For indigenous peoples, these limitations on freedom originate in historical and socio-political variables distancing them from major sites of political power so that indigenous ill-health is partly attributable to 'social disadvantage and… the particular relationship of Indigenous Australians to mainstream society' (Marmot, 2011, p. 512). The relationship is a neo-colonial one with outcomes paralleled in other jurisdictions and cultural contexts. Marmot (2011) compares the social gradient in health outcomes between indigenous Australia and England to note the importance, in both contexts, of

> creating the conditions that enable people to take control of their lives. If people were living lives they value, either in remote rural areas or the margins of cities, that would be one thing, but if Indigenous Australians do not have the conditions… that would allow them to live lives that they would choose to live, ill-health is an inevitable result (p. 512).

In short, political rights need to be operationalised in a world of inequality, which the capabilities approach to development considers by providing scope for indigenous peoples to establish greater shares in national political authority, which can be achieved through a differentiated or two-tiered construction of citizenship, as it was discussed in Chapter?

Health as Freedom

  Health policy is not simply a matter of attending to the clinical requirements for the treatment of ill-health, but is a significant matter of moral and political philosophy because: 'The freedom to be and to do is not guaranteed by getting the distribution of social goods right even though the distribution of social goods is, in itself, important' (Marmot, 2008, p. 881). Indeed, political philosophers routinely ask 'whether the equality most relevant to political distribution should be understood, primarily, as equality of well-being, or equality of resources, or equality of opportunity, or equality of capabilities' (Nussbaum, 1997, p. 274). The question challenges the

politics of indigeneity's traditional concern for a 'particular' distribution of power and resources by suggesting a broader view of the constituents of freedom, as 'the language of rights is not especially informative, despite its uplifting character, unless its users link their references to rights to a theory that answers at least some of these questions' (Nussbaum, 1997, p. 275).

Health is practically and morally important because it is concerned with preserving human capabilities; especially the physical and mental capacity to define and pursue one's own conception of well-being. Colonisation's relationship with ill-health attaches particular and urgent moral significance to health policy. For example, relationships between mental illness and colonisation are important to recognising a capabilities approach to human well-being (Nagel et al., Sherwood, 2013). In 2013, Indigenous mental illness is starting to attract greater scholarly attention. However, research in the field has 'until recently' been constrained by limited national data on the burden of mental illness as the only statistical information was the 'hospitalisation rate for diagnosed mental disorders, emergency department attendances for mental health and substance misuse-related conditions and contacts with public community health services'. These data indicated an indigenous prevalence rate between two and three times the national population's burden of mental illness (Jorm et al, 2012).

Overall population health is a measure of 'fairness' (Marmot et al., 2010), which makes health and capabilities important considerations in moral philosophy:

Impairments of normal species functioning reduce the range of opportunity open to the individual in which he may construct his 'plan of life' or conception of the good. Life plans for which we are otherwise suited are rendered unreasonable by impairments of normal functioning. Consequently, if persons have a fundamental interest in preserving the opportunity to revise their conceptions of the good through time, then they will have a pressing interest in maintaining normal species functioning by establishing institutions, such as health-care systems that do just that (Daniels, 1990, pp. 280-81).

Meeting these conditions of justice do not occur simply by providing all citizens with access to a health system; especially one based on the normative values and preferences of another cultural group. The health system is an input into human well-being, but its efficacy for *all* not just *some* of those who use it is the output that determines its contribution to human capabilities. It is also the output that determines the health system's strength as an instrument of self-determination and reconciliation. It is reasonable, then, for public policy's moral values and supporting administrative arrangements to ensure that indigenous aspirations are included in: 'The *normal opportunity range* for a given society [which] is the array of life plans reasonable persons in it are likely to construct for themselves' and: 'If an individual's fair share of the normal range is the array of life plans he may reasonably choose, given his talents and skills, then disease and disability shrinks his share from what is fair' (Daniels, 1990, p. 281).

Daniels (1990) does not propose that disease and disability are *themselves* unfair, but that their causes can be profoundly unjust. Indeed, relationships between colonisation and ill-health illustrate the ways in which just health policy transcends the health system itself and the ways in which the state asserts its neo-colonial presence as a key political determinant of indigenous health. Indeed, as Sherwood and Edwards' (2006) article title puts it: 'Decolonisation: A critical step for improving Aboriginal health'. Sherwood and Edwards' (2006) continue to imply a relationship between colonisation and capabilities through the proposition that an intellectual shift in policy making ought to occur to secure 'the decolonising of Aboriginal health so that the experts in Aboriginal health, namely Aboriginal people, can voice and action' policy measures responsive to self-identified needs and expectations (p. 178).

If some people's capabilities are unfairly insufficient to allow them to live lives that they have reason to value, public policy ought to examine the nature of that unfairness and make restitutive or restorative arrangements to raise capabilities on the grounds that:

> all human beings reasonably participate (or try to) in the planning and managing of their own lives, asking and answering questions about what is good and how one should live. Moreover, they wish to enact their thought in their lives - to be able to choose and evaluate and to function accordingly. This general capability has many concrete forms and is related in complex ways to the other capabilities, emotional, imaginative, and intellectual. But a being who altogether lacks this would not be likely to be regarded as fully human in any society (Nussbaum, 1992, p. 219).

From this perspective, justice is not concerned with equal or even equitable outcomes, but with equal inputs on the assumption that what people do with their endowments reasonably differs across time and culture.

Essentialist Capabilities and Indigenous Health

The capabilities' approach's utility is that it provides guiding principles: 'if we formulate a definite list of the most central capabilities, even one that is tentative and revisable' (Nussbaum, 2003 p. 36). The risk that universal capabilities necessarily become too Australian Bureau of abstract and divorced from different contexts must be balanced against undue prescription's tendency to overlook some peoples' interests and perspectives. One needs, then, to find in Nussbaum's list of 'central human capabilities' support for the development of a general theory of capability – a theory of capability as self-determination - to which groups can add, modify and contextualise for their own purposes. Such a theory's principal characteristic is that it accepts plurality, in what people 'have reason to value'. It does not admit a heterogeneous measurement of development and, therefore, sets aside pressures for policy to develop only with reference to a dominant group's normative preferences.

Nussbaum (2003) suggests that her list is neither exhaustive nor unalterable, should be open to public scrutiny and debate, and capable of incorporation into national constitutions (Nussbaum, 2003). Nussbaum's 'central human capabilities' are:

1. Life - a normal life expectancy
2. Bodily Health -good health including reproductive health
3. Bodily Integrity - free movement, protection from violence, including sexual assault
4. Senses, imagination and thought - a range of issues including creativity, artistic and political expression, and enjoyment of pleasure
5. Emotions - emotional development and attachment, to love and be loved
6. Practical reason - to develop a conception of good, and make life plans
7. Affiliation - to be able to live for and in relation with others, to develop empathy, pursue justice and friendship
8. Other Species - relations with the natural world and animals
9. Play - to laugh and play and relax
10. Control over one's environment - this includes political participation, material control over resources, and employment rights (pp. 40-41).

Like Sen's (1999), Nussbaum's (2003) generality is precisely what allows attention to cultural difference. However, the test of the list's applicability and utility to indigenous health policy ultimately rests on whether indigenous people would seriously contest its presumptions about what is good or suppose that any of its capabilities are, in fact, injurious to cultural imperatives. The conceptual question can be reduced to one of whether capabilities can have a universal essentialist character; a proposition that has been accepted by policy actors as diverse as the indigenous Cape York Institute for Policy and Leadership and the Australian National University's Centre for Aboriginal Economic Development, whose perspectives are among those that provide deeper conceptions of social justice than one 'that says, simply, 'All citizens are entitled to freedom understood as capability' (Nussbaum, 2003, p. 48).

The anti-essentialist objection is one that insists that 'politics must refuse itself a determinate theory of the human being and the human good' because there cannot be universal agreement of

those 'elements of human life [that] have most importance' (Nussbaum, 1992, p. 208). The objection makes it logically inconsistent to draw on universal legal instruments to advance domestic political aspirations when, in fact, indigenous peoples have otherwise relied heavily on these to give international authority to their claims against the state. For example, the United Nations' *Universal Declaration on the Rights of Indigenous Peoples* (2007) provides indigenous peoples with recourse to a moral codification of rights that transcend domestic law. For example, the *Declaration* provides that

> Indigenous peoples have the right to the full enjoyment, as a collective or as individuals, of all human rights and fundamental freedoms as recognized in the Charter of the United Nations, the Universal Declaration of Human Rights and international human rights law (Article 1);

and that

> Indigenous peoples have the right to maintain and strengthen their distinct political, legal, economic, social and cultural institutions, while retaining their right to participate fully, if they so choose, in the political, economic, social and cultural life of the State (Article 5).
.

  The rejection of universal norms means that there is no recourse to international law to challenge the non-essentialist position's most extreme expression - the judicial acceptance of cultural integrity as a partial defence against the sexual violation of women and children. In 2005, the Northern Territory Supreme Court's ruling that cultural precepts partially excused an elder's non-consensual sexual relationship with a 14 year old girl was made on grounds that deny some people's claim to basic capabilities, which is especially significant given the contribution that violence makes to indigenous women's ill-health and premature deaths (Macrae et al, 2013).

  The defence necessarily relied on the presumption that culture can ultimately and properly be defined, even when its relevant precepts are sharply contested, by the more powerful in the relationship. The girl's capability to say 'no' was undermined as Chief Justice Martin sentenced the 55 year old to one month's imprisonment because in this 'extremely difficult case':

> You [the defendant] believed that traditional law permitted you to strike the child and to have intercourse with her... The Crown accepts that you believed that intercourse with the child was acceptable because she had been promised to you [at the age of four] and had turned 14. The Crown also accepts that, based on your understanding and upbringing in your traditional law, notwithstanding the child's objections, you believed that the child was consenting to sexual intercourse (Martin, 2005).

This example illustrates that to 'throw out all appeals to a determinate account of the human being, human functioning, and human flourishing' is 'throwing away too much' of humanity itself (Nussbaum, 1992, p. 205). The argument's essential poignancy is the recency of the policy influence of colonial doubts about indigenous human equality.

> The aboriginal is, indeed, a very curious mixture: mentally, about the level of a child who has little control over his feelings… He has no sense of responsibility and, except in rare cases, no initiative (Spencer, 1914, p. 38).

Spencer's view was representative of prevailing government policy thinking and provided much of the philosophic rationale for the forced removal of indigenous children from their families, which occurred systematically across Australia from the early 1900s until the 1970s (Dodson and Wilson, 1997).

The removal policy undermined the basic capability of caring for one's children. For those who were removed, the capability to choose one's diet or where to live, develop familial relationships, select a marriage partner or pursue an education were restricted. The restrictions on these capabilities were deliberate, systematic and comprehensive (Dodson and Wilson, 1997). As Pat Anderson (2012) whose mother was removed in the 1930s remarked

> the promised benefits of this violent disruption to her and her family's lives never eventuated: the state that took her (supposedly 'for her own good'), never even taught her to read and write.

The removal of children and its rationale laid the foundation for the passive welfare and general dysfunction that characterises many contemporary indigenous lives, yet the removal policy, could not have enjoyed theoretical acceptance had a universal account of humanity prevailed.

Indeed, it is such an account that calls into question the betrothal of young girls to older men in a context where one might argue that sexual violence has increased as a mark of social and cultural dysfunction, rather than as the mark of accepted cultural values.

If culture is what people, themselves, define, one cannot admit contested practices becoming sacrosanct simply because a society's more powerful members claim their importance. 'People's attitudes towards the norm of 'cultural integrity' will depend a great deal on whether it does or doesn't provide a justification for maintaining oppressive traditions' (Kymilcka, 1999, p. 292). If cultural practices are contested within the group itself they cannot, logically, be claimed as practices required for the group's collective good. One can see, then, that women's agency underlies 'development as freedom' (Sen, 1999, p. 203).

Nanette Rogers, the former Alice Springs Crown Prosecutor, explained the relationship between capabilities and violence in a television interview in 2006 that precipitated the Northern Territory Emergency Response (Intervention):

> violence is entrenched in lots of aspects of Aboriginal society… Aboriginal people choose not to take responsibility for their own actions [and]… Aboriginal society is very punitive, so that if a report is made or a statement is made implicating an offender in that potential witness is subject to harassment, intimidation and sometimes physical assault' (Rogers, 2006).

Vesting indigenous women and children with the capability to resist would constitute an important expression of human dignity and self-determination and respond to injury as the cause of 15% of indigenous deaths (Macrae et al., 2013). Although a review of the Intervention, in 2008, upheld indigenous objections, on the grounds that it breached human rights (O'Sullivan, 2012), the indigenous academic, Marcia Langton (2011), described it in contrast as 'a metaphorical dagger, sunk deep into the heart of the powerful, wrong-headed Aboriginal male ideology' (p. 3). From this perspective, human rights are universal and incapable of subservience to real or imagined normative cultural practices. Universal human rights are not the imposition of

neo-colonial values, but norms accepted by the international community as inherent to human being: 'No one may invoke cultural diversity to infringe upon human rights guaranteed by international law, nor to limit their scope' (United Nations, 2010). Support for the Intervention was significant among indigenous women concerned at the levels of social dysfunction reflected not just in the sexual abuse of children, but also in the incidence of drug and alcohol related violence. Indeed, as Langton (2008) put it:

> To expect that people who reel from one traumatic event to another can enjoy the much-lauded Aboriginal 'rights to self-determination' while their own community and the larger society repeatedly fail them is an indulgent fantasy (p. 15).

Membership of a functioning cohesive culture is among the capabilities required to choose to live a life that one has reason to value because:

> Liberalism rests on the value of individual autonomy - that is, the importance of allowing individuals to make free and informed choices about how to lead their lives - but what enables this sort of autonomy is a fact that our societal culture makes various options available to us. Freedom, in the first instance, is the ability to explore and revise the ways of life which are made available by our societal culture (Kymlica, 1997, p. 75).

These objectives are raised in the context of extraordinary political complexity where ideas are sharply contested and ideology, at least as much as evidence, guides policy decisions. One example is Pearson's (2011) contrast of the Intervention's welfare sequestering with the Cape York procedure which privileges local rather than state authority. While the Intervention sequestered all residents' welfare payments, Cape York decisions are made only on the grounds of established irresponsibility. These decisions are made by community elders acting as a Family Responsibilities Commission. The underlying difference is one of philosophical attitudes towards the capabilities that people might enjoy: 'the Cape York scheme encourages community

members to take up their responsibilities. If people are being responsible, they are not affected by income management' (Pearson, 2011).

Essentialist capabilities contribute to the development of a politically useful liberal theory of indigeneity, capable of identifying political spaces of opportunity for indigenous freedom and conceptualising indigenous 'belonging' to the modern state in ways that create possibilities *for* and *of* freedom (Tully, 2000, p. 37). There is also a 'deep complementarity' between social context and personal agency so that one needs to see 'individual freedom as a social commitment' (Sen, 1999, p. xii), supported by an inescapable connection between the politics of indigeneity and the proposition that development

> requires the removal of major sources of unfreedom: poverty as well as tyranny, poor economic opportunities as well as systemic social deprivation, neglect of public facilities as well as systematic social deprivation, neglect of public facilities as well as intolerance or overactivity of repressive states (Sen, 1999, p. 3).

The politics of indigeneity depends on individual freedom because it is preliminary to personal agency which is, in turn, 'the "capabilities" of persons to lead the kind of lives they value - and have reason to value' (Sen, 1999, p. 18). Personal agency 'is inescapably qualified and constrained' by social, political and economic contexts and opportunities (Sen, 1999, p. xi), but remains preliminary to indigenous political authority as well as to health and well-being. Individual freedoms are necessarily linked to group freedoms and, indeed, are often conditional on such freedoms. However, it does remain that capacity for good health is also the product of collective capabilities 'because individual lives and choices are so affected by structures of living together, one cannot assume that their choices, including what they value are independent of these structures' (Deneulin, 2008, p. 116). One must accept, as Gasper (1997) points out, the limits of the 'reduction of all types of feeling to a single currency' ones 'own utility' (p. 285). However, the important philosophical presumption is that what people value and the aspirations

they pursue are matters for themselves, not matters to be decided and imposed by others according to alien values or political objectives.

> Man is to be defined neither by his innate capacities alone, as the Enlightenment sought to do, nor by his actual behaviours alone, as much of the contemporary social science seeks to do, but rather by the link between them, by the way in which the first is transformed into the second, his generic potentialities focused into his specific performances (Geertz, 1973, p. 52).

Capabilities as Agency

Agency expresses political freedom, where an agent is 'someone who acts and brings about change, and whose achievements can be judged in terms of her own values and objectives' (Sen, 1999. p. 19). Political freedom is a constituent of broader human freedom, and

> exercising civil and political rights is a crucial part of good lives of individuals as social beings. Political and social participation has intrinsic value for human life and well-being. To be prevented from participation in the political life of the community is a major deprivation (pp. 6-7).

Indeed, policy inattentiveness to indigenous concerns is an outcome of the difficulties that indigenous peoples encounter in exercising the agency that is due to them as citizens of the Commonwealth. Effective exclusion matters because democratic arrangements help 'society to form its values and priorities' (Sen, 1999, p. 7). Indigenous peoples' effective exclusion from parliamentary government, on account of their significant minority population status is important because 'the freedom to participate in critical evaluation and in the process of value formation is among the most crucial freedoms of social existence' (Sen, 1999, p. 287). Social values and normative practices are constructed through democracy, which means that the exclusion of some people from the democratic process precludes their contribution to the values and institutions by which they are governed.

Democratic institutions 'cannot be viewed as mechanical devices for development' (Sen, 1999, p. 158) because deliberation's role in the shaping of public opinion 'can be central to the

acknowledgement of injustice' (Sen, 1999, p. 287), meaning that 'one of the strongest arguments in favor of political freedom lies precisely in the opportunity it gives citizens to discuss and debate - and participate in the selection of - values and the choice of priorities' (Sen, 1999, p. 31). Indigenous rights and expectations are, partly, grounded in the proposition that equitable Indigenous access to a culturally responsive policy process is preliminary to sustained improvements in Indigenous peoples' health outcomes. The capacity to flourish is an essential public policy concern and it is the responsibility of the political order to see that everybody may share in the good life (Aristotle, 1988). The question then becomes one of which political philosophy would most reasonably and substantively extend 'happiness' to the greatest number of Indigenous people, given that happiness must at least take 'into account the determination of Indigenous peoples to retain their own distinctive cultural identity, avoid assimilation and exercise a degree of autonomy' (Durie, 2008, p. 370).

Conclusion

The following Chapter considers possible meanings of the capabilities approach for liberal democratic political arrangements. However, as a foundational proposition it is important to admit that a general understanding of capabilities as self-determination is preliminary to a just indigenous health policy framework. Capabilities as self-determination requires certain essentialist capabilities to be operationalised, so that people have political agency based on a distribution of resources and authority concerned with equal opportunities to make choices, rather than just an egalitarian concern for equality of outcomes. The presumption is that outcomes will be just if they are the result of people being able, in practical terms, to make choices to live lives that they have reason to value. The political question then becomes one of what opportunities for agency the state admits, not simply one of what material resources it owes

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indigenous peoples. Such a theory proceeds from the view that human rights alone provide an insufficient political basis for indigenous peoples to claim the capacity to make decisions consistent with improved health.

The capacity to exercise responsibility draws Sen and Nussbaum's capabilities approach into an alignment of common aspiration with the politics of indigeneity to provide the basis of a liberal understanding of how to admit indigenous cultures and aspirations into prevailing political structures to enhance the opportunities that are available to indigenous peoples to lead lives that they have reason to value.

The capabilities approach contextualises and adds to the politics of indigeneity by proposing a broader view of the constituents of freedom by drawing on an essentialist and determinate account of humanity itself to propose, among other considerations, that membership of a functioning and cohesive culture is an essential requirement of capabilities as self-determination. An essentialist account of the human person does not preclude cultural differences because the capabilities approach to development necessarily requires that it is persons who decide for themselves what it is that they have reason to value.

CHAPTER EIGHT

Capabilities and Policy

Introduction

Political values and context influence individual conceptions of justice. These, in turn, influence the capabilities that one will prioritise and be realistically able to pursue. In this context, the claim to self-determination does not

> rest on just one particular merit, but at least three: its contribution to freedom, its instrumental contribution to accountable government and its practical contribution to the development of values and collective understanding of the needs and aspirations that political arrangements ought to serve (Sen, 1999).

So it is significant that Australian liberals increasingly admit these attributes of self-determination to give at least some recognition to Fraser's (2003) argument that group rights are essential requirements of justice (Rowse and Goot, 2003). Indeed, as Fraser (2003) argues:

> It is unjust that some individuals and groups are denied the status of full partners in social interaction simply as a consequence of institutionalised patterns of cultural value in whose construction they have not equally participated and which disparage their distinctive characteristics (p. 29).

Restoring capabilities requires genuinely and substantively inclusive democratic arrangements that presume relationships between capabilities and political agency and recognise that indigenous peoples' genuine freedoms require release from passive welfare, access to fair and functioning markets for labour, health services and the purchase of nutritious foods. All of these are preliminary to people's capabilities to make choices consistent with good health, and it is for these reasons that Pearson (2007) develops Nussbaum's capabilities into a policy framework based on 'enabling' systems, structures and people to work to enhance and exercise certain capabilities as fundamental marks of human being. In these ways, Nussbaum's developments from Aristotle and Sen, together with Pearson, among other indigenous policy actors, provide a

juxtaposition between the capabilities approach to development and the politics of indigeneity to provide an account of capabilities as self-determination. There is an associated imperative to develop policy from examples of what actually works in indigenous health, some of which are cited in this Chapter.

The former Prime Minister, John Howard's, conception of equality as sameness (O'Sullivan, 2007) may retain some influence, but certainly not of an uncontested kind, to show that the choice between isolable self-determination and western measured equality is a mischaracterization of political possibilities. It misrepresents what indigenous peoples, themselves, routinely understand as self-determination and conceptualise as meaningful equality, so that K0wal (2008) is not necessarily correct to argue that self-determination's political vulnerability is explained by the proposition that: 'reconciling the innate difference of indigenous people with the universalism of the liberal state will always be a provisional, ambiguous, and uncertain process' (Kowal, 2008, p. 345). While some might object to plural political recognition (Little, 2003), broader conceptions of liberalism remain open to intellectual alignment with the politics of indigeneity, meaning that it may not, in fact, be necessary to 'move beyond the liberal paradigm' in responding to cultural plurality, as Little (2003) proposes. Indigenous peoples may find it more productive and pragmatic to examine what recourse exists within liberal theory itself for thinking about the claims that they wish to make against the state (Tully, 2000). Liberalism, then, would reduce the possibility of 'blind[ing] itself' to its own partiality in the eyes of non-liberal groups' (Little, 2003) to assert that 'discourses of difference and multiculturalism are part of the liberal tradition' (Little, 2003). Liberalism is, then, equipped to make distinct contributions to debates about what indigenous peoples might reasonably claim against the state and several responses emerge to Little's (2003) question of why non-liberal societies would accept Rawls'

proposition that they would wish to contribute 'to an overlapping consensus' on the institutions and processes of government that are 'established on liberal territory' (p. 21). However, the pragmatic point is to juxtapose the politics of indigeneity with liberal theory to create institutions that are sufficiently flexible and responsive to indigenous aspirations to provide for deliberative inclusion and cultural respect and to offer conceptual clarity on the rights and expectations that indigenous people might claim. It is in this context that Indigenous Australians most keenly explore differentiated citizenship's sub-national possibilities through professional bodies such as the Australian Indigenous Doctors' Association, Congress of Aboriginal and Torres Strait Islander Nurses, the Indigenous Dentists' Association and regional bodies such as the Cape York Institute, and the national representative entity, the National Congress of Australia's First Peoples, established in 2010.

It is too early to assess the Congress' political efficacy, however it does allow 'policymakers to give special status to Indigenous Australians in health policy dvelopment' (Donato and Segal, 2013, p. 232) and its reconfiguration of the ways in which people think about representation is potentially transformative. Its capabilities enhancing potential for indigenous women is evident in their successful lobbying to have the Congress distinguished by the equal representation of men and women (National Congress of Australia's First Peoples, 2010, p. 12) for the 'protection of liberties and freedoms' (Sen, 1999, p. 6).

Self-determination and an Indigenous Health Purchasing Authority

Congress' representative model transcends the equation of democracy with simple majority rule to constrain the influence of powerful unrepresentative elites. The Congress insists that 'human rights standards and obligations' ought to inform the development of the National Aboriginal and Torres Strait Islander Health Partnership, which it describes as 'a tremendous

opportunity to further deconstruct falsely held beliefs and old ways of thinking, and set the scene for an optimistic future' (National Congress of Australia's First Peoples, 2013, p. 6). Congress argues that the plan ought to be evaluated against its capacity to 'promote constructive partnerships between Aboriginal and Torres Strait islander people, government and other stakeholders at the national, regional and community level' to 'directly target the barriers to good health' and to 'tackle the issue of racism'(National Congress of Australia's First Peoples, 2012, p. 2). A further measure of success is that: 'Functioning health-care facilities and services, are available in sufficient quantity and in safe physical reach' (National Congress of Australia's First Peoples, 2013, p. 4). For Congress (2013), 'A philosophy of partnership, shared ownership and Aboriginal and Torres Strait Islander leadership needs to operate at levels of health planning and delivery' (p. 4). These aspirations are consistent with those proposed in 2009 in the National Health and Hospitals Reform Commission's government commissioned report on administrative arrangements in the health sector, which argued for ways of enhancing self-determination, particularly through strengthening community health services (National Health and Hospitals Reform Commission 2009).

The Commission's recommendation to establish a single national Indigenous Health Purchasing Authority comprising Indigenous members and empowered to make contestable funding allocations conditional on outcomes, could perhaps:

> catalyse a cultural shift within the health system to support a genuine partnership between government and Indigenous peoples and their representatives … This not only reflects the human rights of Indigenous peoples, but is also common sense from a policy perspective (Calma, 2009).

such as those that potentially align self-determination with liberal emphasis on choice to create policy space for the idea that:

Indigenous peoples have the right to promote, develop and maintain their institutional structures and their distinctive customs, spirituality, traditions, procedures, practices and, in the cases where they exist, juridical systems or customs, in accordance with international human rights standards (United Nations, 2007).

Human rights and a revised conception of Indigenous citizenship are also implicit because:

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 Commission proposed that community health services ought to provide services to a single Indigenous purchasing authority, with assured Indigenous representation. The structure would allow indigenous community-controlled health services to share power and authority as well as provide the administrative simplicity of working with only one government purchasing agent (National Health and Hospitals Reform Commission, 2009). It may simultaneously extend contemporary policy measures and address some significant shortcomings in administrative arrangements. For example, the problem of multiple accountabilities is significant (Alexander et al., 2010; Christensen and Ebrahim, 2006) and it is important that Aboriginal Community Controlled Health Organizations do not 'morph into quasi-governmental providers' (Tenbensel et al, 2013, p. 2); compromising their responsiveness to indigenous peoples. Accountability is reciprocal. But, in practice, the balance is towards the state which makes indigenous organisations the subject of 'accountability regimes' rather than partners (Sullivan, 2009). Accountability is confused as contractual arrangements variously and inconsistently position people and organisations as 'individual citizen/clients… a disadvantaged minority group [or]…as culturally distinct polities' (Sullivan, 2009). These considerations compromise indigenous development and contribute to 'a deficit in democratic accountability to aboriginal people' (Sullivan, 2009). Administrative arrangements demonstrate effective public accountability to the

non-Indigenous polity, but not to indigenous communities themselves. However, as the independent 'close the gap' campaign co-chair Tom Calma (2010) put it:

> A good start has been made by the government to addressing indigenous health equality but ultimately inequality will only be addressed if all departments and agencies work collectively and cooperatively in partnership with Aboriginal and Torres Strait Islander people. That is why we look forward to working with Prime Minister Gillard to Close the Gap (p. 1).

The Authority would build on the advisory role of the National Indigenous Health Equity Council, established in 2008 in association with the 'Closing the Gap' strategy, by affording an Indigenous-focused body the power to make decisions about what services are to be provided, by whom and in which ways. It would complement the policy function of the Indigenous-elected Congress of Australia's First Peoples.

The Commission does not propose panaceas for the reclamation of Indigenous rights and its recommendations do not guarantee improved health outcomes, but 'indigenizing mainstream policy-making processes' maximizes the inclusive possibilities for Indigenous peoples to play a significant role in priority setting and the allocation of public money (Maaka and Fleras, 2009). 'Indigenising' the mainstream policy process may also counter the influences of prejudice, policy inertia and bureaucratic complexity in policy-making and implementation, and as Congress proposes, an Authority could be involved in the assessment of the impact on health of policies in education, housing, infrastructure, employment, justice, and economic development (National Congress of Australia's First Peoples, 2012). It potentially recognizes the relationship between individual and group rights and the sometimes-necessary association of cultural imperatives with personal freedom. The proposed Authority could provide an institutional conduit between the liberal demand for choice in public policy and indigeneity's concern for self-determination in service delivery.

The proposal imagines a fundamentally different model of self-determination than that which was allegedly ineffective under the Aboriginal and Torres Strait Islander Commission, which operated as an instrument of self-determination between 1990 and 2006 (see Chapter Two). Whereas ATSIC combined representation, advocacy, policy-making, policy delivery and administration under the one institutional structure, the Reform Commission proposals would separate these elements of self-determination to ensure that power is dispersed and contestable. The structure would allow Indigenous community-controlled health services to share power and authority as well as provide the administrative simplicity of working with only one government purchasing agent (National Health and Hospitals Reform Commission, 2009).

ACCHOs incur significant costs that could be reduced by the adoption of single relational contracts, with one funder, which would also address Congress' argument that inconsistent and insecure funding is a determinant of ill-health (National Congress of Australia's First Peoples, 2012). Although its comprehensiveness and effectiveness is not yet apparent, the Abbott Government (2013 -) has, in 2014, proposed the incorporation of relational contracts into the policy equation on the grounds that:

> What we do know about them [prevailing contractual arrangements] is that they are far too complicated… Each program has its independent processes completely separate from everything else: its own application, its own evaluation process, such as it is, in its own acquittal processes, its own reporting processes. I would like to see this come down to five or six programs. Basically, the harmonisation of these programs down to that sort of level can reduce the red tape… We've got to stop the programs driving the agenda… We are supposed to be responding to needs, that's what government does, but instead the government is really responding to the programs… rather than ensuring that we are nurturing the outcomes of the community wants… We want to have more people on the ground actually delivering benefits to the program rather than administration and we think we can do that by reducing the red tape and having a smaller number of programs (Scullion in The Australian, 22 January, 2014).

Relational contracts differ from the classical short term model because they define services more broadly and over longer terms (Lavoie, et al., 2010). They develop new public management

theory's funder-provider split (Boston et al., 1996) and the use of contracts 'to promote participation and responsiveness (with accountability)' (Lavoie, et al., 2010, p. 669), which are among self-determination's principal characteristics. Carey and Riley (2002) argue that policy makers have the option of regulating indigenous civil society's involvement in service delivery through a 'choice and responsibility model' associated with neoliberal contractual arrangements or through one of 'trust' that they argue is more consistent with Marmot's 'social gradient' approach.

The idea that 'individuals are responsible to society through the promotion of social solidarity and cohesion' reflects a particular conception of citizenship; one that is inclined towards 'trust models' of funding for service delivery, where 'organisations are valued for their position within, and networks with local communities. They become accountable to communities rather than to top-down targets and directives' (Carey and Riley, 2012, p. 169). However, such arrangements presume ordered and accepted measures of community democracy. They presume functional communities with well-developed conceptions of self-responsibility as the basis of reciprocal obligations to show that the claiming and expressing of citizenship rights are not automatic, but rather the function of capacity.

The proposal's concession to Indigenous self-determination reflects a significant shift in public policy thinking, which would increase scope for Indigenous communities to claim shared political authority with the state. Indigenous involvement as both purchaser and provider of health services would create new political space for Indigenous people to frame the policy process in their own ways and for their own purposes. Indigenous engagement in the policy process protects the role of culture, a necessarily public construct, in Indigenous peoples' relationships with public institutions to admit self-determination as 'a philosophy which calls on

governments to put aside ineffective regulation which characterised their involvement with Aboriginal people in the past and calls also on Aboriginal people to take action in changing the conditions of their own lives' (Anderson and Sanders, 1996, p. 24). An administrative model based on a single purchasing authority would allow both these ideals to be pursued.

Governments would not withdraw from responsibilities in indigenous health, but they would step back to create space for indigenous peoples to assume influence in setting policy agendas to shape 'the conditions of their own lives'. However, the Commission's recommendations were not accepted by the Gillard Government (2010-2013) and have not attracted full policy attention since the Abbott Government's (2013 -) election. However, Donato and Segal (2013) argued that the newly proposed Health Partnership Plan may, in fact, provide a 'window of opportunity' for the proposal to be returned to the policy agenda 'as an important structural pre-requisite' for improved health outcomes (p. 232). They also argue that Closing the Gap's success depends on the greater 'articulation with… broader health system reform' such as the Commission proposes (p. 234).

Any debate that does arise will be a contestation of 'the extent to which Aboriginal people really are permitted to define their own vision of the good life and require other Australians to let them live it' (Clarke, 2006, p. 122) to position health policy as central to contemporary Australian debates over the claims of indigeneity and its limits. It is also central to the re-construction of citizenship and the distribution of political authority to accept Indigenous expectations of reparation, respect and autonomy.

Capabilities and Markets

The construction of citizenship matters because the

unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon but it is the result of a toxic combination of poor social policies and programs, unfair economic arrangements, and bad politics (Marmot, 2008).

It is in this context that Pearson (2011) stresses the importance of indigenous access to the 'real economy' and for these reasons that Sen (1999) places markets among the institutions that are preliminary to freedom. Poor social policies and programs and unfair economic arrangements create the passive welfare that undermines capabilities, which are also undermined by the absence, or limited access, to free and functioning markets for labour and health services, especially. Entrance to the 'real economy' is similarly compromised by factors such as discrimination, poor education and welfare dependence. Markets assume the capability to interact with others, yet in education, the labour market and, indeed, the health system, racism is significant and deeply compromising (Sen, 1999).

Labour markets fail indigenous peoples for reasons originating in their conscious historic exclusion from education for the primary labour market (Attwood, 2005). Systemic obstacles were also created to indigenous peoples' exploring what Sen (1999) describes as a relationship between markets and liberty. 'The loss of freedom [to participate in the labour market] and the absence of employment choice and the tyrannical form of work can itself be a major deprivation' (p. 113) as indigenous unemployment remains at almost 3 and a half times the national level of 5.5% (Australian Bureau of Statistics, 2013).

Constraints on the freedom to access traditional natural resources also stifle market functioning, not just in the conventional economic sense, but also in compromising the development of the alternative markets that Altman (2001) proposes ought to 'include the customary economy' (p. v). Altman (2001) estimates that although not easily quantifiable because it is not 'monetised', the customary economy is large and significant, and distinguished

by 'cultural continuities: hunting, gathering and fishing… land and habitat management, species management and the maintenance of biodiversity' (p. 11). His argument is that the customary economy's potential means that there is not necessarily 'too little' state support for indigenous development 'it is just of the wrong form' (Altman, 2001, p. 4). In contrast, there are examples, particularly from indigenous engagement with the mining industry of Winer et al.'s (2011) observation that

> By building capabilities, indigenous people are able to assert their right to take responsibility and make choices that result in the sustainable development of their lands and their economic and social situation.

The Queensland *Wild Rivers Act 2005* (repealed in 2012) was illustrative of further public policy decisions impeding indigenous economic opportunities. Its alleged rationale was to protect the environmental heritage of the Cape York region in northern Queensland. However, its restrictions on indigenous communities' authority to use traditional lands for commercial purposes is relevant to relationships between incomes and good health (Daniels et al., 1999). Relationships between health and access to land have, for example, created opportunities for people to engage in environmentally focused, physically demanding 'caring for country' projects on traditional land (Burgess et al., 2009; Rowley et al., 2008). Participants in these projects exhibited lower rates of obesity, diabetes, high blood pressure, psychological distress and risk of cardio-vascular disease (Burgess et. al. 2009). Similarly, Rowley et al., (2008) found that greater access to land, culture and community, including traditional food sources coupled with atypically regular access to primary health services, accounted for mortality and morbidity rates of about half the Northern Territory's Indigenous average. Yet in 2014, the Abbott Government (2013 -) is considering the introduction of a fee for GP visits that will be incurred in addition to the

contributions that taxpayers presently make to Medicare, the principal funder of primary health services.

Market failure in the distribution of nutritious foods also compromises good health (Browne et al, 2009). In the three Northern Territory communities that Brimblecombe et al (2013) studied, food consumption was distinguished by 'very poor dietary quality' to reflect no improvement from the earliest studies of the topic almost 30 years earlier. Policy proposals such as requiring food stores to provide for nutritional requirements or sequestering welfare payments to control what people can purchase does not address the obstacles of cost. Indeed, relationships between food insecurity and income are significant determinants of capability as a typical high income household needs to spend around 10% of its income on food to ensure nutritious purchases, whereas a typical low income household must spend in the order of 30% (Ward et al, 2012). Indeed, as one indigenous participant in Kowanko et al's (2011) study put it:

> But, you know the other thing that puts people off? Is to eat healthy your bill goes from $100 to maybe $180. It - my bill, that food shopping bill, has just doubled. And it's sad, because you're trying to look after yourself and eat healthy, and money is your first object before we do anything. And our bill's gone up like massive because we're buying the healthy vegies and stuff. You look for the cheaper version of vegies, but you can't get Black and Gold bananas, can you, you know (Kowanko et al, 2011, p. 59)?

Fair and functioning markets are essential to differentiated citizenship's normative utility. They are preliminary to the Cape York Institute's basic philosophy that people ought to have greater agency than governments, where agency requires an understanding of 'how progress works in a more or less liberal capitalist world' (Pearson, 2011) and acceptance that: 'You can't contract leadership out to external NGOs and government employees. There must be ownership and responsibility in Aboriginal hands' (Pearson, 2011).

'Welfare State to Opportunity Society'

For Pearson (2011), the capabilities approach supposes a transition 'from welfare state to opportunity society' where 'guaranteed social opportunity from the government plus personal responsibility from the individual equals solutions to poverty'. Too much government service delivery, especially services developed without reference to their impact on capabilities, can be decidedly harmful as policy makers fail to ask 'whether they displace responsibilities that should be properly undertaken by individuals, families or communities' (Pearson, 2011).

Pearson's Sir Robert Menzies Lecture, in 2011, showed unequivocally the Cape York Institute's understanding of the capabilities approach through its title: 'There is nothing the government can do for you that you are unwilling to do for yourself' (Pearson, 2011). The question for the politics of indigeneity then becomes one of which capabilities are important to the realisation of particular rights. Which of the rights that indigenous peoples have established at international law are to be prioritised and which political, collective, familial and personal capabilities are required for them to develop from the abstract to the tangible?

Pearson's (2007) response includes the proposition that health policy's particular aims should include 'promoting individual responsibility through better health norms' – an overarching objective that ought to be incorporated into a public health model that would:

- Make space for public health campaigns targeting high-risk behaviours and health norms in any given community.
- Establish services that help re-establish health norms in the family and extended family through:
    - Fostering of good doctor-client relations
    - Providing family based counselling and support
- Can establish links with schools, shops community organisations and reform projects to help develop appropriate expectations
- Sets up regular trip mechanisms around environmental health standards, good dietary and nutrition behaviours and occupational health and safety concerns.

These goals are complemented by a 'health enabling framework' to facilitate the relationship

between capabilities and improved health outcomes. These 'enabling structures' would aim to:

- Improve recruitment and retention of health professionals including Aboriginal and Torres Strait Islander people
- Provide incentives to attract appropriate full time permanent personnel who can gain community trust
- Ensure increased community presence and responsiveness of primary health care services in town and outstations, as a hook for individuals to be more proactive about their health
- Enable progressively sophisticated information transfer families and individuals through individual and group consultations and training sessions (e.g. nutrition tours through local shop to pick healthy foods).
- Engage in ongoing training and up-skilling of community leaders; initiating youth health leaders program
- Engage in policy advocacy… [to remove] structural barriers to improved health behaviours are prohibitive (e.g. insufficient funding for primary care or inadequate water or power infrastructure)
- Develop programs such as grog strategies with community involvement.

Pearson's proposals complement Al-Yamin and Higgins' (2011) detailed account of what

works in indigenous health.

- Community involvement and engagement. For example, key success factors in Indigenouscommunity-based alcohol and substance-abuse programs were strong leadership, strong community–member engagement, appropriate infrastructure and use of a paid workforce to ensure long-term sustainability.
- Adequate resourcing and planned and comprehensive interventions. For example, a systematic approach with appropriate funding arrests the escalating epidemic of end-stage kidney failure, reduces suffering for Indigenous people and saves resources. A strong sense of community ownership and control is a key element in overcoming Indigenous disadvantage.
- Respect for language and culture. For example, capacity building of Indigenous families and respect for culture and different learning style were considered to be important for engaging Indigenous families in school readiness programs.
- Working together through partnerships, networks and shared leadership. For example, an Aboriginal-driven program increased knowledge about nutrition, exercise, obesity and chronic diseases,

including diabetes. The educational component, participation of local Indigenous people in the program and committed partnerships with the organisations involved were important to the program's success.

- Development of social capital. For example the Communities for Children initiative, under the Australian Government's former strategy (The Stronger Families and Communities Strategy 2004–2009)highlighted the importance of a collaborative approach to maternal and child health, child-friendly communities, early learning and care, supporting families and parents, and working together in partnership.
- Recognising underlying social determinants. For example, data from the Longitudinal Study of Australian Children demonstrated that financial disadvantage was one factor among other variables that may affect school readiness and progress for young children.
- Commitment to doing projects with, not for, Indigenous people. For example, the evaluation of the NSW Count Me In Too Indigenous numeracy program found that contextual learning was successful and critical, professional development for teachers was essential, effective relationships were vital and Aboriginal community buy-in was also essential for ongoing success.
- Creative collaboration that builds bridges between public agencies and the community and coordination between communities, non-government and government to prevent duplication of effort. For example, a collaborative project between health and education workers at a primary public school in South Australia (The Wadu Wellness project), in which a number of children were screened, has resulted in follow-up and support for children for hearing problems and dental treatment, and social and emotional support.
- Understanding that issues are complex and contextual. For example, frequent house moves, neighbourhood conflict, functionality of housing amenities and high rental costs were found to have an impact on children's schooling (p. 2).

Al-Yamin and Higgins' (2011) analysis of indigenous health interventions found that those consistent with the above resulted in:

- A number of interventions achieved small but measurable reductions in modifiable risk factors for chronic disease, such as weight and blood pressure, among Indigenous people.
- Systematic treatment of Indigenous people with chronic disease was found to reduce death rates.
- A Northern Territory program to reduce kidney disease risk factors was found to be cost effective.
- A community-based antenatal program was found to increase the number of women's antenatal visits and reduce the number of preterm births and perinatal mortality schooling (p. 21).

Vos et. al (2009) suggest that there are just 11 risk factors whose prevalence accounts for more than half the life expectancy differential. These are: 'tobacco, alcohol, illicit drugs, high body mass, inadequate physical activity, low intake of fruit and vegetables, high blood pressure, high

cholesterol, unsafe sex, child sexual abuse and intimate partner violence' (Vos et. al. 2009, p. 474). An assessment of a series of case studies describing successful initiatives focussed on one or more of these risk factors highlighted the relationship between cultural attentiveness and people's willingness to accept professional advice. In another study (Dwyer, et al, 2011) a South Australian hospital worker remarked that:

> We're seeing people here who actually haven't accessed the system so their cancers are very, very advanced. We've seen [Aboriginal people] who have got… major carcinoma that's disfiguring, just distorting their body shape… so they've obviously been in pain… for a long time and that suggests to me that… they're reluctant or reticent or unable to access systems for whatever reason (Dwyer, et al, 2011, p. 18).

It is significant, then, that Vos et al (2009) found a common focus on community based educative measures and social marketing to encourage and empower people to support one another in making dietary and lifestyle choices commensurate with good health. Culturally safe practices include sensitive and 'empathetic personal contact, acknowledgement and respect for Aboriginal family structures, culture and life circumstances, an understanding of the significant role of non-verbal communication, and the importance of history, land and community' (Shahid et al., 2009). Specifically, culturally safe practice in cancer care has been found to correlate positively with 'the development of a strong therapeutic bond, adherence to therapy, understanding of treatment risks, reduced patient anxiety, patient satisfaction and reduced risk of medical mishaps or malpractice claims.' Conversely, poor communication can lead to misdiagnoses, patient ignorance about treatment and unhealthy lifestyle choices and practices, and lack of informed consent for treatment (Shahid, et al., 2009). The role of culture in health outcomes may, therefore, be among the points that justify a differentiated policy approach to indigenous health.

Durie (2008) proposes a 'link between cultural certainty and good health' (p. 7), to make the point that health outcomes transcend clinical practices and require a shift in underlying political values about relationships between health and culture. Recognising the relationship is preliminary to people's ability to conceptualise health in their own terms and for their own reasons. It maximises systemic capacity to support equitable treatment outcomes and establishes a democratic argument for nationally mandated culturally safe clinical practices because 'unsafe cultural practice … diminishes, demeans or disempowers the cultural identity and well being of an individual' (Nursing Council of New Zealand, 2002). Culturally unsafe practices diminish people's capacity to take responsibility for their own health and systemic capacity to give all people an equal opportunity to access effective treatment.

Carter et al.'s (2009) analysis of Australian cancer policy papers over the previous ten years found culture referred to only in deficit terms. Culture was presented as a negative determinant of health because Aboriginality puts one at greater statistical risk of developing the disease. The possibility of locating treatment and care in cultural context was not considered, yet in New Zealand, parallel policy statements referred to ethnic disparities not simply to position culture as a risk factor but to use 'the cultural values and understandings of Maori ... to talk about cancer risk' and to develop strategies for risk reduction (Carter, et al., 2009, p. 1453). Nevertheless, cultural safety assumes that the prejudices and biases of individual actors and institutions will be removed from the policy process. In 2004, the Australian Health Ministers' Advisory Council adopted a *Cultural Respect Framework* to recognise relationships between culture and health, in ways that can still purposefully be incorporated into health policy. The *Cultural Respect Framework* proposed that public hospitals ought to recognise relationships between culture and health outcomes by, for example, ensuring that Indigenous patients have access to interpreters

and traditional healers and that specific Indigenous protocols and guidelines be established in maternal health as well as in responding to Indigenous deaths (Australian Health Ministers' Advisory Council, 2004, pp. 10–12).

Health policy should not, then, be seen simply as the delivery of services to passively receptive patients, but as empowering people with the capabilities to care for themselves and make unconstrained choices commensurate with good health (Pearson, 2007). ACCHOs and other health entities facilitate these capabilities. There are further examples that reflect differentiated citizenship and are grounded in a human rights approach to health. Indeed, the Cape York Institute for Policy and Leadership's sustained contributions to public policy discourse exemplifies differentiated citizenship, where engagement is on indigenous terms, for indigenous purposes and unmediated by state or non-indigenous policy actors. Jordan *et al* (2010) explain that the Institute's 'capability approach' to development 'has sometimes been held up as the theoretical framework for understanding well-being that can best accommodate cultural differences and aspirations and life choices' (p. 344).

The Institute's 'Capability Indicators' are measures of substantive citizenship, and include the 'number and type of employment opportunities' available to the community. They include income levels, which 'indicates consumption possibilities', and the 'net worth of a household or individual, which gives the capacity to sustain consumption possibilities. Further indicators are income 'passivity' which is the 'degree of the dependence on unearned income, which depletes other capabilities over time'. Infrastructure is the 'ability to access basic services, such as roads, water, sewerage power and communications'. The ability to acquire 'a quality education', enjoy access to 'adequate housing' and 'governance' are also important determinants of health (Jordan et al., 2010, p. 347).

Health, itself, is a 'Capability Indicator', measured through the 'ability to depend on sound government institutions' and the 'ability to access quality health services and maintain a healthy state (both physical and mental)' (Jordan et al., 2010, p. 347). Capability Indicators provide a 'practical' construction of citizenship that privileges difference as the basis of socio-economic development to counter arguments that the two are incompatible (Johns 2008; Hughes 2007; Sutton 2009).

Conclusion

Capabilities include the practical expression of self-determination, which remains a contested but cautiously accepted aspiration in indigenous public policy. Capabilities are democratically important for their contribution to human freedom and are legitimately pursued as both individual and group rights. There are also important relationships between capabilities and political agency, both of which require a political order that confronts passive welfare and guarantees access to functioning markets. Pearson's development of Nussbaum and Sen's work in the context of development policies in Cape York is intend as an 'enabling' framework from which people might claim the capacity to do certain things as marks of their human being. Pearson provides a juxtaposition between the capabilities approach to development and the politics of indigeneity as a theoretical justification for the continuance and development of policy measures based on what actually works in indigenous health. These measures are discussed as indigenous health policy's ultimate purpose. The capabilities approach also recognises Mundine's argument (2013) that

> There are many people in the world through history who have suffered terrible wrongs and dispossession who have none-the-less managed to re-build their communities and achieve prosperity in successive generations... social stability requires that people embrace the idea of contributing to their communities. This means abiding by laws, respecting culture, performing

civic duties, ensuring school attendance, finding a job, showing civil treatment to others and volunteering. This is an ethos that was very much a part of traditional Indigenous nations. Everyone was expected to bring something to the campfire and people would not turn up empty handed (Mundine, 2013).

CONCLUSION

Indigenous health is distinguished by a median age of death in the order of 20 years less than that of the non-indigenous population (Australian Bureau of Statistics, 2011). The differential is largely explained by a high incidence of Indigenous premature but avoidable deaths (Australian Bureau of Statistics, 2009) in a politically complex policy domain where contests between distinct conceptions of citizenship and 'belonging' to the one liberal polity are played out. This, and other differentials, are neither inevitable nor immutable. Although matters of profound clinical concern the differentials are also attributable to considered political choices and administrative arrangements. The differentials are matters of important clinical concern, but political values, too, impact on people's opportunities to influence the burden of disease. They influence the ways in which societies respond to discrepancies in health outcomes and the ways in which they conceptualise what it actually means for an indigenous person to exercise the status of citizenship. Good health is not simply a matter of personal responsibility or good fortune. Choices are made in the context of opportunities and constraints that can occur beyond the individual's capacity to control or even influence. The just distribution of material resources and political authority are important additional variables.

Political history also helps to explain contemporary policy context and it is significant that it was only in 1973 that the Commonwealth systematically concerned itself with indigenous health policy. It was then during the 1990s that broader legal and political developments exposed racism's full presence and influence. It was at that point that policy makers began to think about the nature of common citizenship and its effective political meaning. In particular, the proposition that indigenous peoples belong equally to the one Commonwealth brings concepts

such as self-determination, participatory parity, recognition and relational justice to public discourse's sharply polarised centre. These theoretical perspectives combine to counter the policy influences of democratic exclusion and political misrecognition, and provide ways of admitting the genuine political debate and contestation of ideas that liberal democracy not only presumes but requires for its effective functioning. Public policy outcomes can, reasonably, be expected to improve if political relationships are grounded in trust, respect and confidence in the political system derived from genuinely and demonstrably equal membership of the political community where cultural aspirations and the reparative objective of correcting injustice are accepted as legitimate policy considerations. In other words, it is the argument that politics might privilege non-domination, through relative and relational self-determination.

Self-determination proposes terms of indigenous belonging to the state as ones that challenge traditional presumptions of sovereignty residing solely and inflexibly in the institutions of the nation state. It became prominent with its acceptance, in limited form, by the Whitlam Government (1972-1975) and while the Howard Government (1996-2007) took steps to discredit its philosophical propriety and practical efficacy in public administration, the concept had, by this time, acquired substantive recognition at international law and become central to the ways in which indigenous peoples conceptualise and express their political aspirations and claim equitable participation in the policy process. Self-determination protects indigenous peoples' distinctive identities as peoples with political rights and aspirations that cannot be subsumed into a state prescribed homogenous understanding of liberal democratic citizenship.

Instead, self-determination proposes a particular indigenous share in public authority based on relative and relational autonomy within the state. It is claimed and expressed through, for example, the National Congress of Australia's First Peoples, Aboriginal Community Controlled

Health Organisations and indigenous professional associations whose policy focus centres on alternatives to the liberal tendency to marginalise or even extinguish minority voices as the liberal order struggles, but remains capable, of admitting arrangements that privilege cultural difference and substantive deliberative agency over 'sameness'. For example, it was only through sustained indigenous advocacy that indigenous peoples' engagement into the Closing the Gap policy processes was accepted. Neither Closing the Gap nor the Intervention were initially developed on the assumption that they should be significantly shaped by indigenous peoples' aspirations and expectations. Yet, Closing the Gap, in particular, could instead have been structured to serve indigenous peoples' self-determination and the reparative purpose with which health policy might reasonably concern itself.

Colonial political assumptions mean that balanced political relationships distinguished by trust and integrity are difficult to achieve, even as these are the essential preliminary bases to policy development as contemporary policy developments concerned with repairing the often intended harm occasioned by earlier measures. So, in spite of the increasing number of policy initiatives of an alternative philosophical disposition there remain examples that illustrate significant distance between Australia's rhetorical interest in promoting policies that provide a 'fair go to all' and its willingness to compromise human rights through its chosen policy directions.

Reparation depends on democratic inclusion and, for indigenous peoples, arrangements that admit extant political rights of first occupancy as part of a broader politics of indigeneity through which indigenous peoples express and justify the terms on which they wish to belong to the modern state. The politics of indigeneity is a theory of justice that claims belonging with reference to the aspirations that indigenous peoples, *themselves*, establish as important and reasonable. Political arrangements responsive to indigeneity have, in fact, been able to consider

cultural perceptions of what actually constitutes good health and allow space for indigenous organizations to exercise independent authority over their own affairs. These political arrangements pay particular attention to group rights, including the right to a representative voice in public affairs. This is because indigenous group rights are preliminary to the individual freedom that the liberal society theoretically offers but practically withholds from many of its indigenous citizens. Yet, it is true that in 2014, these freedoms are not withheld with the same force and enthusiasm that has traditionally distinguished indigenous public policy.

There are contemporary policy illustrations of cautious but broadening acceptance of liberal political theory's more inclusive possibilities distinguished by relational justice, for example the *Cultural Respect Framework* (2004), *National Mental Health Policy* (2008), the *National Aboriginal and Torres Strait Islander Health Plan* (2013). These policies' further common characteristic is their rejection of sameness as the proper basis for belonging to a common liberal community. In so doing, they contest the proposition that liberal egalitarianism alone is sufficient to meet indigenous peoples' just public policy claims. The contrast between egalitarianism and the politics of indigeneity illustrates health policy's deeply political character and shows that indigenous peoples' policy ambitions transcend egalitarianism's measurement of success with reference only to statistical equality.

Political tensions over what the health system should aim to achieve for indigenous peoples and what they, themselves, might reasonably expect are also played out in health workers' day-to-day professional activities. Health workers are influenced by personal political values as their decisions about what to prioritise and how to engage with indigenous patients can position them to either constrain or transcend official policy objectives. Professional discretion can give people the power to manipulate Weber's 'iron cage' of bureaucratic control with decisions of intended

negative consequence, just as much as they are able to have positive professional impact in ways that might differ from those that the state imagines. Their work is among the political determinants of health and the ways in which they approach it reflects perceptions of the values that ought to underpin the public health system.

Professional health work is distinguished by multiple and potentially conflicting loyalties: to the patient, the profession, the state, and personal conscience, including values concerning indigenous peoples' legitimate policy expectations. Conscience and values are important to the deeply political context in which professional discretion is exercised as the very idea of the indigenous patient receiving equal care is one that has only relatively recently been granted official sanction and, indeed, indigenous people continue to report widespread racism on the part of health professionals. The incidence of racism shows that proposing that people be treated equally remains contested in clinical practice, while individual political values and workplace cultures demonstrate, the contribution that politics makes to people's opportunities for good health, even as Australia accepts the right to health care as universal human right. However, the street level worker's acceptance or rejection of the right to the highest quality of health care is a political, not a clinical, proposition that makes the worker a policy activist with significant capacity to influence health policy as it is actually received and understood by the patient,

Together with the politics of indigeneity, human rights, constructs a deeper relationship between politics and health. Their concern for culture and self-determination means that it is insufficient for policy to proceed only as a matter of distributive justice. Indigenous civil actors increasingly claim and express the right to self-determination, and the human rights framework simultaneously sets out a range of moral, legal and political principles governing indigenous peoples' reasonable health entitlements. They bring clarity to complex political, ideological and

policy relationships to ensure that what is just and reasonable is not merely a matter of prevailing public opinion, with all its prejudices and appeals to conflicting sets of self-interest. Human rights provide breadth to the meaning of citizenship and human equality and provide useful analytical tools for assessing a given policy proposal's moral legitimacy.

The recourse to international law that the human rights framework increasingly provides to indigenous peoples is especially important in the absence of established domestic instruments, such as the Treaty of Waitangi in New Zealand, to provide a broadly accepted liberal account of reasonable political expectations. Human rights are politically significant because they allow indigenous claims to be expressed in liberal terms and contribute to a liberal theory of the right to health care for indigenous peoples. Such a theory is essential to reducing the conflict and intellectual uncertainty that pervades the indigenous health policy environment to undermine opportunities for good health.

Human rights standards are politically useful because as they are universally accepted benchmarks against which to measure political opportunities and aspirations they allow reasonableness to be defined without the influence of local prejudice and the limiting argument that egalitarian distributive justice is both sufficient and fair in defining indigenous peoples' expectations of the public health system. Human rights have been especially useful in establishing the limitations of measures such as Closing the Gap and the Intervention. In these contexts, human rights have emphasised political agency and access to the full rights of liberal democratic citizenship, when these have otherwise been sharply contested. Indigenous responses, led by the Aboriginal and Torres Strait Islander Social Justice Commissioner, have argued for a human rights approach to health policy, with recourse to the United Nations' *Universal Declaration on the Rights of Indigenous Peoples* (2007), the *United Nations' Charter* (1945), the

International Convention on the Elimination of All Forms of Racial Discrimination (1965) the *Declaration of Alma-ata* (1978), the *Ottawa Charter for Health Promotion* (1986), *Vienna Declaration And Programme of Action* (1993) and the *Bangkok Charter for Health Promotion in a Globalized World* (2005).

These instruments require inclusive constructions of citizenship to frame policy possibilities and to assess the justice of any particular proposal. Citizenship's accepted character influences political opportunities and its construction in broad terms to admit differentiation or a two-tiered model that gives effect to the politics of indigeneity's aspiration to self-determination within a liberal paradigm. Differentiated citizenship allows the concept's rights and privileges to be enjoyed in preferred cultural contexts and provides for collective participation in national political affairs. It simultaneously allows indigenous peoples to retain their own identities and political structures through which to define and pursue their own understandings of collective well-being. In these ways indigenous peoples can collectively pursue common interests through land rights, effective education, access to traditional resources and by defining and pursuing health and well-being with reference to personal values and aspirations. Liberal citizenship need not, then, silence indigenous political voice or constrain the terms of indigenous belonging to the one political community in ways that presume and impose assimilation. Citizenship is a useful theoretical construct because it defines the terms of indigenous peoples' belonging to the state which, in turn, sets out the limits and opportunities created through membership of the one political community. Citizenship can be utterly unresponsive to indigenous peoples' needs, rights and aspirations while, on the other hand, it also offers transformative potential for thinking about how and on whose terms indigenous people belong to a political community whose normative

political values and practices have developed without their sustained and substantive participation.

The question of just how differently indigenous peoples ought to be treated in the political community is not one that is easily answered. However, it is significant that the question can even be raised as a matter of liberal possibility as societies respond to indigenous claims of first occupancy and claims beyond distributive justice.

The claim to active citizenship is becoming important. It is a claim that citizenship ought not admit the passive welfare that afflicts indigenous communities as an outcome of the tendency in distributive justice to confine obligations to the right to state income protection in times of unemployment or ill-health. Active citizenship is an essential alternative to passive welfare as human agency requires that people are not positioned simply as materially poor. In contrast, deeper understandings of citizenship are required to consider the full causes of material poverty and alienation from the education and labour markets which are among the foundational determinants of material health and well-being.

Citizenship might also admit that, as rights of indigeneity, access to culture and economic security conditions opportunities for health and well-being. These considerations are particularly important because they extend understandings of citizenship to enhance its substantive meaning for indigenous peoples. The welfare state is intended to provide short-term financial security, but it does not provide personal or collective agency which are important determinants of health and preliminary to broader constructions of indigeneity.

Citizenship and human rights provide analytical frameworks for thinking about the general political rights of indigenous peoples and the ways in which these rights can inform responses to sustained indigenous ill-health. However, it is not sufficient for these rights to be considered only

in the abstract and it is the capabilities approach to development that has contributed most in recent Australian discourse to giving these rights practical meaning and tangible policy significance. The capabilities approach to development is grounded in Aristotle's concern for human flourishing as the purpose of all political activity. It is consistent with indigenous self-determination because its interest is in how to achieve the conditions in which all people can decide for themselves what it is that they have reason to value and pursue those aspirations for themselves and in their own ways. The capabilities approach is inherently counter colonial because it allows indigenous peoples to define what it is, exactly, that they mean when they pursue a right to self-determination. It requires that justice is measured with reference to people's real opportunities that people have, including the opportunity to influence policy development so that policy priorities are set with reference to what people themselves say that they value. The capabilities approach to development has been applied by indigenous entities, such as the Cape York Institute, as an expression of self-determination and as an example of the policy imperative to think broadly about the reasons for indigenous disadvantage so that targeted responses can be made to increase people's opportunities for good health. The Institute's 'Capability Indicators' embody substantive citizenship, grounded in human rights and are enhanced through inclusive democratic practices. They emphasise the characteristics of a life that Cape York people, themselves, indicate that they would have reason to value. For example, meaningful and appropriately remunerated employment, household wealth, community infrastructure, access to a good equality education and housing, all of which are established determinants of health.

Health, itself, is a 'Capability Indicator' and it is through capabilities – the capability to lead a life that one has reason to value – that self-determination loses its abstract character to become a practical and tangible mark of human potential. In this way Sen (1999) and Nussbaum's (1997,

2003) capabilities approach to development is aligned with the politics of indigeneity to add significantly to liberal understandings of the means and rationale for admitting indigenous cultures and aspirations into liberal political structures, relationships and practices.

Health is a profoundly political concern, just as much as it is a clinical one. Opportunities for good health are, at least partly, attributable to the ways in which theoretical constructs such as relational justice, participatory parity, recognition and self-determination interact and intersect to provide an account of indigenous peoples' entitlements. People may then enjoy, what is expressed in the Wiradjuri language as, *yindyamarra winhanga-nha*, 'the wisdom of respectfully knowing how to live well in a world worth living in'.

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