The International Covenant on Economic, Social and Cultural Rights and the right to health: is Australia meeting its obligations to Aboriginal peoples?

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Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) recognises the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health".[1] The ICESCR entered into force in Australia in 1976 and provides the principal framework for the universal right to health.[2] As a State party to the ICESCR, Australia is obliged to submit 5-yearly reports to the United Nations Committee on Economic, Social and Cultural Rights (CESCR) on how these and other rights are being implemented. The CESCR, established to monitor the ICESCR, examines each report and addresses its concerns and recommendations to the State party in the form of "concluding observations".[3]

There is evidence that Australia's reports to the UN neglect valid and meaningful reference to efforts required under Article 12 to enhance the health of Aboriginal and Torres Strait Islander peoples, given that this population has worse health than other Australians and indigenous peoples in other developed countries.[4] In view of the evidence that primary health care services influence improvements in population health standards,[5-9] even despite the continued existence of social inequalities,[10] is there sufficient expenditure on non-hospital health systems for this population to bridge the gap in health standards? Has Australia committed to using "the maximum of its available resources" to realise this population's right to health? Fulfilling the right to health requires governments to allocate sufficient resources to ensure health services are available, accessible, affordable, acceptable, and of good quality.[1]

While there are no examples of international human rights instruments having enhanced political commitment towards better health for Aboriginal and Torres Strait Islander peoples, and despite all its limitations, reporting to the UN allows Australians to take stock of the nation's approach towards ensuring equality of health status and may help in influencing health policy agendas.

Australia's reports to the UN

Australia submitted its Third Report to the CESCR in 1998,[11] and the Fourth Report was due in 2005. However, by March 2007, the Attorney-General's Department was still coordinating an Australian response. The draft Fourth Report simply asserts that, although "Aboriginal and Torres Strait Islander people are the most disadvantaged group within the Australian community, Australian governments are making headway in addressing social and economic disadvantage", followed by a short list of various government strategies. It states that Indigenous-specific programs "are in addition to other social benefits such as universal health coverage and income support, which are available to all Australians, and Indigenous programs and services funded by State and Territory governments". The annexed statistical data summarise the usual statistics on health inequity but provide no quantitative information on relative health expenditure.[12]

ABSTRACT

- There is evidence that Australia is not meeting its obligations to Aboriginal and Torres Strait Islander peoples for their right to the "highest attainable standard" of health, required under the International Covenant on Economic, Social and Cultural Rights (ICESCR).
- Poor access to primary health care for Aboriginal peoples and substantial shortfalls in government spending to address this are in violation of the ICESCR.
- Aboriginal and Torres Strait Islander peoples' share of the universal health coverage expenditure offered to all Australians is less per person than for other Australians.
- The failure to monitor the provision of mainstream health services to Aboriginal peoples and inequitable distribution of health facilities and services compound these violations.
- Equality in health between Indigenous and non-Indigenous Australians is achievable, but not until the shortfall in health services expenditure for Indigenous Australians is addressed.

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What should the Australian Government be reporting on primary health care?

According to the ICESCR, among the steps required from Australia (as a party to the Covenant) is the "creation of conditions *which would assure to all* medical service and medical attention in the event of sickness" (our italics). In 2000, the CESCR, in order to assist parties with implementation and reporting obligations, clarified that this refers to the provision of community-level preventive and curative care, screening programs, and essential drugs; and the participation of the population in these health services. Access to primary health care is identified as a core obligation under the ICESCR. The CESCR also stated that "indigenous peoples have the right to specific measures to improve their access to health services and care … States should provide resources for indigenous peoples to design, deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health".[1]

Violations of the ICESCR

The CESCR clarified that violations of the ICESCR include "insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalized; the failure to monitor the realization of the right to health at the national level, for example by identifying right to health indicators and benchmarks; [and] the failure to take measures to reduce the inequitable distribution of health facilities, goods and services".[1]

Insufficient expenditure resulting in the non-enjoyment of the right to health by Indigenous Australians

Aboriginal and Torres Strait Islander peoples' share of the universal health coverage offered to all Australians is *less per person* than for other Australians: in the 2001–02 financial year, their Medicare expenditure was only 39% of that for other Australians; for dental services it was 24%; and for pharmaceuticals, 33%.[13] Per-capita spending on medicines through the Pharmaceutical Benefits Scheme (PBS) in 2001–02 was $73.23 overall for Indigenous Australians, and only $59.82 in urban and regional areas, compared with $220.29 for other Australians.[13] This conservatively amounts to a $67 million annual underspend, based on the national average, or a significantly higher shortfall if based on need. Aboriginal peoples have reduced access to medicines for a range of reasons similar to those for their overall poor access to primary health care.[14]

For a population with three times the rate of morbidity, and social, educational and economic disadvantage, overall spending on primary health care per person was only 23% higher for Indigenous Australians compared with other Australians in 2001–02.[13] This included spending from all governments on state-run community health services, Aboriginal community controlled health services (ACCHSs), public health activities, non-admitted hospital services, Medicare, pharmaceuticals, patient transport, dental services, and aids and appliances. Federal and state/territory government commitment to ACCHSs, in their critical role as providers of culturally appropriate, comprehensive primary health care services to Aboriginal peoples,[15] is not of sufficient scale to offset this inequitable expenditure.[16,17]

Analysts commissioned by the Australian Government in 2004 reported that funding for Indigenous-specific primary health care services should be around $1244 per capita.[18] In reality, only $306 per capita was expended through such services by the Office for Aboriginal and Torres Strait Islander Health (OATSIH) in 2001–02.[13] While the budget for these services has been growing,[19] the gap has not closed (increases in annual expenditure to 2002 approximate those for health services used by non-Indigenous Australians),[13] nor has growth been of a proportion commensurate with addressing inequity. Of Australia's federal health expenditure of $38.4 billion in the 2005–06 financial year, the OATSIH budget comprised only 0.8%.[20]

Failure to monitor the realisation of the right to health at the national level using right to health indicators and benchmarks

Recently, the Aboriginal and Torres Strait Islander Health Performance Framework (HPF)[19] and indicators of Indigenous disadvantage[21] were developed to gauge Aboriginal peoples' health improvements over time, based on select health determinants and health systems. While important, and an improvement on earlier indicators, they lack "right to health" indicators (designed to monitor the realisation of specific right to health norms, to hold duty-bearers to account),[22] and targets and benchmarks to assess the health system's responsiveness to Aboriginal peoples.[5] For example, while the burden of Aboriginal children's hearing loss is a measure in the HPF, proportionate federal government expenditure towards provision of hearing services in response to this problem is not. Differential access to the PBS is measured, but not efforts to enhance the quality use of medicines by Aboriginal peoples.[23] Per-capita expenditure on primary health care disaggregated by Indigenous status is identified, but targets for the optimal level of expenditure are not.[19]

There is also an inability to report on the mainstream health sector's relative expenditure on Aboriginal and other Australians under the bilateral Public Health Outcome Funding Agreements, which support schemes such as the National HIV/AIDS Strategy and the National Cervical Screening Program. Financial incentives for general practice and Divisions of General Practice initiatives also lack targets for proportionate funding to help address the excess disease burden in the Aboriginal population. Consequently, where data exist, they indicate that Aboriginal peoples are "locked out" of such programs, as shown below.

Failure to take measures to reduce the inequitable distribution of health facilities, goods and services

Overall spending per person on health services was only 18% higher for Aboriginal and Torres Strait Islander peoples than non-Indigenous Australians in 2001–02 (making up 2.8% of national health expenditure for 2.4% of the population), but nearly half of this expenditure was for use of hospital services, which was proportionately greater than hospital utilisation by other Australians.[13] The two times higher rate of hospitalisation largely reflects Aboriginal peoples' poor access to primary health care causing otherwise avoidable admissions, the use of emergency departments for primary care needs, and their need for renal dialysis.[19]

There is evidence of an inequitable distribution of health-related goods and services for Aboriginal and Torres Strait Islander peoples, including poorer access to: hospital procedures,[24-26] population health programs developed for all Australians (eg, screening for breast and cervical cancer),[27,28] rehabilitation services (eg, Commonwealth Hearing Services Program,[29] cardiac rehabilitation programs[30]), immunisation,[31] and general practice programs.[32] As yet more frameworks designed to enhance health service delivery to Indigenous Australians[33,34] are added to existing ones,[15,35] an impression is created that action is being taken. Since duty-bearers are not held accountable in the provision of these services to Aboriginal peoples, and with few health policy reforms, there is little progress to report.

Call for equality of health

It has been argued that the Australian and global commitment to the UN's Millennium Development Goals, which have a strong focus on rights to health for those in underdeveloped nations,[36] may be harnessed in a set of development goals for the Indigenous Australian population.[37] The Aboriginal and Torres Strait Islander Social Justice Commissioner also called for all governments to commit to achieving equality of health status between Indigenous and non-Indigenous Australians within 25 years,[5] but to do so requires a genuine commitment to the intent of the ICESCR. This is not evident in Australia's draft Fourth Report to the UN, nor in the Australian National Framework for Human Rights.[38]

It is clear that Aboriginal peoples have substantially worse health than is enjoyed by other Australians (defined as the highest attainable), and they still have a long way to go before reaching an equal standard of health.[5] Given current expenditure relativities, the Australian Government cannot be confident that adequate resources are being directed towards enhancing the health system's responsiveness to Aboriginal peoples' health needs.

Under the ICECSR, a "State which is unwilling to use the maximum of its available resources for the realization of the right to health is in violation of its obligations".[1] There is ample evidence that this is the case in Australia — a situation that is far from equity-generating. Unless efforts are made to address this funding shortfall, the gap in health standards will not be bridged and Australia will remain in violation of Aboriginal peoples' right to health by a systematic failure to make health services accessible to them.

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Competing interests

None identified.

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