

A 'hypothetical' complaint to the United Nations Committee on Economic, Social and Cultural Rights (the Committee) in reference to the Draft Optional Protocol (DOP) to the International Covenant on Economic, Social and Cultural Rights (ICESCR).

Other relevant international (United Nations) procedures

- First Optional Protocol, Covenant on Civil and Political Rights (Art.2-individual discrimination, Art.27 cultural rights of minorities) (Human Rights Committee)
- Art. 14 and “Urgent action procedure”, Convention on the Elimination of Racial Discrimination (Art.5.e.iv)
- Optional Protocol to the Convention on the Elimination of Discrimination Against Women (Arts.12 and 14)

Admissibility criteria (Similar to FOP, OP CEDAW)

1. **A communication must contain allegations that, if substantiated, would constitute a violation of rights contained in the Covenant (ratione materiae);**
2. **the State against which it is directed must be a party to the protocol;**
3. the alleged violations occurred after the protocol entered into force with two exceptions (eg: continued effect);
4. the complaint must not be an “abuse of the right to submit a communication”;
5. **domestic remedies must have been exhausted;**
6. the complaint is not being examined under another international procedure

1. Allegations that if substantiated constitute a violation of Covenant

- Complaint alleges violation of **Article 2 on right to non-discrimination and Article 12 on the right to health**, of the International Covenant on Economic, Social and Cultural Rights
- Specifically alleges violation of the **right to non-discriminatory and equitable access to medical care** identified as “**core obligations**” in **General Comment No.14**
- This includes access to services designed and run by Indigenous peoples eg: Aboriginal Community Controlled Health Services (GC 14, para.)

2. Australia's ratification status

- First Optional Protocol, ICCPR (1991)
- International Covenant to Economic, Social and Cultural Rights (1976)
- Declaration under Art.14, International Convention on the Elimination of Racial Discrimination (1993)
- CEDAW (1983)
- Not party to the OP to CEDAW

6. Exceptions to rule of “Exhaustion of domestic remedies”

- “where the application of the remedies is **unreasonably prolonged**” (5(2)(b) of the DOP)
- If remedies would be **ineffective, and are not available to the complainant** (The Model Complaints Form for the FOP, CERD)

Status of domestic remedies in Australia

- Race Discrimination Act (Cth) 1975 (RDA) (Article 9) however no complaints have yet been made concerning the right to health under this Act.
- RDA normally deals with direct discrimination against an individual however *Wadeye* case on right to education important test case (Monash 2006)

Other barriers

- HREOC needs more resources to be able to “operate effectively and to deal both with individual complaints and initiate test cases in relation to systemic racism.”
- Lengthy period between the lodgement of complaints and their resolution.
- Need for “policy and legislative reform governing the status of bodies such as HREOC” to ensure their greater independence from the Government.
- Indigenous people can be limited in their ability to use legal complaints procedures due to lack of knowledge and resources, and cannot be represented by third parties in the current system.
- Complainants do not have access to funding for legal services in making complaints to HREOC procedures.
- Sanctions and remedies are limited with no criminal penalties.

HREOC National Consultations: Racism and civil society, 2002.

1. Substantiation of allegation

1. Health status indicators
2. Health expenditure indicators
3. Access to primary medical care indicators
 - i. Availability
 - ii. Accessibility (Non-discrimination, physical economic, information access)
 - iii. Acceptability (cultural appropriateness)
 - iv. Quality
4. Health and Indigenous policy indicators

1. Health status indicators

- Life expectancy
 - Approx 20 years less for Aboriginal peoples (ABS 2002)
- Infant mortality
 - Nearly 3 times for Aboriginal peoples (ABS 2000)
- Disease
 - Significantly higher rates of most diseases for Aboriginal peoples (AMA 2002)

Health expenditure

- Despite Indigenous peoples' much poorer health status - **estimated expenditures**, per person, for health services for Aboriginal and Torres Strait Islander peoples are **only marginally higher than for the rest of the population**. (AIHW 2002)
- Estimated **\$3,901 per Indigenous person**, compared with the **\$3,308 per non-Indigenous person**, a ratio of **1.18:1**. (AIHW 2002)
- Per person expenditure through the major Australian government-funded health programs, **Medicare and the Pharmaceutical Benefits Scheme (PBS)**, was much lower for Indigenous peoples ie: **37% of that for non-Indigenous people**. (AIHW 2002)
- States with a large proportion of Indigenous people living in remote regions generally had higher per person expenditures on hospital services.[\[1\]](#) These higher hospital expenditures are partly due to the higher cost of providing services in remote regions. If the higher costs of providing services in remote areas could be factored in, the ratio of Aboriginal and Torres Strait Islander health service use to non-Indigenous services use would be lower than the expenditure ratio of 1.22:1. (Dunn *et al* 1999)

Availability

- Public health and human rights experts assert that there are problems with the availability of both Aboriginal Community Controlled Health Services (ACCHS) and mainstream health services for Aboriginal and Torres Strait Islander peoples.
- Couzos and Murray assert that **despite the growth in ACCHS, there are major gaps in coverage.** They note that: “[m]any towns and communities with significant Aboriginal populations, and some quite large geographical areas such as the Cape York peninsula” do not have an ACCHS.(2003)
- **NACCHO similarly assert that there are inadequate ACCHS** which, together with the under-use of mainstream health care services results in Indigenous peoples having inadequate access to primary health care services.(1998)
- **The AMA also observe that there is a lack of culturally appropriate primary health care services for Indigenous people,** which together with their higher illness rates, are the main causes for higher hospital admission rates of this group.(2002)

Accessibility: Non-discrimination

- There has been a **long history of racism in health care against Indigenous peoples in Australia.** (Couzos and Murray 2003)
- Cousoz and Murray note that **“the attitudes and approaches” of GPs to Indigenous peoples continue to impede their access to these services.** (2003)
- With respect to accessing mainstream health services **in urban areas specifically, NACCHO asserts** that Indigenous people residing in these areas will often not access these services for reasons including concerns that **service providers may be, inter alia, “racist or judgmental”.**(2004)
- The **working group for the National Aboriginal Health Strategy also recognized** the problem of discrimination in health care services noting in their final policy statement in 1989 that **one of the benefits of ACCHS was that these services prevented “overt and covert racial discrimination” against Indigenous people by health care staff.**(1989)
- Lynne Macer note that **nurses in mainstream health services were likely to view Indigenous people negatively,** reflecting discrimination in the broader community, and particular ethocentricity in hospitals.(1998)
- Dale A. Fisher and Tarun S. Weeramanthri assert that **the causes of differences in the use of specialist care by Indigenous and non-Indigenous people** (the former having fewer diagnostic and specialist procedures) **should be further researched to ensure that the system is not racially discriminatory.**(2004)

Physical Accessibility in rural and remote Australia

- The centralisation of services and the smaller number of health care services in rural and remote areas, significantly contribute to the *physical* barriers of distance to these services for Indigenous people.
- Low incomes and lack of private transport among Indigenous peoples, in addition to the lack of public transport, poor roads and communications in remote areas compound the difficulties presented by distance barriers. (NACCHO, 2001, Cousoz and Murray 2003, John Wakeman 1999)

Physical accessibility in urban Australia

- NACCHO assert that **one of the factors impeding the access in urban areas is “lack of transport to reach services** (Aboriginal people generally live in highly disadvantaged urban areas with a lack of services close by).”(2001)
- “[t]he lower “visibility” of Aboriginal people in some urban areas can in fact contribute to a **lack of appropriate services eg: appropriate substance misuse, dialysis, and dental care services** are sorely needed in urban areas as in other areas.” (NACCHO 2001)

Economic accessibility

- There are growing problems with economic access to health services for people on low incomes which includes many Indigenous people.
- Both the median individual income and household income of Indigenous people are lower than that of non-Indigenous people.(ABS)
- Access to health services, including waiting times for essential treatments, vary according to a person's income and capacity to afford private health insurance. (ACOSS 2006/7)
- Availability of bulk billing a key factor affecting level of access for Aboriginal people to private GPs. (Cousoz and Murray 2003)
- Bulk billing has declined from 80% in 1996 to 69% in 2003. (ACTU, 2003)

Acceptability (cultural appropriateness)

- A number of public health experts find that mainstream health services are often “unacceptable” due to a lack of cultural appropriateness. (Henry *et al* 2002, PSA 2001, NACCHO 1998)
- For example: NACCHO notes with respect to Medicare funded private practice services:

“While Medicare fee-for-service arrangements appear to work fairly well for the general community and mainstream service providers, the model of short consultations in a private practice setting does not fit with the needs of Aboriginal people for holistic, comprehensive care in a culturally appropriate setting.”(1998)

Quality: Australia

- The quality of mainstream health services may be declining as a result of the gradual decline in the Federal Government's Medicare Rebate according to the Australian Council of Social Services (ACOSS).(2003)
- The lack of resources in ACCHS, particularly under-staffing, is widely acknowledged by public health experts.(AMA 2002, Couzos and Murray 2003, NACCHO 2001, Wakeman 1999)

4. Health and Indigenous policy indicators

- Policy on Indigenous peoples health care
 - Mainstreaming Indigenous health care
- Policy on participation of Indigenous peoples in decision-making and implementation on health issues
 - National Aboriginal Health Strategy 1989 not implemented
 - ATSIC dissolved

Further information and model complaint form

- UN Office of the High Commissioner for Human Rights: <http://www.unhchr.ch>
- Model complaint form for ICCPR and CERD:
<http://www.ohchr.org/english/bodies/docs.annex1.pdf>