ACL Submission to Inquiry into the application of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) in Australia

SUBMISSION:

Inquiry into the application of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) in Australia

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AUSTRALIAN CHRISTIAN LOBBY

About Australian Christian Lobby

Australian Christian Lobby's vision is to see Christian principles and ethics influencing the way we are governed, do business, and relate to each other as a community. ACL seeks to see a compassionate, just and moral society through having the public contributions of the Christian faith reflected in the political life of the nation.

With around 250,000 supporters, ACL facilitates professional engagement and dialogue between the Christian constituency and government, allowing the voice of Christians to be heard in the public square. ACL is neither party-partisan nor denominationally aligned. ACL representatives bring a Christian perspective to policy makers in Federal, State and Territory Parliaments.

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ACL Submission to Inquiry into the application of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) in Australia

Joint Standing Committee on Aboriginal and Torres Strait Islander Affairs

18 October 2022

Dear Sir/Madam,

On behalf of the Australian Christian Lobby (**ACL**), I welcome the opportunity to make a submission to the Joint Standing Committee on Aboriginal and Torres Strait Islander Affairs' (Committee's) Inquiry into the application of the United Nations Declaration on the Rights of Indigenous Peoples in Australia (Inquiry).

The ACL strongly supports efforts to advance the human rights of Aboriginal and Torres Strait Islander peoples (ATSI peoples) in Australia. ATSI peoples were the first inhabitants of Australia and are a very valuable part of both Australia's heritage and diverse multicultural society today.

ACL's submission includes some repetition as we start with a summary and then seek to elaborate further on each section. I apologise for its length but our basic premise is that:

1. ATSI peoples continue to experience unequal health outcomes, especially in remote areas.
2. Some remote ATSI communities experience specific issues relating to poor water quality and disparate hospital access. These may be factors contributing to health inequality, and are, at the very least, obvious areas in respect of where change is required.
3. UNDRIP principles support action to generally address an inequality of health outcomes, improve access to health services, and improve the sanitation and health conditions in remote ATSI communities. In our view, they may also provide a supporting rationale to address any issues in relation to water quality and disparate hospital access in remote ATSI communities specifically.
4. The Government should take further action in accordance with the UNDRIP in this regard. Not only does the UNDRIP provide a supporting rationale for such action, but the ongoing existence of health inequality among ATSI peoples and the importance of our valuable remote ATSI communities also necessitates it. While we commend the Government for the work it is already undertaking to 'Close the Gap' in respect of the health of ATSI peoples generally, it is clear that there is more work to be done. Taking specific action to rectify any issues relating to water quality and disparate hospital access would improve adherence to UNDRIP principles in Australia.

We make the following submissions to urge the Government to consider specifically investigating and rectifying any issues in respect of water quality and disparate direct hospital access in remote ATSI communities. In any case, we also generally urge the Government to improve the application of the UNDRIP in Australia by implementing new initiatives with the goal of addressing ATSI health inequality.

I would appreciate an opportunity to meet with the Committee to discuss this submission and confer regarding how the Government might contribute to real and tangible change in this area.

Yours Sincerely,

Wendy Francis
National Director of Politics

ACL Submission to Inquiry into the application of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) in Australia

EXECUTIVE SUMMARY

The ACL strongly supports efforts to advance the human rights of ATSI peoples in Australia. ATSI peoples were the first inhabitants of Australia and are a very valuable part of both Australia's heritage and diverse multicultural society today.

Improving the application of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) in Australia is obviously one mechanism by which the human rights of ATSI peoples may be enhanced. The Federal Rudd Government's endorsement of the UNDRIP in 2009[1] reversed Australia's initial stance against the UNDRIP.[2] Australia's endorsement of the UNDRIP now reflects our commitment to the UNDRIP's principles, even if the declaration is not strictly legally binding.[3] The UNDRIP itself confirms that its principles are "a standard of achievement to be pursued…" by parties.[4]

ACL's submissions are particularly directed towards addressing the following Terms of Reference regarding the application of the UNDRIP in Australia (as set out on the Inquiry webpage[5]):

(ii) options to improve adherence to the principles of UNDRIP in Australia; and/or

(iv) any other related matters.

The UNDRIP addresses a broad range of different matters. At this stage, our submission only focusses on how Australia's adherence to the UNDRIP might be improved relating specifically to sanitation and health. We have focussed on this issue as the ACL is very concerned by ongoing reports that the health and wellbeing of some ATSI communities continues to fall short of that experienced in other Australian communities, particularly in remote areas. We are also concerned by reports of sub-standard water quality and disparate hospital access in remote areas. In our view, it is vital that the Government take further action to address the fact that ATSI peoples continue to experience unequal health outcomes, and also address any issues of water quality and disparate hospital access contributing to this problem.

The UNDRIP itself affirms that Indigenous peoples have a right to the improvement of their social conditions including sanitation and health. The UNDRIP principles clearly justify action to address inequality of health outcomes, improve access to health services, and improve the sanitation and health conditions in ATSI communities generally. Indeed, the wording of the UNDRIP seems to make it incumbent on the Government to seek to continually improve the social (including sanitation and health) conditions of ATSI communities and take necessary steps to progressively realise an outcome by which ATSI peoples enjoy the highest attainable standard of physical and mental health on par with all other Australians. While ATSI peoples in Australia continue to experience an inequality of health outcomes compared to other Australians, we consider that the need clearly remains an urgent priority.

There are some obvious practical ways in which the Government might contribute to progress in this area, including specifically directed to improving water quality and direct hospital access in remote communities. For example, we are aware of some studies and reports indicating that water quality in some remote communities may not meet health guidelines. This is an issue that seems to have escaped obvious attention in Commonwealth initiatives to 'Close the Gap', and at the very least requires investigation to ascertain the extent of the problem. If such reports are substantiated, then it appears obvious that action must be taken to ensure remote water quality meets the guidelines.

[1] See, for example, this article published in the Sydney Morning Herald in 2009: This link.
[2] See discussion about Australia having reversed its initial position on this United Nations website: This link.
[3] As discussed in this United Nations FAQ document regarding the UNDRIP: This link.
[4] See page 7 of the UNDRIP: This link.
[5] At This link.

We are also aware of reports of disparity in respect to hospital access for some remote ATSI communities in places such as the Northern Territory (NT), Western Australia (WA) and Queensland (QLD) compared to other remote (non-ATSI) communities. A recent study indicated this may be a widespread issue. After our own research, we believe there is, indeed, obvious disparity. Some remote communities with a large ATSI population do not have direct access to a hospital, while other comparatively sized remote communities without a large ATSI population do, without any obvious other distinction. The Government is apparently generally aware that remote communities face increased difficulties accessing health facilities and hospitals, but may not have specifically considered whether the size of some particular remote ATSI communities justifies the placement of a proximate hospital, as has occurred for other non-ATSI communities of similar or even less population. In our view, this should be met with practical action to establish new large healthcare facilities and/or hospitals within selected remote ATSI communities, with clear and long-term resulting benefits.

We are aware that there may exist practical and logistical challenges in respect to developing water and health infrastructure within remote communities. However, in our view, the health of Australia's remote communities and the unequal health outcomes of ATSI peoples are such important issues that they mandate that the Government take meaningful steps to contribute to progress in this area.

As such, our submissions address the following matters:

1. **ATSI peoples continue to experience unequal health outcomes, especially in remote areas. Some remote ATSI communities experience specific issues relating to poor water quality and disparate direct hospital access. These are factors contributing to health inequality, and are obvious areas in respect of where change is required:** It is well known, including to the Government, that ATSI peoples in Australia continue to experience unequal health outcomes, particularly in remote communities. While there are, no doubt, many contributing factors, some remote ATSI communities also specifically experience problems relating to poor water quality, and/or disparate hospital access compared to other remote communities. While addressing the broader problem of overall health inequality may be challenging, specific problems of poor water quality and disparate hospital access in respect of affected remote ATSI communities could be improved in obvious ways. As these challenges contribute to unequal health outcomes in some remote ATSI communities, they should be addressed. At very least, they are obvious areas in which progress can, and should, be made.

2. **UNDRIP principles support action to address inequality of health outcomes, improve access to health services, and improve the sanitation and health conditions in remote ATSI communities generally. They may also provide a supporting rationale to address any poor water quality issues and disparate hospital access specifically:** The UNDRIP contains provisions regarding the right of Indigenous people's access to health services, and their equal right to the highest attainable standard of physical health. It also contains provisions relating to the right of Indigenous peoples to the improvement of their social conditions, including (among other things) in respect to sanitation and health. These principles seemingly justify all sorts of initiatives with the overarching goal of improving the health of ATSI peoples and addressing factors that may be contributing to an inequality of health outcomes generally. In our view, they may also provide a supporting rationale to investigate and address any issues of poor water quality and improve any disparate hospital access specifically, as these matters are inherently connected to the health and sanitation of ATSI communities and the physical health standards attainable within them.

ACL Submission to Inquiry into the application of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) in Australia

3. **The Government should take further action in accordance with the UNDRIP towards improving the sanitation and health conditions in some remote ATSI communities, including initiatives to address any poor water quality issues and improve disparate hospital access:** In our view, the Government not only *may*, but also *should*, take further action to improve the health and sanitation conditions of ATSI communities and address health inequality. Not only does the UNDRIP provide a supporting rationale for such action, but the ongoing existence of health inequality among ATSI peoples and the importance of our valuable remote ATSI communities also necessitates it. While we commend the Government for the work it is already undertaking to 'Close the Gap' regarding ATSI health, it is clear that there is more work to be done and taking further action to address this problem would improve Australia's adherence to the UNDRIP's principles. In our view, the rectifying of issues in respect to poor water quality and enhancing the direct hospital access of remote ATSI communities are inherently connected to achieving practical progress in ATSI health. As such, we believe the Government should make it a priority to investigate and address these issues specifically. This may contribute to tangible improvements in the overall problem of ATSI health inequality and would have evident long-term benefits for the relevant ATSI communities. We urge the Government to improve the application of the UNDRIP in Australia by implementing new initiatives to secure real and tangible change in ATSI health. Our view is that more progress is essential and the Government must do all it can to forge change.

Recommendations:

1. The ACL recommends that the Commonwealth Government improve adherence to the principles of UNDRIP in Australia by committing to, and funding, new initiatives to seek to improve the sanitation and health conditions in remote ATSI communities. In particular:
    a. The Government should commit to initiatives to investigate and substantiate the depth of the issue of poor water quality and lack of water quality testing in remote ATSI communities, and take practical action to 'Close the Gap' in delivery of safe drinking water. While outside of ACL's area of expertise, some possible practical options to address this problem might include things which other relevant stakeholders have suggested, such as:
        i. funding a national water quality monitoring program to establish 'the gap';
        ii. seeking input from communities, governments, regulators, utilities, research institutions, etc. regarding the issue, challenges, and solutions;
        iii. expanding funding for new water grid technology for remote ATSI communities;
        iv. enshrining water quality and related health outcomes in national initiatives;
        v. formalising (eg. through legislation and regulation) the Australian Drinking Water Guidelines for all communities, including remote ATSI communities; and
        vi. governments committing to, and reporting against, drinking water quality targets.

    b. The Government should consider whether disparate hospital access may be improved specifically by funding (together with states) the establishment of new hospitals in close proximity to targeted remote ATSI communities based on population levels, lack of existing access and need. To assist, we have outlined below some examples of remote communities with high ATSI populations that may possibly justify the placement of a hospital. The Government's access to a range of other relevant information about catchment areas, future projections and logistical considerations, would be a helpful starting point for identifying potential locations for construction of new facilities.

Our submissions are discussed in more detail below. Any **bold** emphasis in quotes or extracts is ours.

ACL Submission to Inquiry into the application of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) in Australia

SUBMISSIONS

1. **ATSI peoples continue to experience unequal health outcomes, especially in remote areas. Some remote ATSI communities experience specific issues relating to poor water quality and disparate direct hospital access. It is not a stretch to believe that these factors contribute to health inequality, and are, at the very least, obvious areas in respect of required changes.**

Introduction

It is well known, including to the Government itself, that ATSI peoples in Australia continue to experience unequal health outcomes. This is particularly the case in remote communities. While there are no doubt many contributing factors, some remote ATSI communities also specifically experience problems relating to poor water quality, and/or have disparate hospital access compared to other remote communities.

While addressing the broader problem of overall health inequality may be challenging, any specific problems of poor water quality and disparate hospital access in respect of affected remote ATSI communities could be improved in obvious ways. As these challenges contribute to unequal health outcomes in remote ATSI communities, they should be addressed. At very least, they are obvious areas in which progress can and should be made.

ATSI peoples continue to experience unequal health outcomes

There is a wealth of information, including published by Government entities, which indicates that ATSI peoples in Australia continue to experience unequal health outcomes as compared to other Australians, particularly in remote communities.

It would be impractical (and likely unnecessary, given that this is apparently a well-known issue) for our submission to discuss this issue or the range of sources which indicate this in any level of detail.

However, to point to one particularly recent and poignant example highlighting the ongoing disparity, the Australian Institute of Health and Welfare (AIHW) (an Australian Government entity) published this web article[6] on 7 July 2022 in relation to 'Indigenous health and wellbeing' (Report).

Among other things, the AIHW Report clearly discussed that life expectancy is generally lower for Indigenous people living in remote and very remote areas:

> *"Life expectancy and deaths are widely used as indicators of population health. Given current mortality patterns, Indigenous males born in 2015–2017 could expect to live 71.6 years, and Indigenous females 75.6 years (ABS 2018).* ***In general, life expectancy is lower in remote areas, with Indigenous males and females living in major cities expected to live around 6 years longer than those living in remote and very remote areas****."*

It also clearly pointed to Indigenous people continuing to experience a much higher 'burden of disease' than other Australians (although the absolute gap narrowed between 2003 and 2018):

> *"Conditions that generally cause illness and disability, rather than death, can have a major impact on the health of individuals and communities – for example, depression, arthritis, hearing loss, and asthma. One way of combining the fatal and non-fatal effects of diseases in a comparable way is through* ***burden of disease analysis****. This* ***measures the impact of different diseases and injuries in terms of the number of years of healthy life lost due to illness or premature death****.*
>
> *…*

[6] See https://www.aihw.gov.au/reports/australias-health/indigenous-health-and-wellbeing.

> ***Comparison of burden of disease results for Indigenous and non-Indigenous Australians shows that, overall, Indigenous Australians experience burden at 2.3 times the rate of non-Indigenous Australians, but that the absolute gap narrowed between 2003 and 2018**."*

The AIHW Report also discussed data which shows that Indigenous Australians experience a rate of suicide almost twice that of non-Indigenous Australians, making this a 'public health priority':

> *"Reducing deaths by suicide and suicidal behaviour among Indigenous Australians is an issue of major concern for many Indigenous communities and a **public health priority** for all Australian governments. **Data from 2016–2020 show that the rate for suicide of Indigenous Australians is almost twice the rate of non-Indigenous Australians**, with the differences being greater for people aged under 45 (AIHW 2021a). **Suicide was the fifth leading cause of death among Indigenous Australians in 2020, accounting for 5.5% of all deaths, and the 14th leading cause of death for all Australians (1.9% of all deaths)**. It was also the leading cause of death for Indigenous children aged 5–17 (ABS 2021a)."*

It also pointed to higher rates of Indigenous dental/oral problems and preventable vision problems:

> *"**Indigenous children are more likely than non-Indigenous children to experience tooth decay and to be hospitalised for dental problems** (AIHW 2020). Several factors contribute to the **poorer oral health of Indigenous children**, including social disadvantage and lack of access to appropriate diet and dental services.*
>
> *…*
>
> ***Preventable vision problems, such as trachoma, diabetic retinopathy and cataracts affect Indigenous Australians aged 40 and over at much higher rates than non-Indigenous Australians of the same age**."*

The website for the Australian Government Department of Health and Aged Care also specifically acknowledges higher rates of psychological distress and chronic diseases among ATSI peoples:[7]

> *"The **burden of disease** for [ATSI] people is **2.3 times** that of non-Indigenous Australians. **Rates of psychological distress and chronic diseases are higher among [ATSI] people. There are disparities across the social determinants of health,** such as education, housing, employment and income."*

Even from just these couple of sources, it seems very clear that ATSI peoples continue to experience unequal health outcomes compared to other Australians, and there is much need for progress.

The Commonwealth 'Closing the Gap' Implementation Plan is already focussed on directing Government work to improve life outcomes experienced by ATSI Australians.[8] As the Committee might already be aware, Outcome 1 of the Plan is that "People enjoy long and healthy lives".[9] Its targets include to "Close the Gap in life expectancy within a generation, by 2031".[10]

The ACL commends the Commonwealth for its ongoing work to improve the health outcomes of ATSI peoples within Australia. As the Commonwealth Plan itself notes, health is a "fundamental human right" which has flow-on effects, "enabling full participation in life, including the capacity to

[7] See This link.
[8] See the National Indigenous Australians Agency website: This link.
[9] See page 23 of the Plan: This link.
[10] See page 23 of the Plan: This link.

fully participate in education, employment and economic activity".[11] Without addressing the inequality of ATSI health outcomes, progress towards equality in these other areas may be dulled.

Unfortunately, it is evident that there is still much work to be done to achieve legitimately equal health outcomes for ATSI peoples in Australia, including in remote communities. We reiterate the importance of the Government continuing to work towards meaningful and long-term progress.

Apparent issues relating to water quality in some remote ATSI communities

In addition to potentially experiencing unequal health outcomes generally, some remote ATSI communities also experience specific issues relating to poor water quality.

The ACL is very concerned by such reports. As Water Quality Australia, an Australian Government Initiative, points out, maintaining good water quality "is essential to human health".[12] The World Health Organisation (WHO) notes that contaminated water may be linked to the transmission of diseases and expose individuals to preventable health risks, and that the presence of chemicals can also be of health significance. This may also have flow-on economic and social effects.[13]

In terms of remote ATSI communities specifically, the Water Services Association of Australia (WSAA) also notes that safe drinking water is not only critical in its own right, but also to 'Closing the Gap': [14]

> *"**For remote First Nations communities, the delivery of safe drinking water is not only critical in its own right, but fundamental to many closing the gap targets**, particularly its:*
>
> - *Impact on **public health***
> - *Impact on **remote living** and **integration with public housing***
> - *Impact on **wellbeing of people and communities**".*

In WSAA's view, water has however "been nearly lost from the Closing the Gap framework, and we do not know the true scale of the gap in water provision to remote communities". [15]

Though there are comprehensive Australian national guidelines for water quality, WSAA indicates that there are a number of reports of water quality issues within remote ATSI communities: [16]

> *"In Australia, **the Australian Drinking Water guidelines set out a comprehensive national framework for water quality** that is safe to drink and has acceptable taste, colour and odour.*
>
> *Most of us take this for granted; but **as a number of reports have noted, Australia is falling short in its delivery of services to remote First Nations communities**, as measured against the United Nations Sustainable Development Goal 6: Ensure availability and sustainable management of water and sanitation for all.*
>
> ***Studies by the Productivity Commission (2021) and Infrastructure Australia (2021) have identified shortcomings in provision of services to remote communities, but there is a lack of both available and consistent information**."*

[11] See page 23 of the Plan: This link.
[12] See https://www.waterquality.gov.au/issues.
[13] See: This link.
[14] See page 4 of the WSAA report here (discussed further below).
[15] See page 8 of the WSAA report here (discussed further below).
[16] See page 4 of the WSAA report here (discussed further below).

Other sources also apparently substantiate this issue. For example, published research indicates that some remote WA Aboriginal communities have "unsafe drinking water quality" and that this may be connected to specific health problems. In particular, this study published in 2018[17] discussed that:[18]

- Chronic Kidney Disease (CKD) "is a multi-factored health problem", but one "suspected causal factor" is contaminated drinking water.
- CKD occurs globally but is found in particularly high concentrations among people of certain ethnic and disadvantaged social groups living in very different locations around the world.
- It has "become endemic" in WA where hospital admissions for Aboriginal people requiring renal dialysis or treatment for diabetes are much higher than for the general population.
- The study examined the drinking water quality among communities such as these. It was found that water chemistry analysis in these areas "indicates that the nitrate and uranium content greatly exceed officially recommended levels". Concerningly, most of these communities rely on raw groundwater to supply their domestic needs, and "it is very likely that the people are unwittingly ingesting high levels of nitrates and uranium, probably including uranyl nitrates".
- Very few such remote communities have access to treated drinking water, and cost-effective water treatment systems are required to provide potable water at the local scale.

A Follow-up Report on 'Delivering Essential Services to Remote Aboriginal Communities' by the Western Australian Auditor General in June 2021 also indicates that this is an ongoing issue. For example, its 2015 audit found shortcomings in the delivery of water (among other things) to 84 out of 143 audited remote WA communities, and although some progress was made in intervening years, water still tested positive for contaminants in 37 communities in the 2 year period to 2019-2020 (apparently nearly one-quarter of all remote WA communities audited). A further 51 communities were not tested for water quality until late 2019. As the report acknowledges, these situations exposed residents to public health risks and some of those risks remained:[19]

> *"This audit looked at the Department of Communities' management of essential services to **143 communities in remote WA**, and it follows up on the recommendations from our 2015 audit when the State provided services to 84 of the larger communities.*
>
> *…*
>
> *Our **2015 audit found shortcomings in the delivery of power, water and wastewater services to 84 remote Aboriginal communities** under the Remote Area Essential Services Program (RAESP). The **report highlighted poor water quality in some communities, difficulties coordinating services and weaknesses in the application of service eligibility criteria**.*
>
> *…*
>
> ***Water quality has improved in 38 communities** and wastewater is now monitored in line with contracts. Power and water supplies are more reliable. The Department has taken steps to improve coordination with other State entities and improved its contract management. It has also reviewed essential service eligibility and clarified its roles and responsibilities for essential services in remote Aboriginal communities.*
>
> ***However, water still tested positive for contaminants in 37 communities in the 2 year period to 2019-20. A further 51 communities were not tested for water quality until late***

[17] Rajapakse, Rainer-Smith, Millar, Grace, Hutton, Hoy, Jeffries-Stokes, and Hudson (2018). Unsafe drinking water quality in remote Western Australian Aboriginal communities. *Geographical Research* 57 (2) 178-188. https://doi.org/10.1111/1745-5871.12308.

[18] Note: A full-text copy of the article is apparently available here: This link.

[19] See particularly pages 2 to 5 of the Western Australian Auditor General's follow-up report.

> ***2019, 4 years after they were included in the REMS program. This exposed these communities to the risk of illness from chemical and biological contamination.***
> …
> *New assets and water management plans have contributed to* ***improved drinking water in around half of the communities we looked at in 2015, reducing risks from poor water quality****. The* ***number of times water-borne microbes posed a risk to public health has declined****, with 4 in 5 of those communities having water supplies free from microbes in recent testing compared with less than half in 2015.*
> …
> ***Contamination of the water supply by microbes, nitrates or uranium still occurred in 37 of the communities we looked at in 2015****. In the 2 years to 2019-20, test results confirmed* ***Escherichia coli (E. coli) or Naegleria species*** *in 21 communities,* ***high nitrate levels*** *in 19 communities, and* ***high uranium levels*** *in 4 communities.* ***Public health risks from drinking contaminated water remain in these communities."***

The follow-up report also seems to suggest the existence of associated issues regarding things like transparency, prioritisation of larger communities, documentation of decisions, the division of federal/state responsibilities, funding and communication with remote communities: [20]

> *"****Although the Department has reviewed essential service levels, the criteria it uses and how they are applied are not transparent****.* ***The Guidelines specify service levels based on community size, prioritising large communities*** *in line with the State Government's 2016 road map Resilient Families, Strong Communities. But the Department also considers additional factors outside the published criteria. Its* ***documentation of decisions affecting remote communities is also poor****. With a lack of public reporting on performance of service delivery and no formal process for remote Aboriginal communities to raise concerns, it is hard for people living in these communities to assess the services they receive.*
> …
> ***There was no water quality testing in 51 of the smallest communities previously serviced by the Commonwealth until November 2019.*** *The Department told us in early 2020 that it did not test regularly and had no plans to do so because the Commonwealth had not done it, it was neither necessary nor practical and the Department was not funded to do it. However, in October 2020 it varied contracts to include annual chemical testing in 501 of these communities and started microbial testing in 6 of them. These tests found 2 with microbial contamination and unsafe levels of uranium and fluoride in another.* ***Even when tests were done, the Department did not always act promptly on the results. It took 9 months to issue a 'no drink' notice to 1 community after a water quality test result exceeded Australian Drinking Water Guidelines in 2019. The delay in notifying the community of the test results meant it was exposed to unsafe water for those 9 months.*** *There are no plans to ensure existing water treatment systems in these communities are adequate by testing the water quality output. Apart from the limited testing mentioned above, the Department intends only to protect bores and carry out annual inspections and preventative maintenance of these systems. However,* ***source protection and system maintenance alone cannot ensure that assets are functioning as expected and that drinking water sources are clean****. We note that the Public Health Act 2016 (Act) requires entities to take all reasonable steps to avoid harm to public health. In May 2017 the Department advised the Minister for Housing that the Act applied to remote communities. In September 2019 it acknowledged that it may need to seek*

[20] See particularly pages 2 to 5 of the Western Australian Auditor General's follow-up report.

> *exemption under section 267 of that Act for an unspecified number of communities because of **budgetary constraints**. Regulations under the Act have not yet been gazetted, but if they are the Department will need to ensure it is compliant."*

Commentary on the Murdoch University website here calls this follow-up report "damning" and points to specific disease risks associated with contaminants mentioned in the report like high nitrate levels.[21]

By some estimates, perhaps almost 200,000 Australians overall do not have safe drinking water.

In particular, WSAA published this preliminary report on 'Improving water services to remote First Nations communities' in August 2022.[22] It notes that despite important 'Closing the Gap' initiatives, stories "regularly emerge" of remote communities with limited or no access to safe drinking water:[23]

> *"**Many stakeholders across Australia are leading many important initiatives in "Closing the Gap' for First Nations peoples**, addressing health, social, economic and other aspects. **Yet amid this work, stories regularly emerge about remote communities with limited and sometimes no access to safe drinking water, poor health outcomes associated with lack of clean and reliable water supplies, and unclear accountabilities** for providing water services."*

As such, WSAA commissioned a review of remote water services in 2021. The full report will be released in November 2022,[24] but the preliminary report still clearly indicates a problem. For example, it identified reports about a range of concerns about water supplies in remote communities:[25]

> *"For all its importance, **the review has identified that people living in remote communities report a range of concerns about their water supplies**:*
>
> - *They **report problems with contamination and water quality,** and they are **backed up by evidence from various reputable health and epidemiological studies as well as water quality reports from water utilities and service providers**. The reports reveal that water quality **issues are persistent, and in some cases are getting worse, in many remote communities across Australia**.*
> - *They **report issues with the taste, smell, and colour of their water** and they are concerned about **calcium and uranium**.*
> - *They **report problems with the reliability of supply**. Many communities see delays in maintenance and poor customer service compounding their water supply issues, leading to an **increase in the already high cost of living, resulting in neglect**.*
> - *They also report being distrustful of government and frustrated by a **perceived lack of accountability, transparency and communications** between service providers and communities.*
> - ***Some communities, logically, report that they are concerned about the potential health impacts on their communities**."*

The WSAA also quoted other sources pointing to a lack of water quality and/or testing in remote and Indigenous communities: [26]

[21] See https://www.murdoch.edu.au/news/articles/delivering-safe-water-to-aboriginal-communities.
[22] See This link.
[23] See page 3 of the WSAA report.
[24] See page 3 of the WSAA report.
[25] See pages 6 and 7 of the WSAA report.
[26] See page 9 of the WSAA report.

ACL Submission to Inquiry into the application of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) in Australia

> *"**Our report will quote a recent article published by the National Indigenous Times (NIT) which highlighted that in WA a large number (44) of communities' water supplies are not tested for water quality and they haven't been tested in more than a decade**.*
>
> ***A recent Western Australian Auditor General's report** (ref), Delivering Essential Services to Remote Aboriginal Communities, **highlights a range of issues associated with water quality in small First Nations communities including**:*
>
> - ***There was no water quality testing in 51 of the smallest communities** previously serviced by the Commonwealth **until November 2019**.*
> - ***It was reported that the Department of Communities didn't undertake regular testing because it was neither necessary nor practical and there was no funding for it**.*
> - ***Microbial contamination and unsafe levels of uranium and fluoride were detected in some communities when water quality testing started**."*

It noted that its findings were also "consistent with the work of Dr Paul R. Wyrwoll from the ANU who found in recent research that 408 remote or regional communities lacked access to good quality drinking water and 40 percent of these communities are First Nations communities".[27]

WSAA is apparently referring to this published study involving Wyrwoll.[28] According to the study, almost 200,000 people across over 115 locations may access water which does not comply with the relevant guidelines, and perhaps up to around 630,000 across 408 locations lack access to 'good' quality water more broadly. Notably, 40% of all locations with recorded health exceedances were remote Indigenous communities:

> *"Drinking water quality remains a persistent challenge across regional and remote Australia. We reviewed public reporting by 177 utilities and conducted a national assessment of reported exceedances against the health-based and aesthetic guideline values of the Australian Drinking Water Guidelines (ADWG). Four definitions of a basic level of drinking water quality were tested to quantify service gaps across regional and remote areas of each subnational jurisdiction in 2018–2019. **At least 25,245 people across 99 locations with populations <1000 reportedly accessed water services that did not comply with health-based guideline values. Including larger towns and water systems, the estimated service gap rises to at least 194,572 people across more than 115 locations.** Considering health parameters and the ADWG definition of 'good' aesthetic characteristics, the reported service gap rises further to at least 627,736 people across 408 locations. **Forty percent of all locations with recorded health exceedances were remote Indigenous communities**…"*

The researchers also thought that the actual incidence of non-compliance could even be much higher than the study's estimates, and that there was a need for 'place-based solutions':

> *"…**Monitoring and reporting gaps indicate that the actual incidence of non-compliance with the guideline values of the ADWG could be much higher than our estimates.** Our results quantified the divergence in the assessment of water quality outcomes between Sustainable Development Goal Target 6.1 and the ADWG, demonstrated disparities between service levels in capital cities and the rest of Australia, and **highlighted the need for place-based solutions**. **The methods and dataset provide a 'proof-of-concept' for an Australian national drinking water quality database to guide government investments in water services**."*

[27] See page 8 of the WSAA report.
[28] Wyrwoll, P.R., Manero, A., Taylor, K.S. et al. Measuring the gaps in drinking water quality and policy across regional and remote Australia. *NPJ Clean Water* 5, 32 (2022). https://doi.org/10.1038/s41545-022-00174-1.

ACL Submission to Inquiry into the application of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) in Australia

A published study in 2020[29] also considered the factors associated with sugar-sweetened beverage consumption among Indigenous Australian children aged 0 to 3 years old. It found, among other things, that sugar-sweetened beverage consumption prevalence was "significantly lower in urban and regional v. remote areas". Notably, "key informants highlighted the role of water quality/safety on [sugar-sweetened beverage] consumption". As such, the researchers concluded that improving water quality was one upstream strategy (among others) that should be employed to reduce the consumption of sugar-sweetened beverages among young Indigenous children. The study clearly discussed specific concerns being raised about water quality in many regional and remote settings:

> *"In addition,* ***many people living in regional and remote communities in Australia do not have ready access to safe drinking-water*** *(,48,49).* ***In the focus group, RAOs raised concerns about water quality in many regional and remote settings, citing problems such as yellow bore water, high levels of lead in water and 'poisoned' water*** *(such as contamination with per- and polyfluoroalkyl substances in Katherine, Northern Territory ,50)).* ***Previous research suggests that tap water is perceived as 'unhealthy' in some settings*** *(,51),* ***including due to a history of water quality problems*** *(,49).* ***RAOs explained that, when concerned about water taste or safety, many people avoid drinking tap water and buy bottled water or other beverages; when bottled water is the same price as SSB, people may opt for SSB. This fits with previous research suggesting that the lack of palatable water can lead to high consumption of SSB and other ready-to-drink beverages in Australia*** *(,48) and internationally (,52).* ***For example, research in an Australian (,53) and a Canadian (,52) remote community with poor water quality identified that it was common to mix water with cordial or tea to make it drinkable, and that soft drinks were more commonly consumed than tap water****. Redressing water conflicts in Australia could have multiple benefits for [ATSI] peoples' well-being, including decreased SSB consumption (,48,54,55)."*

This seems to clearly indicate that poor water quality in some remote communities may be linked with higher consumption of sugar-sweetened beverages, including among young ATSI children. This obviously might also be linked with corresponding public health issues and outcomes.

Some health entities also acknowledge reports of water quality issues in remote ATSI communities.

For example, Australian Medical Association NSW acknowledges on its website here that the burden of inequity in access to safe drinking water disproportionately affects remote areas, often with a high population of ATSI people. It points out that "out of sight" communities should not be "out of mind":[30]

> *"The* ***burden of inequity in terms of access to safe drinking water*** *in Australia* ***disproportionately affects remote areas****, and* ***these areas often have a larger population of [ATSI] people****.*
>
> ***Having access to safe drinking water is a fundamental human right****. Water remains a critical issue for many communities across Australia, particularly those who were at risk of losing their water supplies at the height of the recent drought. As devastating as losing water supplies might sound,* ***many [ATSI] communities live without safe drinking water every day. In prosperous countries such as Australia, it is often assumed that safe drinking water is accessible to everyone – but it is not.***

[29] Thurber, K. A., Long, J., Salmon, M., Cuevas, A. G., & Lovett, R. (2020). Sugar-sweetened beverage consumption among Indigenous Australian children aged 0-3 years and association with sociodemographic, life circumstances and health factors. *Public health nutrition*, 23(2), 295–308. https://doi.org/10.1017/S1368980019001812.

[30] See https://www.amansw.com.au/water-crisis/.

ACL Submission to Inquiry into the application of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) in Australia

> ***In many remote or very remote communities bore water is often the primary source of drinking and household water, but it is often contaminated and fails to meet the standards of the Australian Drinking Water Guidelines. Water chemistry analysis in some communities indicates that the nitrate and uranium content far exceed recommended levels for drinking.*** *The burden of inequity in terms of access to safe drinking water in Australia disproportionately affects remote areas, and these areas often have a larger population of [ATSI] people.* ***The fact that Indigenous people live without safe drinking water is unacceptable and it should not be the case that people in remote communities are out of sight, therefore, out of mind.****"*

It calls for "immediate attention and action by all levels of government", confirming that this is actually a "public health issue" and that without attention and action on safe drinking water the health gap between ATSI peoples and other Australians "will remain wide and intractable":[31]

> *"[ATSI] people in remote communities represent an important part of Australia's heritage and* ***local, state, territory and federal governments must take urgent action to address the water crisis facing many remote communities. Not only is access to safe drinking water a human rights issue, it is also an important public health issue****. The lack of water and affordable healthy food in rural and remote communities is* ***strongly linked to the epidemic levels of diabetes and renal disease among [ATSI] people****. Sugary drinks are more readily available than low sugar drinks, and in some communities, they are more accessible than running water. In a recent study published by the Australian National University,* ***concerns about the safety and quality of drinking water in rural and remote areas have led residents to avoid tap water and instead buy bottled water, cordial or other sugary drinks.***
>
> *It is* ***unfathomable that in Australia, there are some communities that do not have access to safe drinking water – this is essential for good health and wellbeing****. While most of us enjoy free, safe drinking water from the tap, those who can least afford it often have to pay just to ensure they are not drinking water sourced from rivers, streams, cisterns, poorly constructed wells, or water from an unsafe catchment.* ***It is an issue that demands immediate attention and action by all levels of government – without it, the health gap between [ATSI] people and their non-Indigenous peers will remain wide and intractable.***
>
> *The AMA sees an interim policy opportunity for the Commonwealth Government through Outback Stores to ensure that bottled water is affordable and available, especially where the supply of drinking water to homes and communities may be inadequate.* ***Over the long term, governments must invest in the appropriate infrastructure, such as proper treatment facilities, water storage facilities and distribution systems to meet the water needs of communities****. Access to safe drinking water is an important policy issue for the AMA and is something that we will continue to advocate for – all Australians have the right to permanent and free access to safe drinking water regardless of where they live."*

In addition to general indications that water quality issues may impact the public health of affected communities, there are also reports of specific instances where water quality issues have impacted the delivery of actual health services in remote health facilities.

In particular, according to this ABC article in May 2021,[32] a remote ATSI community's water quality was pinpointed as the reason for delays in dialysis chairs being installed in the Doomadgee hospital. While six dialysis chairs were set aside for people in Doomadgee, some of them were unable to be

[31] See https://www.amansw.com.au/water-crisis/.
[32] See This link.

used because water quality issues resulted in the need for further filtration devices (the chairs require a very specific water quality for operation, higher than general drinking water). As a result, haemodialysis patients from Doomadgee had to travel to, or permanently move to, Mount Isa or Townsville to receive treatment. It probably goes without saying that a delay in the availability of dialysis chairs due to a lack of high quality water might have associated public health impacts for a remote community, particularly for patients unable or unwilling to travel or move to other locations.

Given the number of different sources highlighting such reports, including published studies, it seems evident that there may in fact be issues relating to water quality in some remote ATSI communities. In some cases, this may include water which does not comply with the relevant Australian guidelines.

If so, given the potential health, social and economic impacts of poor water quality, there is clearly a pressing need for action. We find it hard to fathom that any communities in modern Australia, whether remotely located or not, lack access to water of a quality that meets the standard health guidelines.

As WSAA points out, there is in fact a more basic need to "elevate these issues in the national conversation" and substantiate the depth of the issue, along with recommending actual ways to 'Close the Gap' in the delivery of safe drinking water.[33] There is clearly a need for this issue to be investigated, substantiated, and, where needed, prioritised for remediation at a national level.

These issues have achieved some recent recognition by media sources at least. For example, this article by the ABC in August 2022[34] discussed the WSAA report and the Wyrwoll study, and published interviews with locals who reported their experiences and health issues associated with poor water quality. Obviously, this would have had some effect in bringing this issue to the general public's attention, and indeed, was one factor which contributed to ACL conducting research into this issue.

However, the apparent gap in respect of water quality in remote and ATSI communities is apparently not currently a part of the Commonwealth's Plan to 'Close the Gap' discussed above. Given the importance of this issue to public health and to the wellbeing of remote ATSI communities specifically, we consider that this is an oversight which requires rectification. We expect that other ongoing efforts to 'Close the Gap' in ATSI health might be rendered less effective if water quality remains an issue.

At the very least, the Government should commit to initiatives to investigate and substantiate the depth of the issue of poor water quality and any lack of water quality testing in remote ATSI communities. If the reports are substantiated, the Government should commit to take practical action to 'Close the Gap' in the delivery of safe drinking water.

The WSAA preliminary report does contain numerous recommendations about how practical gains may be achieved, if those recommendations might assist the Committee to formulate specific recommendations for practical action. To broadly summarise some of WSAA's suggestions, it recommends that the Commonwealth Government should immediately:[35]

- fund a national water quality monitoring program with transparent reporting to establish the gap that all stakeholders need to work towards closing;
- fund a national roundtable on water quality for remote ATSI communities, seeking input from organisations including representatives from communities, governments, regulators, utilities, research institutions, etc.;

[33] See This link.
[34] See This link.
[35] See page 5 of the WSAA report. See also more detail on pages 11 onwards of the WSAA report.

- expand the remit of National Water Grid funding to appropriate technology for remote ATSI communities; and
- enshrine water quality and related health outcomes in a revised National Water Initiative.

WSAA also recommends that: [36]

- the Commonwealth, States and Territories should move to formalise (preferably through legislation and regulation) the Australian Drinking Water Guidelines for all communities, including ATSI communities;
- the National Health and Medical Research Council, as owners of the Australian Drinking Water Guidelines, be provided with funding of $2M to revise the Community Water Planner; and
- all governments should commit to, and report against, targets in Closing the Gap and the Sustainable Development Goals on drinking water quality.

While this is obviously well outside of ACL's usual area of expertise, we suggest that the Committee and/or Government at least consider the utility of the WSAA recommendations (particularly once finalised in the final WSAA report due to be published in November).

Whether the specific WSAA recommendations are adopted or not, in our view it is clear that the Government must take some action towards substantiating the depth of this issue and seeking to 'Close the Gap' in water quality and testing.

WSAA acknowledges ongoing challenges in relation to the supply of adequate and safe drinking water, such as limited qualified personnel, lack of resources, remoteness, ageing infrastructure, logistical complexities, etc.[37]. We would expect that these sorts of considerations would be practical challenges to be overcome for action to be taken on this issue.

However, WSAA also points out that this is an issue that affects the wellbeing of people and communities, and may have impacts on public health, social disadvantage, the costs of health services, liveability conditions in remote communities, cost of living, etc. [38] In our view, the challenges that exist regarding this issue *must* be overcome if we are to truly 'Close the Gap' in respect of ATSI peoples and their health. Essentially, despite the obvious logistical and practical challenges to widely addressing issues of poor water quality and testing, it is too important to ignore.

Apparent disparate hospital access in some remote ATSI communities

The Government is apparently already generally aware that some remote ATSI communities face increased issues relating to hospital access.

This is possibly an obvious conclusion from even a logistical perspective – it stands to reason that people in remote ATSI communities may need to travel further than people living closer to major population centres to access health services and hospitals, and therefore face additional hurdles.

Government material directly acknowledges this known issue.

For example, the AIHW Report discussed above[39] clearly indicates that differences in access to health services may be a 'key contributor' to Indigenous Australians in remote areas having higher rates of disease burden and lower life expectancy compared with those in non-remote areas:

[36] See page 5 of the WSAA report. See also more detail on pages 11 onwards of the WSAA report.
[37] See page 5 of the WSAA report.
[38] See page 5 of the WSAA report.
[39] See https://www.aihw.gov.au/reports/australias-health/indigenous-health-and-wellbeing.

ACL Submission to Inquiry into the application of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) in Australia

> *"**On average, Indigenous Australians living in remote areas having higher rates of disease burden and lower life expectancy compared with those in non-remote areas. Key contributors to this include differences** in educational and employment opportunities, **in access to health services**, in housing circumstances, and in other factors that support healthy behaviours (such as the availability and cost of fresh fruit and vegetables)…".*

This apparently varies within regions, with different communities experiencing different issues:[40]

> *"… **But areas of relative advantage and disadvantage also exist within these regions. Local areas and communities may experience different issues and outcomes to others and have different needs and priorities. Looking at variations across smaller geographic areas can help to highlight specific areas of need,** so that programs and services can be directed where they will be of most benefit."*

The website for the Australian Government Department of Health and Aged Care also specifically acknowledges that people in rural and remote areas face additional difficulties accessing healthcare:[41]

> *"**Access to health services is reduced for various reasons, including cost and lack of accessible or culturally appropriate health services** where and when they are needed.*
>
> *…*
>
> ***People living in rural and remote areas also face difficulties accessing health care, especially specialist services, due to distance**."*

As such, the Government is apparently generally aware that remote communities face increased difficulties accessing health facilities and hospitals and that this may have associated health impacts. Outcome 1 of the Commonwealth Plan to 'Close the Gap'[42] also clearly indicates that the Government is taking action to support the delivery of new healthcare programs and services for ATSI people.

However, after considering this problem, we query whether there may also be a specific disparity in respect of hospital access for some remote ATSI communities compared to other similarly-sized remote (non-majority ATSI) communities. Essentially, some remote ATSI communities may now be a of a size which justifies their need for direct hospital access, especially considering other remote non-ATSI communities of similar sizes which have hospitals. It is a reasonable question as to why they may have been overlooked or not yet considered as a possible site for the location of a new hospital.

Notably, there is some published research which seems to suggest that there is a disparity. In particular, this published study in June 2020[43] reviewed the availability of inpatient hospital services in Australian towns with a population between 1,000 and 4,999. It compared towns with a population of more than 80% being ATSI peoples with other towns. The vast majority of these towns either had a hospital with acute inpatient beds or were within 50 kilometres of a nearby hospital. However, concerningly, it found that "towns with a population of more than 80% [ATSI] people are less likely to either have a hospital or be within 50 kilometres of one":

> *"We used census data from the Australian Bureau of Statistics and jurisdictional and federal health department website data to conduct a review of the availability of inpatient hospital services in Australian towns with a population between 1,000 and 4,999, based on the Accessibility/Remoteness Index of Australia (ARIA+) classification system.4 **We compared***

[40] See https://www.aihw.gov.au/reports/australias-health/indigenous-health-and-wellbeing.
[41] See This link.
[42] See page 23 onwards of the Plan: This link.
[43] Francis, J. R., Verma, S., & Bonney, D. (2020). Disparity in distribution of inpatient hospital services in Australia. *Australian and New Zealand journal of public health*, *44*(4), 326. https://doi.org/10.1111/1753-6405.12996. See https://onlinelibrary.wiley.com/doi/10.1111/1753-6405.12996.

> ***towns with a population of more than 80% being [ATSI] people with other towns*** *using Fisher's exact test for comparison of categorical variables, and a p-value <0.05 was considered significant.*
>
> ***There are 533 towns in Australia with a population between 1,000 and 4,999*** *(median population 1,819).* ***Of these, 14 (3%) have an [ATSI] population that accounts for more than 80% of the total population.***
>
> ***The vast majority of these towns either have a hospital with acute inpatient beds*** *(226/533, 42%)* ***or are within 50 kilometres of a nearby hospital*** *(282/533, 53%).* ***Towns with a population of more than 80% [ATSI] people are less likely to either have a hospital or be within 50 kilometres of one (5/14, 36% vs 503/519, 97%; p<0.001), see Table 1".***

The researchers published this table[44] comparing the towns with a high population of ATSI peoples (over 80%) to other towns and their hospital access:

Table 1: Access to inpatient hospital services in Australia, comparing towns where >80% population are Aboriginal and/or Torres Strait Islander people, with other towns, with total population 1,000-4,999.

	Towns >80% Aboriginal/Torres Strait Islander (n=14)	Towns ≤80% Aboriginal/Torres Strait Islander (n=519)	Total towns, population 1,000–4,999 (n=533)
Median population (interquartile range)	1,273 (1,116–2,165)	1,830 (1,263–2,707)	1,819 (1,256–2,664)
Hospital with inpatient beds (%)	5 (36%)	221 (43%)	226 (42%)
Within 50km of a hospital with inpatient beds (%)	0	282 (54%)	282 (53%)
Either a hospital with inpatient beds or one within 50km (%)	5 (36%)	503 (97%)	508 (95%)

Essentially, this study indicates that among Australian towns of similar size, those with a higher population of ATSI peoples were less likely to have access to hospitals.

As to possible reasons for the disparity, the researchers noted that it was difficult to rationalise the poorer hospital access in respect of ATSI towns, as it could not be explained by proximity to larger centres or a lesser need for services:

> *"We strongly support calls for increased support for Aboriginal Community Controlled Health Organisations and acknowledge the importance of bringing focused attention to bear on primary and preventive health needs within [ATSI] towns.* ***It is difficult to rationalise the poorer access to local inpatient hospital services found here. It cannot be explained by proximity to larger centres or by a lesser need for services, as neither of these are true.*** *The [ATSI] towns without hospital services within 50 kilometres are all very remote towns in Northern Australia, which experience disproportionately high burdens of morbidity and mortality. The lack of locally accessible hospital services does not only increase the risk of death and disability, it also contributes to substantial health costs associated with retrieval and relocation to distant centres for hospital care."*

The study does not overtly suggest that ATSI towns are less likely to have direct hospital access based solely on the fact that they are ATSI towns, and we acknowledge there could be other factors at play.

[44] A formatted version of the table (rather than a text copy) is available from a copy at this link: This link.

However, it clearly indicates at least that there is a clear rationale and need for improving the hospital access of ATSI towns specifically (not just the hospital access of remote communities generally).

Indeed, the researchers themselves called for consideration to be given to developing hospital services in ATSI towns, concurrent with efforts to improve primary and preventative healthcare:

> *"**In such towns where hospital services are not currently available, consideration should be given to developing these concurrently with efforts to improve primary and preventive health care** and to facilitate increasing Aboriginal control and strengthening of the [ATSI] health workforce. **Such an initiative is likely to require a combination of federal and state or territory funding and should involve communities in the development and control of these services.**"*

Since becoming aware of this study, we have also begun considering examples of some remote communities with high ATSI populations that may possibly justify the placement of a proximate large health facility/hospital as has occurred for other similarly-sized remote communities.

Again, while this is not our area of expertise, our understanding is that some remote communities with a large ATSI population do not have direct access to a hospital, while other comparatively sized remote communities without a large ATSI population do. We see no obvious reason for the difference.

We have compiled a document summarising the results of our research so far, and have annexed it in **Annexure 1** for the Committee's convenience.

To draw out a few comparisons which might assist the Committee to understand our concerns:

- **Maningrida, NT**: Maningrida is one of the largest Aboriginal towns in the NT, situated approximately 500km east of Darwin in Arnhem Land.[45] For some key statistics:
  - **Population:** Maningrida itself apparently has a population in excess of 2,500 – for example, according to this NT Government website, its population was estimated at 2,686 in 2020.[46] The Australian Bureau of Statistics' (**ABS**') 2021 Census data for Maningrida here indicated a population of 2,518.[47] Outside of the town centre, people also live on 30 outstations around Maningrida[48] (around 375 in the 2021 ABS Census data here).[49] The total district population may in fact be around 3,500 (so around 1,000 people also live in the catchment area around Maningrida), according to this Maningrida Local Emergency Plan 2020/2021 of the Territory Emergency Management Council.[50] Other sources like the ABC also indicate that Maningrida and its surrounding homelands are resident to around 3,500 people.[51]
  - **ATSI population:** Maningrida *does* have a majority ATSI population – the NT Government website indicates that approximately 92% were Indigenous in 2020.[52] Official ABS Census data from 2016 here also indicated that almost 89% were ATSI peoples,[53] and ABS' 2021 Census data similarly indicated that 91.2% of the population were ATSI peoples.[54]

[45] See this Charles Darwin University website: https://remotengagetoedu.com.au/communities/maningrida/.
[46] See https://bushtel.nt.gov.au/profile/362?tab=demographics.
[47] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/SAL70172.
[48] See website for National Centre for Indigenous Genomics here: This link.
[49] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/ILOC70400302.
[50] See page 8 of the Territory Emergency Management Council plan.
[51] See ABC article at This link.
[52] See https://bushtel.nt.gov.au/profile/362?tab=demographics.
[53] See https://www.abs.gov.au/census/find-census-data/quickstats/2016/IARE704003.
[54] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/SAL70172.

- **Hospital:** Maningrida has a community health centre providing regular clinic programs[55] including antenatal care, Under 5's, Well-Baby clinic, immunization, aged care, etc. However, Maningrida *does not* have a hospital. If emergency hospital care is required, evacuation to Darwin is provided by a medivac service operated by NT Aero-med.[56] Otherwise, Maningrida is around 509 kilometres from Darwin hospital, an around 9 hour drive[57] or a flight time of around 1.5 hours.[58]

To give examples of similar-sized towns for comparison:

- **Boonah, QLD:** Boonah is around 86km from Brisbane, approximately a 1 hour drive:[59]
  - **Population:** ABS' 2021 Census data here indicates that Boonah has a population of 2,557 people.[60] This is similar to the 2016 Census data here, which counted 2,484 people.[61]
  - **ATSI population:** Boonah *does not* have a high ATSI population – in 2016, ABS Census data pointed to an ATSI population of 1.9%,[62] and in 2021 it was 2.5%.[63]
  - **Hospital:** Boonah *does* have a hospital (website here).[64] It has around 22[65] to 23 beds[66] and an emergency department.[67]

- **Cloncurry, QLD:** Cloncurry is around 770km from Townsville, approximately an 8.5 hour drive:[68]
  - **Population:** ABS' 2021 Census data here indicates that Cloncurry has a population of 3,167 people.[69] This is similar to the 2016 Census data here, which counted 2,719 people.[70]
  - **ATSI population:** Cloncurry also *does not* have a majority ATSI population – in 2016, ABS Census data pointed to an ATSI population of 20.6%,[71] and in 2021 it was 23.7%.[72]
  - **Hospital:** Cloncurry *does* have a hospital (website here). It has around 15 beds and an emergency department.[73]

These are but a few examples of remote towns with populations of around 2,500. Though Maningrida is of a similar size to these other towns (and, in fact, has an apparently even larger population to consider if residents of surrounding outstations and the district area are also considered), it does not have a hospital while the other remote towns mentioned above do. This is despite being much further away from any other existing hospital as well. Although there may be many factors at play here, we query whether remote ATSI towns like Maningrida should be considered for the establishment of a new hospital. While the percentage of ATSI peoples living in a town is largely irrelevant to whether

[55] See this website for the Mala'la Health Service Aboriginal Corporation: This link.
[56] See website of Remote Area Health Corps: https://www.rahc.com.au/maningrida.
[57] See calculations on Google: This link.
[58] See calculation on Trip.com: https://www.trip.com/hot/flight-time-from-darwin-to-maningrida/.
[59] See calculations on Google: This link.
[60] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/SAL30321.
[61] See https://www.abs.gov.au/census/find-census-data/quickstats/2016/SSC30323.
[62] See https://www.abs.gov.au/census/find-census-data/quickstats/2016/SSC30323.
[63] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/SAL30321.
[64] See https://www.westmoreton.health.qld.gov.au/location/boonah-health.
[65] According to this Queensland Government website: This link.
[66] According to this Hospital Stays website: https://www.hospitalstays.com.au/hospitals/boonah-hospital/710.
[67] According to this Queensland Government website: This link.
[68] See calculations on Google: This link.
[69] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/SAL30628.
[70] See https://www.abs.gov.au/census/find-census-data/quickstats/2016/SSC30633.
[71] See https://www.abs.gov.au/census/find-census-data/quickstats/2016/SSC30633.
[72] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/SAL30628.
[73] See http://www.performance.health.qld.gov.au/Hospital/Index/243.

the town is deserving of a hospital or not (as all Australians are of course equally deserving of proper healthcare regardless of their heritage), the intentional placement of new hospital facilities within such remote ATSI towns may be a vital step towards 'Closing the Gap' in ATSI health outcomes. This is particularly so for Maningrida given that it is one of the largest Aboriginal towns in the NT. It also seems justified regardless, based on the population that such a hospital would service generally. As per other examples below, even towns with much smaller populations have dedicated hospitals.

To give another comparison that may be useful regarding three slightly smaller ATSI-majority towns:

- **Aurukun, QLD:** Aurukun is around 800km northwest of Cairns:[74]
  - **Population:** ABS' 2021 Census data here indicates that Aurukun has a population of 1,101 people.[75] This is similar to the 2016 Census data here, which counted 1,269 people.[76]
  - **ATSI population:** Aurukun *does* have a majority ATSI population – in 2016, ABS Census data pointed to an ATSI population of 90.2%,[77] and in 2021 it was 88.7%.[78]
  - **Hospital:** Aurukun has a primary healthcare facility with visiting specialists.[79] However, it *does not* have a hospital.

- **Kowanyama, QLD:** Kowanyama is over 600km from Cairns, approximately an 8 hour drive:[80]
  - **Population:** ABS' 2021 Census data here indicates that Kowanyama has a population of 1,079 people.[81] This is similar to the 2016 Census data here, which counted 944 people.[82]
  - **ATSI population:** Kowanyama *does* have a majority ATSI population – in 2016, ABS Census data pointed to an ATSI population of 90.9%[83] and in 2021 it was 86.8%.[84]
  - **Hospital:** Kowanyama has a primary healthcare facility with visiting specialists.[85] However, it *does not* have a hospital.

To give examples of similar-sized towns for comparison:

- **Esk, QLD:** Esk is around 99km from Brisbane, approximately a 1.5 hour drive:[86]
  - **Population:** ABS' 2021 Census data here indicates that Esk has a population of 1,641 people.[87] This is similar to the 2016 Census data here, which counted 1,698 people.[88]
  - **ATSI population:** Esk *does not* have a high ATSI population – in 2016, ABS Census data pointed to an ATSI population of 3.3%[89] and in 2021 it was 3.5%.[90]
  - **Hospital:** Esk *does* have a hospital (website here). It has around 20 beds and an emergency department.[91]

[74] See calculations on Google: This link.
[75] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/SAL30104.
[76] See https://www.abs.gov.au/census/find-census-data/quickstats/2016/SSC30104.
[77] See https://www.abs.gov.au/census/find-census-data/quickstats/2016/SSC30104.
[78] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/SAL30104.
[79] See this Queensland Government website: This link.
[80] See calculations on Google: This link.
[81] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/SAL31575.
[82] See https://www.abs.gov.au/census/find-census-data/quickstats/2016/SSC31590.
[83] See https://www.abs.gov.au/census/find-census-data/quickstats/2016/SSC31590.
[84] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/SAL31575.
[85] See this Queensland Government website: This link.
[86] See calculations on Google: This link.
[87] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/SAL30984.
[88] See https://www.abs.gov.au/census/find-census-data/quickstats/2016/SSC30994.
[89] See https://www.abs.gov.au/census/find-census-data/quickstats/2016/SSC30994.
[90] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/SAL30984.
[91] According to this Queensland Government website: This link.

- **Blackall, QLD:** Blackall is around 213km from Longreach, approximately a 2.5 hour drive:[92]
  - **Population:** ABS' 2021 Census data here indicates that Blackall has a population of 1,365 people.[93] This is similar to the 2016 Census data here, which counted 1,416 people.[94]
  - **ATSI population:** Blackall *does not* have a high ATSI population – in 2016, ABS Census data pointed to an ATSI population of 5%[95] and in 2021 it was 5.1%.[96]
  - **Hospital:** Blackall *does* have a hospital (website here). It cost $20.11 million, was newly opened in late 2020 and has around 10 beds and emergency department bays.[97]

Again, these examples of remote towns all have similar populations of around 1,000 to 1,500 people. Though Aurukun and Kowanyama are of a similar size to Esk and Blackall, they do not have hospitals while the others do, despite being more remote from other hospitals. Again, we query whether remote ATSI towns like these should be considered for the establishment of new hospitals in future to help with 'Closing the Gap' in ATSI health outcomes and given the general size of the population that such prospective hospitals could service in any case.

The same sort of comparison can also be applied to even smaller remote towns. For example, to name three smaller ATSI-majority remote towns:

- **Angurugu, NT**: Angurugu is over 630km east of Darwin[98] on Groote Eylandt[99] (the largest island in the Groote archipelago in the Gulf of Carpentaria[100]), accessible by passenger ferry or flight[101]:
  - **Population:** ABS' 2021 Census data here indicates that Angurugu has a population of 883 people.[102] This is similar to the 2016 Census data here, which counted 855 people.[103]
  - **ATSI population:** Angurugu *does* have a majority ATSI population – in 2016, ABS Census data pointed to an ATSI population of 97.3%[104] and in 2021 it was 97.2%.[105]
  - **Hospital:** Angurugu has a health centre (website here).[106] However, it does *not* have a hospital. In fact, Groote Eylandt more broadly apparently does not have a hospital at all (only an additional health centre in Alyangula).[107] Interestingly, a testimonial on the Northern Territory General Practice Education website here indicates that "most days" a patient would be evacuated to Gove or Darwin for treatment in larger hospitals.[108]

- **Yuendumu, NT:** Yuendumu is around 290km northwest of Alice Springs along the Tanami Highway:[109]

[92] See calculations on Google: This link.
[93] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/SAL30270.
[94] See https://www.abs.gov.au/census/find-census-data/quickstats/2016/SSC30272.
[95] See https://www.abs.gov.au/census/find-census-data/quickstats/2016/SSC30272.
[96] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/SAL30270.
[97] See this Queensland Government website: This link.
[98] See calculations on Google: This link.
[99] See https://www.eastarnhem.nt.gov.au/angurugu.
[100] See https://www.britannica.com/place/Groote-Eylandt.
[101] See https://www.eastarnhemland.com.au/places-to-go/groote-eylandt.
[102] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/SAL70011.
[103] See https://www.abs.gov.au/census/find-census-data/quickstats/2016/SSC70011.
[104] See https://www.abs.gov.au/census/find-census-data/quickstats/2016/SSC70011.
[105] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/SAL70011.
[106] See https://www.rahc.com.au/South-East-Arnhem-Area.
[107] See https://www.rahc.com.au/South-East-Arnhem-Area.
[108] See https://ntgpe.org/testimonials/claire-demeo-reflects-her-time-groote.
[109] See https://centraldesert.nt.gov.au/yuendumu.

- **Population:** ABS' 2021 Census data here indicates that Yuendumu has a population of 740 people.[110] This is similar to the 2016 Census data here, which counted 759 people.[111]
- **ATSI population:** Yuendumu *does* have a majority ATSI population – in 2016, ABS Census data pointed to an ATSI population of 85.5%[112] and in 2021 it was 83.4%.[113]
- **Hospital:** Yuendumu has a community health centre.[114] However, it does *not* have a hospital. Interestingly, the ABC reported here in 2018 that some members of Yuendumu were boycotting the local health clinic over concerns about patient mistreatment and accidents. The ABC also reported that the Royal Flying Doctor Service conducted the second highest number (200) of aeromedical flights in the NT in 2017 from Yuendumu.[115]

- **Bidyadanga, WA:** Bidyadanga is around 190km south of Broome by road.[116] It is the largest remote Aboriginal community in WA:[117]
  - **Population**: ABS' 2021 Census data here indicates that Bidyadanga has a population of around 600 people.[118] This is similar to the 2016 Census data here, which counted 617 people.[119] However, a website for the Bidyadanga Aboriginal Community La Grange Inc here indicates that its population in fact totals around 750 to 800 people.[120]
  - **ATSI population:** Bidyadanga *does* have a majority ATSI population – in 2016, ABS Census data pointed to an ATSI population of 89.9%[121] and in 2021 it was 87.2%.[122]
  - **Hospital:** Bidyadanga has a health centre (website here), although it is closed on Friday afternoons.[123] However, it *does not* have a hospital.

To give examples of similar-sized towns for comparison:

- **Quilpie, QLD**: Quilpie is around 210km from Charleville, approximately a 2.5 hour drive:[124]
  - **Population:** ABS' 2021 Census data here indicates that Quilpie has a population of around 530 people.[125] This is similar to the 2016 Census data here, which counted 595 people.[126] According to Outback Queensland, Quilpie's population is currently around 650 people.[127]
  - **ATSI population:** Quilpie *does not* have a majority ATSI population – in 2016, ABS Census data pointed to an ATSI population of 19.9%[128] and in 2021 it was 15.1%.[129]

[110] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/SAL70301.
[111] See https://www.abs.gov.au/census/find-census-data/quickstats/2016/SSC70301.
[112] See https://www.abs.gov.au/census/find-census-data/quickstats/2016/SSC70301.
[113] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/SAL70301.
[114] See This link.
[115] See this ABC article: This link.
[116] See calculations on Google: This link.
[117] See website for Bidyadanga Aboriginal Community La Grange Inc here: https://www.bidyadanga.org.au/.
[118] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/ILOC50100203.
[119] See https://www.abs.gov.au/census/find-census-data/quickstats/2016/UCL521004.
[120] See https://www.bidyadanga.org.au/copy-of-our-community.
[121] See https://www.abs.gov.au/census/find-census-data/quickstats/2016/UCL521004.
[122] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/ILOC50100203.
[123] See This link.
[124] See calculations on Google: This link.
[125] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/SAL32377.
[126] See https://www.abs.gov.au/census/find-census-data/quickstats/2016/SSC32401.
[127] See website for Outback Queensland here: https://www.outbackqueensland.com.au/town/quilpie/.
[128] See https://www.abs.gov.au/census/find-census-data/quickstats/2016/SSC32401.
[129] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/SAL32377.

  - **Hospital:** Quilpie *does* have a hospital (website here) including an emergency department[130] and around 6 available beds.[131]

- **Alpha, QLD**: Alpha is located around 250km from Longreach (approximately a 2.5 hour drive)[132] or 400km from Rockhampton (approximately a 4 hour drive):[133]
  - **Population**: ABS' 2021 Census data here indicates that Alpha has a population of around 559 people.[134] The 2016 Census data here counted 335 people.[135]
    ATSI population: Alpha does *not* have a high ATSI population – in 2016, ABS Census data pointed to an ATSI population of 5.3%[136] and in 2021 it was 3.4%.[137]
  - **Hospital**: Alpha *does* have a hospital (website here). When it was opened in 2016 it included (among other things) emergency facilities, two inpatient beds, two observation beds and two resuscitation bays.[138]

- **Gnowangerup, WA**: Gnowangerup is around 300km from Perth[139] and around 62km from Katanning hospital:[140]
  - **Population:** ABS' 2021 Census data here indicates that Gnowangerup has a population of around 568 people.[141] The 2016 Census data here counted 598 people.[142]
  - **ATSI population:** Gnowangerup does *not* have a majority ATSI population – in 2016, ABS Census data pointed to an ATSI population of 15.3%[143] and in 2021 it was 13.4%.[144]
  - **Hospital:** Gnowangerup *does* have a hospital with an emergency department[145] and 12 beds.[146]

These examples of even smaller remote towns all have similar populations of around between 500 and 1,000 people. Though Angurugu, Yuendumu and Bidyadanga are of a similar size to Quilpie, Alpha and Gnowangerup, they do not have hospitals while the others do. Again, we query whether remote ATSI towns like these should be considered for the establishment of new hospitals in future to help with 'Closing the Gap' in ATSI health outcomes and given the general size of the population that prospective hospitals could service in any case. Though evidently quite small communities, they are comparable to other communities which do have the benefit of established hospitals.

These are, of course, only examples of some remote communities with high ATSI populations that may possibly justify the placement of a proximate large health facility/hospital (the document attached to Annexure 1 also provides some other selected examples). There are many other remote ATSI

[130] See South West Hospital and Health Service website here: This link.
[131] See this Queensland Government website: http://www.performance.health.qld.gov.au/Hospital/Index/118.
[132] See calculations on Google: This link.
[133] See calculations on Google: This link.
[134] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/SAL30045.
[135] See https://www.abs.gov.au/census/find-census-data/quickstats/2016/SSC30045.
[136] See https://www.abs.gov.au/census/find-census-data/quickstats/2016/SSC30045.
[137] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/SAL30045.
[138] See this Queensland Government news release in 2016: This link.
[139] See calculations on Google: This link.
[140] See calculations on Google: This link.
[141] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/SAL50564.
[142] See https://www.abs.gov.au/census/find-census-data/quickstats/2016/SSC50562.
[143] See https://www.abs.gov.au/census/find-census-data/quickstats/2016/SSC50562.
[144] See https://www.abs.gov.au/census/find-census-data/quickstats/2021/SAL50564.
[145] See This link.
[146] See https://www.hospitalmanagement.net/hospitals/gnowangerup-hospital/.

communities across Australia which could also be of a size to justify their consideration for the location of a new hospital. While the Government would obviously have access to a range of other relevant information about possible hospital catchment areas, future projections and logistical considerations which we do not have to hand, these examples may be a helpful starting point if the Government is amenable to identifying potential locations for the construction of new health facilities.

In any case, we propose that these examples demonstrate a broader point – that the size of some particular remote ATSI communities justify the placement of a proximate health facility/hospital as has occurred for other similar-sized communities. The research study which we have referred to above also indicates that this disparity might be an issue for widespread consideration.

The Government is obviously already taking action to 'Close the Gap' regarding healthcare services for ATSI people, and we commend the Government for doing so. However, in our view, the Government should also consider whether disparate hospital access may be improved specifically by funding the establishment of new hospitals and/or large health facilities in closer proximity to certain remote ATSI communities than existing infrastructure. This may contribute to real progress in actually 'Closing the Gap' in ATSI health outcomes in remote communities, and may also be justified regardless, based on the general population that such hospitals would be able to service generally.

While the construction of new health facilities and hospitals would involve significant funding commitments and outlays (at both federal and state level), we consider the long-term benefits associated with such projects would also be substantive, including likely tangible progress towards 'Closing the Gap' in Indigenous health outcomes, along with other measures.

On a practical level, governments may also save costs associated with the operation of remote evacuation and transport services currently operating out of towns which would benefit from newly constructed hospitals. They may also gain some efficiencies by co-locating any new hospitals together with existing community health centres and other primary healthcare facilities and programs which they currently operate in some remote areas.

Obviously any new facilities or hospitals would also be equipped to serve non-ATSI people living in such areas as well. They would therefore be of general benefit to the entire population living in the benefitted catchments, in addition to specifically contributing to 'Closing the Gap' in ATSI health specifically. If the locations chosen are based on population, lack of existing access and need, then widespread benefit seems likely to result from the construction of such facilities wherever located.

As foreshadowed above, this would include benefits associated with better public health – including greater productivity and the ability for people to fully participate in the workforce or education and better care for their children and families.

The construction of new health facilities and hospitals is also likely to have other corresponding social benefits within remote communities. For example, they would bring new employment opportunities, result in the development of other new infrastructure, shops and businesses, boost the local economy and potentially increase tourism to remote areas.

Overall, we expect that the construction of new large healthcare facilities or hospitals within any remote ATSI community is likely to contribute to progress in improving ATSI healthcare access and outcomes generally, while also bringing a range of other corresponding economic and social benefits.

2. UNDRIP principles support action to address inequality of health outcomes, improve access to health services, and improve the sanitation and health conditions in remote ATSI communities

generally. They may also provide a supporting rationale to address any poor water quality issues and disparate hospital access specifically.

Introduction

The UNDRIP contains provisions regarding the right of Indigenous people to access to health services, and their equal right to the highest attainable standard of physical health. It also contains provisions relating to the right of Indigenous peoples to the improvement of their social conditions, including (among other things) in respect to sanitation and health. These principles seemingly justify all sorts of initiatives with the overarching goal of improving the health of ATSI peoples and addressing factors that may be contributing to an inequality of health outcomes generally.

In our view, they may also provide a supporting rationale to investigate and address any issues with poor water quality and improve any disparate hospital access specifically, as these matters would be inherently connected to the health and sanitation of ATSI communities and the physical health standards attainable within them.

Articles in the UNDRIP that relate to the health of Indigenous peoples and the improvement of social conditions in respect of health and sanitation

The UNDRIP addresses a wealth of different matters relating to the rights of Indigenous peoples. However, it is evident that, among many other things, various articles uphold the health of Indigenous peoples and social conditions in respect of health and sanitation.

For example, Article 21 of the UNDRIP states:[147] *"Article 21*

> *1. **Indigenous peoples have the right**, without discrimination, **to the improvement of their economic and social conditions, including,** inter alia, in the areas of education, employment, vocational training and retraining, housing, **sanitation, health** and social security.*
> *2. **States shall take effective measures and, where appropriate, special measures to ensure continuing improvement of their economic and social conditions.** Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities."*

This Article apparently specifically affirms that Indigenous peoples have a right to the improvement of their social conditions, including in the areas of sanitation and health, and commits States to take effective (or perhaps even special) measures to ensure the continuing improvement of such conditions.

In our view, this Article would support the Government taking further action with the overarching goal of improving the social conditions of remote ATSI communities in respect of sanitation and health. We consider that this could ground the action we have suggested above regarding improving poor water quality, which may be connected to sanitation, and health (as discussed above). We also consider that it would ground action to improve direct hospital access within ATSI communities, as this would likely enhance the accessibility of healthcare within such communities and therefore also contribute to better public health among ATSI communities generally.

We note that in the wording of this UNDRIP Article, any measures undertaken to improve such conditions must be "effective" and may constitute "special" measures where appropriate. In our view, this underscores the importance of investigating and substantiating the depth of issues in respect to things like poor water quality, and carefully considering any appropriate locations to establish new

[147] See page 17 of the UNDRIP in this UN PDF document: This link.

health infrastructure such as hospitals. It also justifies the Government giving special attention and priority to such projects in order to ensure that social improvements continue to occur.

In addition, Article 24 of the UNDRIP states:[148] *"Article 24*

> *1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals.* ***Indigenous individuals also have the right to access, without any discrimination, to all social and health services.***
>
> *2.* ***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."***

This Article affirms the rights of Indigenous individuals to access all health services without discrimination, and their equal right to the highest attainable standard of physical health. It also commits States to take necessary steps to progressively realise this outcome.

In our view, subsection (1) of the Article adds to the rationale for the Government to take action to improve poor water quality and direct hospital access within remote ATSI communities. For example, it might be interpreted in the sense that ATSI individuals have the same right as all other Australians to water which meets the relevant water quality standards and guidelines. They also have the same right to access health services such as hospitals without any discrimination. While obviously hospitals cannot be established in every location, we believe the Government should ensure that the criteria which justifies the establishment of a hospital in one location equally applies to the establishment of a hospital in another location regardless of the proportion of people in the area who have ATSI or non-ATSI heritage. Obviously, remote ATSI communities should not be unintentionally overlooked. In fact, given the inequality of health outcomes being experienced by such communities, in our view they should in fact be intentionally targeted as the beneficiaries of new healthcare infrastructure.

Subsection (2) of the Article might also expressly require Government to take "necessary steps" towards securing an outcome where ATSI peoples tangibly realise their "equal right to the enjoyment of the highest attainable standard of physical and mental health". In our view, we are yet to see the "full realization" of this right in respect of ATSI Australians, given the inequality of health outcomes which they continue to experience, especially in remote areas (as discussed above). As such, we consider that this Article supports the Government taking continued action to progressively work towards securing an equality of health outcomes for ATSI people. Until ATSI Australians are able to actually tangibly enjoy the highest attainable standard of physical and mental health on par with other Australians, there remains work to be done, and the UNDRIP seemingly requires that work to be done.

In addition to these two UNDRIP articles which expressly relate to Indigenous health and social conditions, one other UNDRIP article may also indirectly incorporate relevant international laws.

In particular, Article 1 of the UNDRIP states: [149] *"Article 1*

> ***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****."*

[148] See page 18 of the UNDRIP in this UN PDF document: This link.
[149] See pages 7 and 8 of the UNDRIP in this UN PDF document: This link.

Essentially, this Article refers to the human rights of Indigenous people as protected by international human rights law and things like the Universal Declaration of Human Rights (UDHR). These may also separately affirm specific rights of Indigenous peoples in relation to health and medical care.

For example, an excerpt of Article 25 of the UDHR states:[150] *"Article 25*

> *1. **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. …"*

This affirms the right of Indigenous people to the full enjoyment of a "standard of living adequate for" health and well-being, including medical care. Obviously, this could potentially justify Government action to improve access to medical care within remote ATSI communities (and particularly if there are any remote ATSI communities in which people are not able to practically access medical care adequate for their health and wellbeing). For example, it could justify the establishment of new health infrastructure and hospitals on the basis that it would greater ensure that everyone within remote ATSI communities is fully able to access medical care adequate for their health and wellbeing.

In our view, it could also support Government action with the goal of improving the quality of drinking water in Indigenous communities. For example, it could justify action taken to ensure that ATSI communities have access to water of a quality commensurate with "a standard of living adequate for [their] health and well-being". Obviously, the quality of drinking water is inherently connected to health and wellbeing and the standard of living within a community, and the relevant guidelines regarding water quality in Australia would obviously meet that required for an adequate "standard of living". ATSI peoples also obviously have the right to drinking water of that same quality.

Overall, we consider that various UNDRIP principles justify action to address inequality of health outcomes, improve access to health services, and improve the sanitation and health conditions in ATSI communities generally. In fact, the UNDRIP seemingly actually *requires* that Governments implement effective or special measures to ensure the continuing improvement of social sanitation and health conditions, as well as take necessary steps towards the progressive realisation of equal Indigenous rights to the highest standard of attainable heath.

In our view, the UNDRIP principles may also justify action to investigate and rectify any issues with water quality and improve direct hospital access for remote ATSI communities specifically. Such initiatives would undoubtedly be consistent with the overarching goals of the UNDRIP in relation to ATSI health and sanitation at very least. They would likely positively impact public health and sanitation conditions within ATSI communities specifically, as well as contribute to helping ATSI peoples realise the highest standard of attainable health on par with other Australians more broadly.

For clarity, the ACL is not suggesting that remote ATSI communities are generally unsanitary, that they currently do not have *any* standard of living adequate for their health and wellbeing, or that they are intentionally discriminated against by the Government in terms of health access. Obviously, many remote communities have a standard of living similar in many ways to other Australian communities, and the Government is obviously aware of and taking action to 'Close the Gap' in respect of the inequality of health outcomes for ATSI peoples generally. However, it seems clear that there are some specific areas in which progress may be made in some remote ATSI communities in improving poor

[150] See page 7 of the UDHR in this UN PDF document: This link.

water quality and enhancing direct hospital access. In our view, while the potential for improvement exists, the UNDRIP supports that the Government takes practical action in this regard.

3. **The Government should take further action in accordance with the UNDRIP towards improving the sanitation and health conditions in some remote ATSI communities, including initiatives to address any poor water quality issues and improve disparate hospital access.**

Introduction

In our view, the Government should take further action to improve the health and sanitation conditions of ATSI communities and address health inequality. Not only does the UNDRIP provide a supporting rationale for such action, but the ongoing existence of health inequality among ATSI peoples and the importance of our valuable remote ATSI communities necessitates it. While we commend the Government for the work it is already undertaking to 'Close the Gap' regarding ATSI health, it is clear that there is more work to be done and taking further action to address this problem would improve Australia's adherence to the UNDRIP's principles.

In our view, rectifying issues in respect to poor water quality and enhancing the direct hospital access of remote ATSI communities are inherently connected to achieving practical progress in ATSI health. As such, we think the Government should make it a priority to investigate and address these issues specifically. This may contribute to tangible improvements in the overall problem of ATSI health inequality and would have evident long-term benefits for the relevant ATSI communities.

We urge the Government to improve the application of the UNDRIP in Australia by implementing new initiatives to secure real and tangible change in ATSI health. Regardless of what specific initiatives it chooses to implement, our view is that more progress must be made and the Government should do all it reasonably can to forge that change.

The Government should take action to address poor water quality issues and improve disparate hospital access

Such action would improve the application of the UNDRIP in Australia

As discussed above, the UNDRIP principles justify all sorts of initiatives with the overarching goal of improving the health of ATSI peoples and addressing factors that contribute to an inequality of health outcomes generally. They support action to address inequality of health, improve access to health services, and improve the sanitation and health conditions in remote ATSI communities generally. We consider that they may also provide a supporting rationale to address poor water quality issues and disparate hospital access specifically.

In our view, they support the need for the Government to seek to implement measures with such goals in remote ATSI communities. Indeed, the wording of these principles seems to make it incumbent on the Government to seek to continually improve the social (including sanitation and health) conditions of ATSI communities and take necessary steps to progressively realise an outcome by which ATSI peoples enjoy the highest attainable standard of physical and mental health on par with all Australians. While ATSI peoples in Australia continue to experience an inequality of health outcomes as compared to other Australians, we consider the need to address the issues remains an urgent priority.

The existence of the UNDRIP, our Government's commitment to it, and the strongly worded provisions it contains regarding Indigenous health are all reasons for the Government to take further action to address ongoing ATSI health inequality, including addressing poor water quality issues and disparate hospital access specifically.

ACL Submission to Inquiry into the application of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) in Australia

While we commend the Government for the work it is already undertaking to 'Close the Gap' in respect of the health of ATSI people, it is clear that there is more work to be done and taking further action to address this problem would improve adherence to the principles of UNDRIP in Australia.

Overall, in our view, the Government *may*, and *should*, improve adherence to the principles of UNDRIP in Australia by seeking to improve the sanitation and health conditions in remote ATSI communities. A primary, and in our view necessary, vehicle for doing so is for the Government to implement specific initiatives to improve poor water quality and disparate hospital access in remote ATSI communities.

The ongoing problem of ATSI health inequality and the importance of our valuable remote ATSI communities necessitates action

As discussed above:

1. ATSI peoples continue to experience unequal health outcomes, especially in remote areas.
2. Some remote ATSI communities may apparently also experience issues relating to poor water quality and disparate hospital access.

In our view, each of these realities also necessitates the Government taking further action in accordance with the UNDRIP. While the Government is obviously already working to 'Close the Gap' in respect of Indigenous health, it is clear there is more work to be done. The importance of our valuable remote ATSI communities reinforces that we cannot be ambivalent about seeing real, tangible progress made.

In our view, rectifying any issues in respect of poor water quality and enhancing the direct hospital access of remote ATSI communities specifically is inherently connected to practically achieving progress in respect of ATSI health inequality more broadly. As such, we ask the Government to make it a priority to investigate and address these specific issues in addition to its ongoing work to 'Close the Gap' more generally. The Government should strongly consider implementing initiatives to work towards progress in these areas in addition to its other ongoing initiatives in ATSI health.

This would contribute to tangible improvement in the overall problem of ATSI health inequality, and have evident, long-term benefits for the relevant ATSI communities.

We urge the Government to consider improving the application of the UNDRIP in Australia by continuing to expand and develop its work to 'Close the Gap' in respect of Indigenous health. More progress *must* be made and our Government should do all it reasonably can to forge the necessary change. The future health and wellbeing of our valuable ATSI Australian communities is at stake. While the UNDRIP both allows and justifies Government action in this regard, the ongoing problem of ATSI health inequality and the importance of these valuable people to our nation also necessitates it.

Annexure 1

Please find attached a copy of research document of Australian towns by population and facilities.