Making the right to health a reality

UNSW SYDNEY

UNSW Australian Human Rights Institute

Authors

Lubna Sherieff
Alicia McKenzie
Alfred Nguyen
Rabiba Pervez

Editors

Justine Nolan
Janani Shanthosh
Drew Sheldrick

Acknowledgment of Country

The Australian Human Rights Institute acknowledges the Bedegal people of the Eora Nation as the Traditional Custodians of the land on which our office is built. We confirm our support for the Uluru Statement from the Heart which calls for a constitutionally guaranteed Voice to Parliament.

Australian Institute of Human Rights

Room 125, The Law Building
UNSW Sydney, NSW 2052
Australia

E humanrights@unsw.edu.au
W humanrights.unsw.edu.au

Published

September 2021

Contents

Executive summary

The right of everyone to the enjoyment of the highest attainable standard of physical and mental health is recognised in article 12 of the *International Covenant on Economic, Social and Cultural Rights (ICESCR).* Like many other rights, the right to health is interrelated with and dependent upon the realisation of a number of other human rights.

This report provides an overview of the human right to health, how it applies in the Australian context and examines how its implementation might differ if acknowledged as a right to health incorporated in a national charter of rights.

Many of the *ICESCR* rights, including the right to health, are reflected in the provision of public services in Australia, but such services cannot be claimed as a right and can be withdrawn at any time.

A national charter of rights and freedoms would benefit the whole Australian community and have an important impact on the protection of health rights in Australia. It would help prevent human rights violations, provide a powerful tool for challenging injustices and foster a culture of understanding and respect for human rights.

A right to health would help promote the principles of accessibility, availability, acceptability and equality consistently in health systems across Australia and would be a powerful first step in achieving equal access to health for everyone.

The Australian Human Rights Institute has joined with other leading rights organisations in Australia to campaign for a national charter of rights. We believe that a full right to health should be recognised in a charter so that everyone can access quality healthcare when they need it, regardless of their background.

You can visit charterofrights.org.au for more information on this campaign and to keep up to date with its news and activities.

What is the right to health?

The right of everyone to the enjoyment of the highest attainable standard of physical and mental health is recognised in article 12 of the *International Covenant on Economic, Social and Cultural Rights* ('ICESCR').[1] Since the adoption of the *ICESCR* in 1966, global health issues have changed significantly and the COVID-19 pandemic has recently brought global attention to the implementation of this right.

The right to health is not a right to be 'healthy'.[2] Governments in countries around the world are not expected to ensure the good health of all people within their borders or provide protection against every cause of ill-health.[3] Instead, the right to health should be understood as the right to the necessary facilities, goods, services, and conditions that a government has the responsibility to provide for its people so they can attain a reasonable standard of health.[4]

The right to health under article 12 has two key elements: the right to timely and appropriate health care and the right to the underlying determinants of health.[5]

The right should be implemented in a manner that ensures non-discrimination and equal treatment to all.[6]

Like many other rights, the right to health is interrelated with and dependent upon the realisation of a number of other human rights, including the rights to an adequate standard of living, work, education, privacy, non-discrimination and equality.[7] It is also reflected in other international human rights treaties, which affirm and expand the application of the right to health as it applies to different marginalised groups in society.[8]

The Australian Government has accepted that it has specific obligations and duties under international law to respect, protect and fulfil the right to health.[9]

- **Duty to respect:** Australia has a duty to cease any acts that directly violate the right to health.[10] It must also refrain from interfering directly or indirectly with anyone's enjoyment of the right to health.[11]
- **Duty to protect:** Australia must adopt legislation or take other measures to prevent third parties (mainly individuals, groups or corporations within the private health sector) from violating the right to health of others.[12]
- **Duty to fulfil:** Australia must facilitate, provide and promote the right to health by adopting 'appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the realisation of the right to health.'[13]

However, human rights obligations and duties under international law are not automatically enforceable in Australia unless they have been implemented through domestic legislation and the *ICESCR* (as a whole) has not. The 'external affairs' power under the Australian Constitution gives the Commonwealth Parliament the authority to enter international human rights treaties such as the *ICESCR*.[14] Although states and territories also have an important role in promoting economic, social and cultural rights, it remains a federal responsibility to enact domestic legislation compatible with its international human rights obligations.

Many of the *ICESCR* rights, including the right to health, are reflected in the provision of public services in Australia, but such services cannot be claimed as a right and can be withdrawn at any time.

> "Australia has been described as having a 'patchwork quilt' approach to the protection of human rights, pieced together from an unplanned and uncoordinated collection of constitutional provisions, common law, legislation, policies and procedures, and institutions across state, territory and national jurisdictions, with the notable absence of a national human rights law."[15]

Australia's existing human rights framework

In December 2008, the Australian Government launched a national consultation to consider the protection and promotion of human rights in Australia at a federal level. Known as the 'National Human Rights Consultation', its key recommendation was that Australia should adopt a federal human rights act or charter.[16] The Australian Government instead adopted a more limited human rights framework, part of which involved the introduction of a parliamentary scrutiny process under the *Human Rights (Parliamentary Scrutiny Act) 2011* (Cth) (*'Parliamentary Scrutiny Act'*).

The *Parliamentary Scrutiny Act* establishes a Parliamentary Joint Committee on Human Rights which examines and reports to the Commonwealth Parliament on the human rights compatibility of any proposed Bills, legislative instruments, and other matters referred to it by the Commonwealth Attorney-General.[17] Members of Parliament who want to introduce a new law must also table a 'statement of compatibility' in Parliament that assesses whether the proposed law is compatible with the rights and freedoms contained in the seven core international human rights treaties that Australia has signed.[18]

Concerns have been expressed about the quality of these compatibility statements[19] and the limited impact of the parliamentary scrutiny regime in protecting and enhancing human rights.[20] The *Parliamentary Scrutiny Act* does not specifically protect or promote human rights and only states how the Commonwealth Parliament can examine new laws in light of Australia's international human rights obligations.[21] Even if a law is declared to be non-compliant with these human rights obligations, the Commonwealth Parliament can choose to still pass the law.[22] Courts at a federal level also have no role in determining whether human rights have been breached and individuals cannot seek a remedy under the *Parliamentary Scrutiny Act* if their human rights have been violated.[23]

States and territories: human rights and the right to health

The Australian Capital Territory (ACT), Victoria, and Queensland are the only three Australian jurisdictions with their own statutory charter of human rights. Each recognises aspects of the right to health to varying extents.

The ACT's *Human Rights Act 2004* (ACT) sets out fundamental civil and political rights, including the right to life[24] and protection from torture and cruel, inhuman or degrading treatment under which no one may be subjected to medical treatment or experimentation without their consent.[25] Victoria also includes these two rights amongst the 20 rights protected in the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (*'Victorian Charter'*).[26]

Queensland's recently-enacted *Human Rights Act 2019* (Qld) is largely consistent with Victoria and the ACT's model of rights, following a 'dialogue' model which aims to 'promote a discussion or dialogue about human rights' between the three branches of government: the legislature, the executive and the judiciary.[27] However, it also includes two economic, social and cultural rights – one being the right to health services.

Section 37 of Queensland's *Human Rights Act* states that:

(1) Every person has the right to access health services without discrimination; and

(2) A person must not be refused emergency medical treatment that is immediately necessary to save the person's life or to prevent serious impairment to the person.

Although this section is based on article 12 of the *ICESCR*, it excludes the right to the underlying determinants of health.[28] In the Explanatory Notes to the Bill, the Queensland Parliament stated that this was deliberate: section 37 is not intended to encompass rights concerning the underlying determinants of health, such as food and water, social security, housing, and environmental factors.[29] Given that this exclusion means that the wording in section 37 is narrower than article 12, the full scope of this right is difficult to determine.[30]

Each of these three Acts recognise a range of human rights but their protections are limited to the specific state or territory that enacted them. It means that the human rights of every person in Australia, especially in relation to the right to health, are not adequately and consistently promoted throughout the country.

ACT, VIC and QLD: How do their statutory charters of rights work?

Any new law proposed in the ACT, Victorian and Queensland parliaments must be accompanied by a statement of compatibility that considers its compatibility or incompatibility with the human rights expressed in each of the respective human rights acts.[31] The responsible parliamentary committee must also review all legislative proposals for their compatibility with human rights.[32] If a Bill is deemed incompatible or inconsistent with human rights, it is not necessarily invalid – it can still be passed by each parliament.[33]

Courts and tribunals must interpret all legislation consistently with human rights.[34] But if courts find that a statutory provision is inconsistent with the rights contained in the Acts, it cannot invalidate or 'strike down' the relevant provision or Act; it can only issue a declaration of incompatibility[35] or a declaration of inconsistent interpretation.[36] The responsible Minister (or in the case of the ACT, the ACT Attorney-General) must then prepare a written response within six months and table it in parliament.[37] It is then up to the parliament in each state or territory to decide whether or not to change the law to eliminate the incompatibility or inconsistency.

It is unlawful for public authorities to act inconsistently with human rights or fail to properly consider human rights in any decision-making process.[38] In the ACT, an individual who believes that their human rights have been infringed by a public authority may commence proceedings against them in the ACT Supreme Court.[39] The *Victorian Charter* does not give individuals the right to commence a legal action for a potential human right infringement. Instead, an individual can only invoke the *Victorian Charter* during an existing legal dispute.[40] Queensland's Act is similarly constructed.[41] None of these Acts establishes an individual's distinct right to damages if a human right is violated.[42]

The human rights set out in each of these Acts are not absolute. Ultimately, the parliaments in each of these jurisdictions can pass laws that limit or are contrary to the human rights contained in the Acts if it expresses a clear intention to do so.[43]

Victoria's 2020 public housing lockdown: A proportionate health response?

Amidst a rise of COVID-19 infections, the Victorian Government announced on 4 July 2020 that approximately 3,000 residents of nine public housing towers in Flemington and North Melbourne would be immediately detained in their homes for 14 days and unable to leave them unless in exceptional circumstances.[44] Hundreds of police officers were soon deployed to the area.[45] Restrictions were relaxed five days later over eight of the nine towers after a blitz of COVID-19 testing, but the tower located at 33 Alfred Street, North Melbourne remained in hard lockdown as a number of residents had tested positive.[46]

The Victorian Ombudsman launched an investigation into the treatment of the public housing tenants to see whether the Victorian authorities had acted compatibly with the *Victorian Charter*.[47] The Victorian Ombudsman found that, even though the temporary detention of residents at 33 Alfred Street may have been an appropriate measure to contain the COVID-19 outbreak, imposing the restrictions with immediate effect – and without further preparation and specific health advice recommending this approach – was not justified and reasonable in the circumstances.[48] Significantly, the Victorian Ombudsman found that the lockdown was not compatible with the residents' human rights and their rights were not given proper consideration when the restrictions were introduced.[49]

The Public Accounts and Estimates Committee of Victoria also investigated this lockdown as part of its parliamentary inquiry into the Victorian Government's response to the COVID-19 pandemic.[50] Together, these investigations found:

- Urgent requests for medication were delayed or neglected by authorities administering the lockdown. Residents were forced to rely upon family or community volunteers to collect and deliver essential supplies.[51]
- Residents experienced significant delays in receiving food. When it did arrive, for some residents it was culturally inappropriate and lacking basic staples.[52]
- Residents were not given access to fresh air and exercise until a week into the lockdown.[53]
- Some police were not wearing protective equipment, social distancing or using hand sanitiser and sometimes obstructed the delivery of food, medicine and healthcare to residents.[54]

Although the Victorian Ombudsman briefly recognised article 12 of *ICESCR* and the role of the *Public Health and Wellbeing Act 2008* (Vic) in promoting and protecting the health of people in Victoria, the investigation mainly assessed the residents' health and wellbeing, and access to healthcare under the right to life.[55] The right to health is interrelated with the right to life but is a distinct right. It has its own unique freedoms and entitlements in relation to the access to healthcare and the underlying determinants of health which deserve full recognition and consideration in health decision-making.

Within Victoria, the Flemington and North Melbourne public housing estates are known to have a higher number of residents from culturally and linguistically diverse backgrounds.[56] Culturally and linguistically diverse communities in Victoria have been disproportionately affected by COVID-19.[57] The United Nations states that these communities often have low-socio economic status and are overall subject to entrenched discrimination, which also makes them more vulnerable to harsher treatment by law enforcement under emergency measures.[58]

The United Nations Office of the High Commissioner notes that although COVID-19 requires governments to take extraordinary emergency measures to protect the health and wellbeing of its population, obligations on the core content of the right to health must remain in effect even during emergencies.[59] The Victorian Ombudsman found that proper consideration of human rights would have allowed for time to communicate and better plan the public health response as it would have put health (and not security) at the forefront and would have reduced or eliminated much of the distress to residents that followed.[60]

A right to health in a charter could have encouraged the Victorian authorities to ensure that any emergency measures were proportionate to the fulfilment of this right and did not discriminate against vulnerable people during a crisis.

How does the principle of non-discrimination apply to the right to health?

Non-discrimination is a key principle in international human rights law and is essential to attaining the right to health. Article 2(2) of the *ICESCR* obliges governments to guarantee that the rights in the Covenant are "exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status".[61] This list of prohibited grounds is non-exhaustive.[62] 'Other status' includes sexual orientation and health status (e.g. HIV/AIDS status) and could include the denial of someone's legal capacity because they are in prison and intersectional discrimination (e.g. where access to a service is denied on the basis of sex and disability).[63] As a 'core obligation' in the right to health, this principle means that Australia has an immediate obligation to ensure that access to healthcare and the underlying determinants of health do not discriminate and are accessible to all.[64]

Although a number of Australian federal and state laws prohibit discrimination on the basis of age, race, sex, and disability,[65] these do not provide comprehensive protection against all forms of discrimination in every area related to the rights set out in the *ICESCR*.[66]

What does the right to health mean for vulnerable groups in Australia?

The right to health requires our health system to be designed in a way that ensures that disadvantaged individuals and communities enjoy the same access to health as those who are more advantaged. Groups such as children, women, indigenous people, ethnic and racial minorities, prisoners, LGBTIQA+ people, people with disabilities, the elderly, asylum seekers and refugees, and homeless people each face unique barriers in attaining the highest standard of health in Australia.

Ensuring non-discrimination and equality in health means that governments must prioritise the needs of these groups to reduce their existing health inequalities. A right to health in a charter would create a legal foundation for progressive policies that target the health barriers of vulnerable groups, some of which are highlighted below.

People with disabilities

People with disabilities often have a higher risk of developing ill-health due to higher levels of poverty, discrimination, violence and social exclusion, and because of significant barriers in access to healthcare services.[67] Promoting their right to health includes targeting the attitudes and environmental and structural barriers that prevent their access to healthcare.[68] Some of these barriers include a lack of physical accessibility of health services (especially in rural and remote areas), a lack of accessible health information (e.g. information in Braille), communication barriers (especially for children and adults with intellectual disabilities), inappropriate models of consent to medical treatment, and higher financial costs of healthcare.[69]

Asylum seekers and refugees

Asylum seekers and refugees in Australia experience poorer health due to both pre-arrival and post-arrival factors, including a lack of care in their country of origin, trauma related to their forced migration experiences, prolonged detention and barriers to appropriate healthcare upon arrival.[70] Financial constraints can prevent them from accessing private services and instead depend upon community-based services in Australia.[71] Other barriers include different levels of settlement support, language differences and unfamiliarity with the Australian health system and discrimination.[72] Asylum seekers on certain visas are also excluded from accessing Medicare.[73] People in detention are at particular risk and are more likely to suffer from serious mental health issues.[74]

LGBTIQA+ people

The LGBTIQA+ community faces its own unique challenges in accessing the health system. For example, models of consent for LGBTIQA+ children are generally insufficient to promote their health needs as individuals born with variations in sex characteristics may be subject to unnecessary medical interventions at birth.[75] Gender diverse children in out-of-home care and the youth justice system are unable to access stage two hormonal treatment without court authorisation.[76] LGBTIQA+ people experience poorer mental health outcomes and have higher risks of suicidal behaviours which are directly related to experiences of stigma, prejudice, discrimination and abuse on the basis of their LGBTIQA+ status.[77]

Children

Some children are at greater risk of poorer health outcomes due to factors including geography, health literacy, and socio-economic circumstances. Children in remote areas especially are more likely to suffer abuse or neglect, experience young parenthood, and die due to intentional self-harm, giving them a unique set of healthcare needs that need to be addressed through age-appropriate forums.[78]

Aboriginal and Torres Strait Islander (hereafter Indigenous) communities

Indigenous health involves a 'whole of life' view of health involving not just the wellbeing of the individual, but the wellbeing of the whole community.[79] The whole-of-life view involves the cyclical concept of life-death-life.[80] Factors such as ongoing marginalisation, separation from culture and land, food and resource insecurity, intergenerational trauma, disconnection from culture and family, systemic discrimination and poverty have led to poorer health for many Indigenous people, as well as an increase in chronic conditions.[81] The most recent Closing the Gap report found that the two health-related targets to close the life expectancy gap and child mortality between Indigenous people and non-Indigenous people are not on track to be met by 2031.[82]

Indigenous communities and the COVID-19 vaccine rollout

In the early stages of the COVID-19 pandemic, the Australian Government appropriately recognised Indigenous communities as being at higher risk of serious infection in its COVID-19 *Emergency Response Plan*.[83] Accordingly, Indigenous people were recognised as a priority group in the COVID-19 vaccine rollout plan, with Indigenous people aged 55+ eligible for vaccination since March 2021 under Phase 1b, and those aged 16 – 54 eligible since June 2021 under Phase 2a.[84]

However, as of September 2021, Indigenous people were significantly behind non-Indigenous people in the vaccination rollout across Australia.[85] Experts said the discrepancy in vaccination rates was mostly due to early issues with ensuring Pfizer-BioNTech vaccine supply to GPs in regional and remote Indigenous communities but was also made worse by existing inequalities experienced by Indigenous people, including access to healthcare, housing, education and employment.[86]

During the mid-2021 COVID-19 outbreak in NSW, only 12.5% of the Indigenous population in NSW were fully vaccinated by the end of August 2021 compared to 30% of non-Indigenous Australians.[87] No Indigenous medical practices in NSW were supplied with Pfizer-BioNTech vaccines prior to Sydney's lockdown on 28 June 2021, despite a third of the total Indigenous population living in NSW.[88] Subsequently more than 1,000 Indigenous people in NSW contracted the virus between June–September 2021.[89] Most cases in rural communities in Western NSW, including the regional town of Wilcannia, resulted from low COVID-19 vaccine supplies, overcrowded housing, and lower access to primary healthcare services.[90] Wilcannia, for example, recorded 73 cases amidst its population of 720 as of September 2021, the highest transmission rate in NSW.[91] This is despite the federal government being warned by Indigenous health services in 2020 that Wilcannia needed urgent action to avoid the catastrophe of a potential COVID-19 outbreak.[92]

There has been evidence of Indigenous people not being sufficiently included in the planning and implementation of the rollout.[93] However, Indigenous communities in Victoria that have experienced a degree of vaccination success pointed towards strong partnerships between community-controlled Indigenous health services and health departments as the reason.[94] Recognising self-determination for Indigenous people and delivering health information in first languages results in higher uptake of health services and better health outcomes.[95]

Part of the right to health includes governments taking steps for the prevention, treatment, and control of epidemic and other diseases.[96] In managing the COVID-19 pandemic, this requires Australia to use its maximum available resources[97] to acquire, equitably distribute, and administer COVID-19 vaccines, prioritising its most vulnerable communities first.

A right to health would encourage governments to not only recognise the health needs of Indigenous communities as a priority during a health crisis, but to take concrete steps that achieve their access to health.

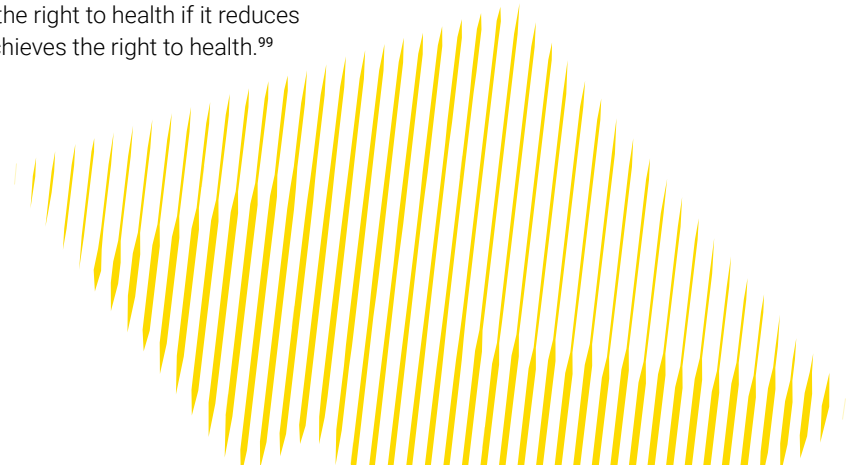
What should a health system look like to fulfil the right to health?

The United Nations Committee on Economic, Social and Cultural Rights (CECSR) states that, under the right to health, all health facilities, goods and services – including the underlying determinants of health – must be **available**, **accessible**, **acceptable** and of good **quality**.[98]

Availability	All health facilities, goods and services, and programmes, must be available in sufficient quantity.
Accessibility	All health facilities, goods and services must be geographically and financially accessible, provided on a non-discriminatory basis, and must ensure that health information is accessible.
Physical accessibility	All health facilities, goods and services must be within physical reach of the entire population, including people in rural areas.
Economic accessibility	All health facilities, goods and services, whether publicly or privately provided, must be affordable.
Information accessibility	Everyone must be able to seek, receive and impart information and ideas concerning health issues. People should be given all of the information required to make an informed decision about their health. Everyone also has the right for their medical information to be treated confidentially.
Non-discrimination	All health facilities, goods, and services must be available to everyone without discrimination on any ground (e.g. race, colour, sex, religion, political status, national origin, disability and sexual orientation).
Acceptability	All health facilities, goods and services need to be designed and delivered in a way that is culturally-sensitive to the needs of various members of the community. Services must accommodate factors such as an individual's cultural background, sex and religion to ensure that patients are treated in a culturally-sensitive manner that best protects their dignity.
Quality	All health facilities, goods, services and programmes must be scientifically and medically sound and of a high quality. Medical personnel must be properly trained and skilled, medical procedures must be scientifically approved, and access to safe and potable water must be guaranteed.

Source: CESCR General Comment 14

Under the *ICESCR*, a government can violate the right to health if it reduces the funding or eliminates a program which achieves the right to health.[99]



Australia's health system

Responsibility for Australia's health system is divided between the federal, state and territory governments, with private health providers, local governments, and other key stakeholders also playing a role.[100]

Australia's constitutional structure means that the Commonwealth shares jurisdiction with the states over health and healthcare policy.[101] Under the Australian Constitution, the Commonwealth Parliament has the legislative power to make laws on the provision of pharmaceutical, sickness and hospital benefits and medical and dental services.[102] Section 96 of the Australian Constitution also allows the Commonwealth Parliament to provide financial assistance to the states, on any terms and conditions as it sees fit.[103] In practice, this has meant that healthcare funding is primarily a federal responsibility while states are largely responsible for the administration and distribution of healthcare.[104]

Medicare and the Pharmaceutical Benefits Scheme (PBS) are Australia's main healthcare programs. Under the *Health Insurance Act 1973* (Cth), Medicare provides Australian citizens and most permanent residents with subsidies for GP visits, specialists and hospital care to assist in the delivery of **affordable** healthcare.[105] The quality, safety and efficacy of all medicines and medical devices are regulated through the Therapeutic Goods Administration (TGA), while the PBS is the main mechanism through which medicines are made both **accessible** and **affordable** for Medicare-eligible people.[106]

Other health programs funded by the Commonwealth include aged care[107] and disability services,[108] health services for veterans,[109] rural health programmes,[110] alcohol and other drug treatment services,[111] and vaccination[112] and cancer screening programs.[113]

States manage public hospitals, primary health services, ambulance services, deliver preventive services (e.g. cancer screening and immunisation programs) and handle health complaints.[114]

The private health sector sits alongside the public healthcare system and consists of private hospitals, medical, dental and allied professionals, pharmacies, the aged care sector, most radiology and pathology services and private companies.[115] The private sector is licensed and regulated by the federal and state governments.[116]

The National Healthcare Agreement promotes the **acceptability** of healthcare by requiring states and territories to maintain an independent body that hears complaints from individuals about the public health system.[117] The Private Health Insurance Ombudsman hears and investigates complaints against private insurers[118] while the Commonwealth Ombudsman hears complaints about Medicare.[119]

The Medical Board of Australia provides for the **quality** of the medical profession by developing standards, codes and guidelines for medical practitioners and establishing the registration requirements for medical practitioners and students.[120] Individual states and territories each have medical boards that support the national board.[121]

Local governments provide services on environmental health (e.g. waste disposal, water supply and quality and food safety monitoring) and deliver some public health services and health promotion activities.[122]

Accessibility is also promoted through charters such as the *Australian Charter of Healthcare Rights* which outline the rights individuals can expect when accessing the healthcare system, including rights to be treated in a culturally-sensitive manner and rights to health information and privacy.[123] However, these types of charters are not binding and do not have legal force.

The *Australian Institute of Health and Welfare Act 1987* (Cth) provides for the Australian Institute of Health and Welfare, which collects information and statistics on Australia's health. Effective health monitoring and disaggregated data collection assists in providing a transparent image of the welfare of all Australians.

Australia's pressure points: Limitations in fulfilling the right to health

Availability	During the mid-2021 outbreak of the COVID-19 delta variant in NSW, hospitals faced significant pressure under the increasing caseload.[137] Concerns were raised that understaffing was made worse during the outbreak, with ICUs not meeting professional staffing standards.[138] Nurses also reported that care in non-COVID-19 ICU and other sectors were affected as staff were moved to COVID-specific units, forced to isolate after exposure or relocated to vaccination clinics.[139]
Physical accessibility	People living in rural and remote areas experience **physical inaccessibility** to health in comparison to people living in metropolitan areas, with higher rates of hospitalisations, mortality, injury and less access to primary health care services due to their geographic isolation.[140] Remote communities, especially Indigenous communities, have experienced significant issues with accessing **safe, uncontaminated water**.[141]
Economic accessibility	Dental care is not covered under Medicare, even though oral diseases are linked to other diseases such as cardiovascular disease, cancer and diabetes.[142] Approximately 5.7 million Australians have at least one dental or oral health issue[143] but many Australians do not receive the recommended level of oral health care due to its higher **economic costs**.[144]
Information accessibility	By the mid-2021 outbreak of the COVID-19 delta variant in primarily multicultural communities in Western Sydney, the federal government's online translated **information** about vaccines was discovered to be months out of date.[145] Not only was official COVID-19 information in English found to be too complex, translated information and communication was initially found to be sparse, intermittent and not culturally-appropriate in many cases[146] even though many culturally and linguistically diverse people experience significant language barriers in accessing health information.[147]
Acceptability	Sexual and reproductive health services are not sufficiently providing culturally-**acceptable** services for migrant and refugee women in Australia.[148]
Non-discrimination	The 'Medevac Bill' previously allowed asylum seekers and refugees in offshore detention to be brought to Australia for urgent medical treatment.[149] Its repeal in December 2019 means that asylum seekers and refugees in offshore detention are prevented from accessing the same level of healthcare as Australian citizens because of their legal status.[150]
Quality	The recent Royal Commission into Aged Care Quality and Safety exposed horrific cases of widespread abuse and neglect of elderly people in aged care, revealing serious issues about the **quality** of aged care services.[151] The NDIS is also facing a high number of allegations of abuse and neglect.[152]

Struggling to access the National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) is a federal scheme that funds costs associated with disabilities. The *National Disability Insurance Scheme Act 2013* (Cth) requires that a person meet certain age, residency and disability or early intervention requirements to be eligible for the NDIS.[124]

A person is eligible for the NDIS if:

- They are under the age of 65;
- They are an Australian citizen or permanent resident;
- They have a disability that is due to a permanent and lifetime impairment; and
- Their impairment substantially reduces their ability to participate in everyday life.[125]

While the NDIS has made progress in improving access to its services,[126] many people with disabilities still struggle to meet its strict eligibility requirements and receive its support.

For example:

- The co-existing nature of health issues means that many find it difficult to prove the ongoing and permanent nature of their disability and identify the correct service system for needs, which means they often fall through the cracks of the health system.[127] *The Australian* has reported that two children suffering from chronic intestinal pseudo-obstruction (a rare condition that makes it impossible to absorb nutrients from food) were ineligible for NDIS as their disease has an 'underlying medical cause' and the scheme is not designed to cover support for medical expenses.[128]
- When people with disabilities first enter the prison system, staff do not have the time, training or tools to identify people with disabilities and their support needs.[129] The lack of disability assessment prevents persons with disabilities from becoming NDIS participants and developing NDIS support plans before community release.[130]
- The requirement that the relevant impairment is permanent disqualifies people with psychosocial disabilities (which are episodic in nature) but have demonstrable need for assistance.[131] It fails to account for how psychosocial disabilities can be difficult to classify as permanent.[132]
- The age limit of 65 means that older persons with disabilities must rely on aged care that often lacks specialist disability support.[133]
- Young people with disabilities who do not live with their family or carers, or without stable housing, face challenges in collecting the necessary paperwork and evidence to support their applications.[134] People who experience financial hardship generally find it difficult to prioritise the NDIS access process when their focus is on their basic and immediate needs.[135]
- The residency requirements means that children with severe disabilities on special category visas but who were born or have lived in Australia for most of their lives are still ineligible.[136]

A right to health would encourage policymakers to improve the NDIS eligibility requirements to ensure that it is truly available and accessible for people with disabilities and does not discriminate (whether directly or indirectly) against the vulnerable individuals it should aim to support.


Support your Local
Planet

Our most urgent health emergency: climate change

The World Health Organisation has declared that climate change is the "greatest threat to global health in the 21st century".[153] Climate change is already severely impacting the underlying social and environmental determinants of the right to health in Australia, including clean air, safe drinking water, adequate housing and food, economic security, social relationships, and community life.[154]

The 2019-2020 Black Summer bushfires, exacerbated by climate change,[155] burned across south-eastern Australia and had devastating health impacts. Many people breathed in toxic, polluted air for months.[156] A study estimated that exposure to bushfire smoke caused people to experience significant cardio-respiratory issues and contributed to at least 417 deaths and more than 3,000 hospitalisations.[157] The overall long-term health impacts of the bushfires are still not fully known, however there are already concerns about the effect of bushfire smoke exposure on pregnant women.[158]

Climate change is also increasing the duration, frequency and intensity of heatwaves in Australia.[159] Heatwaves can cause heat exhaustion, increase the risk of illness and death among people with pre-existing medical conditions, and increase mortality.[160] As the adverse impacts of heatwaves on human health grow, health and emergency services experience greater demand and pressure.[161]

Food and water security is also under threat. Droughts can both destroy crop production and cause significant mental health issues in rural communities, including personal distress and the loss of community networks.[162] Rising temperatures and rainfall variability are also increasing the risk of vector-borne, food-borne and water-borne diseases in Australia.[163]

The health impacts of climate change will not be experienced equally. Women, young people, the elderly, people with disabilities, people from Indigenous and rural communities, people with pre-existing health conditions and people from lower socio-economic backgrounds will be disproportionately affected.[164] Indigenous people are particularly vulnerable to the impacts of climate change because of their close connection to nature and dependence on wildlife, plants and healthy ecosystems for food, medicine and cultural needs.[165] Many Indigenous communities depend on ecosystems that are vulnerable to the effects of climate change, including floods, droughts, heatwaves, bushfires, and cyclones.[166]

The Intergovernmental Panel on Climate Change (IPCC) has recently warned that there is now only a narrow path to avoid climate catastrophe, but only if governments make immediate, deep and sustained emissions reductions.[167] Although Australia has committed to the Paris Agreement targets of holding global warming below 2° celsius and achieving global net-zero emissions by 2030, there is currently no national policy mechanism that ensures Australia is meeting these targets.[168] Climate change is not mentioned at all in Australia's 'Long-Term National Health Plan' or listed as a national health priority.[169]

In 2019, five UN human rights treaty bodies stated that a government's failure to take measures to prevent foreseeable human rights harm caused by climate change, or to regulate activities contributing to that harm, could constitute a human rights violation.[170]

In October 2021, the Australian Human Rights Institute, along with The George Institute for Global Health and the Institute on Inequalities in Global Health, University of Southern California will host a major conference examining *'Health and Human Rights in the Climate Crisis: Charting Challenges and Solutions'*.

humanrights.unsw.edu.au/conference

How could a charter of rights make a difference in Australia?

A national charter of rights and freedoms would benefit the entire Australian community and have an important impact on the protection of health rights in Australia.

A charter would do three things:[171]

- Ensure governments consider people's human rights when creating new laws and policies, and also when delivering services (e.g. aged care, Medicare and disability services). Government decisions and actions would be guided by values of **freedom**, **equality**, and **dignity**.
- Enable people to take action and **seek justice** if their rights are violated.
- List all of our rights and freedoms in one place, so everyone from school children to new Australians can **know** their **rights** and **freedoms** and facilitate the realisation of their rights.

In short, a charter would help **prevent human rights violations**, provide a **powerful tool for challenging injustices** and foster a culture of **understanding and respect** for human rights.

A right to health would help promote the principles of accessibility, availability, acceptability and equality consistently in health systems across Australia and would be a powerful first step in achieving equal access to health for everyone, regardless of background.

In 2009 the National Human Rights Consultation Report found that, generally, a national charter of rights would: redress the inadequacy of existing human rights protections, ensure greater protection of the rights of marginalised people, improve the quality and accountability of government to the people and contribute to a culture of respect for human rights.[172] These imperatives remain.


MELANIE, MARCH 2020
BY JOHANNAH CHURCHILL
National Portrait Gallery
PRESENTED BY
HRH THE DUCHESS OF CAMBRIDGE
NATIONAL PORTRAIT GALLERY
HOLD STILL
A PORTRAIT OF OUR NATION IN 2020
EXPLORE THE FINAL 100 PORTRAITS
NPG.ORG.UK/HOLD-STILL
co op
SUPPORTED BY
COOP.CO.UK/CO-OPERATE

Endnotes

1 *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) art 12.

2 Committee on Economic, Social and Cultural Rights, *General Comment No 14 (2000): The Right to the Highest Attainable Standard of Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights* UN ESCOR, 22nd sess, Agenda Item 3, UN Doc E/C.12/2000/4 (11 August 2000) [8] ('*General Comment 14*').

3 Ibid [9].

4 Ibid.

5 Ibid [11]. *General Comment 14* states that the 'underlying determinants of health' are the range of socio-economic factors that promote conditions in which people can lead a healthy life. These include access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information. The ability to participate in all decisions about health at community, national and international levels is another important aspect of this right.

6 Ibid [18]-[27].

7 Ibid [3].

8 *Convention on the Rights of the Child*, opened for signature 20 December 1989, 1577 UNTS 3 (entered into force 2 September 1990) art 24; *International Convention on the Elimination of All Forms of Racial Discrimination*, opened for signature 21 December 1965, 660 UNTS 195 (entered into force 4 January 1969) art 5(e)(iv); *Convention on the Elimination of All Forms of Discrimination against Women*, opened for signature 18 December 1979, 1249 UNTS 13 (entered into force 3 September 1981) arts 11.1(f), 12; *Convention on the Rights of Persons with Disabilities*, opened for signature 13 December 2006, 2515 UNTS 3 (entered into force 3 May 2008) art 25; *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 10 December 1984, 1465 UNTS 85 (entered into force 26 June 1987). Australia has signed each of these treaties.

9 See, eg, *General Comment 14* (n 2) [33].

10 Ibid [50].

11 Ibid [34].

12 Ibid [51].

13 Ibid [33].

14 *Australian Constitution* s 51(xxix).

15 Adam McBeth, Justine Nolan and Simon Rice, *The International Law of Human Rights* (Oxford University Press, 2nd Edition, 2017) 301.

16 National Human Rights Consultation Committee, *National Human Rights Consultation Report* (2010) xxxiv (recommendation 18) ('*National Human Rights Consultation Report*').

17 *Human Rights (Parliamentary Scrutiny) Act 2011* (Cth) ss 4, 7.

18 Ibid ss 8-9; See above nn 8 and accompanying text. These seven core treaties include the *ICESCR* and the *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976).

19 Australian Human Rights Commission, *Australia's Third Universal Periodic Review: Submission by the Australian Human Rights Commission* (Report, July 2020) 2.3 [8].

20 See, eg, Daniel Reynolds, Winsome Hall and George Williams, 'Australia's Human Rights Scrutiny Regime' (2020) 46(1) Monash University Law Review 256.

21 George Williams, 'Australia's Constitutional Design and the Protection of Human Rights' in Matthew Groves, Janina Boughey and Dan Meagher (eds), *The Legal Protection of Rights in Australia* (Hart Publishing, 2019) 18.

22 Ibid.

23 Ibid.

24 *Human Rights Act 2004* (ACT) s 9 ('*ACT Act*').

25 Ibid s 10(2).

26 *Charter of Human Rights and Responsibilities Act 2006* (Vic) ss 9, 10(c) ('*Victorian Charter*')

27 Explanatory Notes, *Human Rights Bill 2018* (Qld) 6.

28 Ibid 28.

29 Ibid.

30 Queensland Human Rights Commission, Right to Health Services (Web page) <https://www.qhrc.qld.gov.au/your-rights/human-rights-law/right-to-health-services>

31 The ACT's Attorney-General must prepare the statement of compatibility: *ACT Act* (n 24) s 37. In Queensland and Victoria, the Member of Parliament introducing the Bill must prepare the statement of compatibility: *Human Rights Act 2019* (Qld) s 38 ('*QLD Act*'); *Victorian Charter* (n 25) s 28.

32 *ACT Act* (n 24) s 38; *QLD Act* (n 31) s 39; *Victorian Charter* (n 26) s 30.

33 *ACT Act* (n 24) s 39; *QLD Act* (n 31) s 42; *Victorian Charter* (n 26) s 29.

34 *ACT Act* (n 24) s 30; *QLD Act* (n 31) s 48; *Victorian Charter* (n 26) s 32.

35 *ACT Act* (n 24) s 32; *QLD Act* (n 31) s 53.

36 *Victorian Charter* (n 26) s 36.

37 *ACT Act* (n 24) s 33; *QLD Act* (n 31) s 56; *Victorian Charter* (n 26) s 37.

38 *ACT Act* (n 24) s 40B; *QLD Act* (n 31) s 58; *Victorian Charter* (n 26) s 38.

39 *ACT Act* (n 24) ss 40B–40C.

40 *Victorian Charter* (n 25) s 39.

41 *QLD Act* (n 31) s 59.

42 *ACT Act* (n 24) s 40C(4); *QLD Act* (n 31) s 59(3); *Victorian Charter* (n 26) s 39(3).

43 *ACT Act* (n 24) s 28; *QLD Act* (n 31) s 43; *Victorian Charter* (n 26) s 31.

44 Hon Daniel Andrews MP, *Statement From The Premier* (Media Release, Victorian Government, 4 July 2020).

45 'Victoria coronavirus cases rise by 108 as Daniel Andrews strengthens lockdown at nine public housing estates', *ABC News* (online, 4 July 2020) <https://www.abc.net.au/news/2020-07-04/victoria-coronavirus-cases-rise-by-108-lockdown-new-postcodes/12422456>.

46 Michael Fowler and Paul Sakkal, 'Coronavirus Victoria: One public housing tower to remain in lockdown, restrictions to ease on others', *The Age* (online 9 July 2020) <https://www.theage.com.au/national/victoria/one-public-housing-tower-to-remain-in-lockdown-as-restrictions-on-others-to-be-eased-20200709-p55amh.html>

47 Victoria Ombudsman, *Investigation into the detention and treatment of public housing tenants arising from a COVID-19 'hard lockdown' in July 2020*, (Report, December 2020) ('*Victorian Ombudsman Report*').

48 Ibid 177 [954].

49 Ibid 179 [1].

50 Public Accounts and Estimates Committee, Parliament of Victoria, *Inquiry into the Victorian Government's response to the COVID-19 pandemic* (Parliamentary Paper No 203, February 2021) ('*Public Inquiry Report*').

51 Ibid 192; *Victorian Ombudsman Report* (n 47) 135 [676]-[678], 139-141, 175 [925].

52 *Public Inquiry Report* (n 50) 191.

53 *Victorian Ombudsman Report* (n 47) 172 [888]-[889].

54 *Public Inquiry Report* (n 50) 189.

55 *Victorian Ombudsman Report* (n 47) 126 [633]-[634].

56 Ibid 151 [748].

57 See, eg, Luke Henriques-Gomez, '"We should not pretend everybody is suffering equally": Covid hits Australia's poor the hardest', *The Guardian* (online, 27 September 2020) <https://www.theguardian.com/australia-news/2020/sep/27/we-should-not-pretend-everybody-is-suffering-equally-covid-hits-australias-poor-the-hardest>

58 United Nations, *COVID-19 and Human Rights: We are all in this together* (Report, April 2020) 11.

59 United Nations Office of the High Commissioner, *Emergency Measures and COVID-19: Guidance* (Publication, April 2020) <https://www.ohchr.org/Documents/Events/EmergencyMeasures_Covid19.pdf>

60 *Victorian Ombudsman Report* (n 47) 5.

61 *ICESCR* (n 1) art 2(2).

62 Committee on Economic, Social and Cultural Rights, *General Comment No 20 (2009): Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic and Social and Cultural Rights)* UN ESCOR, 42nd sess, Agenda Item 3, UN Doc E/C.12/GC/20 (2 July 2009) [15].

63 Ibid [27].

64 *General Comment 14* (n 2) [18].

65 See Australian Human Rights Commission, *A quick guide to Australian Discrimination Laws* (Publication) <https://humanrights.gov.au/sites/default/files/GPGB_quick_guide_to_discrimination_laws_0.pdf> for an overview of anti-discrimination legislation in Australia.

66 Committee on Economic, Social and Cultural Rights, *Consideration of Reports Submitted by State Parties under Articles 16 and 17 of the Covenant: Concluding Observations of the Committee on Economic, Social and Cultural Rights: Australia*, 44nd sess, UN Doc E/C.12/AUS/CO/4 (12 June 2009) [14].

67 Catalina Devandas-Aguilar, *Report of the Special Rapporteur on the rights of persons with disabilities*, UN Doc A/73/161 (16 July 2018) [5].

68 Ibid [7].

69 Ibid [34], [39].

70 Au et al, 'A model explaining refugee experiences of the Australian healthcare system: a systematic review of refugee perceptions' (2019) 19(22) *BMC International Health and Human Rights* 1, 2.

71 See, eg, The Royal Australasian College of Physicians, *Policy on Refugee and Asylum Seeker Health* (Report, May 2015) 14.

72 Ibid.

73 Ibid.

74 See, eg, Public Interest Advocacy Centre, *In Poor Health: Health care in Australian immigration detention* (Report, 2018); Médecins Sans Frontières, *Indefinite Despair: The tragic mental health consequences of offshore processing on Nauru* (Report, December 2018).

75 Australian Human Rights Commission, *Children's Rights in Australia: a scorecard* (Report, 20 November 2019), 16 ('*Children's Rights in Australia*').

76 Ibid.

77 See, eg, LGBTIQ+ Health Australia, *The 2021 update* (Web page, 13 May 2021) <https://www.lgbtiqhealth.org.au/statistics/>.

78 See generally, *Children's Rights in Australia (*n 75*) 15.*

79 See, eg, Australian Indigenous Health*InfoNet*, *Overview of Aboriginal and Torres Strait Islander Health status* (Report, 2020) 15.

80 Ibid.

81 Ibid.

82 *Closing The Gap* (Report, February 2020) 16, 78.

83 Department of Health (Cth), *Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19): Management plan for Aboriginal & Torres Strait Islander communities* (Report, July 2020).

84 Casey Briggs and Maani Tru, 'Why is the Indigenous COVID-19 vaccination rate 20 per cent lower than the national average?', *ABC News* (online, 4 September 2021) <https://www.abc.net.au/news/2021-09-04/indigenous-covid19-vaccination-rates-behind-national-average/100432238>.

85 Ibid.

86 Ibid.

87 Morgan Liotta, 'NSW Communities Left "High and Dry" in Vaccine Rollout', *Royal Australian College of General Practitioners NewsGP* (online, 1 September 2021) <https://www1.racgp.org.au/newsgp/clinical/nsw-communities-left-high-and-dry-in-vaccine-rollo>.

88 Teela Reid, 'Sydney First Nations at risk of COVID catastrophe', *The Sydney Morning Herald* (online, 6 July 2021) <https://www.smh.com.au/national/nsw/sydney-first-nations-at-risk-of-covid-catastrophe-20210705-p586tu.html>.

89 Shahni Wellington and Kirstie Wellauer, 'Indigenous COVID infections climb past 1,000 in NSW as vaccination efforts ramp up', *ABC News* (online, 7 September 2021) <https://www.abc.net.au/news/2021-09-07/nsw-covid-outbreak-vaccinations-urgent-as-aboriginal-cases-grow/100436516>.

90 Bridget Brennan and Ella Archibald-Binge, 'COVID-19 was never supposed to get into Indigenous communities. Now it's at the "doorstep"', *ABC News* (online, 26 August 2021) <https://www.abc.net.au/news/2021-08-26/covid-delta-unvaccinated-indigenous-communities-outbreak/100406682>.

91 Lorena Allam, 'Wilcannia Covid crisis: governments sidestep responsibility as response to outbreak labelled "a joke"', *The Guardian* (online, 31 August 2021) <https://www.theguardian.com/australia-news/2021/aug/31/wilcannia-covid-crisis-governments-sidestep-responsibility-as-response-to-outbreak-labelled-a-joke>.

92 Lorena Allam, 'Wilcannia Covid outbreak: leaked letters show federal government was warned last year of potential catastrophe', *The Guardian* (online, 30 August 2021) <https://www.theguardian.com/australia-news/2021/aug/30/wilcannia-covid-outbreak-leaked-letter-shows-federal-government-was-warned-last-year-of-potential-catastrophe>.

93 See, eg, Kalinda Griffiths, 'First Nations People Urgently Need to Get Vaccinated, but Are Not Being Consulted on the Rollout Strategy', *The Conversation* (online, 12 July 2021) <https://theconversation.com/first-nations-people-urgently-need-to-get-vaccinated-but-are-not-being-consulted-on-the-rollout-strategy-164067>.

94 Rhiannon Stevens and Charlotte King, 'Indigenous Victorians leading the country in vaccination rates', *ABC News* (online, 20 August 2021) <https://www.abc.net.au/news/2021-08-19/indigenous-victorian-vaccination-success/100332844>.

95 Griffiths (n 93).

96 *ICESCR* (n 1) art 12(2)(c).

97 Ibid art 2(1).

98 *General Comment 14* (n 2) [12].

99 Ibid [52].

100 Australian Institute of Health and Welfare, *Health System Overview* (Web page, 23 July 2020) <https://www.aihw.gov.au/reports/australias-health/health-system-overview>

101 See generally Russell Solomon, *Australia's Engagement with Economic and Social Rights: A Case of Institutional Avoidance* (Palgrave Macmillan, 2021) 54-55.

102 Australian Constitution s 51(xxiiiA).

103 Ibid s 96.

104 Solomon (n 101) 54-55.

105 Australian Institute of Health and Welfare (n 100).

106 Solomon (n 101) 70.

107 *Under the Aged Care Act 1997* (Cth) most aged care homes are funded by the federal government. The aged care sector is mainly regulated through the *Aged Care Quality and Safety Commission Act 2018* (Cth) and *Aged Care Quality and Safety Commission Rules 2018* (Cth). For a list of other aged care laws, see Department of Health, Aged care laws in Australia (Web page, 26 November 2020) <https://www.health.gov.au/health-topics/aged-care/about-aged-care/aged-care-laws-in-australia>.

108 *The National Disability Insurance Act Scheme 2013* (Cth) provides for the NDIS. *The Disability Services Act 1986* (Cth) provides for the funding and provision of other disability services.

109 Legislation such as the *Veterans' Entitlements Act 1986* (Cth) and *Military Rehabilitation and Compensation Act 2004* (Cth) provides for health services for eligible veterans, serving and former members of the Australian Defence Force and their dependents.

110 The national 'Stronger Rural Health Strategy' includes incentives, funding and bonding arrangements to promote the delivery of primary healthcare in rural Australia. For a list of programmes funded under this strategy, see Department of Health, Stronger rural health strategy - factsheets (Web page, 21 November 2019) <https://www1.health.gov.au/internet/main/publishing.nsf/Content/stronger-rural-health-strategy-factsheets>.

111 Australian Institute of Health and Welfare, *Alcohol and other drug treatment services* (Web page, 22 July 2021) <https://www.aihw.gov.au/reports/australias-health/alcohol-and-other-drug-treatment-services>.

112 The Australian Government is mainly responsible for providing free vaccines to the population. See Australian Institute of Health and Welfare, *Immunisation and vaccination* (Web page, 23 July 2020) <https://www.aihw.gov.au/reports/australias-health/immunisation-and-vaccination>.

113 Funding for cancer services such as breast screening programmes, palliative care, chemotherapy and radiotherapy are shared with states. See Australian Institute of Health and Welfare, *Cancer screening and treatment* (Web page, 23 July 2020) <https://www.aihw.gov.au/reports/australias-health/cancer-screening-and-treatment>.

114 Australian Institute of Health and Welfare (n 100).

115 Solomon (n 101) 58.

116 Australian Institute of Health and Welfare (n 100)

117 Commonwealth Government, National Healthcare Agreement (2011) 57 <https://www.federalfinancialrelations.gov.au/content/npa/health/_archive/national-agreement.pdf>. The National Healthcare Agreement is an intergovernmental agreement that sets out the federal government's health funding to the states, including the terms and conditions for that funding. One requirement is that states establish an independent body to address complaints about healthcare.

118 See generally Commonwealth Ombudsman, *Private health insurance* (Web page) <https://www.ombudsman.gov.au/How-we-can-help/private-health-insurance>. *The Private Health Insurance Act 2007* (Cth) sets out the requirements for private health insurance and insurers and allows the Private Health Insurance Ombudsman to hear complaints from private health insurance consumers.

119 See generally Commonwealth Ombudsman, *Services Australia* (Web page) <https://www.ombudsman.gov.au/How-we-can-help/australian-government-agencies-and-services/services-australia>.

120 Medical Board of Australia, *Medical Board of Australia - About* (Web page) <https://www.medicalboard.gov.au/About.aspx>.

121 Ibid.

122 Australian Institute of Health and Welfare (n 100).

123 Australian Commission on Safety and Quality in Health Care, *Australian Charter of Healthcare Rights (second edition)* (Web page) <https://www.safetyandquality.gov.au/consumers/working-your-healthcare-provider/australian-charter-healthcare-rights>.

124 *National Disability Insurance Scheme Act 2013* (Cth) ss 22-5.

125 For more information on these requirements, see National Disability Insurance Scheme, *Access to the NDIS Operational Guidelines* (Web page, 16 July 2019) <https://www.ndis.gov.au/about-us/operational-guidelines/access-ndis-operational-guideline>.

126 See, eg, Department of Communities and Justice (NSW), 'Three years of NDIS success in NSW' (Media release, 7 July 2021).

127 Victorian Council of Social Service, Submission 153 to the Joint Standing Committee on the National Disability Insurance Committee, *Inquiry into Independent Assessments* (March 2021) 8 (*'Submission 153'*).

128 Sam Crosby and Angela Jackson, 'We're failing the people NDIS was designed to support', *The Australian* (online, 17 October 2020) <https://www.theaustralian.com.au/commentary/were-failing-the-people-ndis-was-designed-to-support/news-story/3883aff68986b55b11fce29d9e06ec56>.

129 Human Rights Watch, *"I needed help, instead I was punished" Abuse and Neglect of Prisoners with Disabilities in Australia* (Report, February 2018) 66.

130 Ibid 89.

131 Disabled People's Organisations Australia, *Disability Rights Now 2019: UN CRPD Review of Australia* (Fact Sheet 8, 14 August 2019), 1 <https://dpoa.org.au/crpd-review-factsheets/>.

132 Ibid.

133 Ibid.

134 *Submission 153* (n 7) 7.

135 Ibid.

136 See, eg, 'Denham Sadler, 'These children are in limbo: the New Zealanders locked out of Australia's NDIS', *The Guardian* (online, 29 February 2020) <https://www.theguardian.com/australia-news/2020/feb/29/these-children-are-in-limbo-the-new-zealanders-locked-out-of-australias-ndis>.

137 Anne Davies, 'Covid putting Sydney's hospital system under 'enormous pressure', NSW health minister admits, *The Guardian* (online, 17 August 2021) <https://www.theguardian.com/australia-news/2021/aug/17/covid-putting-sydneys-hospital-system-under-enormous-pressure-nsw-health-minister-admits>.

138 Elias Visontay, 'Sydney ICU nurses sedating patients more to manage workload as Covid outbreak strains hospitals', *The Guardian* (online, 30 August 2021) <https://www.theguardian.com/australia-news/2021/aug/30/sydney-icu-nurses-sedating-patientsmore-to-manage-workload-as-covid-outbreak-strains-hospitals>.

139 Ibid.

140 Australian Institute of Health and Welfare, Rural & Remote Health (Web page, 22 October 2019) <https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health/contents/summary>.

141 Ted O'Connor, 'Some Kimberly Indigenous communities still without microbial drinking water testing', *ABC News* (online, 29 July 2021) <https://www.abc.net.au/news/2021-07-29/water-testing-kimberley/100326220>; Chelsea Hanning, 'New funding to improve water quality in remote NT communities as data shows high contamination levels, ABC News (online, 22 April 2021) <https://www.abc.net.au/news/2021-04-22/water-issues-remote-aboriginal-communities-nt-government/100086824>.

142 Solomon (101) 66.

143 Lesley Russell, 'The dental divide - and the decay of public dental services', *ABC News* (online, 21 August 2018) <https://www.abc.net.au/news/2018-08-21/dental-divide-and-the-decay-of-public-dental-services-medicare/10138870>/.

144 Australian Institute of Health and Welfare, *Oral and dental care in Australia* (Web page, 23 March 2021) <https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/costs>.

145 Tom Staynor, 'Federal government scrambles to update outdated translated COVID-19 information', *SBS News* (online, 12 August 2021) <https://www.sbs.com.au/news/federal-government-scrambles-to-update-outdated-translated-covid-19-information>.

146 See Danielle Marie Muscat, Julie Ayre, Kirsten McCaffery and Olivia Mac, 'No wonder people are confused. Most official COVID vaccine advice is way to complex', *The Conversation* (online, 30 July 2021) <https://theconversation.com/no-wonder-people-are-confused-most-official-covid-vaccine-advice-is-way-too-complex-165307>.

147 See generally NSW Council of Social Services, *Issues, barriers and perceptions about the COVID-19 vaccine amongst culturally and linguistically diverse communities in NSW* (Report, August 2021).

148 See, eg, Multicultural Centre for Women's Health, *2021 Sexual and Reproductive Health Data Report* (Report, August 2021).

149 See generally Nicholas Procter and Mary Anne Kenny, 'Explainer: how will the 'medevac' bill actually affect ill asylum seekers?', *The Conversation* (online, 13 February 2019) <https://theconversation.com/explainer-how-will-the-medevac-bill-actually-affect-ill-asylum-seekers-111645>.

150 See, eg, Karen Middleton, 'Medevac refugees: we face special punishment', *The Saturday Paper* (online, 5 December 2020) <https://www.thesaturdaypaper.com.au/news/politics/2020/12/05/medevac-refugees-we-face-special-punishment/160708680010817>.

151 *Royal Commission into Aged Care Quality and Safety* (Final Report, March 2021).

152 Luke Henriques-Gomez, 'NDIS watchdog is fielding nearly 100 allegations of abuse or neglect a week', *The Guardian* (online, 31 January 2020) <https://www.theguardian.com/australia-news/2020/jan/31/ndis-watchdog-is-fielding-nearly-100-allegations-of-abuse-or-neglect-a-week>.

153 World Health Organisation, *WHO calls for urgent action to protect health from climate change - Sign the call* (Web page, 6 October 2015) <https://www.who.int/news/item/06-10-2015-who-calls-for-urgent-action-to-protect-health-from-climate-change-sign-the-call>.

154 Dainius Pūras, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, UN Doc A/HRC/44/48 (15 April 2020) 16 [71].

155 See, eg, Nerilie J. Abram et al, 'Connections of climate change and variability to large and extreme forest fires in southeast Australia' (2021) 2(8) *Communications Earth & Environment 1.*

156 Lisa Cox, 'The toxic air we breathe: the health crisis from Australia's bushfires', *The Guardian* (online, 20 February 2020) <https://www.theguardian.com/environment/ng-interactive/2020/feb/20/the-toxic-air-we-breathe-the-health-crisis-from-australias-bushfires>.

157 See, eg, Nicholas Borchers Arriagada et al, 'Unprecedented smoke-related health burden associated with the 2019-20 bushfires in eastern Australia' 213(6) *Medical Journal of Australia 282.*

158 Australian Institute of Health and Welfare, *Australian bushfires 2019-20: exploring the short-term health impacts* (Report, November 2020) 25.

159 Climate Council, *Dangerous Summer: Escalating Bushfire, Heat and Drought Risk* (Report, December 2019) 9-13.

160 Ibid 27-28.

161 Ibid.

162 Ibid 29.

163 National Rural Health Alliance, *Position Paper: Rural health policy in a changing climate - three key issues* (Report, January 2021) 15.

164 See, eg, Australian Global Health Alliance, *From Townsville to Tuvalu: Health and climate change in Australia and the Asia Pacific Region* (Report, July 2019) 22-6.

165 David Boyd, *Report of the Special Rapporteur on the issue of human rights obligations relating to the enjoyment of a safe, clean, healthy and sustainable environment*, UN Doc A/74/161 (15 July 2019) 14 [48]

166 Victoria Tauli-Corpuz, *Report of the Special Rapporteur on the rights of Indigenous peoples*, UN Doc A/HRC/36/46 (1 November 2017) 3 [6].

167 See generally Climate Council Australia, *What does the IPCC's latest report mean?* (Web page, 9 August 2021) <https://www.climatecouncil.org.au/resources/what-does-ipcc-latest-report-mean/>.

168 Grattan Institute, *Climate Change and Health: preparing for the next disaster* (Report, December 2020) 9.

169 Ibid 31.

170 United Nations Office of the High Commissioner for Human Rights, *Five UN human rights treaty bodies issue a joint statement on human rights and climate change* (Web page, 16 September 2019) <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=24998>.

171 See more at Human Rights Law Centre, *Frequently asked questions - Charter of rights* (Web page, 2020) <https://charterofrights.org.au/resources/2020/2/7/faqs>; *The National Human Rights Consultation Report* outlines the main arguments in favour of a human rights act: *National Human Rights Consultation Report* (n 16) 265-280.

172 *National Human Rights Consultation Report* (n 16).