Can Public Health Legislation Improve Health in Remote Aboriginal Communities in the Northern Territory?

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The potential for public health legislation to improve health outcomes for Indigenous Australians has been the focus of recent interest in Australia. This paper examines the Northern Territory’s package of public health legislation in an attempt to assess its current and potential impact on health and to identify barriers to its ability to achieve better health for Indigenous people living in remote communities. It is argued that the current legislation in the Northern Territory has little or no practical application in health improvement. This is primarily due to the fact that its directive and regulatory approach is unsuited to dictating the social and environmental conditions that would lead to health improvements in Indigenous communities, or to generating the social change that would be required to initiate these improved living conditions. Proposed technical amendments to the legislation are thus unlikely to alter this lack of effect. Public health legislation does, however, have symbolic value and ensures that the health of Indigenous Australians remains on the political agenda. It may be that a more appropriate role for public health law in this context would be as an educative and non-directive structure, which aims to promote and protect health by supporting the attempts of Indigenous Australians to achieve reconciliation and self-determination.

Key words: Public Health; Legislation; Indigenous Australians; Remote Communities; Northern Territory; Environmental Health

It is widely accepted that the Australian Indigenous population experiences poorer health outcomes than both non-Indigenous Australians and the Indigenous populations of historically comparable nations such as New Zealand, Canada and the United States (Ross & Taylor 2002). The reasons for this are complex and encompass issues as diverse as living environment, education, poverty, dispossession from land and disempowerment (Royal Australasian College of Physicians [RACP] 1997). The recognition that health outcomes might be socially determined accords with the ecological approach to public health (Earls & Carlson 2001). This advocates the development of a multidisciplinary and integrated exploration of the biological mechanisms and social processes that influence health (Susser & Susser 1996). It also suggests that health improvement programs need to look beyond the healthcare system for initiation and support (Jackson & Ward 1999).

One social mechanism that has a potential impact on health outcomes is the law (Hanney et al. 2003). Examples of this impact abound in public health law which provides structures within which outbreaks of infectious diseases might be contained (Senanayake & Ferson 2004), hazardous products might be regulated and, through the enforcement of safety standards, injuries might be reduced (Gostin 2000). In light of this success, the prospect of using public health legislation as a tool for improving Indigenous health outcomes is of interest, particularly in light of the perceived symbolic force of the law in bringing about the social change which would be required for Indigenous Australians to achieve self-determination (Garrow & Murray 1999).
Pursuant to section 51 of the Commonwealth Constitution, the power to make laws with respect to health is held by the States and Territories. As such, each Australian State and Territory has a package of laws that may be classified as public health legislation. In general, this package includes a Public Health Act and legislation relating to infectious diseases, water, hazardous waste, sewerage and sanitation, building safety, housing conditions and occupancy, food safety, injury prevention, the provision of essential services, such as electricity, and the creation of local government structures within whose power the enforcement of many of these Acts remain. Even a cursory glance at this subject matter reveals that it addresses many of the living conditions leading to poor health in Aboriginal communities, for example, limited or erratic water supply, poor water quality, inadequate sewerage and sanitation infrastructure, unhygienic food preparation and storage, and poorly maintained and overcrowded housing.

Given this legislative coverage of relevant subject matter it is perhaps surprising that the capacity of the law to affect Aboriginal health has not been more comprehensively evaluated. Only in Queensland has an organised analysis of the impact of public health legislation, in this case the Health Act 1937 (Public Health Services 2001a), Water Act 2000 (Public Health Services 2001b) and Local Government Act 1993 (Public Health Services 2001c), in remote Indigenous communities been carried out. Of concern, the resultant Reports highlighted the cultural inappropriateness of many of the legislative provisions, an almost complete lack of enforcement in remote communities despite clear evidence of health hazards, and significant structural and operational weaknesses (Public Health Services 2001a,b,c). The conclusion was that, to date, all three legislative enactments have failed to affect positively health outcomes. However, while recommendations for legislative and administrative change were made, the central assumption that public health legislation is an appropriate tool for improving Aboriginal health remained unquestioned.

In 2002, the National Public Health Partnership prepared a summary of all State and Territory public health laws of relevance to remote and Aboriginal and Torres Strait Islander communities (National Public Health Partnership 2002) and the Department of Health and Ageing commissioned a similar report focusing on the accountability of government agencies for the provision of environmental health services pursuant to public health legislation (Urbis Keys Young 2002). While both reports are valuable for presenting the public health legislation in an accessible format and raising questions about potential legal and practical impediments to the functioning of this legislation, the creation of strategies to resolve these barriers remained beyond their scope. Similarly, an assessment of whether the identified impediments were specific to the legislation as enacted, or whether they would be inherent in any attempt to improve Aboriginal health through the use of public health legislation, was not undertaken.

The purpose of this paper is twofold. The first is to examine critically the current and potential impact of the Northern Territory’s public health legislation on the health of Aboriginal people who live in remote communities. The second is to consider whether or not public health legislation can ever be an effective tool for achieving measurable health improvements in Aboriginal communities.

To this end, the second part of the paper considers the applicability of the Northern Territory’s public health legislation to remote communities on both Aboriginal land and Crown land. The next part of the paper then considers issues surrounding the enforcement of some specific provisions of the public health legislation to assess the capacity of this legislation to improve health
in the communities to which it applies. In the last part, the paper argues that when the complex historical, social and economic determinants of Aboriginal health are taken into account, it becomes apparent that legislation is both unable to dictate the conditions that would lead to health improvements in Aboriginal communities, and is too blunt an instrument to generate the social change required to initiate these. The paper concludes by raising the possibility that a more constructive role for public health law might be as a non-directive and educative structure, which focuses more on the promotion and protection of health than the enforcement of specific legal provisions.

Application of the Northern Territory’s Public Health Legislation to Remote Aboriginal Communities

There are three primary forms of land ownership in the Northern Territory: private land, Crown land, and land granted under the Aboriginal Land Rights (Northern Territory) Act 1976 (Cth) (hereafter referred to as ‘Aboriginal land’). While there is no doubt that public health legislation applies to private land, much of the land in remote Aboriginal communities is either Aboriginal land or Crown land and the applicability of the legislation to these forms of land ownership is unclear. As such uncertainty constitutes a significant barrier to the potential use of legislation as a tool for improving health in Aboriginal communities, this issue warrants analysis.

Aboriginal land

The Aboriginal Land Rights (Northern Territory) Act 1976 (Cth) (ALRA) is stated in its preamble to be “an Act providing for the granting of Traditional Aboriginal Land in the Northern Territory for the benefit of Aboriginals, and for other purposes”. As such, it creates the mechanism by which Aboriginal people, through land trusts created for this purpose, could obtain inalienable freehold title to unalienated Crown land of which they were traditional owners, and all Aboriginal reserves in the Northern Territory (Aboriginal and Torres Strait Islander Commission [ATSI] 1998). By 2002, approximately 43% of land in the Northern Territory was Aboriginal land (National Public Health Partnership 2002).

The application of Northern Territory laws to Aboriginal land is dealt with in sections 71, 73 and 74 of ALRA. The general principle, elucidated in section 74, is:

This Act does not affect the application to Aboriginal land of a law of the Northern Territory to the extent that that law is capable of operating concurrently with this Act.

The prima facie test of applicability of a Northern Territory law, then, is consistency with the rights and obligations conferred by ALRA (House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs 1999). Of particular importance in this context is the right of Aboriginal people to use or occupy Aboriginal land in accordance with their traditions, broadly defined by the Act as including traditions, customs, beliefs and observances. The content of these traditions is considered to be flexible and is capable of changing over time. This right is set out in section 71(1) of ALRA:

...an Aboriginal or group of Aboriginals is entitled to enter upon Aboriginal land and use or occupy that land to the extent that that entry, occupation or use is in accordance with Aboriginal tradition governing the rights of that Aboriginal or group of Aboriginals with respect to that land, whether or not those rights are qualified as to place, time, circumstances, purpose, permission, or any other factor.

Section 71 thus narrows the legislative power of the Northern Territory in that it is unable to apply laws to Aboriginal land which conflict with or restrict these rights of traditional use, as defined over time. This limitation of legislative power is further reinforced by section 73, which confers...
upon the Northern Territory government the power to enact laws only to the extent that these laws are able to operate concurrently with ALRA and any regulations made under it. It would seem, therefore, that the key determination to be made when considering whether a law of the Northern Territory applies to Aboriginal land, is whether it interferes with the rights of Aboriginal people to use and occupy that land in accordance with Aboriginal tradition (House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs 1999).

The primary consequence of this approach is that the determination of the applicability of Northern Territory laws to Aboriginal land must be carried out on an ad hoc basis. This is likely to be a cumbersome process as, while it is unlikely that entire Acts will be inconsistent with ALRA, multiple provisions within these Acts might be. For example, Regulation 12 of the Public Health (General Sanitation, Mosquito Prevention, Rat Exclusion and Prevention) Regulations 1960 provides that an occupier must abate overcrowded living conditions when a Medical Officer of Health believes that they constitute a hazard to health. However, it might be that to reduce the number of occupants in this way would be contrary to Aboriginal notions of extended family. Similarly, some of the local government structures created by the Local Government Act 1993 to oversee the provision of health services are likely to be incompatible with traditional Aboriginal forms of governance. Indeed, it can even be argued that the entire prescriptive nature of the Northern Territory’s public health legislation, which relies on specific offences, is inconsistent with Aboriginal people’s customs and beliefs regarding appropriate techniques for problem solving.

In addition, Aboriginal traditions are not static and vary both between communities and over time. Consequently, the same legal provision may be held to apply in one community but not in another. The result is a public health legislative framework which is uncertain, potentially unpredictable and unduly resource intensive because every attempt to enforce the legislation is vulnerable to challenge on the grounds of applicability. The existence of such strong disincentives to utilise public health legislation is clearly a significant barrier to its ability to influence health outcomes for people living on Aboriginal land.

In 1998, a review of ALRA was carried out by John Reeves QC (the Reeves Report). This Report assumed that the purpose of public health legislation was to benefit the entire community, including Aboriginal people. By allowing this legislation to be inapplicable when it is inconsistent with Aboriginal traditional use of land, Reeves argued, Aboriginal people were failing to avail themselves of the opportunity to obtain health gains. His solution was to amend ALRA in two ways. First, he recommended that section 74 be repealed. This would effectively reverse the onus of proof so that Northern Territory laws would apply to Aboriginal land unless they could be shown, pursuant to section 109 of the Commonwealth Constitution, to be directly inconsistent with ALRA (Reeves 1998). Second, he suggested that section 71 be amended to state that Northern Territory laws covering specific subject areas will apply to Aboriginal land, even if these laws are inconsistent with ALRA. The subject areas specified were public health and safety, the supply of essential services, environmental protection and conservation, and the maintenance of law and order. In an attempt to reduce the inevitable concern of Aboriginal people, Reeves added the qualification that “all reasonable steps shall be taken to minimise any negative effects on the use or occupation of the land” as a result of these changes (Reeves 1998, p. 412).

Occurring in the context of a Report whose recommendations would have significantly reduced meaningful Aboriginal control over Aboriginal land (House of Representatives Standing Committee on
Can Public Health Legislation Improve Health in Remote Aboriginal Communities in the Northern Territory?

Aboriginal and Torres Strait Islander Affairs (1999; Oxfam Community Aid Abroad 1999), these proposed amendments to A LRA were, not surprisingly, controversial. Although there was some commitment expressed by the Northern Territory Government to creating legislative certainty, many Aboriginal groups argued that, by focusing on the role of legislation, such an approach was misguided. In its submission to the House of Representatives Standing Committee that was reviewing the Reeves Report, the Central Land Council (CLC) stated that inconsistencies between Northern Territory legislation and traditional uses of land should be resolved by “consultation, negotiation and agreement” (Central Land Council 1999). Indeed, the CLC argued that to legislate so as to systematically subjugate Aboriginal traditional land uses to the legislative power of the Northern Territory government in this way would be to diminish the right of Aboriginal people to enjoy their culture to such an extent that it would breach Article 27 of the International Covenant on Civil and Political Rights (Central Land Council 1999).

Objection was also taken to the inference that, in asserting their traditional rights, Aboriginal people were depriving themselves of the benefit of public health legislation and were thus in some way to blame for their own poor health status. The provision of services for health, housing and education are the legitimate function of all governments, and the Northern Territory government should not be excused from its responsibilities by such a legal technicality. In the words of Oxfam Community Aid Abroad (1999) in its submission:

...The reality is that Aboriginal Territorians are entitled to Government services on an equal basis to any other citizen of the Northern Territory and should not have to sacrifice their hard won land rights in order to receive these services.

While this is an important point in its own right, it is also useful for its inference that public health legislation is not the only, or even the most important, source of the government’s responsibility for providing adequate health services, housing and education.

Ultimately, these recommendations were not adopted by the Commonwealth government and sections 71, 73 and 74 of A LRA remain unchanged (House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs 1999). It thus remains impossible to assess prospectively whether or not a particular legislative provision will be held to apply to Aboriginal land. From a legal perspective, this uncertainty of application and, in turn, reduced likelihood of implementation and enforcement, is a significant limitation to the ability of public health legislation to influence health outcomes in Aboriginal communities. However, the debate surrounding the recommendations of the Reeves Report was also valuable for questioning whether legislation can ever be an appropriate tool for improving Aboriginal health. This issue is discussed in more detail below.

Crown land

In its review of public health law in Australia, the National Public Health Partnership (2002) commented that one of the major limitations of the Northern Territory’s public health legislation is that the Public Health Act 1952 is not stated to bind the Crown. This raises significant doubts as to whether this Act, and therefore its regulations, can apply to Crown land and instrumentalities of the Crown in the Northern Territory. Other legislation which falls within the Northern Territory’s package of public health laws, such as the Water Act 1992, Water Supply and Sewerage Services Act 2000, and the Waste Management and Pollution Control Act 1998 are stated to bind the Crown both in right of the Northern Territory and the Commonwealth and thus clearly apply to Crown land and instrumentalities.

The relevance of whether or not a statute is stated to bind the Crown stems from the long established principle of statutory
construction that there exists a presumption of Crown immunity from statute. This presumption means that statutes do not apply to (or bind) the Crown unless they expressly or impliedly state their intention to do so (ALRC 2000). Commonwealth, State and Territory governments are all entitled to the protection afforded by this presumption (Taylor 2000) and thus, generally, statutes should indicate their intention to bind both the Crown of the enacting legislature (in this case the Northern Territory) and the Commonwealth (ALRC 2000).

Over the past 15 years there have been some significant changes to the test to be applied in order to assess whether a statute impliedly intends to bind the Crown. In 1990, the Australian High Court in Bropho v Western Australia (1990) 171 CLR 1 rejected the traditional narrow approach that only the terms of the statute could be considered in finding such an intention. The majority of the Court in Bropho held that, in ascertaining whether or not there is an implied legislative intent to bind the Crown, all relevant factors should be examined. These factors include the subject matter of the legislation, its purpose, the identity of the Crown entity in question and the context and circumstances of the legislation’s enactment.

It might thus be that an intention to bind the Crown should be implied into the Public Health Act 1952. Although the Act does not state a purpose, it is presumably to improve the health of the population as a whole. This is supported by section 10 which provides for the making of regulations in relation to, inter alia, the prevention of disease, the maintenance of health, sanitation, the care and treatment of sick persons, the promotion of public health, and measures for the control of diseases. Such a population-based approach to health would be significantly restricted if the Act did not apply to Crown land, or if agencies of the Crown were not subject to the same health standards as the rest of the population.

Further, there would seem to be no reason in logic or fairness why people on Crown land should not receive the same health protections as the rest of the population. Indeed, such an approach would reduce the effectiveness of the legislation significantly and raise important issues of equity. Interestingly, the conclusion that it should be implied that the Public Health Act 1952 was intended to bind the Crown, is further supported by the fact that the draft new Northern Territory Public Health Act is expressly stated to bind the Crown.

It is thus arguable that the Northern Territory’s Public Health Act, and associated regulations, would be held to bind the Crown, at least in the Northern Territory. This means that the Act probably does apply to Crown land and that Northern Territory Crown agencies should be bound by it. However, in the absence of a specific judicial determination to this effect, the application of the Act remains uncertain and potentially subject to legal challenge. Once again, this acts as a disincentive to its implementation and enforcement and thus reduces its capacity to achieve its aim of improving the health of the population.

### Implementation and Enforcement of the Northern Territory’s Public Health Legislation in Remote Aboriginal Communities

To date, the only comprehensive evaluation of the effectiveness of public health legislation in improving the health of Aboriginal people has been conducted by Queensland Health’s Public Health Law and Indigenous Health Project (Public Health Services, 2001a,b,c). It found that, despite evidence of significant environmental health problems, the relevant provisions of the Health Act 1937 were rarely enforced (Public Health Services 2001a). This failure was attributed largely to the fact that the Aboriginal and Torres Strait Island councils, who comprised the local government structures for the communities being
Can Public Health Legislation Improve Health in Remote Aboriginal Communities in the Northern Territory?

evaluated, were unable to fund an adequate environmental health workforce to implement and enforce the legislation (Public Health Services 2001a). This implies a belief that with increased funding, the legislation would be more effective.

In fact, the practical barriers to the capacity of legislation to improve health are more complicated than this suggests. The Northern Territory’s public health legislation, like that in Queensland, is prescriptive and comprises multiple specific offences. Thus statutory powers are granted to Health Departments, Health Officers and Municipal Councils to compel owners and occupiers of land to abate health risks on their properties, to condemn premises which are hazardous to either health or safety, and to regulate the hygiene standards of community stores (Urbis Keys Young 2002). A typical example of such a provision is section 7C(1) of the Public Health Act 1952 (NT) which states:

Where, in the opinion of the Chief Health Officer, an owner or occupier of land has committed an offence against this Act or the Regulations which, in the opinion of the Chief Health Officer, causes or may cause a risk to public health, the Chief Health Officer may...by notice in writing, require the owner or occupier of the land to cause the risk to be removed within such time as he specifies in the notice.

Sections 7C(2) and (3) go on to confer power on the Chief Health Officer to organise for the work to be done if the owner or occupier refuses, and to recover the cost from that owner or occupier.

While this approach may be appropriate for the regulation of privately owned premises located in an urban area, it is unlikely to be feasible in impoverished remote Aboriginal communities. A written notice of abatement of risk is of limited practical relevance to an Aboriginal person living in a remote community who neither reads nor writes English, who is unable to afford the repairs even if a contractor could be found, and for whom a Western regulatory framework is quite foreign. Closing a community store that does not strictly adhere to food hygiene standards is not a realistic option if it is the only store in the community. By ignoring the underlying issues of poor food security, lack of knowledge concerning traditional food sources and the loss of role models for food preparation within communities, it is also a grossly inadequate response. Similarly, condemning an inadequate house is of no value if the occupying family does not have access to alternative accommodation. The lack of legislative implementation and enforcement observed in Queensland, which no doubt would be equally striking in the Northern Territory, thus does not, as has been suggested, stem primarily from an inadequate workforce. Rather, it is due largely to the inappropriateness of the attempt to impose the current regulatory scheme onto remote Aboriginal communities (National Public Health Partnership 2002; Urbis Keys Young 2002). Further, as explored above, the uncertain applicability of public health legislation to Aboriginal communities further reduces the incentive for recourse to such measures.

The practical consequences of living in remote areas should also not be underestimated. Despite the fact that there are over 680 discrete Aboriginal communities in the Northern Territory (Australian Bureau of Statistics 2001), the Power and Water Corporation Act 2002 has been interpreted as only requiring the Corporation to supply electricity to urban areas. Although this has been tempered by a Commonwealth-Territory Agreement, even this only requires the Corporation to supply 80 of the largest Aboriginal communities Territory-wide (National Public Health Partnership 2002). Similarly, the Building Act 1993, based on the Commonwealth Building Code, which establishes standards for the building and construction industry, applies only to gazetted areas. Virtually all remote Aboriginal communities fall outside its scope.

In order to compensate for this failure of public health legislation to protect people living in Aboriginal communities, the
Northern Territory Government developed a set of environmental health standards for remote communities (Northern Territory Government Environmental Health Task Group 2001). While these are non-binding, they are based on notions of the importance of information, advice, advocacy and practical support (Urbis Keys Young 2002), and are arguably more appropriate than the theoretically enforceable but practically limited provisions of the major public health statutes.

The legal and practical barriers to the effectiveness of legislation in remote Aboriginal communities render it unlikely that the Northern Territory's current package of public health legislation is capable of improving health outcomes in these communities. It is thus vital that their existence, combined with the success of public health legislation in other contexts, does not lead to complacency and a belief that progress is being made when it is not.

**The Appropriateess of Public Health Legislation as a Tool for Improving Health in Remote Aboriginal Communities**

The aim of the first evaluation of public health legislation that focused on Aboriginal communities was to inform the Legislation Reform Working Group of the National Public Health Partnership (Bidmeade & Reynolds 1997). It is thus not surprising that when the legislation’s effectiveness was questioned in the evaluation, the response was to recommend legislative reform, although the need for more fundamental responses such as empowerment through land, employment and resources were also highlighted (Bidmeade & Reynolds 1997). Nevertheless, the language of legislation has also predominated in subsequent recommendations with talk of “improved compliance” with statutory standards, the importance of “certainty in the application of legislation”, the “modernisation of public health laws”, and the need to support local government structures in their attempts to “maintain public health standards” (National Public Health Partnership 2002). Indeed, even recommendations for the development of an adequate environmental health workforce have focused on its potential contribution to the operation of public health law. Rather than promoting environmental health officers as people who can liaise with communities and provide information, advocacy and support, they have been seen as the key to “law enforcement strategies” (Public Health Services 2001a,b,c). As mentioned earlier, such an approach unduly simplifies the issues surrounding the poor health outcomes of Aboriginal people in remote communities.

This is not to argue that there have been no attempts to adapt public health legislation to Aboriginal traditions, customs and beliefs. For example, the Queensland Public Health Law and Indigenous Health Project recognised the inappropriateness of the terms ‘owner’ and ‘occupier’ which are widespread throughout Australia’s public health law (Public Health Services 2001a). However, their suggested response was merely to change the language of the statutes so as to take account of the various different types of ownership and occupation of land in Aboriginal communities (Public Health Services 2001a). The appropriateness of laws creating statutory offences, which are committed by individual owners and occupiers in communities, regardless of how they are labelled, appears to have been accepted without question.

Indeed, a review of the recommendations for legislative amendment made by the Queensland Public Health Law and Indigenous Health Project (2001) and the National Public Health Partnership (2002) reveals that there exists support for broadening the application of public health legislation to Aboriginal land and for developing complex legal and governance frameworks to underpin the implementation and enforcement of these statutes. Further,
although proposals for preambles and statements of objectives, which both emphasise the population based aims of the legislation and place it within a social context, have been popular, the proposed legislative content remains largely regulatory and is based on specific statutory offences, usually committed by an individual. The legislation would thus continue to function by requiring individual Aboriginal people to undertake specific actions in their capacity as ‘owners’ and ‘occupiers’ and a failure to comply with these requirements would continue to attract penalty, irrespective of the reasons for this failure. Barriers to action such as poverty, lack of access to resources and services, workforce limitations and cultural inappropriateness would remain no defence to these legislative offences.

Interestingly, statutes that impose on government the responsibilities for essential service provision take quite a different approach (Centre for Comparative Constitutional Studies University of Melbourne 1999). For example, both the Power and Water Corporation Act 2002 and the Building Act 1993 remain free to exclude remote Aboriginal communities from their scope on the basis of difficulties of access, resources and workforce. Indeed, rather than create enforceable service provision requirements which attract penalties for non-compliance, governments have taken a broad approach and have addressed their legitimate responsibilities through the creation of non-legislative standards, guidelines and policies. Examples include the Environmental Health Standards for Remote Communities in the Northern Territory (2001), explicitly acknowledge the Northern Territory Government’s responsibility to ensure that environmental health problems are minimised. Indeed, this document concedes that the ability to access essential services and a healthy living environment are basic human rights (Northern Territory Government Environmental Health Task Group 2001). The symbolic powers of these standards are considerable and they provide valuable guidance for those developing interventions. It thus seems incongruous that while the Government has recognised that strict legal requirements for service provision are inappropriate and unable to be enforced, it has not similarly recognised the limitations of imposing regulatory public health legislation on Aboriginal people in remote communities.

This approach seems to place the legal responsibility for health on Aboriginal people rather than governments (Garrow & Murray 1999). Public health law is currently a collection of legislative offences which suggest that if Aboriginal people kept their houses cleaner, lived in less overcrowded conditions and disposed of their waste in a ‘safe’ manner, they would be healthier. Such a view disregards the complex historical and social determinants of Aboriginal health and, in addition, downplays the government’s legitimate service provision function. Further, it forces Aboriginal people to participate in a legal and governance framework within which decisions may be made very differently from their methods of problem solving. Even more disturbingly, in its focus on creating ‘offences’, it seeks to achieve health gains by punishing the people it claims to protect. In the light of this, it is little wonder that the debate surrounding the Reeves Report revealed such a widespread suspicion and distrust of legal mechanisms by Aboriginal people (Central Land Council 1999; Oxfam Community Aid Abroad 1999).

A simplistic and rigid legislative response to public health in Aboriginal communities
is thus inappropriate. Health reform cannot stand alone. Rather, it must be integrated with broad government strategies which recognise the overlap between health and education, the supply of environmental health infrastructure, socio-economic development and the empowerment of Aboriginal people through issues relating to land rights and reconciliation (Anderson 2002). The improvement of Aboriginal health requires social change, which in turn requires the creation of a process for consultation, discussion, negotiation and understanding. A legislative framework built of regulatory offences, such as the current package of public health legislation in the Northern Territory, is inherently incapable of producing or supporting such a process. Indeed, its techniques are, by definition, opposed to it.

**Conclusion**

The failure of public health legislation to improve health in Aboriginal communities is not due simply to uncertainty as to its application or a lack of resources to ensure its implementation and enforcement. Rather, the failure results from a directive and regulatory approach to public health legislation which appears unsuited to generating the social change which is required to address the issues surrounding Aboriginal health. Legislative amendments that clarify legal requirements, improve terminology and enhance mechanisms for law enforcement are unlikely to alter this situation and bring about measurable health improvements. Under such circumstances it is difficult to escape the conclusion that not only is public health legislation currently failing to improve Aboriginal health, it is by its nature unable to either dictate the conditions which would lead to health improvements in Aboriginal communities or generate the social change required to initiate these.

The law can, however, have a significant symbolic force (Garrow & Murray 1999; Territory Health Services 1997) and debates concerning legislative amendments can keep Aboriginal health firmly on the political agenda. Further, documents such as the Environmental Health Standards for Remote Communities in the Northern Territory (2001) can be useful tools for initiating constructive dialogue between Indigenous and non-Indigenous people. This raises the question of whether a more appropriate role for public health law would be as an educative and non-directive structure which aims to promote and protect health by supporting the attempts of Aboriginal people to achieve reconciliation and self-determination (Garrow & Murray 1999), perhaps through the utilisation of human rights discourse.

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**Endnotes**

1. Section 51 of the Commonwealth Constitution sets out the legislative powers of the Commonwealth. Subject matter not specified in this section remain the legislative domain of the States and Territories.
3. Section 109 of the Constitution states that when there is an inconsistency between a Commonwealth and State or Territory law, the latter is invalid to the extent of the inconsistency.
Can Public Health Legislation Improve Health in Remote Aboriginal Communities in the Northern Territory?

4. The traditional narrow approach was set out in Bombay v Municipal Corporation of Bombay [1947] A C 58.

5. A detailed examination of the controversy surrounding the application of the presumption of Crown immunity in the federal context is beyond the scope of this paper (see Taylor 2000).

6. This is evidenced by the increasing tendency of legislation to have a general statement of purpose in these terms. See, for example, the Waste Management and Pollution Control Act 1998 (NT) Section 5 and the Preamble to the Housing Assistance Act 1996 (Cth).

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Natalie Gray and Ross Bailie

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Northern Territory

Building Act 1993
Local Government Act 1993
Power and Water Corporation Act 2002
Public Health Act 1952
Public Health (General Sanitation, Mosquito Prevention, Rat Exclusion and Prevention) Regulations 1960
Water Act 1992
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