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# Challenges in global Indigenous–Disability comparative research, or, why nation-state political histories matter

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Globally, Indigenous people, also known as First Peoples, have the poorest health outcomes of all population groups, resulting in significantly higher rates of chronic disease, ill-health, and disability. Recent research strongly suggests that Australian First Peoples and the Sami peoples of the Nordic region are positioned at opposite ends of the disability–health spectrum. Australia's First Peoples, now experience the highest rates of disability in the nation's recorded history, despite the significant government investment over recent decades in national Indigenous policy. Yet, Nordic Indigenous populations appear to have similar health outcomes and living conditions as the rest of the population in the region. In this paper, we compare some of the global assumptions of the two leading countries of the United Nations Human Development Index– Norway (ranked first) and Australia (ranked second)– and examine the ways in which such rankings act to hide the disparities of life trajectories and outcomes for Indigenous persons living with disability compared to the rest of the population in each country. The findings of the comparative analysis illustrate core areas for consideration when undertaking in-depth comparative research with First Nation's peoples. This includes issues surrounding the differentiated political significance of national population data systems for local Indigenous peoples in their struggles for recognition, and the nuanced processes of population data categorisation that are developed as a result of First Nation's localised struggles for recognition, respect and rights under processes of European colonisation.

**Keywords:** Australia; Disability; Population data; Indigenous; Aboriginal; Methodology; Norway; Sami

## Introduction

At the global scale, there has been growing policy interest in the rights, quality of life and wellbeing of Indigenous people with disability. The lived experience of disability inequality for Indigenous peoples, has been critically examined at a range of United Nations forums

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over recent years, including specialized side events held by Indigenous disability civil society groups at the 10-year celebrations of the Convention on the Rights of Persons with Disabilities in 2016 and expert forums (see Gilroy et al., 2018 in this issue). The overarching aim has been to target increased global efforts for rights realization at the interstice of Indigeneity and disability, specifically by examining impairment created through processes of Indigenous dispossession, discrimination and racism, and developing responsive systems of health and welfare to advance the rights of Indigenous people living with disability (UN Inter-agency Support Group, 2014).

The UN Human Development Index ranks Norway and Australia as the top two (and previously, Norway first and Australia third) countries in the world in terms of human development (UNDP, 2016). These numbers belie the very different outcomes for the Indigenous peoples living within these countries. This is confirmed by the UNDESA State of the World's Indigenous Peoples reports, which place the health and living conditions and outcomes of Aboriginal and Torres Strait Islander Australians (Australia's Indigenous peoples) at some of the lowest levels (UNDESA, 2009, 2015; see also Cooke et al., 2007). Recent studies also compare Indigenous health outcomes across Indigenous and Tribal nations globally (Silburn et al., 2016). One such disparity is the higher rates of disability experienced by Aboriginal and Torres Strait Islander Australians compared to other Australians. Because disability and Indigeneity are not disaggregated in national population data sets at this global scale, comparative analysis of such data between countries will not reveal many of the unique ongoing structural constraints that Indigenous people living with disability face within their local contexts. The HDI addresses Indigenous peoples and people with disabilities as separate disadvantaged groups, and highlights the Sami of Norway as an example of the interrelationship between political representation, self-determination and positive health outcomes. Yet, it makes no mention of the prevalence of disability among Indigenous groups.

In this article, we seek to examine the possibility of direct comparative analysis of the interstice of disability and Indigeneity for Indigenous people living with disability in Australia and Norway. While in disability studies there has been a turn away from the quantitative count of disability, with critiques pointing to processes of objectification in such measurement and counting, in Indigenous studies there has been a growing call to re-examine the use value of national quantitative data to illustrate not only high levels of Indigenous inequality, but also to gain greater control and sovereignty over the policy measures that emerge from assumptions produced through such national data sets. Australian Indigenous scholar Maggie Walter, a key advocate in this growing agenda, argues that national data systems are embedded 'in "who" has the power to make determinations and who controls the narratives surrounding indigenous peoples' lives' (Kukutai and Taylor 2016: 7). To concur with Walter (2016), in countries such as Australia, national population data is shaped by the

political history, meanings and systems of colonial power, denying Indigenous ways of being and narratives of their own lives in the production of such data.

It is to Walter's point of contention that we embed our comparative analysis of disability for Indigenous people in Norway and Australia via the realm of national population data sets. While these two country sites are based in the Global North, and therefore the methodological approach we take is not necessarily transferable to other nation-states, particularly those in the Global South, we suggest that even a direct North–North comparison, though fruitful in some respects, may in fact obscure the long-term historical processes of nation-state formation and Indigenous dispossession that are locally specific. A North–North comparison between Norway and Australia does not reveal how in fact, as writers such as Connell (2011) have illustrated, the disparate inequalities between Indigenous people and all other Australians signals that there is a Global South within this Global North nation-state. We argue against simplified attempts to compare different groups simply because they can be labeled Indigenous, and that the field of disability is an illustrative example.

## Comparative methodologies: mainstream population counting vs. indigenous and disability data contestations

National statistical collections that define internal populations are designed to measure the 'who' of the nation alongside social, political, and economic statistical indicators of wellbeing to determine the future distribution of government funds and policy (ABS, 2017b). These national systems of population statistical indicators, as Walter (2016) suggests, are built upon historical normative processes as circumscribed by the elite and, therefore, too frequently capture only the five Ds of alternative populations– disparity, deprivation, disadvantage, dysfunction and difference – from the viewpoint of the colonizer of the governing nation-state. In comparative methodologies, similar arguments can be made, particularly in relation to those methodologies adopted within welfare state typologies to assess the differential outcomes of welfare state formations for various groups of people within national borders. As Andersen et al (2016) have identified in their global analysis of Indigenous health and wellbeing, long term historical processes of nation state formation and colonial management practices, define processes of population identification. Constitutional, socio-legal and political histories all shape the construction of categories and the processes of statistical data collection for Indigenous peoples.

The clearest example is the work of Esping-Andersen's (1990) *Three Worlds of Welfare Capitalism.* Ebbinghaus (2012:15) argues that this work 'led to a research industry on the merits of fitting real welfare states across Europe and beyond into the three or more ideal-type categories'. These ideal types are premised upon large data sets that rarely consider

historical processes of nation-state development and, in turn, do not capture the First Peoples of nations such as Norway or Australia. For example, Norway is grouped within Scandinavian countries and typically categorized as a social democratic welfare state, with high levels of equality owing to what is referred to as the corporatist model, involving state-regulated labour markets with tripartite agreement of capital, labour and the state, alongside high redistributive mechanisms and public delivery of social provisioning. Australia, within Esping-Andersen's comparative typology, is typically framed as a liberal welfare state with Australian-specific oddities due to the emergence of minimum wages in 1908 and means-tested income support, first awarded to only white settlers (Castles, 1985). Unfortunately, in the development of such comparative methodologies which draw on large-scale assumptions in relation to national political economy, Indigenous political economies and socio-cultural practices are excluded from the typological construction. Nor is disability a category of inclusion. To concur with Walter (2016), dominant comparative methodologies and approaches, too, have long historical trajectories that do not take account of First Peoples in their construction. Thus, internal populations within the borders of the nation-state are flattened, hiding locally produced disparities, inequalities and exclusionary welfare-state structures. Despite the dominance of this model at the global comparative level, it fails to recognize the long standing inequalities of Indigenous peoples and persons with disability, and long standing injustices of colonization in population governance and management.

In the realm of disability studies, there has been almost no comparative analysis of nation-states in relation to identifying persons with disabilities and documenting the interrelationship of nation-state formation with population management. The few studies that have emerged are limited in their scope. The focus has largely been on aspects of the law, such as disability discrimination law (Degener, 2005); the emergence of eugenics as a governing ideology at the turn of the early 20th century across the transatlantic (Jarman et al., 2002); classification systems of disability and the development of special education as a global norm (Florian et al., 2006; Richardson and Powell, 2011); and the restructuring of welfare measures with the advance of neoliberal policies, such as welfare to work (Grover and Soldatic, 2013). Although important, this work yet again excludes Indigenous people with disability, because disability and Indigeneity are not disaggregated in the analysis, despite the nation-state managing both Indigenous and disabled populations simultaneously, driven by a unified political, ideological and moral discourse of biological inferiority and moral deficiency (see Soldatic, 2015).

Indigenous studies of comparative structures of colonization offer probably the best approach to identifying the interrelationship of nation-state formation and population management, and the role of national statistics in legitimizing particular forms of nation-state formation. Comparative approaches between white, colonial, liberal welfare states, including Australia, Canada and New Zealand, and then among the social democratic Scandinavian countries of Norway, Sweden and Finland, both offer unique insights into understanding Indigenous

dispossession as central to processes of nation-state formation and are particularly important in attempting to construct a comparative analysis of the situation of Norway and Australia for Indigenous people living with disability. For example, while First Peoples of both nations experienced processes of colonization, Norway's emergence as a nation-state is often described as a process of 'norwegianisation'– part integration, part exclusion and prosecution, and, at times, limited political recognition of Indigenous peoples (Minde, 2005). 'Norwegianisation' involved colonial structures of power, violence and domination, as we document later, but it also entailed unique forms of both recognition and stigmatization that co-jointly operated as a limited political compromise with expanding European settlement and insistent border enclosure shrinking Sami lands and restricting mobility. Legal recognition and integration was expected to occur through European enculturation, which simultaneously denied the intergenerational transfer of language, cultural practices and Indigenous economies. Even though there are recorded instances of violent confrontations between Sami and Norwegian people, these have predominantly been dealt with as police matters within the framework of Norwegian civil laws. 'Norwegianisation' has thus mostly applied more symbolically violent measures, such as the denial of the use of Sami in education, misrecognition of Sami culture and economic discrimination of traditional Sami industries. This process of 'norwegianisation' is different from the Australian European settlement of white *invasion* and dispossession. White colonial management of Australia's First Peoples has involved direct military confrontation, the total takeover of land and the continual denial of legal recognition as First Peoples through the false assertion of *terra nullius,* which is repealed only in a patchwork sense through native title claims that are successful, the onus being on Aboriginal and Torres Strait Islander groups to 'prove' a continuing association to country, rather than on the white settler population to acknowledge and accommodate prior occupation. Even successful native title claims do not grant complete Indigenous control of land and contain provisos that allow mining and other industries to exploit these lands, generating qualitative new forms of Indigenous inequality and dispossession.

As we illustrate, these differentiated and locally specific trajectories have shaped local Indigenous struggles for rights, recognition and representation. Statistical comparisons that are built upon general statistical national indicators of Indigenous peoples, that is, the way one is counted and in what ways one is counted, therefore take on particular political meanings, varying in their significance for local Indigenous struggles for justice and the historical trajectory of the assertion of cultural collective identity under differing nation-state building enterprises of colonial power. Thus the construction of statistical categories is imbued; constructing categories and the processes of collection that lead to comparative national indicators are thus limited by Indigenous historicity. Thus, these historical trajectories have implications for current comparative realities.

## Mapping the political terrain: Norway and Australia compared

In this section we provide a separate analysis of the political struggles for Indigenous people of Norway and Australia. The aim is to illustrate key historical differences that have driven the national logic of defining Indigenous persons and disabled persons as separate national populations. This section frames the concluding discussion of why comparative analysis of national population data too frequently hides, or conflates, many of the unique ongoing structural constraints that Indigenous people living with disability face within their local contexts. It raises questions about whether the limitations that emerge in attempting to undertake broad scale comparative analysis can be addressed in a coherent methodological approach in line with Indigenous peoples' demands for the construction of statistical data and indicators that is representative of their lived narratives and journeys (Walter, 2016).

***Norway***

*Short historical background*

The Sami people inhabited the northern and central areas of the Scandinavian countries as well as the Kola Peninsula long before the nation-states of Norway, Sweden, Finland and

Russia were founded. Politically, the Sami peoples were recognized already in 1751 when Denmark–Norway (at that time a political union) and Sweden–Finland, agreed on the borders between Norway and Sweden. The agreement contained an amendment– 'Lappekodisillen' – specifying special legal rights for Sami people. Particularly important to Sami people, herding reindeers in a nomadic fashion between the eastern high inland pastures in the winter and the western coastal regions in the summer was the right to freely cross the borders the nation-states had agreed upon. This was, however, just one among several provisions in the amendment. There were also rights specified for those Sami people who did not herd reindeers, but were farmers or fishers. The right of Sami people to natural resources like game and fish was also specified (Pedersen, 2008).

It is quite interesting to note that the civil servants who drafted the amendment in 1751, were quite well informed about the numerous ways of living in different Sami communities. Still, the authors of the amendment recognized the Sami very much as one people in their own right, and set them apart from Norwegians and Swedes as a nation entitled to distinct and separate rights. For example, the amendment specifies that, in the event of a war between Denmark–Norway and Sweden–Finland, Sami people would not have to take part or declare allegiance to either of the nation-states (Pedersen, 2008). The amendment specified a liberal and quite modern policy towards an Indigenous nation and this political recognition of the Sami nation still bears significant importance today. History, however, also tells of strife and conflict, for example between migrating nomadic Sami people and settled Norwegian, Swedish or Finnish farmers. The political recognition in 1751 did not necessarily mean a cultural and social recognition of the Sami and their ways of life. Economically, culturally and socially, Sami people were marginalized by their respective nation-states throughout the nineteenth and twentieth centuries.

In Norway, the Sami were never segregated in terms of general civil rights, and in modern Norway have always been formally recognized as civil citizens equal to any other Norwegian citizen. Nevertheless, the lack of recognition of the Sami languages (ten in total, three of them spoken in Norway), culture and traditional industries have constituted a severe oppression of Sami people as a lingual and cultural minority. This has been especially pronounced within educational systems. Schools would adopt a harsh assimilation policy demanding that Sami children learn and study in Norwegian. The tacit message to Sami children was that Sami was unsuitable as a modern and rational language. Nevertheless, Sami organizations worked to promote Sami rights throughout the twentieth century.

In the late 1970s, the Norwegian National Assembly approved the damming of the Alta river in the north of the country. The construction of the dam was a crucial element in a planned hydro-electric power station. Yet the dam was located in an area important to traditional Sami industries, both fisheries and reindeer pasture. The dam project was widely opposed within the Sami community in Norway and Scandinavia, and different Norwegian activist groups

supported their resistance. Even though the dam was eventually constructed, many have pointed out that the protests sparked a new awareness about Sami rights both within the Sami nation and in the general Norwegian community. The Sami struggle for recognition in Norway has been successful in some areas. The late 1980s marked the transition to new official Norwegian policies towards the Sami nation. Instead of just recognizing Sami people as formally equal citizens with equal access to general civil rights, the modern Norwegian welfare state adopted a more active stance, committing to support and promote Sami languages, culture and the Sami community in general. In 1989, the Norwegian Sami Parliament was established. This is a representative elected body responsible for promoting Sami interests and supporting Sami culture and language. Similar institutions to facilitate Sami representation were established in Sweden and Finland during the first half of the 1990s. Today, many municipalities in Norway have Sami settlers. Ten of these are administrative areas for the Sami language, where Sami and Norwegian have equal status. The inhabitants in these municipalities have the right to use Sami language in their meetings with welfare services. It is the municipal council that decides whether a municipality shall become part of an administrative area for the Sami language.

### *Indigenous identity*

When, as in this article, comparing results from different studies about the Indigenous Sami people, it is important to take into consideration that there are many ways to define Sami identity. In Norway there is no public register of Sami people, except the Sami Parliament's electoral roll (which is not accessible to researchers) (Pettersen and Brustad, 2013). Furthermore, many Sami due to the harsh assimilation process in Norway have abandoned their Sami identity and avoid reporting their Sami ethnicity (Bjørklund, 1985). In addition, the population in northern Norway (where most of the Sami live) has multi-ethnic characteristics, being a mixture of Norwegians, Sami and Finnish (Kvernmo, 2004). In research, there is no common definition of Sami identity (Lund et al., 2008) and this is arrived at in different ways using, for example, language or geographic residence as a marker for Sami affiliation (Brustad et al., 2009).

### *Health services and outcomes for Sami people*

In Norway, the municipalities are responsible for the delivery of primary health care and social services, whereas regional health authorities provide 'specialized health services' (including general and psychiatric hospitals, ambulances and substance abuse treatment) (Olsson and Lewis, 1995). In general, the primary health and social services in Norway are relatively easy to access. Services are either free of charge or cost a small fee, though people in rural areas live further away from some services and therefore need to travel long distances

to access them (Turi et al., 2009). Health services in Norway are mostly public and are therefore equally accessible for all citizens (Stamsø, 2009).

A number of studies look into the health and living conditions of Sami people. They find that the Sami are in a uniquely positive position, having exceptionally good health and living conditions compared to other Indigenous peoples in the circumpolar area (Sjölander, 2011; Snodgrass, 2013). Even though it is plausible that ethnic discrimination is strongly associated with elevated levels of psychological distress (Hansen and Sørlie, 2012), Norwegian research concludes that there are no significant differences in mental health between Sami people and the majority population (Kvernmo, 2004; Møllersen et al., 2005), and that mortality rates are similar across geographical areas with high and with low Sami population density (Brustad et al., 2009). However, one does find differences within the Sami population, taking such characteristics as age, gender and geography into consideration. For example, those living in Sami-dominated areas report better mental health (Kvernmo, 2004) and health conditions than Sami living in marginal Sami areas. Ethnic discrimination may contribute to this inequality in health (Hansen, 2015; Hansen et al., 2010).

Furthermore, there is no overall ethnic difference in the frequency of health service use (Turi et al., 2009), and those living in administrative areas for the Sami language, are not referred either more or less to somatic specialist health care than in comparable municipalities in the north of Norway (Norum and Nieder, 2012). Even so, Sami service users are found to be less satisfied with health services than the majority population (Nystad et al., 2008; Sørlie and Nergård, 2005). According to research, this discrepancy is caused by lack of opportunity to speak their own language alongside a shortage of Sami cultural competence within the health and social services (Hedlund and Moe, 2010; Melbøe et al., 2016; Sørlie and Nergård, 2005), which may create a sense of cultural unsafety and an experience of lack of equality-seeking or rights-oriented care (Stout, 2006).

According to the *Sami Act* of 1987, sections 3–5, Sami people in Norway have a legal right to receive equitable health and social services adapted to the Sami language and culture. Sami organizations now demand special initiatives to ensure welfare services accommodate Sami language and Sami understanding of culture, life and illness (Norske et al., 2010, 2013). Subsequently, in the last two decades there have been established a Sami national competence centre of mental health care, a specialized Sami somatic medical office, and a centre of Sami health research at the University of the Arctic. However, the availability of culturally specific health services depends very much on geography. In some of the predominantly Sami areas, there is a well-organized Sami-focused professional health service run by Sami-speaking personnel (Kvernmo, 2004), whereas such a service is not available outside these areas.

*Welfare policy and disability services*

In general, living conditions for Sami people today are not different to those of the majority population. This is probably due to the organization of the Norwegian welfare state in general. All Norwegian citizens – Indigenous and non-Indigenous alike – are ensured equal access to free health services, free education and a number of social rights and benefits such as sick pay, family allowance and retirement pensions (Brustad et al., 2009; Kvernmo, 2004). Services to the Sami population are thus primarily provided within the framework of the mainstream welfare services, rather than through services specific to the Sami population. Compared to many other countries outside Scandinavia, Norway has a rather comprehensive welfare policy. A main reason for this wide-ranging policy is the extensive rebuilding after World War II, which the public was mostly responsible for as there was limited private capital accessible. Historically, the Norwegian welfare state has aimed to contribute to social integration and political stability through social equality and solidarity across socioeconomic boundaries (though there are socioeconomic differences in Norway, they are not associated with class membership in the way that, for example, British classes can be distinguished). An important part of this effort has been to ensure all citizens real opportunities to participate socially. In principle, the system is universal, which means that all citizens are equally entitled to a decent standard of living and full citizenship rights. However, some benefits are means-tested or selective, for example disability benefits. The aim of the social security system is to ensure an acceptable standard of living for everyone, for example, through a universal minimum pension, while the health policy is intended to remove differences in health conditions and mortality between different social groups (Stamsø, 2009). In short, instead of targeting resources towards specific groups, the Norwegian welfare policy with its strong universalistic and solidaristic traits, intends to integrate and include the entire population (Olsson and Lewis, 1995).

When it comes to the organization of services for disabled people, there has been a gradual change since the 1950s, moving from segregated services that differentiated type and degree of impairment (such as care of the deaf and care of the blind) towards more normalized and integrated services, in line with the growing developments of normalization theory emerging in Scandinavian disability services. This means that people with disabilities should now be treated as equal citizens of society, having the same right to healthy living conditions and opportunities as everybody else, and that services as far as possible, should be offered by the mainstream local welfare services and not by special institutions (NOU, 2001:22). Even though residential institutions for disabled people were closed in the 1990s, recent years have seen the growth of segregated education for students with disabilities.

Research among Sami people with disabilities is sparse (Nordens Välfärdscenter, 2014). Essential findings here, though, are the importance of cultural competence and a culturally

sensitive practice in welfare services (Melbøe et al., 2016; Minde, 2015; Nymo and Minde 2014). Due to a lack of such competence, Sami people with disabilities experience cultural and linguistic barriers within the support system, and do not receive health and social services on a par with the majority population. This variable access to services appears to be linked to disability, rather than Sami identity. Furthermore, the situation of Sami people with disabilities in Norway seems to vary depending on such characteristics as type of impairment, relation to Sami identity, gender, geographic location, age and other variables (Melbøe et al., 2016).

### *Australia*

*A short history of Indigenous dispossession*

Unlike the process of *norwegianisation*, and entailing variant degrees of political recognition, the arrival of European invaders to Australia resulted in violent Indigenous dispossession. The first British invaders did not recognize Indigenous peoples' ownership of the land, nor that they encompassed a rich diversity of over 300 nations and language groups. Conflict, wars, the introduction of diseases and dispossession of their lands, culture and children, resulted in the devastating loss of Indigenous life, with populations shrinking, in some parts from over 10,000 people down to just under 2,000 within years of colonial arrival (Broome, 2005). This was a deliberate strategy of the colonizer to alienate Indigenous peoples from their land, culture, and Indigenous practices of health and wellbeing (Schofield and Gilroy, 2015).

Indigenous people were enclosed onto cattle stations, farms and town camps, with entire Indigenous nations relocated (Broome, 2005). This was not a reservation system, such as that granted by treaty in the USA, but forced removal so that the colonizers could claim the land as their own (Laidlaw and Lester, 2015). As workers of outstations, wages were either not paid, or paid at much lower rates compared to white workers. As Deane (2017:51) argues, this was a form of slavery and servitude. While there have been some attempts for reparation (Korff, 2018), these have been focused on unpaid wages, and do not acknowledge the comparative loss of the intergenerational transfer of wealth and economic gain, as experienced by settler families, that ongoing labour-market participation generates. Today, Aboriginal and Torres Strait Islander Australians are the poorest and most economically insecure of all population groups in the country (Mays et al., 2016).

Moreover, each state developed a raft of so-called protection policies that involved the forced removal of children from their families, particularly children of mixed race, under an ideology of eugenics that emphasized 'breeding out' Indigeneity (Paul et al., 2017). These children were placed with white families so that they could be trained in 'whiteness' (Jacobs, 2009). Severing the intergenerational transfer of Indigenous culture, language and lore,

especially from mothers to their children, was a core strategy of the colonizers' rule (Armitage, 2011). Many of these policies remained, albeit informally, up until the 1970s (Deane, 2017). Yet, the impact reverberates today; recent data suggests that Indigenous children are seven times more likely to be removed from their families as part of so-called child protection policies administered by each state of Australia (AIHW, 2017).

It should not be surprising then, that at the formation of the Australian Parliament in 1901, the doctrine of *terra nullius*– land with no prior owners– was enshrined within the constitution (Taylor, 2016). Moreover, the new national constitution did not name, identify nor recognize Australia's First Peoples as legitimate citizens of the newly formed nation-state. Under Section 51 (xxvi), the Commonwealth of Australia had the power to make laws with respect to 'people of any race, *other than the Aboriginal race in any state*, for whom it was deemed necessary to make special laws' (emphasis added). Section 127 of the constitution reinforced Indigenous exclusion from the new polity: 'reckoning the numbers of people of the Commonwealth, or of a State or other part of the Commonwealth, aboriginal natives shall not be counted'. In the national referendum of 1967, Section 127 was repealed, and the words 'other than the Aboriginal race in any state' removed from Section 51 (xxvi).

The outcome of the 1967 referendum did not lead to the realization of Indigenous political, social, economic nor cultural rights across the nation. Aboriginal and Torres Strait Islander peoples received 'the right' to be included within the national polity and, for the first time, to be counted as valid persons of the Australian state in the national census (Korff, 2017). Yet, with the two references to Australia's First Peoples removed from the constitution, to this day there is no formal recognition of Aboriginal and Torres Strait Islander peoples within constitutional law. Across the nation, Indigenous groups are mobilizing for both constitutional recognition and for a national treaty to advance and secure socio-legal structures and institutions of sovereignty, rights and self-determination (Uluru Statement, 2017).

*Indigenous and disability identity*

Statistical identification for Aboriginal and Torres Strait Islander Australians via national data sets, such as the census, is tied to the process of colonization itself (see Monash University, 2015 for an Indigenous population map of Australia based on census data). While in Norway, Sami people may be hesitant to identify as Sami in national population data, statistical counting holds particular significance for Aboriginal and Torres Strait Islander Australians' struggles for political recognition (Walters, 2016). Across Australia, Aboriginal and Torres Strait Islander peoples have campaigned not only for census questions relating to cultural identification, but also discrete surveys to gain greater understanding of their day-to-day lives. As Walter (2016) suggests, non-Indigenous ways of counting are too frequently

constructed to the exclusion of Indigenous people's own narratives of their daily lives. To illustrate, according to the Australian Institute of Health and Welfare (2010), Aboriginal and Torres Strait Islander identity consists of three components: descent, self-identification and community acceptance. Generally, identifying questions in large-scale population surveys from national census data on health, education and labour-market participation questionnaires, contain a set of direct questions for self-identification only (Thompson et al., 2012). And yet, as Gilroy and Donnelly (2016) illustrate, Indigenous peoples contest these processes of identification, even though they are compelled to participate to gain recognition of their Indigenous identity.

The primary national survey on disability prevalence in Australia– *Survey of Disability, Ageing and Carers* (SDAC) – adopts the standardized questions used in the national census survey in relation to Indigenous identity (ABS, 2015). Disability status is probed in terms of the daily levels of support required, to ascertain severity of disability and its impact upon daily living. Additionally, demographic information such as employment and education, age and gender, is asked about for all survey recipients. Over time, Aboriginal and Torres Strait Islander Australians have increasingly self-identified as Indigenous within the SDAC. As Hollinsworth (2012) has argued, due to the possibility of additional stigma and discrimination from identifying as disabled, Aboriginal and Torres Strait Islander Australians were reluctant to fully report within the national disability survey both their Indigenous identity and disability severity, if at all. With the rise of the Indigenous disability movement, illustrated by organizations such as First Peoples Disability Network Australia, Aboriginal and Torres Strait Islander Australians are increasingly engaging with the survey and reporting both Indigenous and disability status. Disability prevalence among Aboriginal and Torres Strait Islander Australians is higher than for the rest of the population, reported at 21.1 per cent in 2009 (ABS, 2009) and 23.9 per cent in 2015 (ABS, 2015) (the ABS notes that this difference is not statistically significant due to changes in methodology in the data collection). Disability prevalence is said to be higher among Indigenous women than men (25.1 per cent and 22.7 per cent respectively). In contrast, the prevalence of disability in the non-Indigenous population was around 17.5 per cent in 2015, a decrease from 18.5 per cent in the 2012 and 2009 surveys (ABS, 2017a).

### *Health and living conditions of Aboriginal and Torres Strait Islander Australians*

The legacy of European invasion and settlement has directly impacted on the intergenerational health and living conditions of Aboriginal and Torres Strait Islander Australians (Pulver and Harris, 2007). Aboriginal and Torres Strait Islander Australians have the poorest health outcomes across all Australian population groups and experience the highest levels of poverty, housing deprivation and food insecurity (ACOSS, 2016). Combined, these factors have resulted in an average 10-year gap in life expectancy across

some parts of Australia when comparing Indigenous and non-Indigenous mortality (Silburn et al., 2016). Aboriginal and Torres Strait Islander Australians have shorter life expectancies than the Indigenous peoples of Canada, the US and New Zealand (Cooke et al., 2007; Pulver and Harris, 2007; Silburn et al., 2016). While there are clear differences between geographical landscapes – urban, rural and remote – the severe level of inequality in health and living conditions has resulted in high levels of early mortality that are on par with some of the most deprived nations in the Global South.

One of the key issues, as Gilroy and Donnelly (2016) have documented, is that the historical role of western medicine to classify, survey and control Indigenous bodies has resulted in low levels of trust in western medical systems. This is coupled with inaccessible health systems due to culturally inappropriate services and the long history of racism within the Australian settler healthcare system. Socio-lingual issues prevail, with many Indigenous people in remote Australia who use English as a second or third language having little exposure to and needing to negotiate the language of large-scale, bureaucratic western health systems (Neave, 2016). To counter these difficulties, local Aboriginal Medical Services operate across Australia, mostly in regional town centres.

For major medical treatment and interventions, however, people residing in regional and remote areas of Australia often have to travel long distances, at high cost, to large urban, and often unfamiliar, city centres, away from country, family and kin. This is a point of differentiation with Norway, where similar treatments can be accessed in the larger regional towns using Sami-controlled services. For example, in most rural and regional areas, access to dialysis is extremely limited, with many Aboriginal people needing to travel out of their own areas to receive this treatment. There are also few maternal services in regional areas for new mothers and their children born with congenital disabilities. For their children to receive the required care and interventions, Aboriginal mothers are often forced to move, leaving them with no familial supports (Soldatic, 2018a). The emotional socio-cultural isolation in itself can be a direct deterrent to actively seeking vital medical interventions (AIHW, 2009).

The combined effect is that many Indigenous people across Australia are not only denied direct access to health care, but also that illnesses can remain untreated, leading to long-term disabilities. Moreover, many Indigenous people living with disability, due to these vast costs, emotionally, socially and financially, may delay treatment or early intervention. As a result, secondary impairments are more likely to develop over time. Not only does this have implications for their individual health and the day-to-day management of their impairment, the lack of engagement with the western medical system directly impacts on their access to disability service systems and social security, as detailed in the next section.

*Welfare policy and disability supports*

As eugenics ideology infiltrated white colonial policy in all areas of social, political and cultural life, specialist disability institutions and asylums developed alongside white welfare structures and protection policies. There were rare moments when Indigenous persons living with disability entered the disabled asylum (Errington et al., 2018). Many state welfare policies remained in place until the 1970s, when the arrival of the federal Whitlam government signaled active engagement with Indigenous Elders, leaders and communities to bring state welfare policies under a national agenda. A number of restrictions within social security administrative law were amended to remove any references of Indigenous exclusion, providing greater access to regular social security benefits. National working parties were established and experimental programs run to increase Indigenous participation in the labour market, resulting in the Community Development and Employment Program (CDEP) scheme being implemented in 1977 in the Northern Territory and becoming a core component of Australian Indigenous welfare policy for the next 30 years. This enabled Indigenous social security recipients to be gainfully employed in their local communities with wage top-ups funded through the program. The program contained elements of self-determination, as Indigenous organizations in remote and rural locations administered the local projects, responding directly to community needs and concerns. Nationally, the program was well supported by Indigenous communities who actively participated in the ongoing direction and development of their communities and towns.

By 2007, however, the program was increasingly coming under fire from the conservative government at the time. The CDEP has since been reformed as the Community Development Program and is, in effect, a new form of paternalistic management of Indigenous communities (Marston et al., 2016). Participation is mandatory for social security recipients on general unemployment benefits in the communities where the CDP is run. It has been reported that of all welfare programs across Australia and all social security recipients, Indigenous CDP participants are more than 200 times more likely to receive a welfare breach of non-participation, losing access to payments for up to several weeks. Moreover, the cashless welfare card that was first trialed in Indigenous communities and has since been rolled out to more areas nationally, means that a large number of participants receive only a part cash payment that they can personally control for their own needs. The other part of the social security payment remains on a card that can only be used to purchase certain items and only at selected retailers, shops and stores (James, 2016).

These changes to Aboriginal and Torres Strait Islander Australians welfare have occurred simultaneously with increasing eligibility restrictions to the disability social security payment (Disability Support Pension, or DSP). Aboriginal and Torres Strait Islander Australians are

significantly disadvantaged under these new eligibility rules and criteria (Neave, 2016) in two aspects in particular. First, the requirements for a positive DSP determination and access to disability services, income support and disability aids presuppose extensive engagement with the formalized medical system, where an individual can draw upon historical medical records to demonstrate long-term disability. This is one of the core reasons why Aboriginal and Torres Strait Islander Australians have the lowest levels of take-up for disability services and social security payments within the Australian welfare system (Soldatic, 2018b). Second, the eligibility criteria for the DSP is imbued with a set of western normative systems of the body and, therefore, the questions asked of the individual in relation to the impact of disability do not necessarily align with Indigenous cultural engagements with the body and mind: it is 'race blind'. The combined effect is that Aboriginal and Torres Strait Islander people with disabilities are more likely to be assessed for Newstart, the general unemployment benefit, which is a lower payment that also exposes them to higher levels of conditionality (such as breaching penalties in the CDP), further entrenching their structural position of poverty.

## Conclusion

Comparative methodological considerations enrich our understanding of the relationship between nation-state formation and citizenship wellbeing, through examining the interrelationship between structural and socio-political factors and their impact on differing population data processes and methodologies. Most significantly, it enables greater insight into the nation's continued desire to categorize, stratify and manage differing groups within its borders and the influence of historical processes and political institutions on present-day state–citizen relations. This is particularly relevant in identifying and understanding the political processes that result in the segmentation, differentiation and marginalization of different groups, and the ongoing material and cultural inequalities that persist due to these differing historical political structures.

As the UN special rapporteurs (2016), the International Labour Organization (Convention 169) and Indigenous–disability civil society groups from around the world examine the interstice of Indigeneity and disability, concurrently the comparative analysis of population data sets carried out in the UN HDI, data that is then used to inform global development and national policies, obscures impairment created through processes of Indigenous dispossession, discrimination and racism. It counts what is revealed now and how local persons situate their own positionality within these statistical processes of categorisations. To develop responsive systems of health, disability and welfare to advance the rights of Indigenous people with disabilities requires us to look more closely at the colonial histories of individual nation-states and their differing impacts on the social determinants of health for Indigenous people. Any comparative approach to Indigenous disability needs to ground these socio-political population categories in historical processes of colonial power – such a

process is necessary to identify the very real limitations of existing statistical comparisons and potential avenues to address future ambitions for such comparisons. Our examination identifies the significance of political historical processes – *norwegianisation* in Norway and white European settlement in Australia, both forms of colonization. Situating direct comparative analysis within these historical processes can inform future Indigenous population statistical data and disability population data and disaggregation within both, that is, the collection processes and the construction of categories that aim to collect such statistics for comparative analysis (Cook et al., 2007; Walter, 2016).

Most importantly, the historical analysis of the Norway and Australia country examples, two countries that consistently sit at the top of the Human Development Index, illustrate the significance of identifying the limitations of comparative statistical analysis and the ongoing absences that curtail meaningful comparisons for Indigenous peoples, especially for Indigenous persons living with disability. Historical processes of colonization and the colonial practices of Indigenous population management not only obscure the development of statistical categories, but also the ways in which differing Indigenous peoples may and often may not, seek to claim their Indigenous or disability identity, often due to these very historical processes of political struggle against colonisation. Thus, historicizing existing statistical categories aims to illustrate both the limitations of the nation-state systems of population analysis through large scale statistical frames, and also, how these socio-political processes shape the ways in which peoples within the nation engage with existing national population data and statistics through their historical locations of power. This is not to suggest that statistical data is irrelevant or refute its value; as the Australian Indigenous rights movement has qualified, to be counted within the nation state as part of national population census can be a critical component of the political struggle for recognition, rights and sovereignty. The critical point, as illustrated throughout this comparative paper, is that historical processes of biopower and the subsequent ways in which the state constructs population categories, require extrapolation for any direct comparative analysis to occur. This is both in terms of who has the power to define and construct such categories, and then, the types of meanings that are given to those processes of representation in the construction of such categories. This paper therefore, illustrates that the methodological construction of statistical categorization for global comparisons needs to take into account these historical processes of political differentiation and that without such critical considerations, direct comparisons are limited by national socio-political trajectories and the historical processes of internal population management of colonial conquest.

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