Australian Health Inequities Program

Beyond Evidence on Health Inequities: what works, why and how?

Empowerment and Closing the Gap

By

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Good morning ladies and gentlemen, brother and sisters

I begin by acknowledging the traditional owners of the land on which we are meeting today.

I would like to thank the Australian Health Inequities Program for inviting me to speak to you this morning, on the topic of empowerment and closing the gap.

I want to start with a broad look at the theory of the social determinants of health and how it fits with the ongoing struggle to improve the health of Australia's Aboriginal Peoples.

I want to ask how we are doing, as a nation, in our current approach to what has become known as 'closing the gap'.

The social determinants of health are now widely accepted, and even used to form the basis for policy, but how effectively are the implications of this holistic approach to health being put into practice?

It seems to me that one of the critical social determinants, what we know of as 'the control factor' – or what I will call 'empowerment' – is often missing.

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Integrating notions of power and control and putting them back at the centre of the debate on 'closing the gap' seems to me the critical challenge facing all of us – Governments, Aboriginal people, service delivery organisations, and researchers.

I will argue that this means a fundamental recasting of the approach to 'closing the gap', and indeed to the relationship between white and black Australia.

Let me start with the broad theory of the 'social determinants of health'.

As we all know, this theory simply states that the health of peoples is not just about health services.

Access to appropriate health care is of course an important determinant of health.

But health is also strongly influenced by a range of social factors – poverty, employment, education, access to food and transport, housing, stress and social exclusion or racism.

All these have profound and lasting impacts on our health throughout our lives.

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Today, this idea is widely accepted, at least in research, service delivery and policy circles.

This is both welcome and important, particularly when it comes to dealing with the poor health of the Aboriginal Peoples of Australia.

But as we all know, this way of looking at health was not always so widely accepted.

I am not an expert on the history of the theory of the social determinants of health.

Many you here today no doubt have a much better knowledge of how that theory developed.

But my understanding is that, while some of the ideas had been around for a long time, bringing these together under the label of 'social determinants' – and intensively exploring them – is something that has only happened over the last fifteen years or so.

For me personally, it was in the mid-1990s when I first heard this theory being talked about in Aboriginal health policy and research circles in Australia.

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At the time, I was the director of an Aboriginal health service in Darwin, and heavily involved with many other Aboriginal health leaders in the debates on health policy and practice across the country.

So, this new theory that said that there was a whole social, emotional and even political dimension to our health was welcome to us.

It was also instantly recognizable.

It was not as new to us as it might have been to others.

Because the notion that our health was about more than access to services had already been at the heart of the modern Aboriginal struggle for many years.

For example, the definition of health put forward in the landmark 1989 *National Aboriginal Health Strategy* put it simply and well:

> *[quote]*
>
> *[Health is] not just the physical well-being of an individual but the social, emotional and cultural well-being of the*

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whole community. This is a whole of life view and it also includes the cyclical concept of life-death-life ...

[unquote]

This definition of health is as relevant today as it was twenty years ago, and is still used by numerous Aboriginal communities and health services.

Importantly, it appeared <u>before</u> there was any talk of the social determinants of health, yet it seems almost a crystallisation of that theory.

And, although they put it so beautifully, the National Aboriginal Health Strategy Working Party did not invent this Aboriginal idea of health.

The political struggles for Aboriginal rights of the 1960s and 1970s had the same idea, under the label of what we then called the 'underlying causes' of ill health.

Land rights, access to quality education, freedom from discrimination and racism, self-determination: all these were explicitly part of the movement with which we sought to achieve better health for our peoples.

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It was this movement which led to the establishment in the 1970s of the first Aboriginal Medical Services, of which more in a moment.

However, even <u>then</u>, forty or fifty years ago, this understanding that physical health was linked to social, economic and emotional health drew upon deeper sources.

Ultimately, I believe, this holistic view of health springs from the flexible and holistic thinking that epitomises Aboriginal cultures.

It is, in fact, embedded in their unique and imaginative approaches to the world that emphasise the inter-connectedness of all things.

Seen from this ancient perspective, the idea that physical health was inseparable from social health makes absolute sense.

Of course, following the process of colonisation, the idea that poor health was linked to social issues was also reinforced for us every day by our lived experience as Aboriginal people.

We could see in our own communities and own families the effects of poor housing, unemployment, racism, and the day-

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to-day stress of worrying about where this week's rent or the money for the kid's clothes was going to come from.

We could see that this was how the world worked, in a way that was probably not so obvious to those from more privileged backgrounds.

So, when the theory of the social determinants of health appeared out of the research world in the 1990s, telling us that it had now been 'proved' that social, emotional and political issues affected health, it aroused mixed feelings amongst many of us.

There was a temptation to put our hands on our hips, sigh loudly, and say "Yeah, that's what we've been trying to tell you for the last thirty (or fifty or two hundred) years!"

However, that aside, the theory was welcome as a confirmation of our experience and of the 'holistic' approach to Aboriginal health we had been living and advocating.

It provides a powerful new way of conducting the argument about how to improve the health of our communities – in other words it provides an intellectual framework upon which decisions can be made.

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The scientific nature of the evidence is much more difficult for politicians and policy makers to deny than our arguments from political analysis and community experience.

The new theory was also significant in helping to build a bridge between the research community and the Aboriginal community sector.

In the 1980s in Australia, 'research' was still a dirty word in the Aboriginal world.

By then, we had won our rights in many areas of our lives.

But when it came to research, the agenda was still being set in forums to which few of us had access.

Research was still something carried out 'on' us, not 'with' us, and certainly not 'by' us.

Aboriginal health research was overwhelmingly focussed on conditions and diseases – the 'medical model' was largely unchallenged.

But despite the volumes of research, little seemed to change: research projects came and went, but health service delivery and health policy stayed much the same.

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But by the early 1990s, some of us in the Aboriginal health sector began to think about how research could be made more useful and appropriate for our communities.

And this was about the time that this idea of the social determinants of health came on the scene.

This was a research agenda which we <u>could</u> relate to and which we felt had something to offer to our health services.

So we began to develop contact with researchers interested in this 'social determinants' approach.

They became our 'way in' to the research world.

It is no accident that one of the first areas of research that we asked the newly established Cooperative Research Centre for Aboriginal and Tropical Health to look at in the late 1990s was how the evidence on social determinants – then largely from overseas – might fit the Aboriginal world.

So, this idea of the social determinants of health and the research surrounding it have become an important way of us seeing the world, building on our own Indigenous conceptions of health and linking Aboriginal service providers with the research world.

And, over the last ten years, the idea has become almost universally accepted amongst researchers, policy makers and service deliverers in Aboriginal health.

It is now conventional thinking.

No report or policy, no conference or academic article on Aboriginal health is now complete without an acknowledgement of the fact that better health requires action across a whole range of social issues.

You can see the influence of the social determinants of health approach at the highest levels.

COAG's *National Indigenous Reform Agreement* which sets out how all Australian Governments intend to make progress on 'closing the gap on Aboriginal disadvantage' includes seven 'building blocks'.

These are: early childhood; schooling; health; economic participation; healthy homes; safe communities; and governance and leadership.

All of these are important social determinants, and it is a step forward that these are now accepted as the basis for national policy in addressing Aboriginal disadvantage.

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This is the policy – but what about practice?

How well we are progressing, as a nation, in truly adopting a 'social determinants' approach to tackling Aboriginal ill health?

I'd like to make a couple of points about this.

One of the most powerful implications of the social determinants approach, just as with the Aboriginal 'holistic' approach to health, is the inter-connectedness of physical, social, emotional and political factors affecting health.

This is a profound challenge for service deliverers and policy makers.

It should surely change not just what they do, but how they do it.

Unfortunately, what we often see is that people acknowledge the existence of the social determinants, but then go on with 'business as usual'.

Many mainstream health services, for example, can see that poor housing, lack of access to education, poverty and unemployment all profoundly affect the health of their Aboriginal clients.

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Yet these factors are then defined as 'outside' their responsibility.

Other departments, other Governments, other organisations deal with those things – not us.

I'm not blaming practitioners here: this is how people are trained and this is how our health system is set up.

A truly holistic approach is difficult.

But that is exactly what the social determinants theory tells us is needed.

This is why I – along with the great majority of Aboriginal people – support the Aboriginal community controlled health services so strongly.

From their beginnings in the 1970s and 1980s, these organisations have embodied that holistic view of health.

Obviously they don't build houses or run schools.

But they have always seen their role as advocates on behalf of their communities on all issues that affect health.

They speak up on these issues, and community controlled health services have been critically important in having them put on the local and national agenda.

At the same time, these services frequently work at the local level with organisations in other sectors to ensure that the health of their communities is addressed as a whole.

The mainstream health system needs to learn from this Aboriginal model.

Their ability not just to see the big picture but to put it into effect is critical.

The second point I want to make about the challenge that a social determinants approach to Aboriginal health makes is this: they come as a package and they all need to worked on at the same time.

You can't do education this year, housing the next, and employment after that.

They all need to tackled in an integrated and coordinated way.

And, crucially, they all need to be included.

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We can't allow the situation where some of the factors that affect the health of our peoples are accepted, while others are politely acknowledged and then ignored.

Because it seems that Governments are 'getting it' on some of the social determinants of health – but they are passing over other, crucial determinants.

They've 'got it' that education is important.

They've 'got it' that housing is important.

They are beginning to 'get' the importance of early childhood development and investing there.

But in a way these are the easy ones.

Of course none of them are really easy – as the troubled housing program in the Northern Territory makes clear – but houses and schools and teachers and even jobs and income can all be measured in some way.

In broad terms we know how to do those things, even if it is not particularly easy to do them.

The one social determinant however which always seems to slip off the list is to me one of the most critically important.

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It is 'the control factor' – what we might call empowerment.

We know that the evidence on the social determinants of health includes powerful confirmation that disempowerment and social exclusion have negative effects on health.

This evidence cannot be ignored.

It means that issues of empowerment must be at the heart of policy and practice to 'close the gap'.

This is not just a matter of having a policy for empowerment, or empowerment interventions, although these things may be useful.

More fundamentally, it means that <u>any</u> policy or program aimed at reducing the disadvantage of our communities must from its conception through to its implementation and beyond, ask itself how it will increase the ability of Aboriginal people, families and communities to take control over their own lives.

And this is where I think the current thinking of Australian Governments on 'closing the gap' is coming unstuck.

All too often it assumes that the 'real' issue is a technical or concrete one – more houses, more doctors, more children in the

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classroom, more services delivered – while ignoring and often undermining the critical issues of control and empowerment.

Let us take as an example the Northern Territory Emergency Response – known popularly simply as 'the Intervention'.

We all know in broad outline the nature of that Intervention: how it came into being under the Federal Liberal Government in the run up to the 2007 election; and how the Labor Government has largely continued those policies.

On the one hand, the Intervention has led to increased investment in housing, policing, community safety, and health services.

All these things, are positives and can be expected to pull the health of Aboriginal communities in a positive direction.

But the Intervention has also been profoundly disempowering for many Aboriginal people.

For example, the Intervention as originally announced included:

- compulsory health checks of Aboriginal children;

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- blanket quarantining of welfare payments to all Aboriginal people leading to the suspension of the *Racial Discrimination Act*;

- the compulsory acquisition of Aboriginal townships; and

- the scrapping of the permit system that allowed Aboriginal people control over access to their land.

More damaging than these individual ideas was the 'get tough, quick fix' rhetoric that surrounded the whole enterprise.

It was made abundantly clear where the problem lay: it lay with us, it was Aboriginal people who were to blame for the conditions in which we lived.

What we needed was a good kick up the bum, and then the non-Aboriginal State would just have to come in and fix it all for us, as we were obviously incapable of doing so ourselves.

The Federal Labor Government withdrew some of the more controversial of these measures.

It softened the rhetoric.

But the structures and the thinking of the Intervention remain in place.

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Explicitly or implicitly, it rejects self-determination as a 'failed policy'.

It does not approach our communities as having anything valuable to offer or indeed of having achieved anything in the past.

We are to be the passive recipients of non-Aboriginal "help".

This has left many Aboriginal people marginalized from the decision-making processes in their own communities.

It adds to the sense of disempowerment and stress that many already feel.

And we know from the social determinants of health theory that a diminished sense of control and increased stress will lead to poorer health outcomes.

In other words, the Federal Government's approach to 'closing the gap' is pulling in two opposite directions at once – increasing investment in services and housing on the one hand, but undermining control and empowerment on the other.

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To borrow a phrase from a research colleague (used in a different context, I should add) they've got one foot on the accelerator and one foot on the brake.

This is not going to get us anywhere fast.

It is certainly not going to get us to the Government's ambitious 'closing the gap' targets.

So, what do we need to do?

As I said before, on a policy and program level, when it comes to issues of power and control, process is all important: <u>how</u> something is done is at least as important as <u>what</u> is done.

Yet the 'how' seems to receive very little thought.

I was thinking about this when I was watching a program on ABC TV a few weeks ago.

The program was called 'Grand Designs' and the episode I saw was about unemployed and low-income people in Birmingham in England, setting up a cooperative and building their own houses.

Few of them had any experience in construction, but a local housing association trained them in the skills they would need.

Each person specialised in one skill – bricklaying, plumbing, carpentry, electrics.

Over the course of the building project, they all had to put in 20 hours a week on site, working on each other's houses in turn.

At the end, the houses got built – and got built well – and each 'self-builder' owned a share of their own house.

This was significant in itself for people who could rarely have afforded their own homes through normal channels.

But many of them also gained professional skills during the project, which they then used to find full time jobs.

And even more important in my eyes was the sense of achievement they got from actually working together, learning and building their houses.

You could see the pride on their faces at the end of the project, showing the cameras through their houses.

This seems to me an example of the kind of approach we should be using in Aboriginal Australia to ensure that 'closing the gap' addresses the critical areas of empowerment.

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We should be putting the control and the decision making in the hands of local Aboriginal people, and then supporting them to do the job.

This applies not just for housing, but for health services, education, community safety initiatives – all of the many areas that affect health.

This would be truly in keeping with a 'social determinants' approach.

This is, as I say, what is required at the program level.

But getting to this point requires addressing some much deeper historical issues of empowerment and control in Australia.

It believe it requires a fundamental 're-setting' of the relationship between Aboriginal and non-Aboriginal Australia.

Somehow, as a nation, we have to get over this idea that Aboriginal experience and ideas doesn't count.

Because this is what so many Aboriginal people have experienced throughout their lives, and continue to experience every day – especially in today's environment.

I remember the very first time I became consciously aware of this denial of our experience.

I was probably seven or eight years old, at primary school in Darwin.

We were all in the classroom on a hot afternoon, sitting on our wooden benches, and the teacher starts talking and writing on the blackboard about how this man called Captain Cook had 'discovered' Australia.

Now at that age, I didn't have any sense about what had happened at La Perouse, I had no historical knowledge, I had no images, but I just immediately thought, "Hang about, that's not true!"

There was no way I could communicate this to the teacher, of course.

At that stage I didn't have the words.

All I had was my own experience, as an Aboriginal child, and as part of an Aboriginal family and community.

But this experience, of having one's own experience denied, implicitly or explicitly, is a common one for Aboriginal people.

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Just as our peoples' occupation of the lands of Australia was not recognised for over two hundred years until the Mabo decision in 1992, it seems that our experience is a kind of 'terra nullius'.

Because the non-Aboriginal system can't see it, it isn't there.

So, there is this deeper level at which we need to address issues of empowerment and control in Australia if we are serious about wanting to 'close the gap'.

How we do this is not easy.

I don't have any ready-made solutions.

However, we do know that internationally, processes of truth, reconciliation and justice can be important to try and 're-set' relationships in post-conflict societies.

These processes are based on the idea that the 'conflict' doesn't stop when the fighting stops: the psychological, spiritual, physical effects can continue for years, even generations.[1]

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[1] Ideas in this section are taken from Lambourne, W (2004) *Post-Conflict Peacebuilding: Meeting Human Needs for Justice and Reconciliation*. Peace, Conflict and Development – Issue Four, April 2004 ISSN: 1742-0601. Available at: http://www.peacestudiesjournal.org.uk/docs/PostConflictPeacebuilding.PDF

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The evidence is that these are particularly severe in the case of genocidal conflict.

Aboriginal Australia could be seen as a case study of what happens when there is no such process to address the effects of conflict.

The colonisation of this country was frequently accompanied by brutality, killings and sexual violence.

It was followed up by dispossession from land and livelihood, and the removal of children from their families.

Even in those few places which escaped the violence and dispossession, the colonisation process profoundly disrupted processes of meaning and decision-making.

Yet for much of our shared history, non-Aboriginal Australia refused to acknowledge what had taken place.

Even the well-documented history of the Stolen Generations was ignored.

The lack of recognition of the damage done, and the lack of a process to deal with it has, I believe, contributed profoundly to

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feelings of disempowerment and disengagement in our communities.

It still lies at the root of modern day policy-making as we can see from the Northern Territory Intervention.

Addressing these deep issues of empowerment and control, and re-setting the relationship between Aboriginal and non-Aboriginal Australia needs to be based on a process of genuine reconciliation.

The Prime Minister's Apology to Indigenous people, delivered in Parliament in Canberra at the beginning of 2008 was a good start.

The Apology was well overdue, but when it came it was dignified, moving and welcomed by all Australians.

But the Apology should be seen as only the beginning.

True reconciliation is not an event – it is a process.

It means entering into a true dialogue, respecting the results of that dialogue, and acting upon them.

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This means abandoning once and for all the myth that the State can impose solutions on Aboriginal people against their will.

This is complex, and it is difficult, but it means abandoning the kind of 'we know best' attitude that seems so deeply embedded in current attitudes to Aboriginal Australia.

It means putting the issue of true empowerment back at the heart of this nation's work to 'close the gap' between Aboriginal and non-Aboriginal Australia.

Thank you.

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