Beyond Bandaids:

Exploring the Underlying Social Determinants of Aboriginal Health

Papers from the Social Determinants of Aboriginal Health Workshop, Adelaide, July 2004

Edited by Ian Anderson, Fran Baum and Michael Bentley

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Acknowledgments

This monograph is the culmination of a body of work commissioned by the Cooperative Research Centre for Aboriginal Health (CRCAH) as part of the development of its Social Determinants of Health Research Program. The series of papers were presented at a workshop, held at Flinders University, Adelaide, 6–7 July 2004.

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Fran Baum, Michael Bentley and Ian Anderson

Glossary

AARE	Association for Active Educational Researchers
ABC	Australian Broadcasting Corporation
ABS	Australian Bureau of Statistics
ACA	Aboriginal Councils and Associations
ACWA	Association of Children's Welfare Agencies
AECGs	Aboriginal Education Consultative Groups
AGPS	Australian Government Publishing Service
AIHW	Australian Institute of Health and Welfare
AITAC	Australian Indigenous Training Advisory Council
AIATSIS	Australian Institute of Aboriginal and Torres Strait Islander Studies
AHM	Australian Health Ministers
ALRC	Australian Law Reform Commission
AMSANT	Aboriginal Medical Services Alliance Northern Territory
ANTA	Australian National Training Authority
ANTaR	Australians for Native Title and Reconciliation
ANU	Australian National University
APS	Australian Public Service
ATSIC	Aboriginal and Torres Strait Islander Commission
ATSIS	Aboriginal and Torres Strait Islander Services
CAA	Carers Association of Australia
CAAC	Central Australian Aboriginal Congress
CAEPR	Centre for Aboriginal Economic Policy Research
CARPA	Central Australian Rural Practitioners Association
CAT	Centre for Appropriate Technology
CDEP	Community Development Employment Program
CDIP	Cultural Diversity and Inclusive Practice
CRANA	Council of Remote Area Nurses of Australia
CRCAH*	Cooperative Research Centre for Aboriginal Health
CRCATH*	Cooperative Research Centre for Aboriginal and Tropical Health
DDBBB	Danila Dilba Biluru Butji Binnilutlum [Medical Service]
DEST	Department of Education, Science and Training, Australian Government
DETE	Department of Education, Training and Employment, SA
DEWR	Department of Employment and Workplace Relations, Australian Government
DEWRSB	Department of Employment, Workplace Relations and Small Business, Australian Government
DFAT	Department of Foreign Affairs and Trade, Australian Government
DFCS	Department of Family and Community Services, Australian Government (now FaCSIA)
DHA	Department of Health and Ageing, Australian Government
DOJ	Department of Justice, Victoria

FaCSIA	Department of Families, Community Services and Indigenous Affairs, Australian Government
HoNOS	Health of the Nation Outcomes Scale
HR	House of Representatives, Australian Parliament
HREOC	Human Rights and Equal Opportunity Commission
IHS	Indigenous Health Survey
KAMSC	Kimberley Aboriginal Medical Services Council
KHPC	Koori Health Partnership Committee
KHT	Koori Health Unit
KHT Inc.	Koorie Heritage Trust Incorporated
MAC	Management Advisory Committee
MCEETYA	Ministerial Council on Education, Employment, Training and Youth Affairs
MHCA	Mental Health Council of Australia
NACCHO	National Aboriginal Community Controlled Health Organisation
NAHS	National Aboriginal Health Survey
NAHSWP	National Aboriginal Health Strategy Working Party
NAIHO	National Aboriginal and Islander Health Organisation
NATSIS	National Aboriginal and Torres Strait Islander Survey
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NSFATSIH	National Strategic Framework for Aboriginal and Torres Strait Islander Health
NGO	Non-Government Organisation
NHMRC	National Health and Medical Research Council
NHS	National Health Survey
NIIRV	National Inquiry Into Racist Violence
NILF	Not in the Labour Force
NSW	New South Wales
NSWHD	New South Wales Health Department
NT	Northern Territory
NTA	Native Title Act
NTLRC	Northern Territory Law Reform Committee
OATSIHS	Office of the Australian and Torres Strait Islander Health Services, DHA
OHAA	Oral History Association of Australia
PAR	Participatory Action Research
PRA	Participatory Rural Appraisal
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australian College of Physicians
RCIADC	Royal Commission into Aboriginal Deaths in Custody
SA	South Australia
SACE	South Australian Certificate of Education
SES	Socio-Economic Status
SDQ	Strengths and Difficulties Questionnaire
SHRG	Social Health Reference Group
SNAICC	Secretariat of National Aboriginal and Islander Child Care
THS	Territory Health Services
VET	Vocational Education and Training
UNICEF	United Nations International Children's Fund
WA	Western Australia
WHO	World Health Organization
WPAHBH	Working Party of Aboriginal Historians for the Bicentennial History

** The CRC for Aboriginal Health was established in 2003 following on from the CRC for Aboriginal and Tropical Health. It is a virtual organisation that brings together the Aboriginal health sector, government health agencies and research institutions to ensure that research conducted into Aboriginal health is driven by priorities set by Aboriginal people themselves; is of practical use and transferred expeditiously and accessibly to the Aboriginal health sector; and results in the development of research capacity within the Aboriginal community itself (www.crcah.org.au).*

Introduction

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> *In the National Aboriginal Health Strategy, Aboriginal and Torres Strait Islander peoples linked their health to 'control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity (Human Rights and Equal Opportunity Commission 2005:26).*

That social and economic factors determine health status has been acknowledged for centuries. It would, in all likelihood, come as a shock to the ancestors of Aboriginal people[1] in Australia that there could ever have been any doubt that what happens in everyday life and one's position within society would have a massive impact on health. For them, health was a concept indivisible from life itself. While modern medical science has brought many benefits, it has also resulted in a situation where what happens to individuals and their bodies has become abstracted from their social, economic, cultural and community context. Increasingly, health researchers and activists are re-learning the importance of a holistic approach to health and there has been a resurgence of interest in the social and economic factors underpinning health outcomes.

This renewed interest on the role of social and economic factors in health is well demonstrated by the World Health Organization's (WHO) establishment in 2005 of the Commission on the Social Determinants of Health (CSDH). The CSDH has expressed a determination to be driven by evidence, including successful action and research on social determinants that has resulted in improvements in population health. The Commission's encouragement for action on the social determinants of health has also provided a research framework for the work of the Cooperative Research Centre for Aboriginal Health (CRCAH). This focus fits well with the CRCAH's central goals of ensuring that research into Aboriginal health is driven by priorities set by Aboriginal people themselves; is of practical use and accessible to the Aboriginal health sector; and results in the development of research capacity within the Aboriginal community itself.

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[1] Throughout this Introduction we have used the term 'Aboriginal' when referring to Indigenous Australians. Many of the issues raised are also relevant to Torres Strait Islanders.

This monograph, commissioned by the CRCAH, presents a perspective on how a range of social and economic factors—including culture, law, education, employment, models of governance, and social and community interactions—affect the health of Aboriginal Australians. It also suggests fruitful directions for further inquiry into how these factors can be made more health promoting.

Social determinants of health and wellbeing

Social determinants, then, has become the commonly used term to describe the non-medical and behavioral influences on health. The CRCAH uses the term for one of its four program areas (for details of the programs see http://www.crcah.org.au/research_progam_areas/). However, this is done uncritically and we are aware that using the term '*determinants*' implies a rigidity and certainty that does not capture the less deterministic nature of the constellation of factors that create health and wellbeing. In practice, population health and wellbeing reflect fluid processes that result from political decisions or non-decisions. This means that the factors labelled as '*determinants*' are not rigid or fixed in the sense that they cannot be changed. In fact, they are open to influence through policy changes.

In the past few years, and particularly since the publication of the *Little Children Are Sacred: Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse 2007*, policy debates in the Australian media have presented Aboriginal issues as if they are unsolvable and intransigent and caused by 'deviant' characteristics inherent in Aboriginal communities. The policy light is rarely shone on the people with power and resources, as was clearly demonstrated in the August 2007 debate around the Federal Government's new legislation in response to this report. This response was strongly criticised for ignoring evidence on the broader determinants of health. Such indifference emphasises the need to understand current debates about the social and economic determinants of health within an historical context. It is not possible, in our view, to understand the persistent poor health status of the original custodians of Australia since the time of European arrival and invasion, without situating this understanding within the history of dispossession, colonisation, failed attempts at assimilation, racism, and denial of citizenship rights.

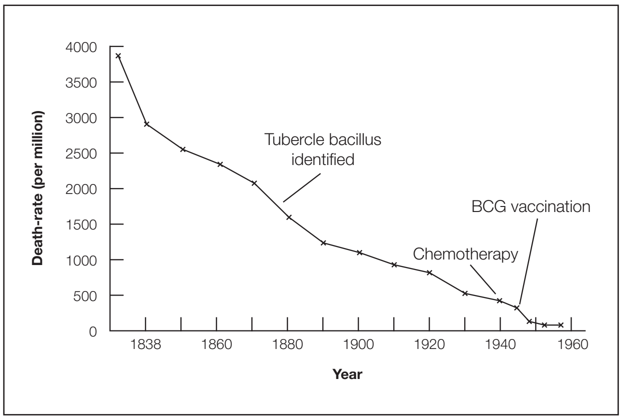
Nor does the current debate take into account the long-term trends in Aboriginal health. In those regions where we have quality longitudinal data we are now able to demonstrate that there have been significant health gains despite the continuing disparities. In the Northern Territory, life expectancy for the years 1967–2001 has improved for both Aboriginal men and women: from 52 to 60 years for men, and from 54 to 68 years for women (Wilson, Condon & Barnes 2007). There has been significant and demonstrable gain in the mortality outcomes for children under five years of age. For example, the work of Freemantle *et al.* (2006) in Western Australia has shown that infant mortality rates for Aboriginal children have improved from a rate of 25·0 in 1980–84 to 16·1 in 1998–2001. It should be noted that despite the gains in infant mortality, the more recent pace of improvement has not kept up with gains in the broader Australian community so that the gap has widened.

When we examine cause-specific trends the pattern is more complex. In the Northern Territory mortality due to infectious diseases has improved significantly over the past four decades. Patterns with respect to chronic diseases show that even these have been increasing at a much slower rate since 1990 (Thomas *et al*. 2006). It is difficult to make clear attribution for the positive changes, but most commentators acknowledge the role of both improved housing quality and the physical environment. It has also been suggested that better access to health care (including preventative programs such as immunisation) has contributed to these advances.

History of social determinants approach to health

An approach to health based on the social determinants of health is not new. Nineteenth-century social and public health reformers (for example, Virchow in Germany and Snow in the United Kingdom) were well aware that the main causes of illness were rooted in social and economic infrastructures (see Baum 2002 for details). In one of the most quoted examples of public health action, Dr John Snow took away the handle from a water pump because he had established that the water from that pump was causing its users to contract cholera. Similarly, Dr Rudolf Virchow identified the working conditions that resulted in ill health among workers in Silesia. Other social reformers in the nineteenth century pointed out that the working and living conditions in rapidly growing urban areas resulting from the industrial revolution were the cause of much ill health. For instance, tuberculosis was in part spread by the close proximity in which people lived in crowded housing, thus proving that tuberculosis is a disease of poverty. Some of the strongest evidence in support of the social determinants of health comes from the decline in rates of turberculosis in the United Kingdom. McKeown (1979) shows that this decline occurred prior to the availability of medical therapies (Figure 1).

FIGURE 1: Respiratory tuberculosis—mean annual death rates (standardised to 1901 population, England and Wales)



Source: McKeown 1979:92

This important analysis does not necessarily hold for Indigenous populations for whom significant declines in infectious diseases mortality occurred after the introduction of effective public health programs such as in tuberculosis control and immunisation (Kunitz 1994). There is now a body of research that demonstrates a link between health care (and primary health care in particular) and population-level health outcomes. In this context, the health outcomes documented fall into four main categories:

- reduced prevalence and incidence of communicable diseases that are susceptible to immunisation programs,;
- reduced complications of chronic disease through effective chronic disease management programs;
- improved maternal and child health outcomes;
- reduction in social and environmental risks through effective local public health advocacy.

It is likely that some of these outcomes require coordination between general practice and other components of the primary health care sector (DHA 2005).

For these reasons, it is generally now accepted that access to health care is an important social determinant. However, this is not a focus that is developed in this collection, and research in this field is taken up by the CRCAH Comprehensive Primary Healthcare, Health Systems and Workforce program. The goal of this program is to improve the performance of health systems with a particular focus on comprehensive primary healthcare services in order to maximise health gains for Aboriginal Australians.

For Aboriginal people, the impact of social and economic factors on health was evident from the time of the European invasion. Colonisation of land, such as Australia, was a process through which European countries sought to gain extra territory and, through it, wealth. Such was the disregard for the rights of the traditional owners of the land that the official position of the British government was of *terra nullius*—Latin for ‘land of no-one’. For any people, the refusal to recognise occupation of land as a basic determinant of health would be crucial, but is even more so for a people who had lived so closely to the land in a stable culture for hundreds of thousands of years.

The dispossession of Indigenous peoples from their land continued throughout the nineteenth and twentieth centuries, although the form varied according to current government policy. Aboriginal Australians were consistently treated as less than human and denied basic human rights. Some key examples demonstrate this: the failure of the Australian Constitution of 1901 to establish the legislative conditions in which Aboriginal Australians could be treated as full citizens; the policy of pulling together people from different tribal backgrounds into missions in the first half of the twentieth century; and the removal of children from their home 'for their own good'. Over the past decade or so, the impact of this history as a social determinant of health has been recognised. Perhaps this happened most powerfully in the *Bringing Them Home* report of the Human Rights and Equal Opportunities Commission's National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families in which the harms done to the 'stolen generation' were documented.

Having said this, the CRCAH's aim is not simply to dwell on the past, but to use an understanding of the past to contribute to a healthy future for Aboriginal people in which social, emotional and economic wellbeing is the norm rather than the exception. This monograph seeks to make a contribution to this process.

Current attention to the social determinants of health

While there has been a consistent strand of public health that has recognised the power of social and economic determinants of health, in the early twenty-first century their importance seems to be reasserting itself (Solar & Irwin 2007). In Australia, the Human Rights and Equal Opportunity Commission's *Aboriginal and Torres Strait Islander Commissioner's Social Justice Report* (2005) put considerable emphasis on the role of social determinants, and stressed that land and culture were important to health and that racism was detrimental to health. The report positioned the relatively poor health of Indigenous peoples as a human rights issue. It also contributed to the formation of a national campaign 'Close the Gap' (http://www.oxfam.org.au/campaigns/indigenous/action.php), which has as one of its three main planks of action 'Addressing critical social issues such as housing, education and self-determination which contribute to the Indigenous health crisis'.

This growing recognition of the social determinants of health has also been recognised internationally as signified by the decision of the late Director General of the WHO, Dr Lee Jong-wook, to launch a Commission on the Social Determinants of Health. Its chairperson, Sir Michael Marmot, has stressed that the work of this Commission is to consider the 'causes of causes of ill-health' (Marmot 2006). In launching the Commission, Dr Lee (2004) noted

> *The goal is not an academic exercise, but to marshal scientific evidence as a lever for policy change—aiming toward practical uptake among policymakers and stakeholders in countries.*

This focus on action parallels the determination of the CRCAH Board to emphasise, in its research program, not just an understanding of the social determinants of Aboriginal health but also an identification of which interventions are likely to improve Aboriginal health and wellbeing. This focus will be vital but, in all likelihood, hard to achieve because there has been so little investment in building an evidence base for the social determinants of health in Australia or overseas. This is especially the case when compared to the massive worldwide investment in the development of medical and pharmaceutical interventions, as the Global Forum for Health Research consistently points out (GFHR 2004; Matlin 2004). Others have noted that there is little in the way of efficacy research—testing interventions in a controlled setting—or implementation research—the 'how' of translating current research knowledge into practice within existing health and social systems (Sanders *et al.* 2004). Ågren (2003:20) states that public health research comes a very poor second to bio-medical research and comments that:

> *Research policy reflects both an over-confidence in the medical care services' ability to solve fundamental health problems and the strong economic interests that exist in the field of medical treatment. An individual and often deep-rooted biological approach dominates within the field of medicine, resulting in socially determined health*

> *discrepancies being studied relatively seldom or in many cases being ignored completely.*

Part of the difficulty in researching the social determinants of health is that evaluation of the interventions is challenging both practically and methodologically. Practical problems concern the need to develop partnerships with agencies that will be funding, planning and implementing interventions, and that sourcing funding for the evaluations is difficult. While the National Health and Medical Research Council (NHMRC) has changed its funding priorities to some degree, social determinants are still under-represented in the type of projects that it funds. It is significant too that the latest classifications of research used by the NHMRC, the draft 'health streams' presented in 2005–06, do not contain a specific category for social determinants. By contrast, biomedical research interests were represented in each of the streams. We are conscious that the kind of evidence needed about the social determinants of Aboriginal health will not be available until some significant national investment is made into researching them. The main focus of the research needs to be either on retrospective studies of occasions and instances in which health has improved in response to social or economic interventions, or on prospective evaluations of interventions based on improving social and economic determinants designed to enhance wellbeing.

In April 2007 the CRCAH hosted an International Symposium on the Social Determinants of Indigenous Health, which was endorsed by the Commission on the Social Determinants of Health. The symposium confirmed the central importance of social factors to Indigenous health status and drew on case studies from around the world to explore the unique nature of the ways in which these social factors have an impact on Indigenous peoples in (post)colonial societies (for report see http://som.flinders.edu.au/FUSA/SACHRU/Symposium/). We return to the themes from this symposium in the conclusion of the monograph, but note here that one of the important themes was the call for applied research.

This monograph resulted from an earlier CRCAH seminar held in 2004 as part of the process to establish priorities for research on the social determinants of Aboriginal health. The papers it contains set the scene for further research on the social determinants of health and strengthen the case for greater research investment to establish which interventions work best. The monograph does this by summarising existing research on the social determinants of Aboriginal health, and by suggesting directions for a future research agenda.

The process of compiling this monograph

Authors (individuals and/or groups) were commissioned to review the literature on particular aspects of the social determinants of Aboriginal health and then, on the basis of this review, to make recommendations for future CRCAH research priorities. Draft papers were prepared and presented to a seminar held at Flinders University in June 2004. The papers were pre-circulated to seminar participants so that discussions could be based on a full reading of the papers. The presentations were made to plenary sessions but the discussion occurred primarily in small groups. Subsequently, the literature reviews and recommendations were sent out for peer review and authors were invited to revise their papers in light of reviewers' comments. The information from the reviews and the seminar has been used to inform the evolving agenda for the CRCAH's Social Determinants of Health research program which is discussed further in the conclusion of this monograph.

The contents

This monograph contains sixteen chapters, each including components of literature review and recommendations for future research. The first two chapters present Koori perspectives of the social determinants of health. Chapter 1 by Tynan *et al.* is based on interviews with Koori people about their health and the ways in which social and economic factors and processes influence their health and wellbeing. The authors found that day-to-day relationships to social processes are closely connected and that 'upstream'/'downstream' and macro/micro factors are experienced simultaneously in a complex and multi-faceted way. Chapter 2, by Vickery *et al.*, concerns the way in which oral history can be used to provide decolonised voices to demonstrate the impact of historical experiences on health. These chapters provide an essential background to those that follow because they serve as a reminder that the dominant voices in the social determinants literature in Australia have been those from non- Aboriginal Australians.

A crucial aspect of the CRCAH agenda is, and will be in the future, funding research that allows the Aboriginal voice to present the complex intersections of social determinants that affect all populations (including education, housing, employment, income, and environmental quality) and those that affect Aboriginal people in particular (culture, a special relationship to land, a history of dispossession, and unique forms of social organisation).

Chapters 3 and 4 are concerned with education and its impact on health. Bell *et al*. (Chapter 3) review international evidence that demonstrates the central role of education in the creation of health. They also consider the intersections between health and education in Australia, how education can be understood both as a determinant of health and as an active intervention to address health inequalities, and set out an agenda for research based on community development principles. Askell-Williams *et al*. (Chapter 4) make a passionate plea for understanding education as a transactional process and as an essential element of wellbeing. They argue that education is required to achieve both the imperative for conceptual change, and conceptual change itself at multiple sites throughout the system.

Chapters 5 to 7 look at the material social determinants of income, poverty, employment and the physical environment. Walter (Chapter 5) demonstrates that Aboriginal Australians are more likely than other Australians to live in poverty and argues that this poverty can only be understood by considering Aboriginality. By this she means the lived experience of being Aboriginal in contemporary Australia, and suggests that future research takes into account the social, political and economic consequences of being in this position. Chapter 6 by Lowry and Moskos is written from the perspective of labour market experts and describes the ways in which Aboriginal Australians participate in a labour force in which they occupy a less advantaged position than other Australians. They conclude that further research would enable a richer understanding of Aboriginal perspectives of labour force status and its impact on health. Wayte *et al*., in Chapter 7, provide a detailed review of the literature on the physical environment and Aboriginal health. They show how common it is for the basic infrastructure that so many Australians take for granted to be lacking in Aboriginal communities. Their chapter also provides a framework to guide future research on this topic. In particular, they recommend that the development and implementation of programs and interventions should be guided by sound research into Aboriginal peoples' perceptions and behaviours in relation to the physical environment, and the determinants, outcomes and relationships between environmental factors and health outcomes.

Chapters 8 to 11 concern the less visible, but vital, aspects of Aboriginal experience in Australia such as social and emotional wellbeing, the importance of community development, effective means of governance, and the value of social capital as an analytical tool. Each of these chapters stress that health status is about much more than simply meeting physical needs. This complements the work of Marmot (2004:1), who notes that even among people who have jobs, good housing, education for their children, access to nutritious food and clean water, there is still a gradient of health—in his words, 'the remarkable finding is that among all of these people, the higher the status in the pecking order, the healthier they are likely to be'. It is among these less visible determinants of health that the reasons for health gradients are to be discovered.

Chapter 8, by Henderson *et al*., provides a thorough and detailed review of the literature on social and emotional wellbeing, including the means of measuring and assessing this wellbeing. They also outline a research agenda that is being used to inform the CRCAH Social and Emotional Wellbeing Research Program. Campbell et al. in Chapter 9 review the literature relating to the use of community development strategies in Aboriginal communities, they determine how these strategies have been used, and identify where they have, and have not, been successful in bringing about sustainable change. The chapter provides a critical view of empowerment, while recognising its central importance to the promotion of Aboriginal peoples' health. In Chapter 10 Sullivan and Oliver provide a critical review of governance and its impact on the life and health of Aboriginal Australians. They include a consideration of Aboriginal political life and custom, and the ways in which Australian society seeks to govern Aboriginal people. Their investigation of how mainstream organisational cultures limit their ability to work effectively with Aboriginal communities is highly relevant in 2007 as the Federal Government seeks to reshape its relations with Aboriginal communities in the Northern Territory. In Chapter 11 Brough et al. consider social capital and its potential role in understanding, and acting upon, the social determinants of health. They point out that the concept of social capital is slippery but has been used to produce a considerable amount of social epidemiology, suggesting that social processes involving trust, reciprocity and cooperation are good for health. They call for greater consideration of how this knowledge can be used to inform health policies and programs.

Chapters 12 and 13 are concerned with law and justice. Reynolds *et al*. provide a thorough overview in Chapter 12 of constitutional rights issues for Indigenous peoples, demonstrating that legal frameworks set the broad societal context within which impacts on health occur. The questions of rights is important given that in Canada, New Zealand and the United States of America, where prior Indigenous interests are formally recognised, Indigenous health, though worse than the average, is substantially better than in Australia. In Chapter 13, Smith considers the links between Aboriginal people and the justice system through a case study of the Koori Court in Victoria. This chapter is especially helpful in highlighting the complex and intersecting problems faced by Aboriginal people, and how addressing social justice issues may also have significant health benefits.

The final three chapters describe aspects of culture as it impacts on the health of Aboriginal Australians. In Chapter 14, Bond and Brough examine the ways in which the concept of culture is used in the public health literature: in terms of being about biology, being a label, being a description of behaviours or representing an ideology that can offer an alternative to dominant thinking. They also found culture positioned as a surrogate for racism or socio-economic disadvantage and, finally, as a panacea that can assist cure both through its role in making programs more effective and through the way in which it might empower people. They stress the importance of appreciating these complex understandings of culture and how the interpretations affect research and practice.

Morrissey *et al*. in Chapter 15 also discuss the complexity of culture and argue that a deeper understanding of culture is required in Aboriginal health research if it is to be a useful guide to social determinants of health responses. They note that serious engagement with Aboriginal culture, while essential to understanding Aboriginal health, is complex because doing so means engaging in a social process that is dynamic, shifting and interrelated. Finally, in Chapter 16 McDonald examines the ways in which the cultures of health services can impede effective service delivery. She explores examples of racism, the assumption of whiteness as the dominant paradigm, and the dominance of biomedical understandings of health. McDonald recommends an increase in cultural competence and cultural awareness training.

Call for action

The body of research in this monograph provides the foundation on which the current CRCAH Social Determinants of Health research program has been built. The work demonstrates the complexity of social determinants research and indicates that research that considers intersections between determinants will be important for the future. It also makes clear that while there is a body of research that describes the impact of the determinants of health, there is little that considers the question of what works in this area. A further lesson learnt from this collective work, is that research designed to address the question of what works must be built on a sophisticated understanding of social and cultural processes.

The CRCAH is committed to conducting research that will make a difference to the wellbeing of Aboriginal people and believes that research designed by Aboriginal people can direct the type of interventions and programs that will improve health. Our hope is that this monograph will contribute to greater attention being focused on social determinants of health, and that it will add to the pressure for concerted and evaluated government action to address these determinants.

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Chapter 1: 'If You Don't Have Health, What's the Use of Living?'

Koori Voices from the Goulburn–Murray Rivers Region on Health and its Determinants

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Introduction

It is often assumed that social factors leading to better health in mainstream Australian society will have the same outcome in Koori communities. However, this would require Aboriginal social processes to be similar to mainstream processes. Not only are there distinct cultural values contributing to different social processes in Koori communities, but the ongoing social marginalisation of Koori people from mainstream society contributes to a substantially different social domain. Research in the Goulburn Valley found that levels of depression were higher among Kooris employed in Aboriginal organisations/positions than those unemployed (Rumbalara Aboriginal Cooperative & Department of Psychiatry, The University of Melbourne 2001:139). Similarly, another study in the Goulburn Valley found no correlation between the level of formal education and employment status among Kooris (Alford 2002:20). These counter-intuitive findings are also reflected in income- and education-related studies in other Aboriginal communities (Hunter 2000; Malin 2003).

There are various models that conceptualise the processes of social determinants of health, some of which are multi-level explanatory frameworks. 'These multilevel explanatory models organise sets of empirical observations, and structure the relationship between these observations' (Anderson 2001:257). For example, Brunner and Marmot's (1999, quoted in Anderson 2001) social model of health interposes social categories, such as work and social environment, between categories of social structure and the psychological domain. This identifies 'upstream' factors important in contemporary public health thinking (Anderson 2001:249). Turrell and Mathers (2000) have developed a complex model linking upstream factors (for example, government policies and social, physical, economic and environmental determinants) to midstream factors (for example, psychosocial factors, healthcare system and health behaviours) and to downstream factors (for example, physiological systems, socio-economic inequalities and biological reactions). Another model, focusing on the relationship of racism to health (Williams 1997, quoted in Anderson 2001), distinguishes between 'basic' or structural causes (such as economic, political, legal, culture and racism) and their 'surface' causes (such as health practices, stress, psychosocial resources and medical care). While the surface causes can be changed, this does not address the underlying structural causes of health (Anderson 2001:255).

While these models may be useful in providing a systematic approach to policy development in Aboriginal health, it is not clear that such policy will be effective without reformulating it to embrace the values, practices and contexts of Aboriginal people. As Anderson argues, 'interventions in policy will only impact on population health outcomes if they impact on individuals or the relations between individuals' (Anderson 2001:257). Robinson (2002:1) expresses a similar point:

> *'notions of hierarchy and class may need to be replaced with culturally informed notions closer to lived experience… [and] psycho-biological research needs elaboration with respect to processes generating strain and risk within the life cycle'.*

This paper embraces the call by Robinson (2002) and Anderson (2001) to understand Koori health from a cultural position. A launching point must be in understanding how Aboriginal people conceptualise their experiences of health and its determinants. Discovering how Aboriginal communities and individuals think about, respond to and understand health can be the basis for developing strategies for these communities and individuals to improve health, including addressing the determining social processes. Through talking with groups of Koori people about their experiences and understandings of health and its causes, this exploratory study documents the voices of some Koori people and relates these to the existing understandings of the social determinants of Koori health. This is based on the belief that Aboriginal communities are owners of their health and it is only through interventions built on understanding their perspectives of health determinants that changes in health are also owned, implemented and successful. So the research aims were to identify a range of Koori perspectives of health and its causes in the Goulburn–Murray Rivers region, and to compare these perspectives to current understandings of the social determinants of health.

While seeking Koori voices, the project acknowledged at the outset that 'research is probably one of the dirtiest words' for Indigenous people (Smith 2001:1). Research on Indigenous communities has involved exploitation, disrespect, theft of knowledge and beliefs, and misinterpretation (Humphrey 2000). However, there is a need for community-level information to support community control (Hunter 1995) and enable communities to be better placed to address local issues in the interests of their members. For these reasons, this study worked in partnership with existing organisations and relationships.

Setting

The project was conducted in the Goulburn–Murray Rivers region of northern Victoria and southern New South Wales. This region includes several Koori communities situated along the Murray and Goulburn Rivers, including Shepparton–Mooroopna, Cummeragunja, Echuca, Kerang, Swan Hill and Wodonga. The project stemmed from a pre-existing partnership between these communities and the School of Rural Health, The University of Melbourne, in Shepparton. This partnership formed the Koori Health Partnership Committee (KHPC), which includes representatives from every Koori organisation providing health services in the region, as well as other community-controlled Koori organisations in the Goulburn and Murray Rivers area. The project was first approved by the KHPC as a whole and all members were invited to participate. The project was conducted under the research protocols previously established with the KHPC, which include community control of data, project protocols and approval for any findings, reports and papers arising out of the project (see Henderson *et al*. 2002).

It is estimated that the Koori population in this region is approximately six thousand people. The population is growing with more than half estimated to be under the age of thirty (Rumbalara Aboriginal Cooperative & Department of Psychiatry, The University of Melbourne 2001; Victorian Advisory Council on Koori Health 2001). Unemployment rates are high and incomes are generally low. Most towns have one or more community-controlled organisations that offer health programs but only some (specifically Shepparton–Mooroopna, Cummeragunja, Swan Hill, Robinvale and Echuca) have a health service that includes medical care.

An Indigenous Goulburn–Murray history

The Maloga Mission was established in 1874 on the New South Wales side of the Murray River. In 1880 a Protector of Aborigines was appointed in New South Wales. The Protector had the power to create reserves and to force Aboriginal people to live on them, which brought about the establishment of Cummeragunja in 1888. Reserves were set up far enough away from towns so that contact with Europeans was limited. Segregation was a key part of Aboriginal Protection Policy. By 1910 there were 116 reserves, with 65 per cent of these created as validation of Aboriginal occupation or in response to requests for land. In Cummeragunja's case the original allocation of 1800 acres was increased to 2965 acres in the early 1900s amid constant resistance from local European settlers. However, it never reached a size that was viable to support the Cummeragunja population despite ongoing petitions from Cummeragunja residents (Barwick 1972:50–1). The government policy that able-bodied residents should support themselves and their families by working outside the station led to active expulsions from 1908 and the bulk of the land leased out to local non-Aboriginal farmers (Barwick 1972:56–7). In the 1920s a number of organisations lobbied for civil rights, self-determination and the abolition of the Aborigines Protection Board. *The Aborigines Act 1940* introduced a new policy of 'assimilation'. The Protection Board was abolished and replaced by the Aborigines Welfare Board. In the name of assimilation, the board concentrated on the revocation of reserves and the relocation of the residents into towns. This policy was opposed by white rural communities and led to struggles over segregation. White residents refused to sell land to the Aborigines Welfare Board, thus denying Aboriginal people even a house block in their own country.

Aboriginal people did not live by the geographic restraints of State borders but by traditional landmarks. In the late 1930s a number of residents left Cummeragunja in protest of the slave-like living conditions and sought employment and education. Many families moved to Daish's paddock between Shepparton and Mooroopna (which was not prone to flooding, but is still by the river). When the Queen visited Australia and Shepparton, the local council gave the Aboriginal community a parcel of land (Rumbalara) to hide the 'eyesore' of people living in sub-standard conditions. At Rumbalara, small, cramped houses were built; some had large families and extended family members living in them.

The discriminatory effects of these policies are still felt today.[1] Unemployment in the local Koori community is three times the non-Indigenous level; school attendance of fifteen to nineteen year olds is only half, compared to 83 per cent of the wider population; with income levels at 80 per cent and home ownership less than half that of the wider population (ABS 2001, quoted in Victorian Local Government Association 2005). Local leaders have claimed that these discrepancies between mainstream and Aboriginal Australians are the very reasons that Aboriginal people made the brave decision to work at improving Aboriginal life and living standards. Since colonisation until now, many Aboriginal people have worked tirelessly, lobbying politicians, gaining mainstream support, and eventually establishing and administering Aboriginal community-controlled organisations in the 1970s. There are over 135 Koori organisations established throughout Victoria, such as the Victorian Aboriginal Legal Service, the Victorian Aboriginal Health Service and other Aboriginal community-controlled health services.[2] When Aboriginal organisations are numbered it is easy to see why some mainstream Australians think that Aboriginal people get special 'treatment'. However, the fact that Aboriginal Australians still live with health standards that can only be compared against the health standards of Third World countries shows otherwise.

Methods

Data collection

Before data was collected, approval for the project was gained in February 2004 from the KHPC. The study design was developed to encourage a diverse range of perspectives from the local Aboriginal communities about the social determinants of health. Focus groups were used because a group discussion could encourage responses about the topic to build (Krueger 1994). Further, focus groups were viewed as culturally appropriate because they did use direct questioning but enabled discussion of ideas while not seeking personal information. Once the study design was developed, approval for the research was gained from The University of Melbourne Human Research Ethics Committee.

The focus groups were semi-structured. A set of seven questions was developed to ask participants about the major health issues in local Aboriginal communities, who is affected by these issues, the causes of these issues and what is known about these issues and their causes. To ensure that participants would discuss the social determinants of Aboriginal health (as presented in academic literature), three handouts were developed and each group was asked to comment on them. This discussion was held at the end of the group discussion, so as not to be leading and to maintain the open-ended questions at the outset of each focus group. The three handouts were based on the existing literature and described (1) rates of disease and other physical health indicators, (2) the socio-economic correlates of health, and (3) claims about the causes of Aboriginal health for which there is little evidence, including self-esteem, dispossession, racism and role models (see Appendix). All seven questions were asked at each focus group and discussion flowed from each question, which often led to further questions. Some focus groups lasted one hour, while others lasted up to three hours. Focus groups were facilitated by, and notes recorded by, the first three authors. In order to be culturally appropriate, where participants were primarily women, a female facilitated, and vice versa. All participants seemed engaged in discussion and members of all groups participated at some point.

Data were collected in June, July and August 2004. Each organisation in the KHPC was mailed a letter asking if its staff, clients/service users or members would be willing to participate in focus groups. Follow-up telephone calls were made to the Chief Executive Officer/Manager of each organisation to again ask for support. If an organisation was willing to participate, the Chief Executive Officer/Manager determined the protocol in which permission from participants was to be obtained and how the focus groups were organised. Some organisations agreed for staff to be asked, while others agreed for groups of service users and/or members to be asked. Some organisations requested Board

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[1] 'Aborigines and Torres Strait Islanders comprise the least healthy identifiable sub-population in Australia' (Thompson 1998:37). Life expectancy at birth is seventeen years shorter, death rates are higher and infant mortality is greater than non-Indigenous Australians (Deeble *et al*. 1998; Thompson 1998). Indigenous Australians have higher rates of chronic illness morbidity, related to the high rates of Type 2 diabetes, heart disease and circulatory system disorders, stroke and renal disease (Thompson 1998).

[2] There are also youth hostels, adult hostels, drug and alcohol recovery centres, women's refuges, Community Development and Employment Projects, childcare centres, elderly hostels and Koori units established within most hospitals, police stations, TAFE colleges, the Victorian Aboriginal Child Care Agency, a number of Koori Open Door Education schools and a Koori educator within most primary and secondary schools.

approval first and this was obtained. Following the specific protocols for each organisation, participants were asked, a focus group time arranged and written consent gained from each member of the focus group. All focus groups were conducted at a site chosen by the hosting organisation—in all bar one case at the organisation in question. Using an inclusive approach, the only criteria maintained was that all participants were Indigenous. In some situations participants were reimbursed for their time, while in others the organisation was reimbursed for staff or service user time, depending on the protocol set by the organisation.

Participants

In total nine focus groups were conducted with sixty-two people (thirty-five women and twenty-seven men). Focus groups ranged in size from three to eleven participants. Some groups were entirely male, others entirely female, while most were mixed gender; this related to the organisation's members/users. The estimated age of participants was between eighteen and fifty-five years. While some participants were staff members with above average levels of income, the majority were members of organisations (general members of the community), while others were service users with particular health and related issues. As a result, participants included drug and alcohol clients, invited community members, members of sporting clubs, and staff in health and cultural organisations. Participants were mainly from Shepparton–Mooroopna but organisations from other parts of the region also participated.

Data analysis

The focus groups were audiotape recorded and notes were also taken. First, the data was analysed by identifying any health issues and social determinants of health reported at any time during the focus groups. Each health issue and cause is presented. Second, major themes were identified to report on the key issues related to health and social determinants as discussed by participants. This presents the findings of the discussions, which move beyond specific issues to describe the relationships, social processes and relevant issues, as discussed by these groups. This process entailed each focus group being analysed as a whole to identify the major understandings of poor health, health determinants and emergent themes. This allowed for each group discussion to be understood in context and as a group discussion. In all cases, we have tried to preserve the meaning of the participants and groups. Finally, the relationships between the key themes were analysed, with similar themes being grouped together. The interrelationships of these themes were then used to critique mainstream models of social determinants of health applicability to Aboriginal health. These three levels of coding and analysis were undertaken by the first three authors, one of whom is Aboriginal, and each level was undertaken by at least two authors so they could be checked.[3] Once the analysis was complete, a draft of the paper was provided to each participant and each participating organisation, and discussed at length with the KHPC. This ensured that Koori interpretations of the data and the key issues raised were included in this paper.

Findings

The nine groups were asked to identify the major health issues in their communities. While many of the Koori participants mentioned specific illnesses and medical conditions (diabetes, hepatitis and cancer), others talked about social issues (drugs and alcohol, family violence and child abuse) and some identified very broad issues, such as 'identity', or issues around 'awareness' and 'understanding' (see Table 1). When talking, participants rarely separated health issues and causes, and frequently mentioned social, cultural and political issues as both health issues and causes.

When asked to identify the causes of these health issues and what is related to these health issues, responses were again diverse and expansive. Many talked about 'awareness', as well as 'pressure' from others and the normalising of poor health behaviours (see Table 1). Some identified particular health and social behaviours, while some spoke about 'dispossession', 'loss' of rights and cultural issues/changes. Interestingly, all responses discussed were viewed as related to health and there was a high level of agreement within the groups when issues were raised.

When asked how respondents knew that these health issues and causes exist, most respondents said they see it, experience it or hear about it in their families and the wider Koori community. When asked who was affected by these issues, Kooris talked most frequently about young people, but others indicated that older people, single parents and/or 'everybody', all community members, were impacted by these issues. Several groups also stated that these issues are 'community' issues, not individual issues.

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[3] All three authors undertook the final level of analysis.

TABLE 1: Health issues and their causes as reported by participants

Health issues identified	
Harmful substance use	People are unaware
Diabetes	Foetal alcohol syndrome
Cancer	Identity issues
Hepatitis	Lack of bulk billing
Heart disease	Mainstream services lack knowledge of Aboriginal health
Loss of sight	Not addressing the 'real' issues of health
Unmotivated people	Gambling
Diet and nutrition	How treated by doctors
Mental health/illness	Preservatives in and processed food
Liver/pancreas/kidneys	Oral health
Family violence	Lack of role models
Child abuse	Lack of emphasis on prevention
Suicide	Lack of activities for youth
Smoking	ADHD
Ear, nose and throat	Learning disabilities in children
Unprotected sex	Hearing

Causes/correlates of health issues identified*	
Unaware of risks/lack of health education	Lack of understanding in wider community
Peer pressure	Mental illness
Family issues/breakdown	Unsafe practices in daily life
Lifestyles	Stolen generation
Lack of role models	Diet/non-traditional foods
Low self-esteem	Education based on lies (e.g. Australian history)
Broken spirits	Lack of recreational activities/boredom
Cultural practices not as strong	Racism
Lack of rights, e.g. land rights	Paranoia
Struggles with mainstream society	Treatment by doctors
Loss and grief	Sexually active at young age
Low education and literacy levels	Lifestyles have changed
Avoidance of other issues	Don't know who to ask for help
People think it's normal/general acceptance	Trouble with police
Unemployment	Body/metabolism not used to current lifestyle
Teachers don't understand our issues	History
Crime	Financial issues
Sharing custom (share food, drink…)	Effects of medication
Lack of transport	People don't care

** Responses are listed in order of those most frequently mentioned to those mentioned only once, with the first column responses followed by those in the second column.*

At the conclusion of the group discussions, all participants were given three handouts (see Appendix). Nearly all the information they contained was mentioned prior to presentation. The handouts were developed to aid discussion but it was found that generally they were not necessary to stimulate ideas. Some respondents said the information was new, stating that they were 'shocked' to see how common their own issues were in other Aboriginal communities. Some expressed frustration and anger that nothing seemed to be being done, and asked what the point of this study is if these figures are just being 'swept under the table'. Many indicated that while they knew Indigenous health was bad, there was a real 'shock of seeing it in writing', especially the dramatic differences between Indigenous and non-Indigenous health. Some were not surprised at these statistics but commented that it made them feel sad and noted that 'if you're honest with yourself' you often see children whose future is very bleak. In some groups, Kooris expressed sadness about the lack of change over recent decades. The statistics were not questioned and many groups acknowledged the similarity between their own community and communities in more remote regions of Australia. There was discussion about 'what are they doing with these figures now they've got them!' A few Kooris stated that they appreciated having the information to keep for their own use.

The first handout focused on physical health and discussion of these statistics moved from agreeing with statistics, based on participants' own observations and experiences, to political issues, social and psychological stress and change. There were many comments about the lack of change in health and questioning about whether the statistics would be 'different in 50 years'. There were a couple of discussions about sameness, and while wanting similar health statistics, Kooris did not want to be viewed as or treated the same as white Australians. The second handout focused on health behaviours and established social determinants such as education, income and employment. Again, stories moved from specific examples to reasons for unemployment, young people leaving school and the political, social and cultural reasons for lower income, education and employment levels. There was also discussion about change, with participants arguing that 'it doesn't have to be as bad as it is'. However, there was little optimism for improvement. The third handout identified more structural determinants of health and respondents reiterated issues mentioned previously, including the need for education, the need to address identity issues, the need for positive role models, and the need for leaders and acknowledgment of history, including the need for an apology for the stolen generations.

From the discussion of health issues and their causes, throughout all the focus group discussions, three overarching themes were identified—*holistic approach to health, identities* and *relationships with mainstream*. Within each of these, a number of closely related sub-themes were discussed, with all having strong interconnections to the overarching theme.

Holistic approach to health

The holistic perspective of health was evident in the ways in which participants talked about health. Discussions about physical health, specific health conditions and biomedical issues were usually brief and talk evolved quickly into more holistic, social, political and identity issues. For example, after briefly listing a range of health issues in response to the first question, one participant stated, 'I think you have to start with… the spiritual side of stuff because then everything else physically comes off that and that's just the past history'. This led into a discussion about the need to address issues around children's identities—how they feel about themselves and their culture. Another response to the first question related to the lack of knowledge by mainstream service providers of Koori health and the underlying causes. Discussion focused on the inability of mainstream services to effectively address the community's needs. Similarly, responses to the first handout listing health status statistics also connected specific health issues to broader cultural, social, economic and historical issues. Physical health issues were discussed but a holistic approach surrounded the discussions of all health issues. Within this holistic approach, however, a few specific issues constantly recurred, including the importance of health knowledge, youth and the devastating role of drugs and alcohol.

Health knowledge: There was a widely held view that Kooris generally did not have enough health information to be properly informed on the range of health issues facing them. One member expressed some incredulity at having been through the education system and not knowing how bad the health statistics of Koori people were. This person was aware of negative health outcomes resulting from practices such as drug abuse, but was not aware of the wider causes and impacts to the whole community. The majority of the focus groups also identified lack of education on specific health issues such as hepatitis C, AIDS and diabetes. Stories described dramatic changes in contextual factors, such as lifestyles, life being 'fast and money-driven' resulting in greater reliance on fast food, and considerably less exercise than when present-day adults were kids. Most participants wanted more information about health, particularly about the relationships between lifestyles, health conditions and prevention.

There was criticism that schools were narrow in their health education, providing sex education but not focusing on other life skills. In one person's words, 'They [schools] have a lot to answer for… they're not delving into [the real reasons]… These kids are sexually active at thirteen years of age, twelve years of age!' However, some participants acknowledged that 'we've got teachers out there that do a wonderful job' but they do not have the skills to deal with kids with behaviour problems. Others groups suggested that the lack of health information was related to leaving school at an early age.

Youth: There was a major concern for young people; adults expressed concern for young people's health and future. For example, one person stated, 'youth are the ones that are affected'. When asked who was most affected by the issues mentioned, 'kids' was the most common response, with many then going on to say 'everybody'. 'Our youth' was not only the primary concern for these groups, but young people were the key motivation for wanting change. When discussing concerns for young people, stories reflected how young people were treated: education ('they get to Year Nine but after that it gets too hard'); following other kids (this could be both positive and negative); and drugs and alcohol. Some Kooris talked about young people having more responsibility than in the past and also facing more risk, such as exposure to harmful substances.

Drugs and alcohol: Alcohol and drugs were repeatedly identified as a key health problem. Numerous reasons were proffered as to the importance and prevalence of this practice. Participants spoke of people drinking 'to wipe themselves out', 'to be the hero' and 'to take their minds off other things'. When elaborating on these reasons, participants identified the pressure on individuals to take their minds off family deaths, stress in all facets of daily life or 'the real world' and associated problems such as depression. Some participants spoke of being regretful when they were told what they had done under the influence, and even scared; the easiest way to escape those emotions and fears was to drink more. Other participants identified the fear of people thinking 'the grog's going to run out' and that many individuals get into the habit of drinking all their lives. Other participants identified additional issues such as peer pressure (or family pressure) and the strong desire to belong. As one participant said, 'Some people can't walk away from the grog or drugs [because then you'd be alone]'. Linked to this issue is the notion of loyalty—that family would think you are against them if you criticised their practices.

Identities

The importance of identity was discussed in all focus groups. It was viewed as being impacted by a number of closely related concepts such as self-esteem, shame and role models, with gender and place being the underlying contexts that contributed to the construction of individual and community identities. Embedded in their discussions of health and health behaviours was the participants' sense of who they and their children were.

Self-esteem: Identity was linked in talk to some of the bigger, macro social determinants through self-esteem. As one participant explained:

> *There has never been recognition of who the first people are… I don't even think we realise that when the leader of our country says we don't acknowledge that there was a stolen generation or… [local Aboriginal] people never existed [reference to unsuccessful Native Title application]—I don't think [we've]… realised the damage that does.*

At a more individual level, the role of lack of confidence was repeatedly identified by participants as a critical health issue, particularly for young people. One participant spoke of being 'scared and ashamed' at school, where 'being black' for him was the equivalent of 'being stupid'. One group agreed that Kooris' spirits are often broken when they are young, resulting in an attitude of not being good enough to do well. Practical health benefits of self-confidence were spoken about; for example, one participant stated, 'If you've got good self-confidence that also helps you deal with the grieving process 'cause you're more confident to let your feelings known to your close relatives instead of just holding it in'. Some participants stated that issues of self-esteem and confidence caused their own identified health problems.

Shame: Negative aspects of shame[4] were closely connected to self-esteem and continually arose in the context of Koori interaction with the mainstream. Ridicule was seen as a form of control used by the mainstream, reinforcing a Koori's lack of self-esteem, knowledge and/or power. Stories reflected that shame prevents participation in education and other social arenas. Adults were identified as having a key role in regards to shame: 'That's something we have to get out of the young [people]'. Shame was also directly linked to silence on important issues, such as child abuse. Participants spoke of a culture of denial in families about abuse issues: 'you're not going to discuss this outside of your family walls because it's a shame job', so perpetrators get away with it. Participants also identified how valued families are in Koori communities and how raising divisive issues, such as child abuse, could result in them being blamed for splitting the family. They also spoke of the failure of mainstream institutions, such as the law and support services, in dealing with abuse issues.

Role modelling: The importance of positive role models was repeatedly raised as a key health issue. In most of the group discussions there was a strong emphasis on same-gender role models within the family and community. This was generally viewed as more significant than high-profile 'outsider' or non-local role models. For example, one young person felt that young Kooris will not achieve in education 'if you don't got the support of your own people'. These discussions suggested that negative role models were seen as instrumental in the normalisation of substance misuse. Some participants spoke of 'growing up with it' from an early age, seeing aunts and uncles drinking all the time. In other cases it can become a defining characteristic of the group, where 'they're all bad'. Particular concern was expressed about boys lacking father figures in single-parent families. Most people identified that having two parents was better then having only one. And it was repeatedly raised that a good father was very important for the development of the young men:

> *[M]y dad's… not really been there for me… If you haven't got a role model to look up to, if you don't have that then it really affects you. I wish I had my dad… wish I knew my dad when I was a little baby but that's the way life is…*

One participant claimed that 'Aborigines are too easy lead', and spoke of the importance of having white friends and being able to associate with these friends, as well as family and friends in the Koori community. This was confirmed by another participant: 'I hang around my white mates because my black mates over there get me in trouble'. This sparked some controversy within the group, where another respondent countered that positive peer environments should be just as feasible within the Koori community. A member of another group spoke of how strong Kooris are and that they are not necessarily looking for the easy way out (for example, just get a prescription) but need to be informed of other options to problems.

Concern for young girls was also talked about, where some mothers identified problems around youngsters becoming sexually active at very young ages. Some mothers spoke about their feelings of failure; these women felt that despite their own positive role modelling and constant caring, their daughters, nevertheless, had become involved in drugs and got pregnant at an early age—the very outcomes they were seeking most to avoid, based on their own experiences.

Place: A strong context for identity occurring across most of the focus groups related to the importance of 'place'. Participants spoke of how they were *'identified as black'* wherever they went. Home was a place where they talked about feeling 'safe' in their identities. For some, including young people in the groups, this was a barrier to leaving their home and community environments; a new 'place' meant being identified as 'black' at all times.

The Rumbalara Football Netball Club was highlighted as an extremely positive development in the community's social development. It is a place where people feel accepted, together and comfortable. One participant mentioned:

> *I wouldn't want to play at another footy club… We got offered money everywhere, no one's took it. We all want to play together, stick together… We can have fun without… getting high… There's not the same vibe [at other clubs]. Rumba offers a vibe.*

Another participant spoke of the club as keeping 75–80 per cent of players away from drugs and alcohol, as well as helping with racism. Other participants spoke of the role of the club in developing leaders and role models. The club's Healthy Lifestyle Program has had a major impact in connecting Kooris with a local gym to pursue fitness—from a handful a few years ago to now about eighty participants.

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[4] In the context of the focus groups participants spoke about shame primarily from a negative perspective. However, shame can characterise a number of mixed emotions, usually felt all at once, demonstrating feelings of ill comfort for Aboriginal people to have a focus on them, good or bad. Humility partly describes this feeling.

As one participant said, ‘That would be the first time that so many people are accessing the gym and that’s marvellous!’

It was also recognised that many more ‘places’ such as the football netball club should be established to provide opportunities for fitness, social participation and being able to feel good about oneself, again with gender appropriateness of these places a significant consideration.

Relationships with the mainstream

The poor relationship between the Koori and mainstream communities was repeatedly raised as a deeply felt issue both at an individual and institutional level. At the individual level, experiences of racism provide an ongoing and profound impact on identity and self-esteem, with particular sites, such as school, frequently discussed. Poor service delivery and neglect of duty of care towards Aboriginal people by mainstream services was seen as compounding existing, deep-rooted social and health problems. These issues were talked about in terms of historical experiences of the Koori community, namely dispossession and colonisation, subsequent loss of traditional cultural practices, ongoing discrimination, the poor understanding of these issues by the mainstream community and the ongoing intergenerational effects that arise from all these factors. On the positive side, participants spoke of the benefits of associating with white people (for example, self-confidence, obtaining ‘employment) and the strong desire to maintain relationships and friendships with non-Aboriginal people and to be part of the broader society’.

Racial discrimination: There were numerous stories of racial discrimination at school in many of the groups, and this was believed to be a significant contributor to low self-esteem in young Kooris. Many participants saw education as the first major attack on Koori identity; they talked about getting ‘picked on’ at school for being black and some teachers ‘write you off’ as a ‘useless blackfella’. Some participants spoke of being expelled from school after physically confronting racist remarks from peers. Such racism was also seen as structurally entrenched, with some teachers employing racist language and the misrepresentation of history. Participants talked about Kooris engaging in physical confrontation because of their lack of confidence to express themselves in words. Some participants acknowledged that ‘we’ve got teachers out there that do a wonderful job’, but they run into trouble with not having the skills to deal with kids with behaviour problems. Relationships with police were also identified as a critical issue, with a strong belief that groups of Koori youth (and Koori people generally) are targeted because of their colour. One group spoke of family socialisation processes that instilled fear in young Kooris towards police because of historical experiences of discrimination. Workplaces were also identified as other sites of significant discrimination.

While much of the discussion spoke about personal experiences of racism, there was also a strong focus on racism at the *institutional* level. A common element of these stories was the need for the mainstream to develop a better understanding of issues affecting Koori people, as well as the need for mainstream services to better meet the needs of Koori communities. Issues within these stories indicated that many mainstream organisations were ignorant of the complexities of Kooris’ concerns and fundamentally failed to address important issues, for example, the failure of the law and support services in dealing with sexual abuse issues. Participants also spoke of the failure of mainstream services to approach the community about how it could best meet their needs. In fact, the opposite was identified, whereby mainstream organisations were asking clients if they were Aboriginal or Torres Strait Islander and, if so, redirecting them to Aboriginal services.

History and its intergenerational effects: At the core of these discussions about the ineffectiveness of mainstream institutions is a lack of understanding of Koori history and the trans-generational impact that issues such as dispossession, the stolen generation and ongoing racism and social exclusion have on Koori individuals, families and communities. As one participant stated, ‘Nothing has changed in the last 200 years… They’re not looking at the issues, addressing the root of the problem [white people’s attitudes].’ Problems with substance misuse and the normalisation of these practices in some families were identified as evidence of intergenerational trauma. The ineffectiveness of services and interventions contributes to the maintenance of these patterns. As one person stated:

> *Lack of… self understanding, self awareness or self respect, or self love… As Aboriginal people we’ve been so devalued for generations and generations that it’s ingrained in us, it’s like something that’s born in us when we’re born… it’s a way of life.*

While all participants acknowledged their communities' responsibility for addressing these issues, they also saw the wider community as being equally responsible for improving their health and wellbeing. As one participant surmised:

> *You paint a house with rotting boards… six months down the track you've got to paint it again because the boards are still rotten and its showing and no amount of paint is going to fix it. And I think what the government is doing is painting rotten boards.*

Trust: The cultural gap arising out of lack of knowledge and understanding by mainstream institutions and individuals, and the practical ramifications that this has for Kooris today—for example, poverty making affordability a key issue in accessing health care—contributes to an often extreme lack of trust by Kooris towards mainstream professionals and services.

> *They [doctors] don't understand, they don't want to understand or if they want to understand they still can't get their head around where the problem's coming [from]… [Their approach is] just deal with it, snap out of it, it's all your fault… [but] it's about your history… it's about your experiences from the past as to whether or not you feel comfortable approaching a health professional in the mainstream and more often than not you don't feel comfortable… and then you got to pay half your family's food bill on top of that for the honour!*

One woman spoke of the enormous time and effort it took her to build a level of trust with a particular doctor and that 'there's so many doctors and none of them particularly want to deal with Aboriginal people… [Trust] is a huge, huge issue.' Like racism, distrust was also reflected at an organisational level—in one example it was felt that mainstream services consistently ignored the community report that had identified the health needs of the community: 'We use that document for submissions and partnerships, some which work, some not. Mainstream just stick it on the shelf.'

Discussion

This exploratory research has highlighted that health and its determinants in Koori communities is complex. Understandings of health are not simple but multi-layered and multi-faceted. Individuals and families are affected by the historical, spiritual, political and social issues, as well as the physical and psychological. Therefore, participants in this study suggested that poor Aboriginal health was due to behaviours, racism, history and a range of factors, none separable from the other. Viewing health in this way means that actions to improve health are complex, if not overwhelming. While a range of health conditions and illnesses was mentioned, discussion moved quickly from these specifics to broader issues of community life, history, lack of resources and opportunities, racism and marginalisation. Health was closely associated with relational concepts such as self-esteem, shame, role models and identity. All the themes and sub-themes identified were also interrelated; stress, self-esteem and trust were seen to be symptoms of dispossession and racism. Similarly, despite the criticisms of the education system, no focus group sought to place blame solely on white teachers or the system, noting that 'we don't lift the bar high enough for ourselves so why should we do it for our kids' and that there was often a lack of family support to do well at school.

Daily realities

Health was not separated from racism, land rights, dispossession, lack of an apology or treaty, and loss and grief. Many stories were told about community members facing a range of issues simultaneously and the interrelationships between psychological, cultural, political, social and spiritual factors that all contributed to the cause and continuation of the issue: 'Aboriginal people… we are trying to fight an uphill battle dealing with our own family's issues and our own personal issues and our kids' issues.' For example, respondents talked about drug and alcohol use as an escape from socio-economic disadvantage, racism, deaths in the community and family issues and that the use of substances lead to unplanned pregnancies, poor diet, loss of traditional cultures and inability to address these issues. Smoking was acknowledged as a major issue; however, in the context of the Koori community there was a strong view that quitting smoking is simply not a priority for most Kooris—there are far too many more immediate concerns. Micro- and macro-level problems were combined and all manifested themselves simultaneously in the experiences of daily life. It is this interrelatedness and immediacy of issues that has lead the authors to identify the complex *daily realities* as central to an understanding of Koori health.

These communities were not found to be ignorant about health and wanted more health information, identifying a readiness for change. However, having a myriad of inseparable issues confronting individuals and families constantly means the focus becomes coping here and

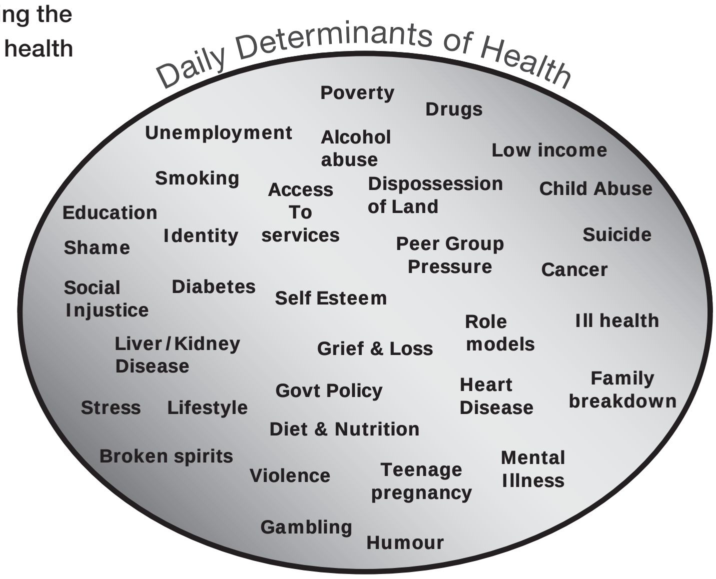

FIGURE 1: Conceptualising the Aboriginal experience of health

now—long-term health prevention cannot be acted upon. For example, faced with a lack of financial resources, the need for employment, physical health issues, emotional health issues, poor housing, social isolation and marginalisation from the mainstream community, how realistic is it to expect someone to diet or undertake a fitness program because they are 'at risk' of diabetes? After the third handout, one respondent stated, 'Really, looking at this, it's a wonder we are still sane!' Similarly, another person commented that 'the thing that has stopped us going off is our sense of humour' and everyone agreed.

Therefore, this paper has found that Koori families face upstream and downstream factors daily, an issue not addressed in the models of social determinants discussed earlier in this paper. The pressure to deal with so many issues simultaneously results in lack of attention to biomedical health. It seems that Aboriginal people experience health in a way that could be depicted by placing all these factors chaotically in one circle, with the individual and their family at the centre (see Figure 1). No one factor can be separated from the other, hence prioritising issues and simply dealing with all the issues presenting simultaneously is easily overwhelming. Understanding the social determinants of health, then, is about understanding the stories, experiences and daily life of individuals, families and communities that negotiate these many co-existing determinants daily. This highlights the importance of mental health, self-esteem and coping if one is to achieve positive health, but the intergenerational and community focus of health for Kooris means that these cannot be ignored, processed or easily addressed. Understanding this daily negotiation is a first step to addressing health from a holistic, empathic and Koori-led approach. Further, changing the marginalisation of Koori people, as exemplified in the lack of understanding and ignorance of history by the mainstream, is at the core.

While this model is based on a small sample in one area of the country, it questions the appropriateness of previous models of the social determinants of health that imply causes and effects that exist in a relatively linear relationship. It also raises questions as to the 'content' of the key social determinants of Koori health and their relationship to established social determinants such as those identified in the mainstream models. The cultural knowledges and social practices of Aboriginal people, including the focus on family/community, the social care of others and the human priorities that differ from Western society, clearly suggest that social determinants models for mainstream Australians are inadequate in the Koori context. It is not surprising, then, that programs in Aboriginal health also need to differ from mainstream programs in order to encapsulate the understandings of those using such programs.

Policy implications and conclusions

The emphasis on health education and wanting more health information at one level clearly indicates that Aboriginal people have embraced the importance of physical health. The identification of illnesses as important health factors, along with the need for bulk billing and adequate medical services, suggests that physical health and medical treatment is very important to these communities. This was made starkly clear in communities without an Aboriginal community-controlled health service, identifying detailed negative impacts on members of not having such a service. While this paper highlights the complexity in establishing a coherent vision for addressing the social determinants of Koori health, it also highlights the ongoing tragedy of the current response to Aboriginal health in the lip service paid to adequately addressing the 'surface manifestation' of poor health in the form of equitably funding Aboriginal primary health care services (see Deeble *et al*. 1998; Mooney 2003). The ongoing need for Aboriginal community-controlled health services to be at the centre of such primary healthcare provision is emphasised by the focus groups' litany of examples of the inability and/or unwillingness of mainstream services to effectively engage with the complexity of Aboriginal health. It is probably only with an adequately resourced community-controlled sector that an effective institutional base can be created to advocate for appropriate accountability of mainstream services to deliver on their responsibilities to Aboriginal people.

However, another at least equally important theme of the focus groups is that the relationship with the mainstream is far more than achieving equitable access to services—it is fundamentally about the relationship between Koori and mainstream societies, and the impact that this relationship has on Koori identity and self-esteem. As one participant said, referring to the negative role modelling in the Koori community:

> *We just got to break the cycle. We got to go out and mingle [with whitefellas]. Don't be ashamed. And if they do turn out to be rednecks, don't have nothing to do with them, just go and find somebody else…*

This plea to be able to participate in mainstream society while maintaining Koori identity in a sense synthesises the multiple responses that refer to the need to address racism in schools, workplaces and other sites of interaction with the mainstream community. It calls for non-Aboriginal people to be educated and to embrace the true history of this country, suggesting another important area for further research—that of mainstream attitudes to Koori people. As Reid and Tromph (1991:32) identify:

> *The constant pattern is that whether whites are hostile or well-intentioned, whether they know themselves to be ignorant or believe themselves to be well informed, the 'Aboriginal problem' is the problem of how white people should decide to deal with Aborigines.*

Also, central to any further investigations on issues of identity is the centrality of 'place' and how policy can support the establishment of places that promote Aboriginal identity. In doing so, these places meet the social and emotional needs of community members, promote health and provide a basis for equal participation in mainstream society.

This means that the models of social determinants of health discussed earlier, which identify a range of health factors, need to acknowledge that the Koori experience does not separate the different types of and levels of factors. The challenge for social determinants research, then, is to articulate how 'upstream' or 'basic' causes simultaneously articulate on a daily basis with 'downstream' or 'surface' factors, and a range of what appear to be (at least some of) the primary motivational domains of contemporary Koori sociality. The ways in which all these factors blend in the complex negotiation of individual, family and communal identity becomes crucial. The corresponding challenge for government policy and programs is how they will be developed and implemented in a way that will see the simultaneous addressing of these factors in a way that accounts for contemporary Indigenous social reality, recognising that improvement of individual indicators in themselves do not necessarily correlate with better health. Health policies that take as their starting point how self-esteem, shame, role models and gender impact on identity, the vexed issue of Koori/mainstream relations and their interaction with health practices such as drug use are clearly needed. Otherwise, future policies, programs and efforts will be simply more examples of 'painting rotting boards'.

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Appendix

Handout 1: What do statistics say about the health of Aboriginal people?

Life Expectancy

- Life expectancy at birth is 17 years shorter than non-Indigenous Australians.

Death Rates

- Death rates are 2.1 times greater than all Australian men and 2.4 times greater than all Australian women.
- Infant mortality rates (infant deaths per 1,000 live births) are 5.7 for all Australians but 17.9 for Indigenous Australians.
- Death rates from diabetes are 12–17 times higher for Aboriginal people.

Rates of Illness

- Indigenous Australians are between 2.5 and 3 times more times likely to be hospitalised.
- Indigenous Australians also have a higher rate of chronic illness, especially Type 2 diabetes, heart disease and circulatory system disorders, stroke and renal disease.
- Up to 30% of Aborigines aged over 35 years have Type 2 diabetes, approximately 4 times higher than non-Indigenous Australians.
- Health problems relating to ear disease, eye disorders, mental illness, substance misuse, and social and emotional problems are also more common.
- Indigenous children have been found to have high rates of asthma, ear and hearing problems, skin problems and chest problems.
- Rates of injury and poisoning are approximately four times higher among Indigenous Australians than non-Indigenous Australians.

Fertility

- Aboriginal women have higher fertility rates, much higher rates of teenage motherhood, higher rates of low birth weight babies, on average 150–300 grams lighter.
- The rate of still-born children is higher as is the rate of low birth weight babies, on average 150–300 grams lighter.

Mental Health in the Goulburn Valley

- 46% of community members have been identified with a mental health problem, 41% of those aged 15–29.
- 14% of community members were identified as suffering acute depression.
- 54% of patients using the Victorian Aboriginal Health Service had evidence of mental health or depression.
- 57% supporting mothers with children were identified as suffering from depression.

Source: Thompson 1998; Deeble *et al.* 1998; Anderson *et al.* 2001; Gray & Boughton 2001; Rumbalara Aboriginal Cooperative & Department of Psychiatry, The University of Melbourne 2001; Victorian Aboriginal Health Service 1999; Lancaster, Huang & Plunkett 1996.

Handout 2: According to published research, what characteristics determine the health of Aboriginal people?

Income

- While 25 per cent of non-Indigenous Australians earn less than $20,000 per annum, 43 per cent of Indigenous Australians earn under this level.
- Similarly 20 per cent of Indigenous Australians earn more than $40,000 per year whereas 43 per cent of non-Indigenous Australians earn more than $40,000.
- 14% of the local Koori population earn more than $350/week compared to 27% of the Victorian Koori population and 40% of the non-Aboriginal population.

Employment

- 30% of the local Koori population are unemployed compared to 28% of the Victorian Koori population and 10% of the mainstream population.
- Aboriginal workers are more likely to be employed as labourers than non-Aboriginal workers (24% and 9% respectively).

Education

- In the 2001 census, 57% of Aboriginal children were students.
- 11% of the local Koori population have completed post-secondary training compared to 20% of the Victorian Koori population and 34% of the non-Aboriginal population.
- 55% of Kooris leave school before 17 compared to 46% of non-Kooris in Victoria.
- Of those 18–24, 10% of Aboriginals are pursuing post-secondary education compared to 28% of non-Aboriginals.

Parenthood

- Aboriginal children are more likely to come from a single parent family.
- Rates of teenage motherhood is well above the same rates for non-Indigenous teenage mothers, 15 per cent in Victoria.

Diet

- Over 60% of Koori people in the Binjirru ATSIC region (including the Goulburn Valley) were overweight or obese, with a further 10% underweight.
- 60% of Aboriginal people aged 35+ have been found to be obese, 75% of women and 51% of men.

Substance Use

- Approximately 25% of those using the Victorian Aboriginal Health Service were identified as using illegal substances compared to 15% of all Australians.
- 58% of men and 30% of Aboriginal women in the Goulburn Valley engage in binge drinking, while 54% and 33% respectively have used marijuana.
- A local study found that 64% Koori adults smoked, almost 3 times as high as the non-Aboriginal population.
- Drinking began in the 12–14 age bracket and about 50% of those 15 to 17 were frequent drinkers.

Source: Alford 2002; Nicholls 1999; D'Abbs & Jones 1996; Ryan & Williams 1997; Victorian Aboriginal Health Service 1999; Winch 1999; Deeble *et al*. 1998; Rumbalara Aboriginal Cooperative & Department of Psychiatry, The University of Melbourne 2001; ABS 1996; Ryan & Williams 1997.

Handout 3: While some work (for example, government reports) claim that the following are important issues related to Aboriginal health there has been virtually no research to back up those claims

Social, emotional and cultural well-being of the whole community

Of those using the Victorian Aboriginal Health Services:

- 20% had been brought up in children's homes.
- 49% had been separated from both parents for significant periods of time during their childhood.

Racism

Of nearly 100 studies done worldwide into the health effects of racism only one has looked at Indigenous Australians.

Self-esteem

Both Aboriginal adults and young people have been identified as having low levels of self-esteem.

Disadvantage/poverty

The Aboriginal population is the most disadvantaged and impoverished group in Australia.

Culture

Some have suggested that there are cultural barriers to seeking health services, seeking health care and living healthy lifestyles.

Stress

Psychosocial stress is currently being explored for its impact on the natural defences of the body to fight off sickness. That is individuals subjected to excessive amounts of stress are more likely to develop physical illness.

Trust

It has been argued that government policy, actions by mainstream people and institutions has consistently undermined Aboriginal people's trust in the mainstream. Further, it is proposed that lack of trust in police, neighbours, government, employers, the education system and the broader community contributes to stress, which in turn can contribute to poor health.

Dispossession

Dispossession from land is thought to be a major cause of poor health.

Role Models

It is the quality of the relationships young people have in their lives, particularly from those they learn from, which can make a difference. Parents, schools, role models and others can provide this.

Source: Sibthorpe 1989; Tynan 2003; Kelly, Hertzman & Daniels 1997; Reid & Tromph 1991; Paradies 2004, personal communication; Victorian Aboriginal Health Service 1999; Mitchell 1996; Hunter 2000.

Chapter 2:

Indigenous Insights into Oral History, Social Determinants and Decolonisation

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This paper is dedicated to Aunty Iris Lovett-Gardiner, Kerrup-Jmara Elder, 1926–2004

> *“I’ve had a good life. I don’t care what it sounds like, I enjoyed it. Of course you get moans and groans off people, but not all the time that sour that it turns you away from life altogether. That’s the wrong attitude”*
>
> **Aunty Iris Lovett-Gardiner, in Lovett-Gardiner & KHT Inc. 1997:100**

Introduction

The concept for this paper arose from a minor Master thesis in public health written by Aunty Joan Vickery (Vickery 2004). The thesis explored the use of oral history as a time-honoured Indigenous Australian research method that could be used to create decolonisation in research to improve health. This paper builds on this and other writings from Indigenous Australians in this area to explore further the relationship between oral history and health.

Rationale

Health research within Australia requires open and inclusive dialogue regarding the methods of identifying and researching Indigenous social determinants of health. This scoping paper enters this discussion by supporting the process of listening to Indigenous peoples’ viewpoints on social determinants that impact upon our health. We suggest that many of these determinants are linked to effects of colonisation and decolonisation within Australia.

Often the only way to understand people’s experiences is to ask (OHAA 2002). While listening may appear easy, the method being put forward here involves listening and learning with respect. This method is Australian Indigenous oral history. It is a powerful research method of inclusion that gives Indigenous people a voice in regard to our own health. It is also part of a time-honoured practice within Indigenous Australia of knowledge transmission. It can provide invaluable insights into the changing issues of Indigenous health over time, and the impact of health determinants upon individuals and communities. Indigenous oral history encompasses a multifaceted definition of Indigenous health, as well as providing ceremony, healing and decolonisation for us as Indigenous people (Vickery 2004).

Very little has been written on social determinants of health that has originated from Indigenous people or our research methods. Instead, the current determinants are predominantly informed by data from the Australian Bureau of Statistics and broader population research (Anderson 2001; ANTaR 2004; Eades 2000; Thompson *et al*. 2003). We believe Indigenous voices have been missing from this area.

Australian Indigenous oral history

Indigenous oral history is the telling of a story through words, culture and identity (Vickery 2004). It consists of three different forms of oral knowledge transmission (Faulkhead & Russell 2006). The first of these is the oral history research method of ‘gathering and preserving historical information through recorded interviews with participants in past events and ways of life’ (OHAA 2002).

A limitation of oral history research is that it has a tendency to remove the flow and identity of the story. This is created through requesting answers to topic-based questions, followed by the possible reinterpretation of the story through another culture’s worldview creating cultural bias. Oral tradition and oral records[1] (Faulkhead & Russell 2006) are two other areas of Indigenous oral history—these do not have this problem, as they recognise the complex responsibilities that come with receiving oral knowledge, as Albert Mullett explains:

> *When the stories were told to me by the old people, when I was learning from my Elders, in those days you didn’t ask them for information, they would call you and tell you. They wouldn’t tell you everything at once, just some of the things and you would have to keep coming back to them to get the full story. This was because you had to understand respect and the meaning of the word. The old people would know that you were seeking information but they had to see if they could entrust that information within you. Over a period of time that trust was built up between you and them along with mutual respect and understanding (in Taylor 1992:75).*

Oral tradition is the continuous cultural practice of transmitting knowledge orally (Atkinson 1984) and is vital within Australian Indigenous culture. It is through oral tradition that, as Indigenous Australians, we maintain the oldest living culture in the world (Atkinson 2002). Oral tradition is expressed and supported though dance, song and images such as paintings and rock engravings, drawings on bark, carved designs on tools and weapons, paintings and etchings on cloaks, engraving on trees, and stone arrangements on the ground (KHT Inc. 1991). In more recent times Indigenous people have drawn on technology for oral knowledge transmission and storage. This recognises that Indigenous culture has never remained static.

Oral records are records of Indigenous knowledge, with the use and access dictated by the knowledge holder. This is an action of decolonisation—where the story is told the way the person would tell it and not presented through another culture’s lens. This knowledge is recorded for various reasons such as educating the Indigenous, Australian and international communities; storage of information, which is feared to be lost, for future generations; personal stories for family members; and stories that the knowledge holders do not want to share until after their deaths.

Social determinants of Indigenous health

Social determinants of health are related to aspects of people’s social environment such as living and working circumstances and their lifestyles (Wilkinson & Marmot 1998). The ten main social determinants for health identified by the World Health Organization (WHO) are social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food and transport (Wilkinson & Marmot 1998).

While the ten social determinants listed by WHO are relevant to Indigenous Australians, they are not framed from an Indigenous viewpoint and omit some important Indigenous social determinants. The few authors who have engaged

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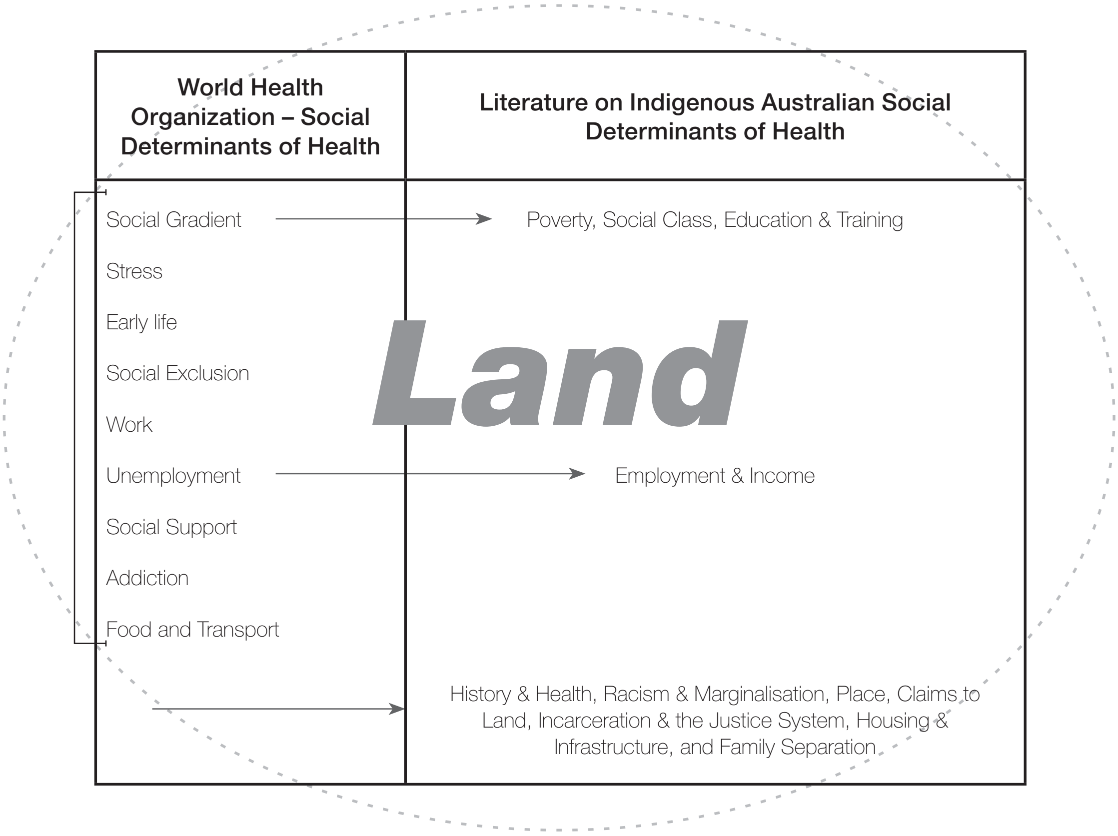
[1] Oral records is a term referring to Indigenous-controlled recordings of their knowledge.

TABLE 1: **Social determinants of health identified by WHO and their relationship to literature on Indigenous social determinants of health**



World Health Organization – Social Determinants of Health	Literature on Indigenous Australian Social Determinants of Health
Social Gradient	Poverty, Social Class, Education & Training
Stress	
Early life	
Social Exclusion	
Work	
Unemployment	Employment & Income
Social Support	
Addiction	
Food and Transport	
	History & Health, Racism & Marginalisation, Place, Claims to Land, Incarceration & the Justice System, Housing & Infrastructure, and Family Separation

in and added knowledge specifically to the discourse about Indigenous social determinants have identified the following social determinants of health for Indigenous people: history of health, racism and marginalisation, poverty, social class, education, training, control over our own health, powerlessness, employment, place, income, incarceration and the justice system, housing and infrastructure, family separation, land and reconciliation (Anderson 2001; ANTaR 2004; Eades 2000; Menzies School of Health Research 2004; Thompson *et al*. 2003; Tsey *et al*. 2003) (see Table 1).

What literature on Indigenous social determinants recognises is that Indigenous health is inextricably linked to processes of colonisation (Anderson 1988). We wish to take this discourse one step further to suggest that the social determinants of Indigenous health arise from the processes of colonisation and decolonisation.

Methods

There are two aims to this literature review.

Aim 1: Colonisation and decolonisation

The first is to identify Indigenous social determinants of health arising from colonisation and decolonisation.

The Indigenous social determinant concepts, identified under the themes colonisation and decolonisation, have been collated from a number of sources. These sources include the oral histories reviewed for the paper, other literature used for this paper and our own knowledge and experiences gained from working in the area. This is not a definitive list of social determinants of Indigenous health; however, it is our contribution to the discussion in this area.

Aim 2: Listening to oral history

The second is to explore through published Indigenous oral histories what has been described about the social determinants of health outlined in Aim 1.

Identification of oral histories

A sample of published oral history narratives of Indigenous Australian people was identified through a search of Monash University and the KHT Inc., both of which house extensive collections of Indigenous Australian oral history literature.

A total of 100 oral histories—thirty-seven men and sixty-three women—were reviewed from eleven books published between 1977 and 2003. The representation across the States and Territories was Tasmania, three; Victoria, forty-six; New South Wales, eighteen; Northern Territory, eleven; Western Australia, three; South Australia, eight; Queensland, seven; Torres Strait Island, one; and three unknown.

Review

Each oral testimony was reviewed for information regarding the social determinants of Indigenous health identified in Aim 1. Information on each of these areas was then collated for emerging themes and issues.

Use of quotes

The importance of oral history does not rest in the production of a factual record of the past, but in the production of a record of what the event meant, or means, to the individual or community who experienced that event (Portelli 1981:96–107). Oral history research allows the 'feelings of those exposed to these experiences' to be recorded (Hamilton 1994:96). For this reason a selection of quotes has been used throughout the paper to illustrate aspects of people's experiences throughout the review.

Results

Aim 1: Colonisation and decolonisation

Colonisation 'shame'

'Shame' is a strong indicator that Indigenous people knew that the treatment they were receiving was detrimental to their wellbeing, and we believe it is an apt Indigenous description of colonisation.

There are three distinct phases of colonisation: invasion and frontier violence, intervention by well-meaning paternalistic religious and philanthropic groups, and the reassessment of government responsibility to Indigenous needs. The last phase is as damaging as the first two, with the State intruding into Indigenous lives and creating dysfunction, dependency and traumatising people further (Atkinson 2002). These phases of colonisation continue to shape and determine quality of life, even after the 'colonisers' formally pulled out (Tuhiwai Smith 1999) and the Australian State assumed the role in 1901 (DFAT 2001). The literature specifically on Indigenous social determinants of health clearly focuses on colonisation. Certain features of colonisation, which we assert should be included, were absent in this literature. These are assimilation, cultural genocide and collective trauma from previous generations. In the Indigenous community 'shame' is often used to mean that something stupid or embarrassing has happened, or that something wrong has occurred or is occurring.

Decolonisation, 'too deadly'

'Too deadly' is an Indigenous term that indicates a person has done 'good' and should take pride in the achievement. Decolonisation occurs when Indigenous people, through self-determination, show we are 'too deadly' in our ability to reverse impacts of colonisation and improve health. We believe this is an apt Indigenous way to describe decolonisation.

Decolonisation is where Indigenous culture and colonisation intertwine. Revisiting and rewriting the past is an integral part of the process of dealing with the unfinished business of colonisation (Tuhiwai Smith 1999). Decolonisation involves us assessing how colonisation has affected our business by telling our stories and doing things our way. Through decolonisation we change the colonising order, which often creates disorder of colonising concepts (Tuhiwai Smith 1999) (see Table 2). The Indigenous social determinants of health

TABLE 2: **Colonisation and decolonisation social determinants of health present and not present in literature on Indigenous social determinants**

Decolonistation Present In Literature	Decolonisation Not Present In Literature	Land	Colonisation Present In Literature	Colonisation Not Present In Literature
• Reconciliation • Land • Control over our own health	• Cultural Survival • Affirming Cultural Ceremony • Oral History • Family Support & Connection • Spiritual & Emotional Well-being • Native Title & Sites Recognition		• Poverty • Social Class • Education & Training • Employment • Income • Racism • Marginalisation • Incarceration • Justice system • Housing • Infrastructure • Family Separation • History & Health	• Cultural Genocide • Assimilation • Collective Trauma From Previous Generation

Source: Anderson 2001; ANTaR 2004; Eades 2000; Menzies School of Health Research 2004; Thompson et al. 2003; Tsey et al. 2003

for decolonisation identified in the literature are reconciliation, land and control over our own health. We believe these determinants insufficiently reflect decolonisation, and should also include cultural survival, affirming cultural ceremony, oral history, family support and connection, spiritual and emotional wellbeing, native title, sites recognition, and self-determination and community control.

Aim 2: Listening to oral history

Colonisation 'shame'

Effects of colonisation are reflected predominately through negative events that occurred to our people despite their resistance. The majority of the social determinants under this section are linked to racist beliefs and practices. Because of this, racism overhangs colonisation in such a way that if it was treated as a separate social determinant in this paper it would become repetitive. Instead, racism is addressed where needed under each social determinant.

It is inconceivable that such a closely connected community would not carry the experiences and memories of past generations, especially when all of the above occurred over a period of four to six generations. The collective trauma of past generations in relation to colonisation continues to influence the decisions and actions of Indigenous people and communities today.

Social class, poverty and income

Through their oral testimonies, Indigenous people frequently mentioned that they were often considered the lowest class in Australia (Dyer 2003; Gilbert 1977; Randall & ABC 2003: xi; Rintoul 1993). This assignment of class led to situations where racism towards Indigenous people was considered acceptable, further compounding the situation of low income and poverty.

> *They were all right when they'd come to your place and they'd always do you a good turn, because Dad worked. He was a good working man. A good man. Mum was a good woman. But it was only if there was a dance or a ball, that's when they'd show their true colours. It would be all the big heads sitting up on the stage if the Governor came across, or any politician, and there would*

> *be the second class further down and then the riff-raffs, the white people, and then the half-castes, as they used to call us, with the policeman standing at the door. That was the dance. Closest to the door (Ida West, Hobart, in Rintoul 1993:9).*

According to the testimonies, 'racism' was not a term recognised or used earlier in our colonial history; however, different treatment and prejudice was obvious (Dyer 2003; Rintoul 1993). This was evidenced by refusal of service (Rintoul 1993) and the unscrupulous practices of some businesses. An example of this was a company that endorsed the practice of specifically signing up Indigenous families to hire purchases that they could not afford, resulting in the repayments only covering the interest (Dyer 2003).

> *Anyone who was really, really fair they didn't mind so much. It was only prejudice and racism. I never realised it, but that was there then. It's only over the past few years in my age now that I've realised that there is a lot of racism against us and that they despise the Kooris and, reading and listening to people, that they class the Aborigines as the lowest people in the world (Joyce Ingram, Redfern, in Rintoul 1993:23).*

Prior to colonisation anything that could not be sourced from the land was traded from other communities. Indigenous people never viewed themselves as poor; this was indirectly supported through the testimonies. Poverty and income are shown as hardships in regards to money, food, clothing and housing (Dyer 2003; Gilbert 1977; Harvey 2003; Tucker 1983; Zola, Gott & KHT Inc. 1992), and through stories of making do with what was available (Lovett-Gardiner & KHT Inc. 1997). The testimonies also evidenced another struggle that occurred with moving into 'houses'. Despite the hardships experienced with their previous homes, many of them had no rent or household bills. With moving into houses they were suddenly expected to pay for rent, gas and electricity (Gilbert 1977)—bills they could not afford to pay.

Employment, education and training

Poverty, social class and income are related to the type of work that Indigenous people undertook. Much of their work was as labourers, some of which involved moving around, for example as seasonal workers (Dyer 2003; Gilbert 1977; Harvey 2003; Jackomos, Fowell & Museum of Victoria 1991); timber industry (Harvey 2003; Lovett-Gardiner & KHT Inc. 1997); boxing tents, showgrounds and rodeos (Jackomos, Fowell & Museum of Victoria 1991; Lovett-Gardiner & KHT Inc. 1997; Purcell 2002:xvi); shearing (Jackomos, Fowell & Museum of Victoria 1991); fishing, railway work, station and farm work, and mines (Gilbert 1977); and the armed forces (Gilbert 1977; Jackomos, Fowell & Museum of Victoria 1991; Lovett-Gardiner & KHT Inc. 1997). Other work included cleaning; domestic work; working in hospitals (Dyer 2003; Gilbert 1977; Lovett-Gardiner & KHT Inc. 1997); factory work (Dyer 2003; Harvey 2003; Jackomos, Fowell & Museum of Victoria 1991); gardening (Randall & ABC 2003); and cutting firewood (Jackomos, Fowell & Museum of Victoria 1991). Some women also trained for secretarial work and nursing (Dyer 2003; Gilbert 1977; Harvey 2003; Jackomos, Fowell & Museum of Victoria 1991).

> *My Dad was always away working. He worked wherever he could get a job—on the roads and in the forestry. He didn't get paid much, nobody got much in those days (Iris Lovett-Gardiner, Vic., in Lovett-Gardiner & KHT Inc. 1997:51).*

Employment difficulties not only included hard work and long hours (Jackomos, Fowell & Museum of Victoria 1991), but also racism, such as being turned down for employment (Harvey 2003; Rintoul 1993) or being sacked due to community pressure (Gilbert 1977). Other difficulties caused families to be separated for long periods of times, such as having to move around for casual or seasonal work, and to find employment, especially during the depression (Dyer 2003; Harvey 2003; Jackomos, Fowell & Museum of Victoria 1991).

> *I tried to get a job in an insurance company and there was no way I could a get a job there. And that was purely on the grounds that I was black and an Aboriginal on top of that (Gary Murray, Vic., in Gilbert 1977:66).*

Despite being forced to undertake manual or unskilled employment, the testimonies spoke of aspirations for trained employment areas such as nursing (Dyer 2003; Rintoul 1993). This employment pattern continued until about the 1970s, when the expansion of educational opportunities led to greater employment opportunities for Indigenous people. Through their testimonies people spoke of the improved opportunities for Indigenous employment through the establishment and development of Indigenous organisations (Dyer 2003; Jackomos, Fowell & Museum of Victoria 1991).

Some Indigenous people treated non-Indigenous education with distrust and little faith. It was viewed as only being successful for the middle class or as a system that contributed to the destruction of tribal ways (Gilbert 1977). Distrust and lack of faith are supported in the testimonies, with accounts of children being prevented from attending school because of their Aboriginality (Jackomos, Fowell & Museum of Victoria 1991; Rintoul 1993); students feeling isolated due to being the only Aboriginals at school (Dyer 2003; Harvey 2003); students leaving school feeling as if they had not learned anything (Rintoul 1993); and students rarely being allowed to go beyond seventh grade into high school in the 1940s and '50s (Harvey 2003; Jackomos, Fowell & Museum of Victoria 1991; Rintoul 1993), let alone university (Gilbert 1977).

To receive an education, Indigenous students attended segregated schools (Rintoul 1993), correspondence schools (Harvey 2003), private or boarding schools (Dyer 2003; Purcell 2002) or mission schools (Lovett-Gardiner & KHT Inc. 1997), which usually involved travel or living away from their families. There were also various overt and covert forms of racism occurring within the schools, such as name-calling (Harvey 2003; Jackomos, Fowell & Museum of Victoria 1991; Purcell 2002; Rintoul 1993); disputes erupting into physical violence (Harvey 2003; Jackomos, Fowell & Museum of Victoria 1991; Purcell 2002); teachers discouraging Indigenous children from continuing with education despite high marks (Gilbert 1977; Rintoul 1993); and Aborigines being recorded negatively in the curriculum (Dyer 2003; Gilbert 1977; Lovett-Gardiner & KHT Inc. 1997). Testimonies also talked about racism from parents and others towards Indigenous children (Dyer 2003; Gilbert 1977; Randall & ABC 2003; Rintoul 1993). These issues contributed to school being a less than enjoyable experience for many Indigenous people.

> *Then he asked why my father was kicking the system because there was no hope for me anyway. My father said, 'That girl is going to university.' The teacher said, 'No hope, no hope. If you must, spend money on a boy. She's just going to end up with seven kids anyway.' My father was really angry (Gloria Brennan, WA, in Gilbert 1977:80).*

Marginalisation

Indigenous people were put on the outer of Australia's society from the start. Despite Indigenous ownership, the British declared *terra nullius* with their invasion of Australia. This action allowed Indigenous people to be viewed as of no consequence and non-existent by the colonial government. It prevented them from having a say in their destiny, and allowed the colonisers to control Indigenous people by whatever means (Dyer 2003; Gilbert 1977; Randall & ABC 2003).

> *The old habit of whites wanting to do things for us remained. Many whites still believed that they were the best people to decide what was in our own best interests (Mollie Dyer, Vic., in Dyer 2003:35).*

Through the assumed Christian superiority inherent in the colonisation process, Indigenous people were placed at the lowest rung of society (Randall & ABC 2003). Colonisation created policies and procedures about Indigenous people that involved their institutionalisation and dependence on government (Gilbert 1977; Randall & ABC 2003).

> *Now in fifty years the missionaries and the whites have assisted the Aboriginals into becoming second-rate people who can't survive without white man's assistance. They've forgotten that they survived for thirty thousand years before that without white help (Elizabeth Pearce, NT, in Gilbert 1977:6).*

These practices included moving Indigenous people onto missions and reserves (Dyer 2003; Gilbert 1977; Harvey 2003; Jackomos, Fowell & Museum of Victoria 1991; Lovett-Gardiner & KHT Inc. 1997), the control of activities and movement—including who to marry, having no free choice, requiring a certificate of exemption or passport to move around or apply for jobs and associate with the non-Indigenous population, exclusion from the census, restricted access to services and welfare and so on—and segregation (Gilbert 1977).

> *We weren't allowed to shit in the white man's toilet, we weren't allowed to sit in the theatre; there were black seats, white seats… that doesn't happen any more nowadays. A few things have stopped (Allan Black, WA, in Gilbert 1977:164).*

Some Indigenous families began living on the edge of towns, either in an attempt to avoid interference in their lives or due to force (Gilbert 1977; Jackomos, Fowell & Museum of Victoria 1991; Tucker 1983). Further examples of marginalisation include the separation of part-Aboriginal people from their communities, and the unfair treatment of Indigenous returned servicemen and women (Dyer 2003; Gilbert 1977). While fighting for Australia they were treated the same as their comrades—only to return to Australia as second-class citizens with no access to the benefits provided to other returning service personnel, such as land grants. Such treatment led to some people not identifying as Indigenous, as it was seen as being shameful (Gilbert 1977; Jackomos, Fowell & Museum of Victoria 1991).

Marginalisation was not a term used in the oral histories; however, when groups and individuals started fighting to have a say, marginalisation is part of what they were fighting against.

Incarceration and the justice system

Even though Indigenous people are supposed to receive the same treatment as the rest of the population in regard to the legal system, the oral histories make it evident that Indigenous people do not view this as so.

> *There was a particular incident in my life when I was twenty-one. Two policemen went onto a reserve at Mareeba one Friday night… they used to go down there and their sport was to sexually assault women. These guys went down there, one was plain-clothes and one was a uniformed guy, and the women that they picked: one was only fifteen, but physically very mature. They ran into their fibro hut and the policemen broke down the door and burst in and really severely assaulted these women, raped them. Those women came to the Advancement League and Joe McGinness and I were the only ones who were in Cairns that weekend, and I had a car and we went up to Mareeba and we went to the reserve and we talked to the people there. They were really, really up in arms; they were distressed and they were angry. We took that matter up and eventually charges were laid against these two guys and I remember sitting through the court case. It was eleven days in the Court of Petty Sessions in Mareeba and those women treated as though they were the perpetrators of the crime, and I remember being so angered by that experience and wanting to do something about that… (Patricia O'Shane, Cairns, in Rintoul 1993:40-1).*

Indigenous people have recorded their treatment through their testimonies of unnecessary police raids (Dyer 2003; Gilbert 1977; Rintoul 1993); of being treated as criminals instead of victims of crime (Rintoul 1993); of being the first to be accused of a crime (Dyer 2003; Jackomos, Fowell & Museum of Victoria 1991); of groups of Indigenous people being picked up for the same crime and of an increased chance of being arrested for being drunk than a non-Indigenous drunk (Gilbert 1977); of police refusing to respond to domestic violence situations (Dyer 2003); and of racism by local police (Gilbert 1977).

> *The police could go into your home… into a tribal or non-tribal Aboriginal's home without a warrant and search it any time they felt like it. And the police used this to the extent where in 1968 I had to tape a conversation between a policeman and woman and threaten police with it (Vi Stanton, NT, in Gilbert 1977:9).*

The situation was no better in the court system. Indigenous people did not have explained to them, or did not fully understand, their rights in regard to the legal system and its procedures. Examples include being given the right to appeal or the right not to be coerced into pleading guilty despite being innocent (Gilbert 1977). Other inequalities included non-Indigenous statements being given more credence than Indigenous statements and the law generally favouring the non-Indigenous population, which has led to many of our people ending up in and out of prison (Gilbert 1977).

> *Mum felt that all the apologies in the world would not compensate for the indignity of having our house searched and her being taken away in a police vehicle while the neighbours looked on. There were many racist implications circulating that the thief could only have been an Aboriginal worker. That hurt us all the most. So despite pressure from our co-workers to stay on, Mum and I gave notice. Many things had happened in a few short years to make me realise that Kooris had a struggle to overcome racism. Despite all of our attempts to fit in and try to contribute positively to the society we lived in, we were still made to feel like second-class citizens. We had become strangers in our own world (Mollie Dyer, Vic., in Dyer 2003:33).*

Housing

Although Indigenous housing varied, depending on place and time, there were two commonalities. The first was that there were two types of housing: that provided by the government—missions and reserves (Harvey 2003; Jackomos, Fowell & Museum of Victoria 1991; Lovett-Gardiner & KHT Inc. 1997) and housing commissions (Dyer 2003; Gilbert 1977)—and homes built on the outskirts of towns, missions or stations from whatever materials could be salvaged or taken from the tip. This second type of housing usually consisted of flattened kerosene tins and hessian with earth floors, or were bag or bark huts (Dyer 2003; Gilbert 1977; Harvey 2003; Jackomos, Fowell & Museum of Victoria 1991; Rintoul 1993).

The other commonality was that there was never enough housing, with many houses being overcrowded (Dyer 2003; Gilbert 1977; Harvey 2003; Lovett-Gardiner & KHT Inc. 1997) or unaffordable (see poverty). This also led to people living in houses that had no running water or sewage and were leaky (Gilbert 1977; Jackomos, Fowell & Museum of Victoria 1991; Rintoul 1993).

With the mission and housing commission houses there are testimonies relating to ridiculous waiting lists for houses (Gilbert 1977); to not being able to have family over (Jackomos, Fowell & Museum of Victoria 1991) due to the mission rules or, when in town, due to the attention it caused with the local police; and to having no experience in living and caring for a house so that houses were not repaired (Gilbert 1977). With mission housing there were also situations where, despite rent being paid, the occupants also had to pay for the maintenance repairs (Gilbert 1977).

There are testimonies regarding the various housing loans offered by the government at different times (Dyer 2003). Some of these have been described as being set up to fail, with people paying more than the house was worth or the house being repossessed when payments fell behind.

> *We just lived in a shack. We lived in a house when I first started school. My father is white. What I know now is that my father had a lot of trouble finding accommodation. We ended up living in a tent for a long time in this isolated place at San Remo and had to carry our water in buckets. He used to cut down kerosene tins and we used to carry buckets of water a mile (Patricia O'Shane, Cairns, in Rintoul 1993:41).*

Infrastructure

The other sections have already mentioned the difficulties with housing, education and employment. Because of the disadvantaged situation of Indigenous communities, they did not have the infrastructure required to maintain their own organisations successfully. The testimonies indicated that the main problem they had with the government was that the Aboriginal Affairs departments were run by non-Indigenous people who did not consult with communities or employ Indigenous people until the late 1960s and early 1970s (Dyer 2003; Gilbert 1977).

With the government having little connection with Indigenous communities, it is not surprising that Indigenous people talk about programs that were set up to fail. Examples of this included the purchase of capital items such as buildings and equipment, but no provision of funds to run them adequately with trained staff or for upkeep (Dyer 2003; Gilbert 1977). In addition, program funding was only provided for a year at a time (Dyer 2003).

Family separation

Family separation is where families have been separated due to government policies and practices.

> *Stolen children happened all over the place. They were taken because they never lived like white people and the Government wanted to turn them into white kids. The welfare people were judging them by the white man's standard—you had to have clean sheets and pillowslips on your bed. They were too poor to have all that so they'd make pillowslips and sheets out of calico bags that you got flour and oatmeal in (Iris Lovett-Gardiner, Vic., in Lovett-Gardiner & KHT Inc. 1997:63).*

Many of the testimonies spoke of the trauma caused by children being stolen. The themes included mothers being coerced into giving their children up (Dyer 2003; Randall & ABC 2003); families learning to hide when they knew the welfare was coming (Dyer 2003; Harvey 2003; Jackomos, Fowell & Museum of Victoria 1991; Rintoul 1993; Tucker 1983); children being removed from schools and hospitals (Dyer 2003; Harvey 2003; Tucker 1983); and the removal of children because there was no food in the cupboards (Zola, Gott & KHT Inc. 1992).

Other themes included children not being taken away when the men were home (Dyer 2003; Rintoul 1993; Tucker

1983); the use of police to remove the children (Dyer 2003; Jackomos, Fowell & Museum of Victoria 1991; Lovett-Gardiner & KHT Inc. 1997; Randall & ABC 2003); and the fear and heartache experienced by the children who were removed, and by the families left behind (Dyer 2003; Harvey 2003; Jackomos, Fowell & Museum of Victoria 1991; Randall & ABC 2003; Rintoul 1993; Tucker 1983).

> *One day some men came from the Aboriginal Protection Board. They said they wanted to take my children away. I said my children are well cared for. They said they were taking all the clever children to educate them. It was the most terrible thing that ever happened to me when they took my two daughters. They rounded up some other girls from Cummera at the same time. Some escaped by swimming to Victoria.*
>
> *I heard later that a policeman resigned after the incident. He said if taking children from crying mothers was a policeman's job, he did not want it…*
>
> *Only those who had experienced the agony of such events can truly know the depth of despair those Aboriginal mothers felt. It is estimated that every Aboriginal family has [been] touched by those removal policies and many Kooris today in their sixties are still searching their origins to try to find lost relatives (Theresa Clements & Mollie Dyer, Vic. and NSW, in Dyer 2003:8–9).*

The testimonies told of the abuse that the children experienced in homes (Dyer 2003; Harvey 2003; Tucker 1983); children running away from the homes (Randall & ABC 2003; Tucker 1983); and the children being told their parents were dead (Lovett-Gardiner & KHT Inc. 1997).

Other stories also looked at different forms of separation, such as family members not being able to visit their immediate families on missions (Jackomos, Fowell & Museum of Victoria 1991), parents leaving children with family members in order to find work (Dyer 2003; Tucker 1983) and children being taken away by a non-Indigenous parent (Purcell 2002).

History and health

Indigenous health has not been terribly good since colonisation introduced diseases and diets that Indigenous people could not cope with.

> *There were normal things we were taught—where things were and how to collect them. Manna was one, and the mistletoe fruits that we loved to eat. We had the buckabuns and the sour-grass and all the things that you get vitamins from. That was how the Aboriginal people had a lot of health—they didn't have sicknesses. They got all the natural foods, they picked them in the wild.*
>
> *Aboriginal people living in towns and cities get all processed food and they have all sorts of sickness such as diabetes and high blood pressure. We didn't suffer from those sorts of things (Liz Hoffman, Vic., in Zola, Gott & KHT Inc. 1992:24).*

The oral testimonies spoke of poor Indigenous health being linked to the change in diet from traditional to mission food (Lovett-Gardiner & KHT Inc. 1997) and the destruction of native foods (Zola, Gott & KHT Inc. 1992) during colonisation. Health has also been linked to European methods of separating health issues, and only dealing with the physical and ignoring the traditional and spiritual health (Randall & ABC 2003). They also tell of not needing doctors due to bush medicine and the belief that many of the illnesses today did not seem to exist back then (Gilbert 1977).

> *The white people came here and they wanted that grazing land for stock. The Aboriginals were pushed off their land—they didn't understand why. All the native food was being destroyed. They destroyed everything native as no good (Uncle Banjo Clarke, in Zola, Gott & KHT Inc. 1992:1).*

Health issues have also been linked to the way hospitals and medical professionals treat Indigenous people, such as mothers not having their situations explained to them (Dyer 2003). The oral testimonies speak of the poor health situation of Indigenous people in general (Gilbert 1977; Rintoul 1993), diseases (Dyer 2003; Gilbert 1977; Randall & ABC 2003), high infant mortality and tuberculosis, and drugs (Jackomos, Fowell & Museum of Victoria 1991).

Drug addiction has been a health problem in our community for a while. First it was tobacco (DDBBB & Ivers 1999), and then later alcohol (Gilbert 1977; Purcell 2002), yarndi (cannabis) (Purcell 2002), petrol sniffing (Gilbert 1977), and other drugs (Jackomos, Fowell & Museum of Victoria 1991). Drug addictions have been linked to various illnesses and, in some situations, to domestic violence (Jackomos, Fowell & Museum of Victoria 1991). The testimonies also speak about tobacco being part of the government rations or used as payment for work, especially on the stations (DDBBB & Ivers 1999).

Indigenous people through their testimonies tell of high stress and depression (Gilbert 1977; Purcell 2002; Randall & ABC 2003), including suicide and mental illness. They also talk of people being locked in mental institutions even when they have not had a psychological problem (Gilbert 1977).

Cultural genocide and assimilation

Assimilation was a government policy that attempted to absorb Indigenous people into the Australian community. Indigenous people were viewed as heathens, so the theory was that they would adopt the coloniser's way of life and discontinue their own culture—in effect destroying Indigenous culture. Assimilation included being moved onto missions and reserves (Gilbert 1977; Lovett-Gardiner & KHT Inc. 1997), having to relinquish control over their children's education and needing a certificate of exemption or passport (Gilbert 1977).

The oral histories refer to cultural genocide as the destruction, or the preventing of practising or passing on cultural knowledge and tradition (Gilbert 1977; Lovett-Gardiner & KHT Inc. 1997; Purcell 2002; Rintoul 1993; Zola, Gott & KHT Inc. 1992). These testimonies describe the loss of culture (Gilbert 1977; Lovett-Gardiner & KHT Inc. 1997; Purcell 2002; Rintoul 1993), language and land (Gilbert 1977); loss of belonging (Gilbert 1977; Lovett-Gardiner & KHT Inc. 1997); and non-recognition that Indigenous people belong to their land (Gilbert 1977; Harvey 2003; Lovett-Gardiner & KHT Inc. 1997).

> *I used to watch the manager come down and inspect Nan's house, come right through the house. They put the houses up pretty quickly and they'd do this patrol in the morning and the matron would come around and make sure everybody's eyes were treated with bluestone and whatever, and Gran, one day I remember, was talking the lingo to us, she was really cranky with us about something, and the manager came around the corner and blew his top because he'd caught her talking the lingo to us. And so, I sort of witnessed our lingo being taken away from us that day, because Nan never ever spoke it again (Isabelle Flick, Collarenebri, NSW, in Rintoul 1993:57–8).*

Other forms of cultural genocide include the desecration and destruction of physical culture such as sacred sites and cemeteries, turning Indigenous people against each other through divisions of tribal versus town and part-Aboriginality (Gilbert 1977).

> *Mum spoke Nunglebie as child and people on the island also spoke it and they used to talk to her but it wasn't allowed. It was part of the divide and conquer rule, to split tribal people from parts or half. It's interesting thing that in Darwin you hear a lot about 'part-Aboriginal'. It's a big thing here, whether you're part or full-blood (Elizabeth Pearce, NT, in Gilbert 1977:8).*

Collective trauma from previous generations

> *Collective or communal trauma refers to traumatic experiences which are experienced by large groups of people, who may therefore share some of the psychological, cultural, physical, spiritual, social and mental distress that results (Atkinson 2002:53).*

Although all of the social determinants listed under colonisation have produced collective traumas, there are a couple that have not been listed. These include massacres (Lovett-Gardiner & KHT Inc. 1997; Randall & ABC 2003); wars (Lovett-Gardiner & KHT Inc. 1997); sexual abuse, loss of freedom and feeling beaten (Gilbert 1977); alcohol addictions (Gilbert 1977; Purcell 2002); family violence and children whose parent/s were taken away (Purcell 2002); and the effects of two or more stolen generations in one family (Jackomos, Fowell & Museum of Victoria 1991).

Decolonisation is 'too deadly'

While colonisation is the negative social determinant of Indigenous health, decolonisation is the positive. Much decolonisation has been achieved through Indigenous communities taking control of their culture and health. Although the cultural genocide caused destruction and loss, this does not mean that Indigenous culture ceased.

Decolonisation has been occurring throughout colonisation and, in many ways, as a response to colonisation. Individuals and communities have continually found ways of retaining Indigenous culture, while locating their place within a new community—Indigenous culture within a new context. Many of these actions went unnoticed by some but were often the beginning of something bigger. All of the determinants listed under decolonisation are a part of cultural survival—culture, people and land as one. Since this is such a broad area, we have divided it into smaller components, while retaining cultural survival as the overall theme.

Being 'too deadly' in achieving cultural, community and personal survival is recounted within the oral histories.

Control over our own health

Colonisers had much control over every aspect of our life. However, Indigenous communities view control over our own health as important. This includes the continuation of traditional health practices and the use of bush tucker (Gilbert 1977; Jackomos, Fowell & Museum of Victoria 1991; Randall & ABC 2003; Zola, Gott & KHT Inc. 1992).

> *Aborigines were very clever people. Their medicine and ways of living were simple to them (Colin Walker, NSW, in Zola, Gott & KHT Inc. 1992:52).*

With the recognition that Indigenous health outcomes were appalling, Indigenous individuals and groups set about establishing Aboriginal health services (Dyer 2003; Harvey 2003), dental units (Jackomos, Fowell & Museum of Victoria 1991). They also developed nursing and Aboriginal health worker courses (Dyer 2003; Harvey 2003), started teaching non-Indigenous health professionals how to relate to Indigenous people (Randall & ABC 2003) and established social worker services (Gilbert 1977), health education (DDBBB & Ivers 1999) and support groups such as Alcoholics Anonymous (Gilbert 1977).

Cultural survival

Cultural survival is the continuation of culture and people, despite the effects of colonisation. Although many of the testimonies speak of the destructive nature of colonisation, they also tell of survival. The main strength of survival has been identity: maintaining knowledge of who we are and where we are from (Gilbert 1977; Jackomos, Fowell & Museum of Victoria 1991; Lovett-Gardiner & KHT Inc. 1997; Randall & ABC 2003); knowing that culture is more important than colour (Dyer 2003; Gilbert 1977; Harvey 2003; Purcell 2002); interconnectedness of land, family and community (Harvey 2003; Randall & ABC 2003); respect for people, land and Elders (Dyer 2003; Gilbert 1977; Harvey 2003; Jackomos, Fowell & Museum of Victoria 1991; Lovett-Gardiner & KHT Inc. 1997; Purcell 2002; Randall & ABC 2003); and celebration through events such as NAIDOC (Dyer 2003; Lovett-Gardiner & KHT Inc. 1997; Randall & ABC 2003).

> *Down at Lake Condah and at Eumeralla Creek our people fought wars against the white settlers to keep their culture, not the way that we express it today but their very living in the way that they existed was the culture to the clans. Everybody has to realise that they weren't only fighting invasion, they were fighting for their culture as well because the invaders had a different way of thinking about things (Iris Lovett-Gardiner, Vic., in Lovett-Gardiner & KHT Inc. 1997:13).*

> *As Koories, we see ourselves in terms of connections to land and family and culture, not by skin colour, as Gubbahs [non Aboriginals] tend to do (Dianne Phillips, Vic., in Harvey 2003:97).*

Indigenous people continue to share what they have with family and community (Dyer 2003; Lovett-Gardiner & KHT Inc. 1997; Randall & ABC 2003; Zola, Gott & KHT Inc. 1992), and to face oppression with humour (Gilbert 1977).

> *Some families never had enough, but they all shared. Everyone helped one another. If someone had a better food than someone else in the bush, they'd share with the rest (Uncle Banjo Clarke, Vic., in Zola, Gott & KHT Inc. 1992:33).*

Despite the barriers placed in the way of education, there are testimonies of happy memories of school (Dyer 2003; Harvey 2003; Purcell 2002); students who excelled at school and/or sports (Gilbert 1977; Jackomos, Fowell & Museum of Victoria 1991; Purcell 2002); parents encouraging their children to continue with education (Dyer 2003; Gilbert 1977; Jackomos, Fowell & Museum of Victoria 1991; Purcell 2002; Randall & ABC 2003; Rintoul 1993); students going on to university (Gilbert 1977; Jackomos, Fowell & Museum of Victoria 1991; Purcell 2002), night school (Randall & ABC 2003) and community colleges (Gilbert 1977; Lovett-Gardiner & KHT Inc. 1997; Randall & ABC 2003); and Elders going back to university later in life (Lovett-Gardiner & KHT Inc. 1997; Purcell 2002).

However, cultural survival has not been easy. It has taken protests (Dyer 2003; Gilbert 1977; Purcell 2002; Randall & ABC 2003; Rintoul 1993) such as the Cummeragunja walk-off (Harvey 2003; Jackomos, Fowell & Museum of Victoria 1991), the fight for Indigenous rights and the creation of Aboriginal organisations (Dyer 2003; Gilbert 1977; Harvey 2003; Jackomos, Fowell & Museum of Victoria 1991; Lovett-Gardiner & KHT Inc. 1997; Randall & ABC 2003) to address the social, health and legal inequalities and to regain community control (Gilbert 1977; Purcell 2002). These actions have involved a lot of hard work, including fundraising and volunteering long hours to establish the organisations (Dyer 2003; Jackomos, Fowell & Museum of Victoria 1991; Purcell 2002). Even today there is a lot of work being undertaken through the Community Development Employment Projects (CDEP), which is basically working for the dole (Jackomos, Fowell & Museum of Victoria 1991).

After years of being told that being Indigenous was something to be ashamed of, these achievements have developed a sense of pride, self-esteem and identity in Indigenous people (Gilbert 1977; Purcell 2002). They have also led to self-determination for Indigenous people, a cultural revival (Gilbert 1977) and initiatives such as Indigenous tourism (Purcell 2002). Music and sports are areas that have continued to thrive, with Indigenous communities claiming numerous musicians and sportspeople (Dyer 2003; Jackomos, Fowell & Museum of Victoria 1991; Lovett-Gardiner & KHT Inc. 1997; Purcell 2002; Randall & ABC 2003; Tucker 1983).

Affirming cultural practices and oral tradition

Cultural practices involve the reinterpretation of knowledge in relation to each generation, and the passing on of that knowledge to the next generation. This is affirming cultural practices (Dyer 2003; Gilbert 1977; Jackomos, Fowell & Museum of Victoria 1991; Randall & ABC 2003; Zola, Gott & KHT Inc. 1992) and affirming knowledge through respecting the past. This affirmation is also achieved through continuing practices that are still known to our communities and recovering those that have been misplaced—oral traditions are an important part of this process.

> *We do not separate the material world of objects we see around us. With our ordinary eyes and the sacred world of creative energy that we can learn to see with our inner eye. For us, these are always working together and we learn how to ‘see’ and ‘hear’ in this inner way from a young age. It took me a long time to understand that white people do not experience the world in this way. We work through ‘feeling’. But we are not using this word feeling to mean ordinary emotions like anger, desire or jealousy, or our sense of physical touch. When we use the English word ‘feeling’ in this way we are talking more about what white people call intuitive awareness. We use this to feel out situations, to read people, and to talk to country (Bob Randall, NT, in Randall & ABC 2003:3).*

Aboriginal cultural education (Gilbert 1977; Randall & ABC 2003; Zola, Gott & KHT Inc. 1992) continues through the teaching of languages (Dyer 2003; Gilbert 1977; Harvey 2003; Purcell 2002), dance (Harvey 2003), family (Lovett-Gardiner & KHT Inc. 1997; Harvey 2003; Jackomos, Fowell & Museum of Victoria 1991) and cultural history (Dyer 2003; Harvey 2003; Jackomos, Fowell & Museum of Victoria 1991; Lovett-Gardiner & KHT Inc. 1997; Purcell 2002; Randall & ABC 2003).

> *You hear a lot of stories about the tribal people rejecting their children, the half-castes. It’s not true. It’s incredible what my mother learnt about herself when the tribal people weren’t even supposed to come near her.*
> *My mother was in the compound, huge wire fence, concentration camp fence and the tribal people, old tribal women would come up to the fence and call the little children over. When the children came over they would hold their little hands through the wire and tell them who they were, who their mothers were, where they’d come from, what their skin was, what their totem and dreaming was. They were caught, belted by the authorities and told not to mix with the dirty blacks, told that they should drive the black people away. There was this constant battle for the children’s minds (Vi Stanton, NT, in Gilbert 1977:11).*

Our oral traditions continue with the passing on of knowledge relating to sites, food sources and bush skills (Gilbert 1977; Randall & ABC 2003; Purcell 2002; Zola, Gott & KHT Inc. 1992), family history (Lovett-Gardiner & KHT Inc. 1997; Purcell 2002), music (Jackomos, Fowell & Museum of Victoria 1991), and the Dreaming and Dreamtime stories (Dyer 2003; Gilbert 1977; Harvey 2003; Jackomos, Fowell & Museum of Victoria 1991; Lovett-Gardiner & KHT Inc. 1997; Randall & ABC 2003).

> *I have written about 20 songs, about eight to ten are children’s songs, the majority of them for my daughters. My children have been a great inspiration. I was looking at their future and I didn’t want nursery rhymes to be the first impressions on them. I wanted to teach them Koori songs about things that really happened. Songs taken*

> *from Dreamtime stories. I wanted them to make up their own stories, use their imagination and their ability to communicate and sing (Wayne Thorpe, Gippsland, Vic., in Jackomos, Fowell & Museum of Victoria 1991:50).*

Spiritual and emotional wellbeing, and family support and connection

We have grouped these two determinants together, as we believe that spiritual and emotional wellbeing is dependent on family.

> *I can remember my grannies and grandfathers and uncles and aunts. There was extended family there and your aunts and uncles, they protected you like your mother and father. That was the way it was—your aunty was your mother when your mother wasn't there, your uncle was your dad when your dad wasn't there. They were looking after us children (Aunty Iris Lovett-Gardiner, Vic., in Lovett-Gardiner & KHT Inc. 1997:31).*

Emotional and spiritual wellbeing involves the comfort and support provided by extended family and kinships (Dyer 2003; Gilbert 1977; Lovett-Gardiner & KHT Inc. 1997; Purcell 2002; Randall & ABC 2003; Rintoul 1993). This is what holds Indigenous society together (Randall & ABC 2003).

Testimonies also talk about the work undertaken to change the justice system so that family breakdown and the emotional trauma of incarceration is prevented; about incarceration being viewed as a last resort (Dyer 2003; Rintoul 1993); and about providing appropriate education to communities in regard to their legal rights (Dyer 2003; Randall & ABC 2003). Indigenous people also talk of the positive effects that working with the police has on the community (Gilbert 1977).

Connection to community is achieved through knowing family and culture (Harvey 2003; Purcell 2002; Randall & ABC 2003). Through connection comes self-respect and pride in heritage (Gilbert 1977; Jackomos, Fowell & Museum of Victoria 1991; Purcell 2002; Rintoul 1993).

Land, Native Title and sites recognition

Throughout colonisation, Indigenous and non-Indigenous views of land have come in to conflict (Bowden & Bunbury 1990; Randall & ABC 2003). Oral histories speak of keeping their connection and spiritual relationship to the land to which they belong despite this conflict (Gilbert 1977; Harvey 2003; Lovett-Gardiner & KHT Inc. 1997; Randall & ABC 2003).

> *For instance, when visitors or tourists visit a site that is all they 'see', a mound or a pile of stones. But when the interpretation of the site is through communication, that place becomes a living thing in the mind's eye and can be clearly understood. Because we have the history of the place being born or raised there, that place becomes very dear to us and even though white man has claimed the land, we still say it belongs to us. We are the land and the land is us (Iris Lovett-Gardiner, Vic., in Lovett-Gardiner & KHT Inc. 1997:7).*

Some Indigenous people have also talked about their continued connection to their homelands despite the adoption of a new home, and about having dual homelands—the place where their family is from and the home they have adopted (Randall & ABC 2003; Rintoul 1993). The land is our mother and family (Lovett-Gardiner & KHT Inc. 1997; Randall & ABC 2003).

> *Cummeragunja that was where my family was from, that was my home. I looked up at the sky and I said:*
>
> *My land, my land.*
> *This is mine, this is mine.*
> *This is my ground. This my place.*
> *This is my country.*
> *They can't take this away! (Olive Jackson, NSW, in Harvey 2003:23).*

Oral histories talk about the importance of land to Indigenous people and the need to protect specific sites (Gilbert 1977; Jackomos, Fowell & Museum of Victoria 1991). They also discuss the importance of site officers, the reclaiming of cultural items, legal battles over the desecration and destruction of sacred sites, and Native Title issues (Gilbert 1977; Jackomos, Fowell & Museum of Victoria 1991; Harvey 2003).

Indigenous people have always maintained special places: it is important to understand how this connection to land relates to the welfare of Indigenous people (Gilbert 1977).

> *Land rights is very important part of the Aboriginal welfare as a whole because everything reverts back to it (Ossie Cruse, NSW, in Gilbert 1977:59).*

Reconciliation

Reconciliation (Lovett-Gardiner & KHT Inc. 1997) was a bit of a catch phrase for Indigenous and non-Indigenous people coming together to respect differences in viewing the world, sharing stories and, above all, healing (Randall & ABC 2003).

> *Reconciliation? The only time we can reconcile is when we all know what's happened and can say, 'Alright, that's happened and it's never going to happen again'. I don't think anything will change unless people get a proper aspect on who Aboriginal people are and how they've come to be this far advanced. Unless non-Aboriginal people realise what Aboriginal people went through, how can they reconcile with us? (Iris Lovett-Gardiner, Vic., in Lovett-Gardiner & KHT Inc. 1997:99).*

Other forms of reconciliation have been the claiming of identity and history, and through activities promoting Aboriginal cultural survival (Dyer 2003; Randall & ABC 2003).

> *Aboriginal people, by and large, recognise this spiritual dimension to reconciliation in Australia. As one of my Aboriginal brothers from Queensland said:*
>
> *'We talk about problems, we talk about healing, we talk about reconciliation. But it goes much deeper. Aboriginal to Aboriginal, Aboriginal to Australians, Australians to us, Aboriginals to the land. It's a deeper problem. It's a spiritual problem' (Bob Randall, NT, in Randall & ABC 2003:242).*

Discussion

The reviewed Indigenous oral histories describe that our land, community, people and health are one—Indigenous people view everything as interconnected. It is therefore difficult to investigate Indigenous health without taking a holistic view and looking at the big picture, as opposed to the individual sections. Although most of the colonisation social determinants relate to cultural genocide and their effects on Indigenous health, it is gratifying to be able to note that cultural genocide was unsuccessful.

In saying this, it was not always easy to separate the experiences told in oral histories into colonising and decolonising (positive and negative) determinants as several could be viewed as both. An example of this was with 'employment, education and training'. While these determinants have been labelled as colonisation, there were references to improved employment opportunities with the introduction of increased education and Indigenous organisations, a method of decolonisation. So determinants labelled as colonisation can have a decolonising opposite of the same name.

The oral histories describe the struggle to create space and resources for decolonisation due to the effects of colonisation. Processes to promote decolonisation need to be well thought out and can be hindered by ongoing colonisation problems. For instance, an employment program may be established with an Indigenous reference group to steer it and increase self-determination. However, such a program may rely on funding with terms attached that may not be driven by Indigenous people.

The process of decolonisation may also be 'messy' and may need to change the processes or values of the colonisers' accepted 'norms'. An example of this is the acceptance of Indigenous students into health-related courses with different qualifications to their non-Indigenous counterparts, or by changing course delivery to blocks of study rather than full-time on-campus study to allow important community and family contact to continue. This recognises that equality is often based on meeting the needs of different people, while the norm may be to 'treat everyone the same'. 'Sameness' is nonsensical—one size shoe will not fit every foot.

The overall view of the oral histories is that colonising effects were disproportionately reported over decolonising. This may be due to the reasons for recording the oral histories, for instance, the purposes of the eleven books reviewed. Four were autobiographies of Elders' lives (Dyer 2003; Lovett-Gardiner & KHT Inc. 1997; Randall & ABC 2003; Tucker 1983), five were thematically based collections (Gilbert 1977; Harvey 2003; Jackomos, Fowell & Museum of Victoria 1991; Purcell 2002; Rintoul 1993) and two were used to investigate a particular topic (DDBBB & Ivers 1999; Zola, Gott & KHT Inc. 1992).

Another limitation to the oral histories is the different methods used to record them, which means that the oral records varied in quality. In some instances little or no description of the method was provided for the oral record. The recording and editing will be affected by who actually carried out these roles. For instance, a non-Indigenous recorder may create cultural bias, in that cultural safety may be lessened and affect what the teller feels 'safe' to record. The relationship between two Indigenous people, such as family members, young person or Elder, may also affect what the teller is able to record.

Conclusion

To ensure self-determination and successful decolonisation in Indigenous health, it is essential that Indigenous people lead the discourse. Indigenous people have different worldviews and experiences and these should be reflected in their social determinants of health.

Decolonisation and colonisation are an Indigenous method of viewing social determinants of Indigenous health. What this paper is suggesting is that social determinants of Indigenous health can be viewed as response-based—colonisation impacts negatively on Indigenous health, so a method of decolonisation can be developed to address this impact.

Indigenous oral history research is a valued decolonising methodology. For this to occur it is essential that Indigenous people are part of the research and analysis to prevent determinants being viewed through another culture's worldview, and to ensure that the cultural integrity of the oral history is retained. Improved documenting of methodology in this area would in turn improve practice and the quality of records. Further exploration of the relationship between the processes of successful decolonisation in the face of colonisation and improvements in health would enhance understanding and health practice.

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Chapter 3:

Education as a Determinant of Indigenous Health

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Introduction

For several decades, it has been universally accepted that the health of population improves with higher education levels, measured in terms of years of formal schooling or adult literacy rates. The most common health indicator used to demonstrate the link is the reduced rate of child mortality, and the effect persists even after controlling for the positive effects that education has on income and employment (Hobcraft 1993). Higher education levels, however, have a much more pronounced effect on child survival and health when accompanied by improved access to primary healthcare services, especially maternal and infant healthcare (Caldwell & Caldwell 1995). It is also well known that Aboriginal peoples and Torres Strait Islanders receive much less formal schooling and have much lower levels of literacy than non-Indigenous people (DEST 2005). Nevertheless, until the Cooperative Research Centre for Aboriginal and Tropical Health (CRCATH) embarked on its Health and Education Research Program in 1997, only one study (Gray 1988) had examined the education–health link hypothesis in relation to Indigenous peoples in Australia.

This paper begins with a brief review of international research, which demonstrates the link between education and health, followed by an account of the quantitative, qualitative and theoretical studies carried out by the CRCATH. We acknowledge at the outset that the interpretation of empirical data on education–health links is highly contested. Sometimes, as we show, the data itself is ambiguous, or incomplete, especially the Australian data. But it is more difficult to arrive at a *shared theoretical understanding* of the two major variables: health and education. This is not as straightforward as simply examining their empirical 'markers'—such as child survival rates, years of schooling and literacy levels. Why? Because both *health* and *education* are cultural 'artefacts' or 'constructs', which mean different things to different people at different times. The confusion is magnified by the assumption of both health and education professionals that the paradigms of their own field transfer in a straightforward way to the other. The confusion becomes almost overwhelming when a cross-cultural dimension is added, because both Indigenous and non-Indigenous peoples have such diverse experiences of education from which to draw an understanding of it.

The second part of this paper is a preliminary report into the progress we have made trying to achieve greater clarity about the meanings of the education–health link, and what action should flow from this in the specific context of Indigenous peoples' health. Our methodology was to undertake a series of semi-structured dialogues between two academically trained researchers—one an educationalist, the other a health professional—and a small number of Indigenous health leaders, including our co-author and project leader.[1] These dialogues helped us to clarify meaning, and also addressed a key finding of the social determinants literature, namely that power and control are at the heart of health inequalities.

The third part of the paper draws together these first two elements—the review of the research literature and the dialogue with the health leaders—to build some illustrative models of the way in which education can be better understood as *both* a determining factor in the reproduction of health inequalities, *and* as an active intervention into overcoming them. In the final section, we suggest some future directions for research and program development.

The research evidence

Health transition studies

Two Australian health researchers writing in 1991 summarised what was then known internationally about 'the cultural, social and behavioural determinants of health', which they, and others working with them, called the 'health transition':

> *The most firmly established generalization… [is] that parental education, particularly maternal education, has a major impact on the survival of children even when controlled for income and other indices of material well-being... There [is] agreement that any kind of modern schooling reduces mortality levels and that the phenomenon occurs in all parts of the Third World. Furthermore, the change is linear, with a reduction in child mortality of 7–9 per cent for each additional year of maternal education (Caldwell & Caldwell 1991:5).*

Several points must be made, however, before we rush to conclude that poor Indigenous health outcomes can be similarly explained. Firstly, the Caldwell studies were of Third World countries where schooling was generally not provided beyond basic primary or junior secondary level. Secondly, they were not studies of participation by minority cultures in mainstream education systems. Thirdly, most of the health data relates to infant and child survival, which while it is important, is not the main contributor to poor Indigenous health status that it once was. Fourthly, the main aim of this work was to find out how Third World countries might move more quickly through the 'transition' from high to low child mortality, in situations where resources were limited. In other words, they were addressing health inequalities on a global scale, between countries more than within countries.

Finally, the 'health transition' researchers were less clear and less unanimous when it came to explaining *why* education, measured either as years of formal schooling or as literacy, had the health enhancing effect it did. In the absence of such explanations, education can appear as a magic bullet, or a black box. We administer it, or put people into it, and they, or more usually their children, have healthier lives. But what are the pathways which explain this effect? Caldwell and his colleagues made many attempts to develop theoretical frameworks capable of some explanatory power (Caldwell 1994), but the work of testing these produced no clear conclusions.

Some things were, however, clarified. Firstly, the positive health effects of education are most often associated with a wider social movement or struggle for increased social and economic equality, especially movements that reinforce women's autonomy. The countries where this was said to have occurred include Sri Lanka, Costa Rica, Cuba and China, and the State of Kerala in India. One of the most striking studies, for example, examined the long-term effects of the 1980–1985 Sandinista popular education and literacy program in Nicaragua (Sandiford *et al*. 1995). This study is important, because it shows a mass adult literacy program achieving a similar health effect to several years of schooling. After controlling for other socio-economic factors, it found that

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[1] The research team included Stephanie Bell, Donna Ah Chee, Clive Rosewarne, Ben Bartlett and Bob Boughton. Additional input was obtained from Pat Anderson and John Liddle.

the children of women who had participated in the program had significantly lower mortality and better health outcomes (measured by nutritional status), compared with the children of those who had not.

Secondly, the effects of education are more pronounced when associated with improved access to primary healthcare services, especially for women and infants. This works in two ways. Improved schooling and literacy works better to improve health when there is more primary healthcare; but improved access to primary healthcare was found to have less of an impact on maternal and child health where there was not a corresponding improvement in education, especially for young women (Cleland 1990).

Caldwell's third and most controversial claim follows on from this finding. He argues that the health effects of education are derived from the fact that it is a proxy measure for the adoption of more scientific and more 'modern' attitudes and practices, including an increased respect for modern medicine and public health, and less reliance on traditional explanations of death and disease; but also of changed practices in relation to personal and domestic hygiene and infant care. This led some Australian commentators (e.g. Christie 1998; Lowell, Maypilama & Biritjalaway 2003) to characterise this view as potentially assimilationist, and to associate it with the questionable Third World development paradigm known as the modernisation theory.

Putting this to one side, and without describing any of the rich contextual detail in the hundreds of studies where the link has been found,[2] the obvious health-enhancing effects of education that have been found internationally are, at least, *prima facie* evidence for asking whether such an effect occurs for Indigenous peoples in Australia.

Social determinants and health transition

The huge international research effort that went into understanding the effects of education within the 'health transition' paradigm occurred quite independently of the more recent 'social determinants' literature (e.g. Marmot & Wilkinson 1999; Evans, Barer & Marmor 1994), which is now focusing Australian health researchers' attention on health inequalities. For example, education is not one of the ten factors listed in *The Solid Facts* (Wilkinson & Marmot 2003), the World Health Organization publication aimed at popularising this research. The main reason appears to be that the social determinants/health inequalities research was primarily concerned with health in advanced capitalist countries, and not with the Third World. Nevertheless, both research communities were examining the same phenomena—the 'social, cultural and behavioural determinants', as Caldwell (1993) called it. Moreover, at least some social determinants researchers claim that education programs can be designed to counter the effects of health inequalities (Swan 1998).

Some health transition researchers, however, did examine modern Western countries, but they did it historically, going back to the nineteenth and early twentieth century to test the basic hypothesis that better health is associated with better education.[3] Why is this important? Firstly, the empirical data, while its inadequacies are acknowledged, suggest that in the First World the transition to low infant mortality and better population health was not so clearly mediated or influenced by education as it appears to have been in the Third World. Secondly, it serves to remind us that 'transition' is an historical concept describing change over time, and that, therefore, the conditions at a particular time are likely to have a health effect that reverberates through generations. Thirdly, it reminds us that the health of the First, Third and Fourth worlds are not independent of each other. The improved health of Western populations in the late nineteenth and early twentieth century was largely achieved by improvements in medical care, public health, housing and nutrition, which were financed in part by the wealth that these countries accumulated from colonisation. The health of populations has a history, and history itself is a determinant of health, both good and bad. As one US social epidemiologist puts it, history leaves its tracks in our bodies (Krieger 1999). Australians—who today enjoy the benefits of one, two and perhaps more generations of better healthcare *and* education—need to remember that one price that was paid for this achievement included the erosion of Aboriginal societies' pre-existing education and health 'systems' and practices, which were integrally bound up with land, its ownership, custodianship and utilisation for economic and cultural purposes.

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[2] Readers are referred to the journal, *Health Transition Review*, in which much of this work was published, which is available on the archived pages of the National Centre for Epidemiology and Population Health website. See Boughton (2000) for a more detailed exploration of the relevance of this work to Indigenous health research.

[3] See the Forum pages of *Health Transition Review*, vol. 1, no. 2, 1991, pp. 221–43.

The wider benefits of learning

In recent years, a new strand of education–health links research has appeared, emanating from the work of the Centre for the Wider Benefits of Learning at the University of London's Institute of Education.[4] This work was originally stimulated by United Kingdom studies of ageing populations, which showed far less subjective health problems and much greater emotional and social wellbeing among people who continued with or returned to education in their mature years (Hammond 2002). It has now grown into a major research program comparing different countries across Europe in terms of their education system outcomes and their population health indicators. In-country studies are pursuing similar comparisons between different regions, connecting with world-wide interest in social capital and social cohesion. These studies are asking: what role are education systems playing in the reproduction of social capital, that controversial attribute of communities, regions and even whole countries which is said to be protective of individual health and wellbeing? This is itself a huge field, not possible or usefully summarised in a paper as brief as this. Two points, however, can be made. Once again, and in a totally different context and research paradigm, education—this time re-configured as learning, as in 'lifelong learning'—has been found to be intimately implicated in health and health development, not just at an individual level but also at a population or collective level. The second point is more salutary. Inter-country comparisons suggest that national education systems *which produce highly unequal outcomes* play a role in worsening, not reducing, health inequalities. Education, in other words, works only for the people it works for. We return to this point below when we look at the Australian data.

Indigenous health transition: a question of governance?

We discovered only one international study—Bjerregaard and Kue Young (1998)—that addresses the 'health transition' in Indigenous populations In it, the authors examined the social determinants of changes in health status over time among Inuit people living in three different circumpolar regions: Greenland, Canada and the old Soviet Union. After exhaustively describing aspects of physical and emotional health status and social history, which mirror many things familiar to people working in Indigenous health in Australia, they conclude:

> ***The improvement of health ultimately requires moving out of the health sector altogether…*** *Health systems need to move 'upstream', from individual based treatment (downstream), through primary prevention and screening (midstream), towards a social policy approach. Upstream interventions include efforts to change government policies, organizational practices and provider behaviours which affect the entire population and its social norms and macroeconomic structure… Thus, it is not so much fine-tuning public health policy, but developing a healthy public policy, which will have the most impact on health. The achievement of* ***a fair degree of self-determination, which is furthest along in Greenland followed by Nunavut****, will provide the preconditions for the effective implementation of more limited, disease specific interventions (Bjerregaard & Kue Young 1998:237, our emphasis).*

This is important, because it draws attention to the social policy dimension, whereas a lot of the work on education has focused, at a more micro-level, on schooling itself (DEST 2000). It does, however, echo the argument in Caldwell and Caldwell (1995) about the wider social change context of the health transition. Bjerregaard and Kue Young (1998) suggest that health benefits require change at an institutional or system level in the relationship between Indigenous and settler populations. This clearly speaks to the literature on regional agreements and treaties, and takes the education debate to quite a different level from simply trying to make schools more 'Aboriginal-friendly'. In Canada and in parts of the United States, education agreements are now becoming a component of regional negotiations.[5]

Educational inequality

We turn now to the Australian data. Australian health professionals today are well aware of the indicators of Indigenous health inequality, but may be less familiar with the corresponding measures of educational inequality. These are canvassed annually by the Australian Parliament in the National Report on Indigenous Education, which is compiled

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[4] An account of this work and some publications are available at www.learningbenefits.net.

[5] A guide to websites where descriptions of some of these can be found is in the report by the CAAC & Boughton (2001).

from exhaustive data collections by the Australian Bureau of Statistics, the Department of Education, Training and Youth Affairs and the National Centre for Vocational Education Research (DEST 2005; Saunders *et al.* 2003; Christie 1998). The data is assembled according to the four main education sectors: pre-school education; school education—broken down into primary, junior secondary and senior secondary; vocational education and training (VET); and higher education.[6] These reports show that educational participation by Indigenous students is increasing in every sector, but in all, apart from in the vocational area, it still remains well below the participation levels of non-Indigenous people. The inequalities are much more marked in junior and senior secondary schooling than in pre-school and primary schooling, and they are extreme in the higher education sector. There are also significant regional differences. For example, junior and senior secondary school retention rates—which measure the proportion of students entering secondary school who progress to years 10, 11 and 12—are much lower in rural and remote areas than in urban areas (Schwab 1999). On the other hand, participation levels in primary schooling, despite being some percentage points lower than non-Indigenous rates, are relatively high by comparison with the rates overseas where the majority of the previously cited education–health links research has been done.

Existing national and State-based policy settings in Indigenous education are not seen by most commentators to be a major problem. In each sector—higher education, VET, school education, and pre-school education—substantial policy development work has occurred over the past three decades. In policy terms, there is no lack of commitment to improving educational outcomes at every level, rather, the problems exist at the level of implementation (Boughton *et al*. 2003; Robinson & Bamblett 1998; Schwab 1995). This is evidenced by the adoption by all governments of the National Indigenous Education Policy in 1989, and the re-affirmation of this policy priority by the Ministerial Council on Education, Employment, Training and Youth Affairs in May 2005 (MCEETYA 2006).

One aspect to this is that education is every bit as complex a bureaucratic field as health, with States and the Commonwealth having overlapping responsibilities. But unlike the Indigenous health sector, Indigenous education has no nationally coordinated effective joint planning mechanisms with independent Indigenous input. This undoubtedly relates to the fact that in education, there is nothing like the level of community-controlled provision that there is in health, and so there is no corresponding Indigenous leadership with an organisational base that has a degree of autonomy from the public or private systems. Most Indigenous education leaders work inside mainstream systems, and the single national organisation based on community-controlled providers—the Federation of Independent Aboriginal Education Providers—only operates in the adult and vocational education and training sector. In higher education, there is a national organisation that brings together Indigenous units on campuses around Australia—the National Indigenous Higher Education Association—but while some of these units now have faculty status, they remain subject to their parent institution. Most State education systems have historically had advisory bodies, the Aboriginal Education Consultative Groups (AECGs), which have tended to focus on schools. The vocational system had a national advisory body, the Australian Indigenous Training Advisory Council (AITAC), but it was abolished in June 2005. Similarly, in the 1970s and 1980s there was a national body, the National Aboriginal Education Council, but it no longer exists, and a more recent attempt by the AECGs to federate in the 1990s was relatively short-lived. The Aboriginal and Torres Strait Islander Commission (ATSIC) / Aboriginal and Torres Strait Islander Services (ATSIS)—note these are closely related agencies—had an education portfolio allocated to a commissioner, but almost no program responsibility or authority, and little experience and expertise. The lack of any autonomous, institutionalised Indigenous power-base within the education sector overall is considered by many to be a major barrier to the effective implementation of national policy, especially to its number one objective, that of increasing the participation by Indigenous people in educational decision making. In recent years, the Commonwealth has resisted attempts to form such a body, preferring to work with consultative agencies with members appointed by government. The most recent example of this policy approach is the National Indigenous Council, appointed after the demise of ATSIC in 2005.

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[6] Note that this data is confined to formal education. There is much less systematic reporting at a national level on adult and community education (ACE) programs which are non-formal and non-accredited.

Recent Australian research on education–health links

Until the CRCATH began its work in 1997, there had been no systematic attempt to investigate links between education and health among Indigenous people. Gray's exploratory study using the 1986 census data found a clear relationship between the level of education of Indigenous women and the survival of their children, but interpretation was confounded by an apparent tendency among better educated women to report to the census more accurately. Changes after 1986 to census questions prevented the investigation from continuing (Gray 1988).

The CRCATH Health and Education Research Program's more systematic study was reported in a number of monographs and reports. Of these, only two were quantitative studies, comparable in this respect to the health transition research work. The first, by Gray and Boughton (2001), was an analysis of the 1994 National Aboriginal and Torres Strait Islander Survey (NATSIS) data, in which the authors set out to examine whether parents with more schooling are also more likely to take 'health-related action' when their children are sick. The expected effect, going on the international literature, would be that more highly educated mothers would take on higher levels of health-related action. The NATSIS data shows that they do, but so do the least educated mothers. After controlling for a large number of possible contributing variables, an unusual and puzzling relationship was found: while those with the most education were more inclined to take action, so too were those with much less education. The real problems appear to be that people who leave school in the 'middle years' are less likely to act than either their better or worse educated counterparts.

Discussions with Indigenous health and education leaders suggested a number of possible explanations for this anomaly. The most credible hypothesis was that the experience of being unable to succeed in junior high school was actually reducing young people's capacity in adulthood to take action on their own behalf. This tallied with anecdotal evidence provided by community leaders, about the young parents most at risk, but could not be proven one way or the other from the available data. Another possibility was that the least educated people were actively being sought out by health service professionals because they were seen to be more at risk. The authors recommended that further study be undertaken utilising the methodologies that had been employed in the international literature, including a combination of national surveys, community censuses and more ethnographic investigation.

The second quantitative study by Ewald and Boughton (2002) was done at a community level using child health data obtained from a screening process undertaken as part of a larger study of environmental health in a central Australian community. This was a pilot study aimed at developing a more participatory methodology utilising an existing dataset. Community informants helped identify the 'carer-mothers' of the children whose health conditions had been measured in the screening. These women were surveyed and their school records checked to establish their schooling history. This was then correlated with the health outcomes. The engagement with the community helped the researchers understand how Indigenous teachers and health workers themselves thought about the education–health link. In the end, however, the data revealed no clear link. The only significant predictor of better health in children was the employment status of their carer-mothers, not their education or literacy levels. The unreliability of the education data, both the schools' own records and the self-reporting by participants, made the authors cautious about drawing any strong conclusions. They recommended, therefore, that a purpose-designed study be undertaken in a number of communities, combining quantitative and qualitative data collection techniques.

The remaining studies were qualitative, ethnographic and participatory investigations of perceptions within a number of Northern Territory communities about the nature of the education–health link, and what the CRCATH and its partner organisations should do about it. A study in two Northern Territory communities—one urban, one remote—found that:

> *The importance of schooling (Western education) was widely acknowledged by the Yolgnu participants, particularly for its role in preparing people for employment although there is some disillusionment about this connection due to the limited employment opportunities in the community and there are concerns about current levels of educational achievement.* ***Western education, however, was not recognised as having a positive influence on health*** *(Lowell, Maypilama & Biritjalaway 2003, our emphasis).*

Malin, likewise, reported that many Aboriginal people expressed little interest in the question of whether 'Western schooling' improved health, and were more concerned with 'the effects of colonisation'. She concluded that the health transition hypothesis, of more schooling leading to better health, could not be applied here, because 'the domination of white Australia in the population and societal structures is also reflected in schools' (Malin 2003). This position echoed views of several other educational researchers who joined the debate, arguing that because schools undermine and challenge traditional knowledge and authority, schooling was potentially a source of individual and community stress and likely to produce worse, not better health outcomes (Christie 1998; Lowell, Maypilama & Biritjalaway 2003).

This 'culturalist' critique is a dominant theme within Indigenous education theory and practice in Australia. It has informed many excellent policy initiatives to increase the value placed on Indigenous languages, cultures and knowledge, for example, 'both ways' schooling and bilingual/bicultural programs. However, the implied contradiction between education (in fact, schooling) and culture is problematic because all societies require educational institutions to reproduce their cultures, and the way they do this favours some cultural practices and devalues others (McDermott & Varenne 1995). To suggest that education can be more or less culturally appropriate obscures the fact that Aboriginal culture depends for its continued existence on social practices, which are themselves educational. As Mick Dodson put it, we cannot assume, in the absence of institutional support, that culture will be reproduced 'somewhere else' so it can 'visit the mainstream institutions on its day off' (Dodson 1997).

Indigenous health leadership views

Without Indigenous leadership in both the education and the health sector, it has become an article of faith, in theory if not always in practice, that no real long-term strategies can expect to succeed. Increasingly, this view is also being applied to research programs and projects undertaken in these fields. The problem we all face, while we may assert this position in principle, is that the leadership and conduct of research has historically been dominated by highly educated people at the apex of the education system. The new Cooperative Research Centre for Aboriginal Health (CRCAH) that developed after the wind up of the CRCATH, as an institution is itself caught up in this contradiction. It sits at the 'crossroads' of education, health and research. It is not surprising, therefore, that attempts to understand and overcome the difficulties of achieving Indigenous leadership over the research program are a major theme of the CRCAH's own research, publication and education programs.

In this project, we initiated a series of dialogues about the education–health link with Indigenous health leaders who have sat on the CRCAH Board and taken part in its work. Our objective was to explore the extent to which the research effort was informing, and informed by, these leaders' understanding and practice, including their understanding of education and other social determinants. As a group, we have a long history of working together in Aboriginal community-controlled organisations, in both the health and education sectors. This experience has taught us that change comes from collective action by Aboriginal and non-Aboriginal people working in partnerships that are characterised by solidarity, critical support and an acceptance of Aboriginal leadership. It has also taught us that the Indigenous 'health transition' involves human agency, and that collective action to overcome racism and discrimination in health systems and in education systems is itself a form of education.

The popular United States educator Myles Horton, who was instrumental in the civil rights movement, used to say that 'we only learn from the experiences we learn from' (Horton & Freire 1990). This apparent piece of 'down-home' wisdom echoes the insights of more sophisticated theories in adult education (e.g. Mezirow 1991), which argue that learning results from the incorporation of new experiences and inputs within our pre-existing systems of meaning. These, in turn, come from previous educational experiences and, at a deeper level, from our culture (e.g. education, in other words, is not a process of 'knowledge transfer', from one 'head' to another). This is what another famous popular educator, the Brazilian Paulo Freire (1970), rejected as 'banking education': education that pretends to make 'deposits' into the heads of others. No—education is an active process of engagement.

The 'bottom line', therefore, is that the only understanding of the education–health link, which will ultimately make a difference, is the understanding that the Indigenous health leadership takes out of this research process. Research and education, in this model, are not two separate things. Research is education and the researchers, if they are not Aboriginal health leaders themselves, must also be educators. By the same token, the educators have to be educated, because the Indigenous health leadership has to be able to apply the research findings and convert them into better informed collective action. This requires research to be a ‘two-way’ educational process, not a transfer of research knowledge from researchers to consumers.

The Indigenous health leadership operates at several levels. In every community, there are health leaders—people who provide leadership to their families and neighbours and kinfolk. They work as health workers, sit on health boards, teach in schools, go on committees, speak up when representatives from government departments visit, provide counselling and support, and maintain social cohesion. On a daily basis, these people address the social determinants of health—regardless of whether or not they have ever heard of the term. Most of them have little formal education because they are typical of their community, with the vast majority having left school before year 10. They have primary school or junior secondary level literacy and numeracy, and any post-school qualifications they have will be lower level vocational ones. The exceptions only serve to prove the rule. The past failure of the education system to provide education to Indigenous peoples to the same level as to non-Indigenous people ensures this situation will continue for the foreseeable future, even if these failures were to be overcome within the life time of the current generation.

However, there is another level of leadership, usually emanating from the community, but operating at the highest levels of health system service management, policy formulation and political advocacy. Leaders at this level are managing multi-million dollar organisations and programs, contributing to regional, State and national policy and planning forums, and helping to set research agendas. They, too, are daily addressing the social determinants of Indigenous health, and have been doing so long before the concept was mentioned in any research report, policy document or other publication relating to Indigenous health.

Research programs that do not enter into dialogue with both these audiences and do not assist with the education of both leaders and researchers simply reproduce the educational inequality that we have identified as the fundamental problem. This is the contradiction at the heart of any attempt to make education work for empowerment, a challenge that can only be addressed by a research program built around a different kind of education–research model, one in which Indigenous health leaders are actively engaged in making meaning. So, what meaning have some of the Indigenous health leaders who have participated in the CRCAH process made of the education–health link and the CRCAH’s efforts to understand it? There was wide agreement among the health leadership who took part in this dialogue that there was an education–health link. This contrasts with other findings reported above, for example, by Lowell, Maypilama and Biritjalaway (2003). Their ideas—collected by the authors during the dialogue—about how this link worked included that education gave people the ‘skills & tools to make choices’; and that it *‘empowers people’* and teaches them *‘how to think better (and) understand things’*. Better educated people, it was thought, are *‘more likely to take responsibility for their actions’* and to have a *‘consciousness about finding ways of doing things for themselves’*. Education helps people to *‘advance themselves or their families… (because you) can’t compete in the world without education’*. Education *‘promotes the concept of work’* and helps people *‘get to know how others live’*. It provides the community and the individual with role models, and it enhances social networks. In health services and the community, the lack of education is seen as a major workforce issue.

The problem was seen as critical because of the rapid growth in the numbers of young people finishing school too early. Young people who dropped out of education were seen as more likely to fall into a culture of violence and despair than those who continued. In many communities, it was said, there was little value placed on education, even by some leaders. There were concerns, too, that young people did not want to go to school and parents were reluctant to force them. This may well have been because parents themselves had negative experiences of education. It was difficult for people to see a value in education when there were few jobs—or only Community Development and Employment Program positions—and being unemployed had become part of the culture. Sometimes ‘Aboriginal culture’ is used as an excuse for not valuing education, or as a substitute for education, but this was seen as incorrect. In the experience of the people we were speaking to, education does not require people *‘to give up law and culture’*.

In these dialogues, a major focus was on the responsibility of the community itself to address the lack of education, especially among young people. This emphasis on the need for Indigenous agency and responsibility is understandable as health leaders have long believed that solutions have to come from Indigenous people themselves. At the same time, however, the education system was subjected to severe criticism for its failure to implement the policy and programs that the community had argued for. This failure was considered to be something requiring research—why had the responsible departments not implemented their own policies and recommendations of all the reports? It was said that there seemed to be *'little questioning of teaching methods'*, and that the education system itself *'makes Aboriginal people powerless'* and is not giving people the idea that they are learning. There is racism in schools, but this is not the primary reason for not going to school, because *'racism is everywhere'*.

One of the strongest themes to emerge was the role of education in reproducing Aboriginal leadership, not just in health but across all those areas that affected health. This raised the role of the CRCAH itself. There was considerable dissatisfaction with the extent to which the previous CRCATH supported the initiatives of Indigenous health and education leaders and to build that leadership's power to take more control of the research and policy agenda. The CRCATH had *'not understood'* the education–health link, especially its own role in it. It saw its education responsibilities chiefly in terms of scholarships and cadetships, not in the education of the research community or the Indigenous leadership.

However, the CRCAH, it was said, should have *'no role'* in choosing leaders; this *'must be left to the community'* and *'any role they play must be under the control of the Aboriginal leadership'*. Some ways in which the CRCAH might support that leadership include:

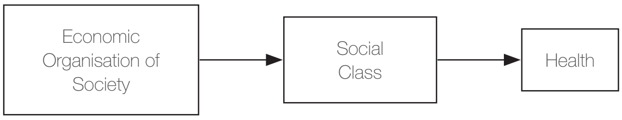
- allocating resources to produce well-informed position papers quickly, which could support Aboriginal leaders in the lobbying of politicians and the bureaucracy;
- explaining the health determinants more clearly, so that health administrators and others working in communities can talk with community members and other community organisations about it;
- educating researchers to be 'less sensitive about straight talking';
- organising more inter-disciplinary collaboration to help strategise difficult community problems;
- examining where and why recommended solutions had not been implemented, thereby demonstrating government inaction;
- assisting community organisations to be involved in the social determinants debate on a more equal level;
- helping to promote a round-table discussion on education—what is happening, what is wrong, how to fix it;
- helping to clarify 'where the (education) money goes'; and
- running all-of-community education program pilots that give community leaders ownership of the education process.

We have reproduced these ideas in the form and wording in which they were raised in the dialogues to give some flavour of the discussions. The final section moves beyond these individual suggestions to a more integrated research program.

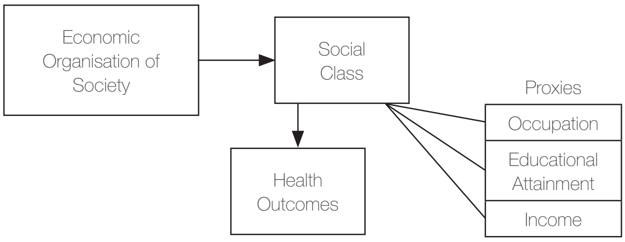
Towards a model of the education–health relationship

How do we make sense of the education–health link in the context of the more recent work on health determinants? As we saw above, social determinants researchers such as Marmot and Wilkinson (1999) and Evans, Barer and Marmor (1994) paid scant attention to education as a determinant, the factor that the health transition literature saw as central. In this section, we try to bring these two literatures together, while drawing on the Indigenous leadership dialogue reported above.

To begin with, few would question that *social class* is related to health status and that the way societies are organised economically is the major determinant of class structure.

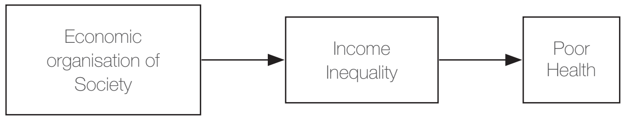


Education has tended to be used in many studies as a proxy for social class, along with income and occupation. This is an implicit acknowledgment that education is a factor in class-determined health inequalities.



However, the social determinants studies have shown that it is not just the people at the bottom of the social hierarchy who have poor health outcomes. In the Whitehall studies (Marmot *et al*. 1984; 1991), people second from the top had two to three times the mortality of those at the top of the civil service hierarchy. So, while poverty is a factor in its own right, it is not the whole story. There is a gradient of health outcomes from the top to the bottom of the social hierarchy. This study showed that after controlling for all known risk factors—for example, hypertension, cholesterol levels, smoking behaviours—the gradient of health inequality persisted. This appears to be related to what has been called the ‘control factor’, that is, the more control a person has over their work, the better their health outcomes (Marmot *et al.* 1997).

There is also evidence that income inequality (as distinct from income level) is itself a determinant. Where a society has a narrow gap between the richest and the poorest, the health of all is better than in societies where there is a wide gap between the rich and the poor (Wilkinson 1996).



We postulate that the ‘control factor’ is the common link between the social and environmental factors (i.e. external factors) and the biological responses that create either good or poor health. These responses are modified individually by genetic predispositions, although these, too, are products of environmental conditions over time (Evans & Stoddart 1994).

Other factors identified as contributing to poor health include low self-esteem and social isolation. People who sit towards the bottom of the social hierarchy are usually well aware that society views them, in today’s parlance, as ‘losers’, which affects their confidence and self-esteem. In this situation, people experience both objective disadvantage in controlling their lives (low income, poor education, poor environmental living conditions, boring job or no job) and subjective disadvantage (low self-esteem, uncontrolled anger or frustration, low confidence). Health status itself will also impact upon the ‘control factor’, since poor health undermines the ability to take control. Moreover, self-esteem and educational success are closely interrelated, each helping to reproduce the other. All this can be modelled in terms of biological responses that are the pathways to disease, as shown in Diagrams 2 and 3 adapted from Brunner and Marmot (1999).

DIAGRAM 1: **Control factor—The missing link?**

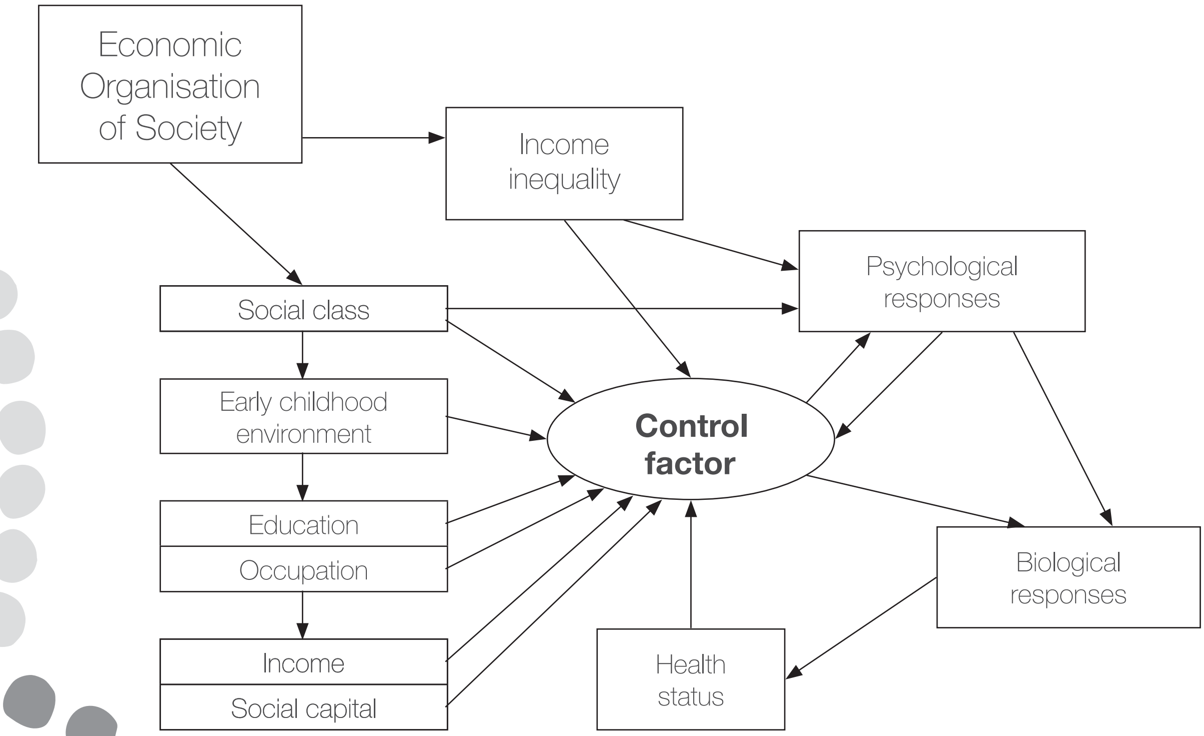


DIAGRAM 2: The biology of power

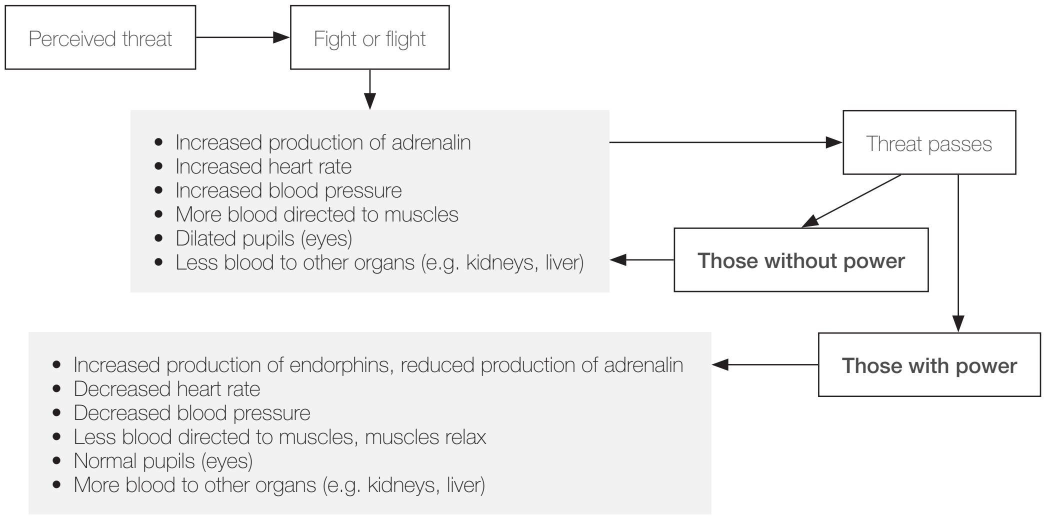
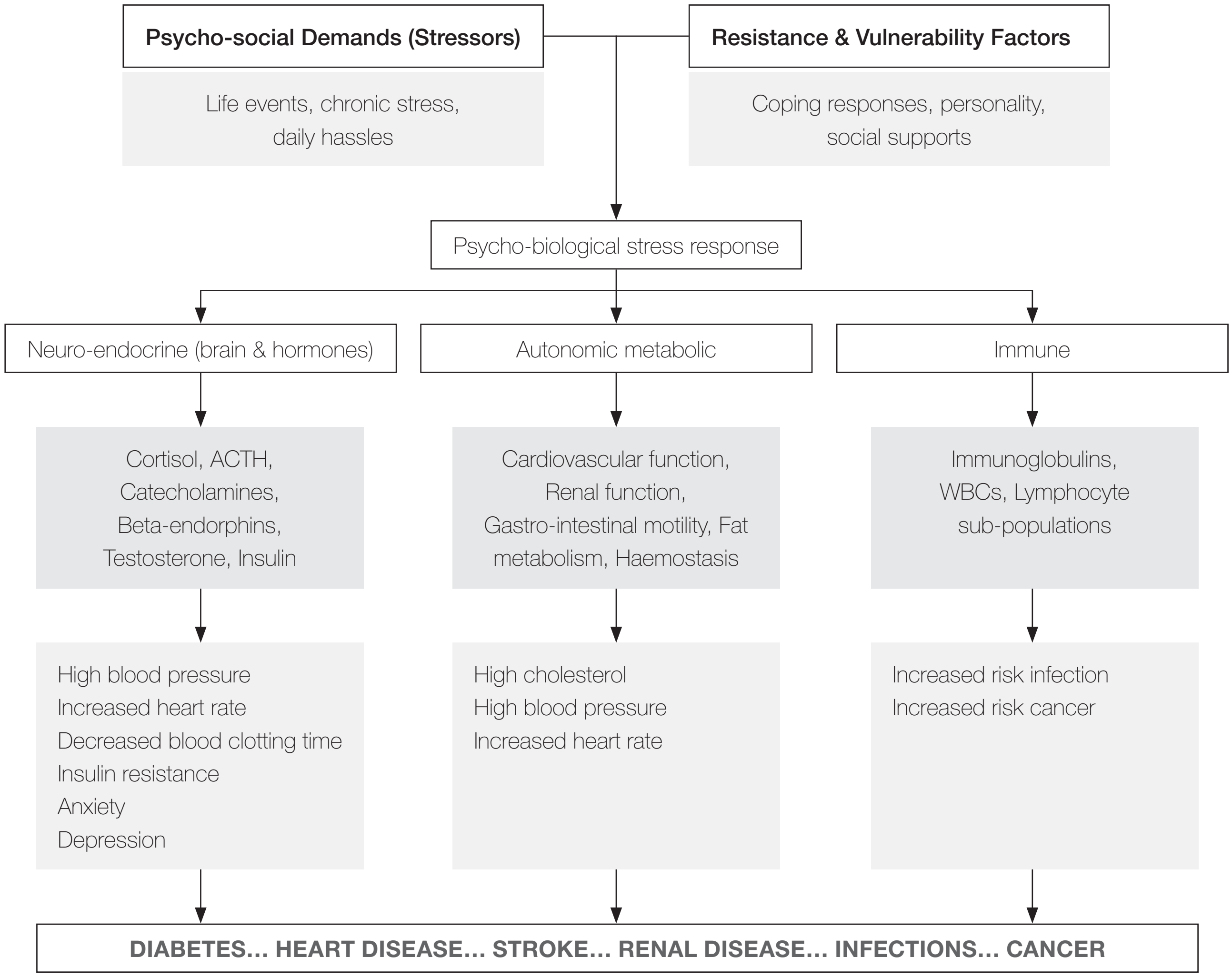


DIAGRAM 3: Biological pathways



The historical/time dimension

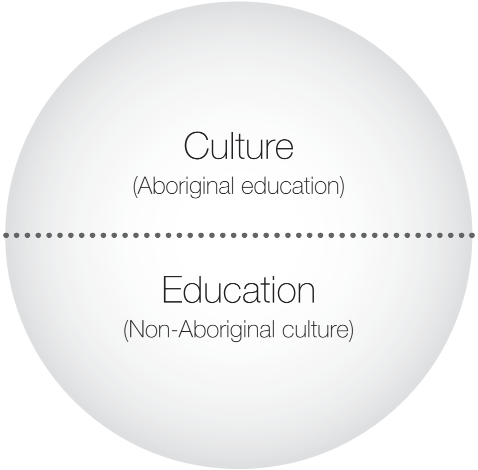
The histories of colonisation and Aboriginal societal responses are an integral part of understanding the changed status of Aboriginal health. In the table below, we have tried to present this schematically, to show a series of transitions from one health–education situation to another. It is important to include this time dimension into the model, because both health status and educational experiences, and the interaction between them, have effects that reverberate throughout an individual's life-course and on to subsequent generations. For example, the falling infant mortality rate in the 1970s translates in subsequent decades to an increased demand on the education and health systems; but, at the same time, the high infant mortality rate from previous decades has reduced the number of traditional education and health leaders available to deal with this.

TABLE 1: **History, health and education**

Period	Health	Education
Pre-Colonisation	High infant mortality Otherwise fit and healthy people Some violence	Aboriginal law and culture—Indigenous education system
Early Colonisation	High mortality from infectious disease, violent conflict over land/resources	Aboriginal education persists, but under stress
Forced Settlements	Decline in economic activity—poor nutrition, decline in activity Overcrowding, high infant mortality	Mainstream education challenges Aboriginal system; mainstream system fails to offer effective alternative to traditional system all but destroyed.
Referendum: 1967–1970s	Decline in infant mortality Early stage of chronic disease epidemic	Resurgence of Aboriginal activism, focus on services, rights, education access limited
1980s	Chronic disease epidemic, rising adult mortality, high fertility	Community controlled organisations, education outcomes remain poor for most Resurgence of Aboriginal law and culture
1990s	High young adult mortality, 60 per cent population under 25 years of age, chronic disease in adults	Education effort nationally, improved access, but poor outcomes Resurgence of Aboriginal law and culture
2000s	Major problem of youth alienation, social dislocation	Slowing in improvements, some reversals (e.g. in higher education

Note that in the above table, we have introduced the idea of an Aboriginal education system maintained through cultural practices to counter the mistaken view that education and traditional culture are two separate things. This view, according to our informants, is itself a barrier to improving educational outcomes. When 'education' is seen as limited to that which is promoted by the dominant non-Aboriginal education system, some young people reject it as becoming 'like whitefellas'. The diagram below tries to illustrate this problem:

DIAGRAM 4: Education and culture



Our view is that education is the means by which culture is replicated. For Aboriginal communities overwhelmed by the dominant settler society, resistance to mainstream education in order to preserve Aboriginal culture may be part of an explanation of poor attendance and lack of commitment by some to schools. For many Aboriginal people, allowing young people to leave their community at twelve or thirteen years of age to go to secondary school means that they will not be around much of the time to participate in Aboriginal ceremonies (shown above as the Aboriginal education system). Further, boys who have been initiated and become men will not go to school and sit with boys who are still boys (i.e. uninitiated), not due to any prohibition, but their choice.

If we accept that education is an important factor in improving health, then these challenges require a strengthened Aboriginal educational leadership at both a system and a local level to ensure that the education system contributes to cultural reproduction in ways that are not only supported by the community, but are also under the control of community leadership. Given the demographic transition that Aboriginal society is now experiencing, which is producing a significant shortfall in the numbers of available adults in proportion to youth, it is unrealistic to expect that an Aboriginal leadership will be able to achieve this alone. Partnerships are required, but ones that are premised on acceptance of Aboriginal leadership. Partnerships may be with others apart from non-Indigenous educationalists.

Finally, a new education strategy must take into account and help communities respond to the main contributors to the current high levels of Aboriginal mortality and morbidity, and the community grief, sorrow and anger that this causes. The following set of diagrams adapted from Bartlett (1999) attempts to illustrate the dynamics in Aboriginal society that link the histories that are so dominant in Aboriginal understandings with the current patterns of Aboriginal morbidity and mortality.

DIAGRAM 5: The cycle of despair and how it is broken

Grief – Anger – Despair Cycle

Colonialism

↓

Devastation of communities through

- Massacres
- Infectious disease (smallpox, influenza, measles, etc.)
- Dispossession of land
- Forced settlement away from country and with different groups
- Taking the children away

↓

Grief – Anger – Despair

↙ ↖

Dysfunctional communities, families, individuals

↙ ↖

Substance abuse, violence, suicide, poor nutrition, child neglect

↘ ↗

Grief – Anger – Despair

↙

How to break the cycle

Dysfunctional communities, families, individuals

↙

Substance abuse, violence, suicide, poor nutrition, child neglect

↙

Community action and solidarity to support individuals/families in crisis

↓

Hope – Optimism – Confidence

↙ ↖

Development of constructive response

↘ ↗

Hope – Optimism – Confidence

When seen from this angle, it is possible to think of education *as an intervention strategy* supporting community action, as well as it being a determinant in its own right. How such an intervention is conceived and implemented may be critical in determining its effectiveness. It must interface clearly with communities' own understanding and their development of constructive responses. The education process should facilitate this.

These models and visual representations have been developed to help illustrate what we have learned about the social determinants of health, in particular education, in ways that facilitate informed discussion with Indigenous leaders working in health service and health development. While they remain a work-in-progress, they have proven to be useful and effective aids in our discussion of the issue of what action—in terms of research and program development—might flow from these understandings.

Research and development priorities

A major aim of the CRCAH's social determinants research is said to be the development of 'effective interventions in policy, planning and service delivery' (CRCAH 2004). In this last section of the paper, we outline three project ideas that fit within this objective. The first is a study of education resource allocation, the second a pilot study of a 'whole-of-community' education for health development program, and the third a professional development program for senior Indigenous health leaders within the CRCAH to enable them to increase their control over the social determinants research agenda and to support community-level health leaders in their work.

Educational resource allocation study

The Education and Health Research Program of the CRCAH's previous incarnation, the CRCATH, identified a number of potential projects. Recommendations for action on these were tabled in a report to the CRCAH Board (Boughton 1999). Subsequent to this, more detailed proposals went forward for some other projects but were not adopted, in part because by that time the funding round was coming to an end. One, which was sponsored by the Central Australian Aboriginal Congress (CAAC) and had wide support including from the Commonwealth and Northern Territory Education Departments, was a study of educational resource allocation. The underlying rationale for this study was that there has

TABLE 2: A simplified model of inequality in educational investment

Sector		Primary	Jnr 2ndary	Snr 2ndary	Tertiary	**Total**
Years of education		7	3	2	3	
Per capita exp.		8000	10,000	15,000	20,000	
Indigenous	Participn %	100%	50%	5%	5%	
	Expenditure	56,000	15,000	1500	3000	75,500
Non-Indig.	Participn %	100%	90%	70%	30%	
	Expenditure	56,000	27,000	21,000	18,000	122,000
Per capita shortfall						**46,500**

been a systematic ‘under-investment’ in education within Indigenous communities over several decades, because Indigenous people historically have not participated in formal education at anything like the rate of non-Indigenous people. A study by the CAAC suggested that, if the Indigenous community had a high school retention rate equal to the non-Indigenous rate of 60 per cent, its young people would be the beneficiaries of an additional $45 million in education investment over a five-year period (CAAC & Boughton 2001). The CAAC continues to argue that quantifying that under-investment more rigorously is the first step towards negotiating a different approach to the problem of non-Indigenous participation in education.

More recent work shows that the combined net public expenditure on someone who graduates from medicine (i.e. for thirteen years of schooling plus a medical degree) is more than $170,000. By comparison, a student who leaves school at year 9 and does no further education has had only around $75,000 of public money spent on his or her education (Burke & Long 2003). The table below, developed by one of the authors of that study, illustrates the results of applying a simple model to calculate the shortfall in per capita investment, at today’s prices, of a mythical average Indigenous person’s education level relative to a mythical average non-Indigenous person’s education level.

This figure, of course, does not make sense in relation to individuals, but does when multiplied out to a community or population level. An average community would have this shortfall in the level of investment in its education hundreds of times over. Moreover, the table is based on the upper end of education participation by Indigenous people; in rural and remote communities the inequality would be significantly higher. The quantum of this under-investment, we suggest, can be linked directly to ‘over-investment’ required by ‘downstream’ services that are forced to ‘pick up the pieces’, including in the health system, the justice system and the welfare system. More importantly, it translates into much higher costs for the community in terms of the burden of illness, mortality, grief and socio-economic disadvantage.

To date, efforts to overcome educational inequality have revolved around spending more money ‘inside’ the education system to try and attract more people. It is no less logical to consider moving some of the investment *out of the mainstream education system*, for example, into Aboriginal community-controlled programs more suited to the needs of the ‘non-participants’ and their communities. The first stage, however, is to get some indication of the relative inequity in educational expenditure between Indigenous and non-Indigenous populations. The proposal to the CRCATH was to do this for the Northern Territory only, but such a study could include other jurisdictions. The value of such a study is that it locates the problem of Indigenous educational disadvantage not with the non-participating individuals and families, but with the system of educational resource allocation that fails to invest in education programs appropriate to its Indigenous citizens’ needs.

Community health development leadership education program

The question was raised above about the relationship between research, education and Indigenous leadership. The existing national Indigenous health leadership grew from a 1970s grassroots primary healthcare movement, which mobilised in its own communities to advocate for improved health services to be developed under community control. It was this experience that taught the health leadership how to interact with the mainstream health system. In the absence of a similar mobilisation, it is unlikely that a new generation of health leaders will come forward. The project proposed here is to pilot a method of developing local grassroots leadership mobilisation in communities with relatively low levels of literacy and formal education, while simultaneously adapting a methodology utilised by development agencies working in Third World countries. This methodology, known generally as popular education, works with adults to identify both the issues and problems within their communities as well as the local resources they have at their disposal to address them. One of its most successful forms, known as the REFLECT program, combines the insights of Paulo Freire's literacy programs in both Brazil and Guinea-Bissau with the methods of Participatory Rural Appraisal (PRA)[7]. Its success overseas in developing a grassroots leadership, including in primary healthcare, has been widely documented, but as yet it has not been used in an Australian context. We propose that the CRCAH run this program as an experiment in one or more communities, and evaluate the contribution it makes to the emergence of a more effective leadership for health development. If it is as successful as it has proved overseas, it might then be the kind of intervention that the government could take up more systematically.

National leadership program

The experience of this small project has taught us that one of the major obstacles to addressing the social determinants of health is that the existing Indigenous health leadership, which operates at the higher levels of policy, planning, and service management and development, is itself significantly under-resourced. Participants in the dialogue of this project had initially seen the CRCATH, and later the CRCAH, as the means to overcome this problem, but things have not, in general, turned out that way. The leaders who took part in this dialogue feel they have not as yet gained any real control over the research agenda, nor has the research played any significant role in terms of informing their own practice. We have identified a number of reasons for this, including the pressures that both health service management and policy development exert: pressures that divert scarce intellectual capacity away from health development towards the immediately pressing needs of service development. The danger is that while leaders are tied up resourcing the development of health services and systems, they will not be able to build their capacity to resource wider health development strategies.

The current CRCAH could help to rectify this imbalance by building into the social determinants of health research program a systematic and structured program of release time and professional development for the Indigenous health service leadership. This should include funding to enable that leadership to employ their own chosen researchers on an as-needs basis to assist them to find out what it is they need to know.

However, health leaders cannot be expected to turn around the education system. One proposal suggested by the Indigenous health leaders who took part in this project is for a national education summit, a dialogue with Indigenous education leaders. Whether this is an appropriate intervention for the CRCAH to sponsor will be a matter of debate. However, given the involvement of a significant number of universities, and of the Australian Institute of Aboriginal and Torres Strait Islander Studies which has is own education research program, it may be worth pursuing.

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[7] Participatory rural appraisal (PRA) is a label given to a growing family of participatory approaches and methods that emphasize local knowledge and enable local people to make their own appraisal, analysis, and plans. See http://www.worldbank.org/wbi/sourcebook/sba104.htm.

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Chapter 4: You Can't Have One without the Other—Transactions between Education and Wellbeing for Indigenous Peoples

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Introduction

This chapter was written in a spirit of collaboration involving Indigenous and non-Indigenous teachers and researchers. The ideas it contains were generated in the course of a series of shared meals involving the authors, at which lively discussion centred around educational and wellbeing issues affecting Indigenous peoples.

We start with a story from one of our authors that tells about the possibility of change. The need for change is highlighted by a short review of the dire situation in health and education for many Indigenous peoples. We argue firstly for a recognition of the importance of transactions, or reciprocal relations, among elements of complex systems such as education and health. We review existing literature on the education–health nexus and consider the applicability of extant research findings to the situations of Indigenous Australians. We then consider contemporary issues in education, such as constructivism and self-regulated learning, with a view to considering how these might inform recommendations for change. A number of areas where change could be effected are then discussed. The first of these involves re-conceptualisation of the multi-level system that influences outcomes in education and wellbeing. Change is also required in the theoretical perspectives used to inform the educational research agenda, in consideration of where, and with whom, educational efforts might be made. We consider how recent research on conceptual change might provoke new locations and imperatives for educational action. Finally, we recommend areas for future research such that ensuing practices are founded on good quality knowledge.

The themes in Uncle Badger's story are central to this paper. We do need to look after our country and the people in it. The urgent need to look after people is made very clear when we consider the statistics related to the health and education of Indigenous groups. We do need to work together, not only as individuals, but also as a social system. In addition, like both Kim and Uncle Badger in the above story, as a nation we need to be prepared to learn and to have the courage to change.

Uncle Badger’s story

As told by Kim O’Donnell of the Barkindji people of western New South Wales

I’d like to share a story with you about my Uncle Badger. It’s a story about changing mind-set and how a conversation about making connections, respect, the need for positive male role models in our family and breaking down barriers has made a difference in the way my Uncle ‘does business’.

Four years ago, I travelled home to Wilcannia for my cousin’s funeral. He was in his early twenties and had taken his own life after his girlfriend ended their relationship. All the family was at a loss as to how this could have happened—after all, he had a permanent job, his own car, his own place to rent, plenty of family to stay with no matter where he travelled and people who loved and cared for him.

A day after the funeral, I visited Uncle Badger and we yarned over a few bottles of red, trying to understand what happened. We talked, we argued, we listened to each other, we cried together, we swore and, in between, we managed to have some good belly laughs. By this stage, I felt comfortable enough to confront Uncle Badger and let him know how disappointed I feel when I see my uncles arguing and swearing aggressively at each other, all because they have different opinions and different ways of dealing with things. I pointed out that nothing gets done when he (Uncle Badger) tells people to go and get stuffed and then walks out in the middle of a meeting. (Uncle used a more expletive word here but it would be inappropriate for me to repeat it. I’m sure you have all used this word from time to time.)

I said, ‘Bloody hell, if you and Uncle showed some respect for each other and made a pact to listen and work together to resolve your problems, you’d move mountains! You’re so bloody competitive against each other and your actions do bugger-all to encourage or help our young people. You are not positive role models for our young boys when you carry on like that. They see it as acceptable behaviour and react in the same way to confrontation.’

I said, ‘How the hell are we supposed to break down the barriers between blackfellas and whitefellas and work together when we can’t break down the barriers between ourselves or be decent role models for our children. Can’t you see, Uncle? Our people’s health has gotten worse over the last twenty-five years. There’s a huge service industry built on improving Aboriginal health. All these services out there but they’re not connected—they’re too busy competing against each other for the power and resources, just like you and Uncle and our people continue to fall through the gaps.’

He roused on me and said that I shouldn’t speak to my Elder that way and that I was disrespectful. I said, ‘Uncle, ya gotta give respect to earn respect’.

After that comment, I thought, well, there goes my bed for the night—I’ll have to camp outside.

About two months later, another family meeting was held. Unfortunately I couldn’t make it. However, I heard on the grapevine how proud my family was of Uncle Badger. Instead of getting angry and walking out when someone disagreed with his point of view, he was the one who stood up when tempers flared, and reminded everyone that it was important to respect each other’s opinions, to listen to each other and not interrupt when someone was speaking and that we needed to work together. He ended with, ‘How are we supposed to break down the barriers between us and white fellas when we keep fighting among ourselves. We gotta work together.’

When I rang my Uncle to ask his permission to tell this story, he replied, ‘Yeah, niece, you can tell it and you can tell them fellas this message from Uncle Badger, too: We all Australians, but Aboriginal people were here first then white people came along. Now, we all gotta sit down and come to some agreement how we can all look after our country and respect Aboriginal culture.’

Enduring expectations

In the 1968 Boyer Lectures, Stanner (1969) discusses how white people's colonisation of Aboriginal land and appalling treatment of Aboriginal peoples was based upon the incorrect assumption that Australian land was without ownership. Colonisation decimated the Aboriginal peoples' deep wells of cultural, scientific and spiritual knowledge, disempowered their complex social networks, and marginalised Aboriginal peoples and their issues. However, Stanner also felt that following the 1967 referendum, which supported equal suffrage for Aboriginal peoples and the development of a new swell of awareness in the general populace, that Aboriginal peoples would re-enter Australian society with greater prominence. Stanner writes:

> *development over the next fifty years will need to change its style and philosophy if the outcome is to be very different. I have begun to allow myself to believe that there is now a credible prospect of that happening (1969:28).*

Twenty-five years later, another series of Boyer Lectures included papers by Noel Pearson (1994), executive director of the Cape York Land Council, and Manduway Yunupingu (1994), lead singer in Yothu Yindi, traditional owner of Gumatj land and principal of Yirrkala school. Pearson refers to 'The shameful health, sanitation, educational, employment and housing conditions of black Australians' (1994:100).

Like Stanner, Pearson also showed optimism, drawing attention to the High Court's finding in the 1992 Mabo case, that British Crown sovereignty over Australia did not extinguish 'the beneficial title of the Indigenous inhabitants which they held under their own laws and customs' (Pearson 1994:97).

> *For many Australians both black and white, Mabo represents an opportunity for the achievement of a greater national resolution of the question of Aboriginal land rights, and an improvement in relations between new and old of this land, a first step in a new direction which might yield the changes necessary for Indigenous people to be genuinely re-possessed of their inheritance (Pearson 1994:98).*

Yunupingu (1994) also speaks with optimism about finding a balance between different cultures' ways of knowing, between traditional Indigenous education and European-style education, and about respecting the contributions of immigrants and the original inhabitants of Australia.

Despite the optimism of these commentators across several decades, the situation of Indigenous peoples in health and education has not shown marked improvement: Pearson's 'shameful conditions' assessment still applies.

The statistics

The current health-related statistics for the Indigenous peoples of Australia have shown little improvement in the past twenty-five to thirty years (Peachey 2003). Disease rates for Indigenous Australians are many times those of non-Indigenous Australians (ABS 2005). From 1999–2003, Indigenous men and women died at almost three times the rate of their non-Indigenous counterparts, and also had higher rates of mortality from all major causes of death. For example, mortality rates for Indigenous males and females for endocrine, nutritional and metabolic diseases (including diabetes) were around seven and eleven times those for non-Indigenous males and females (ABS 2005). The average age of death for an Indigenous male is 59.4 years and 64.8 years for an Indigenous woman, which is approximately seventeen years less than the average age in the total population (Health*InfoNet* 2004).

The statistical picture of Indigenous peoples' education is worrying. McRae *et al*. (2002) and a recent Australian Bureau of Statistics report (ABS 2005) both report positive findings, pointing out that Indigenous peoples' participation in early childhood and primary schooling has improved dramatically: Year 12 retention rates have increased, from under 29.2 per cent in 1996 to about 39.5 per cent in 2004, and participation rates of fifteen- to twenty-four year-old Indigenous students in vocational training approximately equate with those of the total population.

However, these same sources also provide statistics indicating that, compared with non-Indigenous students, Indigenous Australians, among other things:

- are less likely to attend preschool;
- fall well behind mainstream rates in literacy and numeracy skills development before leaving primary school;
- have less access to secondary school in their communities;
- leave school much earlier;
- are less than half as likely to complete Year 12;
- are more likely to be taking bridging and basic entry programs in universities and vocational education programs;
- are under-represented in higher education, with the rate of participation remaining static across 1997–2003; and
- obtain fewer and lower-level qualifications (McRae *et al*. 2002:5).

There is much ground to be made up if the following objective in the Adelaide Declaration on National Goals for Schooling is to be achieved: '[That] Aboriginal and Torres Strait Islander students have equitable access to, and opportunities in, schooling so that their learning outcomes improve and, over time, match those of other students' (MCEETYA 1999:3).

Health as wellbeing

In its constitution adopted on 22 July 1946, the World Health Organization (WHO) stated that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, political belief, economic or social condition,' and defined health as 'a state of complete physical, social and emotional wellbeing and not just the absence of disease or infirmity' (Commonwealth of Australia Department of External Affairs 1948). Thus, as a signatory to the WHO constitution, Australia agrees that health is a human right and that this right includes the creation of good health, not just dealing with disease after it arises. Health business is, therefore, not solely the responsibility of those who cure disease; the creation of positive health outcomes requires the participation of a range of individuals, groups, institutions, government departments, educators and Indigenous communities themselves.

It is still the case, however, that much 'health' data does not reflect the WHO positive definition, and provides limited information upon which to base policies and programs. In the case of Indigenous peoples, Kirke and colleagues (1993) argue that clinical parameters of morbidity and mortality are inadequate indicators of health status because they neither show people in connection with their community and the wider environment, nor reveal the positive aspects of community life (Peppard 2002:187). Recognising the limitations of biomedical approaches to health data collection, Kreiger proposes an eco-social model 'which specifies a range of questions about social structure, cultural norms, ecologic milieu… [that] directs epidemiologists to think about individuals in the context of their everyday lives, as shaped by their intertwined histories' (Kreiger 1994:897).

Kreiger's writing has much in common with the 1946 WHO constitution and with the 1999 WHO Declaration on the Health and Survival of Indigenous Peoples:

> *Indigenous people's concept of health and survival is both a collective and an inter-generational continuum encompassing a holistic perspective incorporating four distinct shared dimensions of life. These dimensions are the spiritual, the intellectual, the physical, and emotional. Linking these four fundamental dimensions, health and survival, manifests itself on multiple levels where the past, present, and future co-exist simultaneously (cited in Durie 2003:510).*

Kreiger points out that the health of all organisms is interconnected and emphasised the need:

> *to shift discussion away from the term person when what is really meant is social group and shift attention away from the notion of 'special' group to focus on what makes populations 'special'—their enforced marginalisation from positions of power (Kreiger 1994:898–9).*

Importantly:

> *In Aboriginal terms, being 'healthy' is understood to encompass the wellbeing of an individual within his or her total environment, including the extended family and community. Health business includes matters such as regaining tenure over tribal lands, ensuring kids have tucker, being able to undertake social responsibilities and participate in ceremonial life (Kirke et al. 1993:99).*

Thus, although inequalities in health status are a measure of the comparative quality of the health systems (Durie 2003), the determinants of wellbeing are not located solely in those systems. Instead, these determinants are embedded in the overall social structure, in political, economic and educational systems, in cultural imperatives, and in local community and Indigenous and non-Indigenous peoples' actions (Boughton 2000; Durie 2003; Jackson & Ward 1999; Malin & CRCATH 2003; Wilkinson & Marmot 2003).

Wilkinson and Marmot (2003) through their analysis of thousands of research studies, some of which followed tens of thousands of people over decades, identify ten social determinants of health. Their work is particularly salient for Indigenous Australians because, arguably, all of those social determinants are relevant to them due to the occupation of their country, their decimation by European diseases and a succession of government policies that removed not only their land and means of livelihood, but also their children. In addition, policies that devalued Indigenous cultures led to loss of languages and traditions and the interruption of the transmission of cultural knowledge.

Wilkinson and Marmot describe a social gradient, where the more disadvantage a group experiences, the shorter the life expectancy and the more diseases they experience: 'The longer people live in stressful economic and social circumstances, the greater the physiological wear and tear they suffer, and the less likely they are to enjoy a healthy old age' (Wilkinson & Marmot 2003:10).

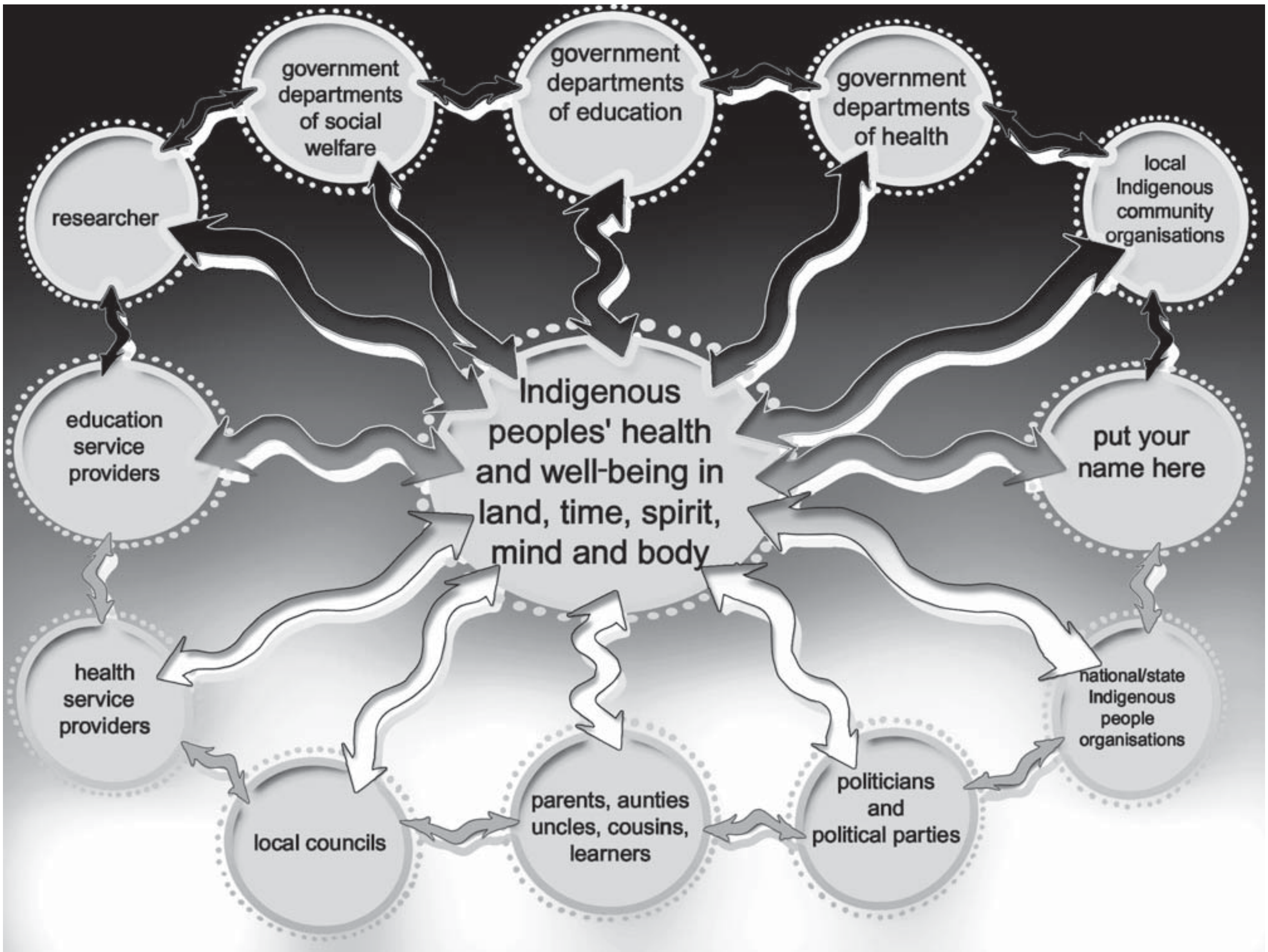
The social determinants of health include the lifelong importance of 'early childhood and the effects of poverty, drugs, working conditions, unemployment, social support, good food and transport policy' and social exclusion (Wilkinson & Marmot 2003:7). In particular, Wilkinson and Marmot (2003:16) demonstrated that social exclusion results from 'racism, discrimination, stigmatization, hostility and unemployment' and 'these processes prevent people from participating in education and training, and gaining access to services and citizenship activities'. In a similar vein, Boughton (1999; 2000) argues that the nature of the structures that sustain the process of marginalisation of Indigenous peoples, and their limited participation in education, needs to be examined.

A transactional model of relationships

In light of the above discussion of the social determinants of health, we suggest that the current education–wellbeing relationship for Indigenous peoples needs to be reconceptualised so that it is situated within a broader system, whereby the various components are mutually regulating. Our attempt to represent this transactional system (see Figure 1) suggests that explicit recognition of complex patterns of relationships must be the starting point for any action in Indigenous education that is expected to bring about change in health status. The transactional nature of education and wellbeing implies that the influence of education needs to be identified at the points of intersection of multiple relationships. If the influence of education is considered to be confined to one sphere, such as schooling, our conceptualisation in Figure 1 suggests that such influence will, at best, have only a limited impact on wellbeing. Further, if the influence of education on wellbeing is isolated from the other sets of influences shown in Figure 1, it seems unlikely that the current situation will improve very quickly.

Figure 1 is not an exhaustive representation of all potential stakeholders and their relationships in this field. However, it does go some way towards illustrating that education is part of a multidimensional and interacting network of relationships associated with wellbeing. Some analyses of the role of education in Indigenous affairs tend to underplay this complexity. For example, although the Adelaide Declaration on National Goals for Schooling recognises the pathway from education to employment, it does not highlight a pathway from education to wellbeing. And conceptualisation of the education–wellbeing relationship as a complex interactive system brings into consideration health issues that impact upon education. For example, the National Inquiry into Rural and Remote Education (HREOC 2000) heard evidence about high rates of disability and illness that affected Indigenous students' attendance and ability to learn at school. Malnutrition, hepatitis B, anaemia, vision disabilities and hearing disabilities all disproportionately affect Indigenous students and impact upon their educational outcomes.

FIGURE 1: A transactional model of relationships impacting upon Indigenous peoples' wellbeing



It is also important to realise that the education–wellbeing transaction does not only operate at an individual level of influence. Healthy communities also influence educational outcomes. The National Enquiry into Rural and Remote Education observed that 'where parents and community members play an active and decision-making role in the school, students enjoy their schooling and feel optimistic about their current and future prospects' (HREOC 2000:57).

Evidence of the importance of parental and community support for students' educational outcomes is also shown in Mercurio and Clayton's (2001) analysis of the reasons underlying the success of Aboriginal students who completed the South Australian Certificate of Education.

Prior research on the education–wellbeing relationship

At a general level there is support for the view that higher levels of educational attainment are associated with better health status (ABS 2005). However, both the factors contributing to this association and the degree to which it can be applied to the Australian Indigenous population remain areas for future research.

Caldwell (1989) identifies two kinds of evidence of the relationship between education and infant and child mortality. The first is that as parental education increases, infant and child mortality declines (Boughton 2000; Caldwell 1989;

Caldwell, Reddy & Caldwell 1989; Lindenbaum, Chakraborty & Elias 1989; Simons 1989). The second body of evidence is that increased levels of education in the whole society lead to decreased infant mortality. Indeed, infant mortality and life expectancy are more closely related to formal education than any other characteristic, including health inputs, nutrition and income (Caldwell 1989).

Caldwell (1989) proposes that studies of third world populations suggest that a key effect of increased education upon health is the development of greater autonomy among female students, which leads to women being more willing to use health services, more confident in asking staff attend to their children and better able to adhere to practitioners' directions. However, other explanations are also possible, as would be expected in a transactional system. For example, in the third world studies, educated women were seen to be more likely to gain better paid employment and/or to marry educated or more financially well-positioned husbands. Such changing circumstances could lead to one or more whole-of-life improvements, such as better living conditions, less onerous physical work, improved maternal and child nutrition, later age pregnancies, higher birth-weights and subsequently better infant and child health (Cleland & Jerome 1989; Lindenbaum, Chakraborty & Elias 1989).

It is also important to recognise, as Lindenbaum and colleagues (1989) point out, that the education–health relationship might not be simple and direct, but may be mediated through learned school-embedded attitudes and behaviours. For example, the third world, schooled mothers in the studies by Lindenbaum and colleagues knew that it was a good idea to take their sick children to health care centres. They also engaged in behaviours such as hand-washing, not because of an underlying germ-theory of disease, but as a valued pattern of schooled behaviour. Similarly, Caldwell (1989) suggests that the impact of mass health promotion interventions were due less to the health promoting content of what is taught, and more to the new self-perceptions that educated parents develop about their capabilities.

However, existing research needs to be re-examined from two perspectives. The first is to consider whether the increased education–better health relationship found in third world populations holds true for the fourth world—the world of the dispossessed minority Indigenous peoples of Australia (and other countries) (Boughton 2000; Gray, Boughton & CRCATH 2001). And if such or similar relationships do hold with Australian Indigenous populations, the second consideration is, What are the components of education that contribute to the education–health dimension? (Caldwell 1989; Simons 1989; Tsey *et al*. 2003).

Applicability to Indigenous Australians

In relation to the first issue, McInerney (1991) draws attention to the inappropriate practice of extrapolating theories, principles and methodologies that were originally grounded in American and Western European populations to other societies and cultures. Resulting deficit explanations of minority group poor performances compared to Western norms divert attention away from deficiencies in the education systems. McInerney also calls into question the practice of extrapolating results found in one Indigenous community to other Indigenous communities.

For example, although Caldwell (1989) proposes a linear relationship between more education and better health, Gray and colleagues (cited in Gray, Boughton & CRCATH 2001) found a non-linear relationship between the level of education of Australian Indigenous women and the survival of their children. Although, the lowest survival of children was for least educated mothers, the highest child survival was for mothers who left school at age fifteen, not for more educated mothers. It may be, as Gray speculates, that the non-linear result was an artifact of the data, in that mothers with more schooling provided more detailed responses, creating the impression that their children were at a greater risk of death. The lack of research that would clarify this situation reinforces the view put by Gray and colleagues (2001) that little other research into the education–wellbeing relationship has been undertaken among Indigenous peoples living as minorities in first world countries, which is the case for Indigenous peoples in Australia.

There is also a possibility that the positive health effects of schooling that have been found in third world populations may be cancelled out for Australia's Indigenous peoples because of the socially exclusionary policies and practices that extend to school classrooms (Malin & CRCATH 2003).

Indigenous Australians are enrolled in schools that they may view as belonging to a society from which they are excluded. In this regard, Boughton (2000) points to the danger of ascribing disadvantage to Aboriginality, rather than to disadvantage *per se*, thus racialising explanatory frameworks and engendering a 'blame the victim' effect. Crude representation of the issue in this way can also mask 'the enormous differences, in terms of needs and aspirations, and of programs required' (Boughton 2000:5).

These perspectives indicate that there is a need to reconsider how the education–wellbeing relationship is viewed at a broad, macro level. There is a similar need to consider how education and wellbeing relate at a much more specific level. For example, the sometimes inordinate demands made by government organisations on people's English literacy skills and knowledge of processes can have the effect of preventing young people, parents and communities from making applications for, and thus gaining access to, funding for educational and other programs (Alston & Kent 2003).

Influences at the specific level are also evident when considering the way people perceive their own capabilities. Self-capability is central to Simon's (1989) proposition that an individual's attributions to the cause of, and sense of control over, life events play a key role in the impact of education on health outcomes. Patterns of attribution of cause, including attributions about the locus of control for outcomes, may be adaptive or maladaptive to effective functioning as an individual and in society (Graham 1991; Weiner 1985). Thus, control and empowerment cannot be ignored in discussions of Indigenous peoples' health (Malin & CRCATH 2003; Tsey *et al*. 2003) and education (Boughton 1999, 2000).

The complexity of the education–wellbeing relationship is further illustrated if one considers the issues affecting Indigenous students' capacity to complete secondary schooling. These include: institutional peer and teacher racism in school environments; ineffective racial harassment policies; ineffective grievance procedures; lack of respect and value for all cultures; poor communication processes with individuals, peers, parents and communities; confusion about the roles of Aboriginal education workers; the need for cultural awareness training of teachers and counsellors; the need for support structures such as dedicated spaces for Indigenous students' homework and tutoring assistance; population transience; and poverty (Rigney, Rigney & Hughes 1998). The range of factors in this list reinforces the need to conceptualise that the education–wellbeing relationship exists within a complex network of relationships.

Another example is provided by findings from a Department of Human Services and Flinders University collaborative research project (Slee & Murray-Harvey, in press) involving 500 families living in urban South Australia who were identified by the Socio-Economic Index for Areas (ABS 2004) as living in areas of relative socio-economic disadvantage. The sample included 7 per cent of parents and 11 per cent of children (0–7 years) who identified as Aboriginal or Torres Strait Islander peoples. The study established a link between education, poverty and child health outcomes; in particular that low education and financial hardship were significantly related to poor child health outcomes. The higher the percentage of parents with less than nine years of schooling, the higher the percentage of families reporting problems/concerns for their children in the physical domain, and the higher the percentage of families with problems/concerns. Similarly, the higher the percentage of families reporting that they cannot make financial ends meet, the higher the percentage of families with children reported as having developmental problems/concerns.

This above discussion illustrates that there is much to be discovered about the education–wellbeing relationship in the Indigenous population. As well as extending what is known about the impact of wellbeing on education and education on wellbeing, there is a need to explore the relationships with other influences such as those included in Figure 1. In addition there is a need to base future research on a more comprehensive and explanatory, and therefore more powerful, representation of the nature of learning and teaching. In the next section we outline key components of such a representation.

Contemporary perspectives on learning and teaching

Situated learning

It is striking that much of the existing literature on the education-health relationship that is based upon sociological, anthropological and policy research identifies themes that are also central to contemporary psychological analyses of learning and teaching. In this latter body of knowledge, represented in the broad overviews presented in texts like that of Bruning, Schraw, Norby and Ronning (2004) and McInerney and McInerney (2002), learning and teaching are represented as situated, socio-cultural activities focussed on the development of self-regulated learners who will be confident and persistent problem solvers in school and in their adult lives. The goal for education, from a situated learning perspective, is to enable students to develop the knowledge, skills and attitudes that will allow them to exert what Bruner (1996) refers to as 'agency'—the ability to act effectively in their interactions with the worlds in which they live and work.

Active learning

A second key principle in the educational literature is that learners build powerful, well-connected structures of motivation, knowledge and belief based upon the foundations of what they already know. The general term for this concept is psychological constructivism (Phillips 2000), although within this general term there are variations in approach. From a psychological constructivist perspective, the learner is not a passive observer of people and events who is acting like a sponge absorbing water; rather, the learner is an active agent in his or her own learning, 'continuously involved in cognition about self and environment' (Winne & Butler 1994:5738).

> *Students must… create meaning for themselves and… (these meanings)… are not simply a function of what teachers intend them to learn. Students make meaning from the tools they bring with them… the backlogs of their experiences and the 'languages' they know how to use. (Eisner 2000:344)*

Self-regulated learning

To a significant extent, all learning is under the control of the learner. This is particularly evident when we consider learners' motivations for engagement in school. Students must have both an appropriate level of expectancy that their efforts to learn will be rewarded, and an incentive to engage with the learning task (Feather 1982). It is also clear that students' levels of self-efficacy and their patterns of attribution for the causes of success and failure (Weiner 1985) will influence their engagement and persistence in the face of difficulty. Where students' motivations are not adaptive for a learning task, it is likely that they *will* exercise control, and decide not to engage with the task. McInerney's analysis suggests that the variables which influenced Indigenous students' levels of motivation at school and their decisions to continue beyond the minimum leaving age were centred on the 'sense of self: self-reliance confidence and goal direction' (1991:167). Like Mercurio and Clayton (2001), McInerney argues that the sense of self of the Indigenous students in his study was buttressed by parental and school community support.

Consideration of the self-regulated nature of learning indicates that we also need to be concerned about whether students know how to be effective learners in school and in other contexts. Often we overlook the important fact that knowledge of how to go about learning, and of how to carry out different learning activities, is not an automatic outcome of experience in learning. Effective learning depends on the sensitive recognition of the existing situation of the learner. In making this point, we are arguing that the 'existing situation' of the learner needs to be seen as a broad life situation that includes:

- the learner's beliefs about self, society and about schooling;
- current family and community situations;
- goals and expectations for participation in school and beyond;
- current knowledge and skills about how to learn;
- current curriculum-related knowledge and skills; and
- the nature of the educational environment that supports learning.

Teaching based upon psychological constructivist principles of learning

In most respects, constructivist perspectives on learning are neither all that new nor all that radical. However, the implications for teaching of the constructivist view of learning have been more problematic. Some educators have interpreted a psychological constructivist approach to teaching as necessitating a reliance on a 'pure' discovery procedure in which students assume a major responsibility for directing their learning. Mayer (2004) argues strongly that not only is such an interpretation misguided, but that it results in inferior outcomes for students compared to teaching approaches, where teachers retain major responsibility for guiding learning. Mayer proposes that:

> *there is increasing evidence that effective methods for promoting constructivist learning involve cognitive activity*

> *rather than behavioral activity, instructional guidance rather than pure discovery, and curricular focus rather than unstructured exploration (2004:14).*

What seems to be lacking is evidence about the widespread application of teaching approaches that are compatible with soundly based constructivist perspectives on learning. If such application was widespread, then many of the points of criticism made of educational practices in Aboriginal schools in research—such as that of Groome (1995), Harris (1990) and Malin and CRCATH (2003)—would not have been needed. Some of those criticisms suggest that some schooling practice has not been based on a sensitive analysis of Indigenous students' life situations. For example, pedagogical approaches that begin with the idea that Indigenous students are somehow 'deficient' typically result in ignoring or devaluing the strengths and prior knowledge that Indigenous students bring to the learning experience. This is poor quality teaching.

All students have idiosyncratic subject-matter knowledge and world-views that will affect how they interpret new information. If information is presented in a way that does not consider Indigenous people's world-views, it is likely to be poorly integrated into their mental models about health and wellbeing. One example of this is the application of Western scientific paradigms to health and disease, while ignoring a holistic concept of health as wellbeing at all levels of land, spirituality, community and individuals (Slee & Shute 2003). Many more specific examples of missing or shattered links between prior knowledge and new knowledge are provided by Trudgen's (2003) accounts of the health-related education for Yolhu people. To rebuild those links, Trudgen suggests employing the basic principles of a constructivist approach to teaching, such as using the Yolhu people's existing knowledge about the life-cycle of turtles to scaffold the acquisition of new knowledge about the life-cycle of skin parasites.

Related to this, Hughes and More (1997) argue that differing cultural backgrounds provide differing learning experiences that may lead students to develop, and to prefer, certain learning styles or approaches over others. The learning style debate rages in contemporary literature, with proponents for and against the idea that people have different ways of processing information and different preferences for accessing information. A recent study by Mayer and Massa (2003) suggests that while some claims about differing learning styles lack supporting evidence, some research does suggest individual differences in cognitive styles and learning preferences along a visual to verbal dimension. It is the task of all teachers to: (1) enable students to develop a range of learning styles and strategies that can be flexibly employed to suit varying tasks over varying contexts; and (2) design and deliver instructional interventions that are responsive to the learning styles and approaches of their students (Hughes & More 1997; Mayer & Massa 2003).

There are clear implications for teacher education. Tertiary teachers must provide opportunities for prospective teachers to learn about Aboriginal culture from Aboriginal perspectives, and also to give prospective teachers opportunities to reflect on their own cultures, beliefs and attitudes and how these might impact on the education and wellbeing of Aboriginal peoples. A recent Cultural Diversity and Inclusive Practice initiative at Flinders University provides one example of progress in this area: staff of Yunggorrendi are preparing a teaching resource for teacher educators that includes strategies designed to assist the process of incorporating Indigenous perspectives into key learning areas (CDIP 2005).

Distributed knowledge

Although knowledge is relatively easy to conceptualise as residing inside an individual's head, we must also consider the existing knowledge held by groups of people: knowledge that constitutes a community's or an organisation's distributed expertise (Wenger 1998). Where community knowledge has been developed with a sense of ownership and control, and where it has been explored and elaborated in community discussions, it is likely to be well connected and useful for addressing community problems. Community groups and organisations that have impoverished or poorly connected knowledge do not have a strong foundation upon which to build new knowledge. This points once again to the importance of connectedness, represented in the need to develop strong *relationships*, such that knowledge is distributed within and between individuals and groups, thus enabling change to be carried forward, even when individual people move aside.

Such a group level knowledge structure—be it of a community, a government department or a whole system—can clearly be compromised if parts of it 'go missing'. In the case of Indigenous peoples' education and wellbeing, if politicians, government officials, teachers, health workers and so on, are transient, the expertise that might be available to any one group is constantly changing. With the promotion, transfer, retirement and so on of even one key person in an organisation, valuable explicit and implicit knowledge may be lost. Bureaucracies have a responsibility to their citizens to ensure consistency and continuity in application of policy. Where this does not occur, the developed expertise (Sternberg 1999) that might be available may not be sufficiently sustained over time to implement change or to maintain existing programs. Distributed knowledge is also vitally important when considering the knowledge loss caused by low life expectancy in Indigenous communities and the consequent loss of Elders and their knowledge.

We see a synergy between the representation of learning and teaching outlined here and the transactional system perspective discussed earlier and displayed in Figure 1. There is a need to pursue the educational–wellbeing relationship on multiple fronts. This requires us to consider the essential locations for education related to education and wellbeing.

Sites for educational intervention

Who needs the education?

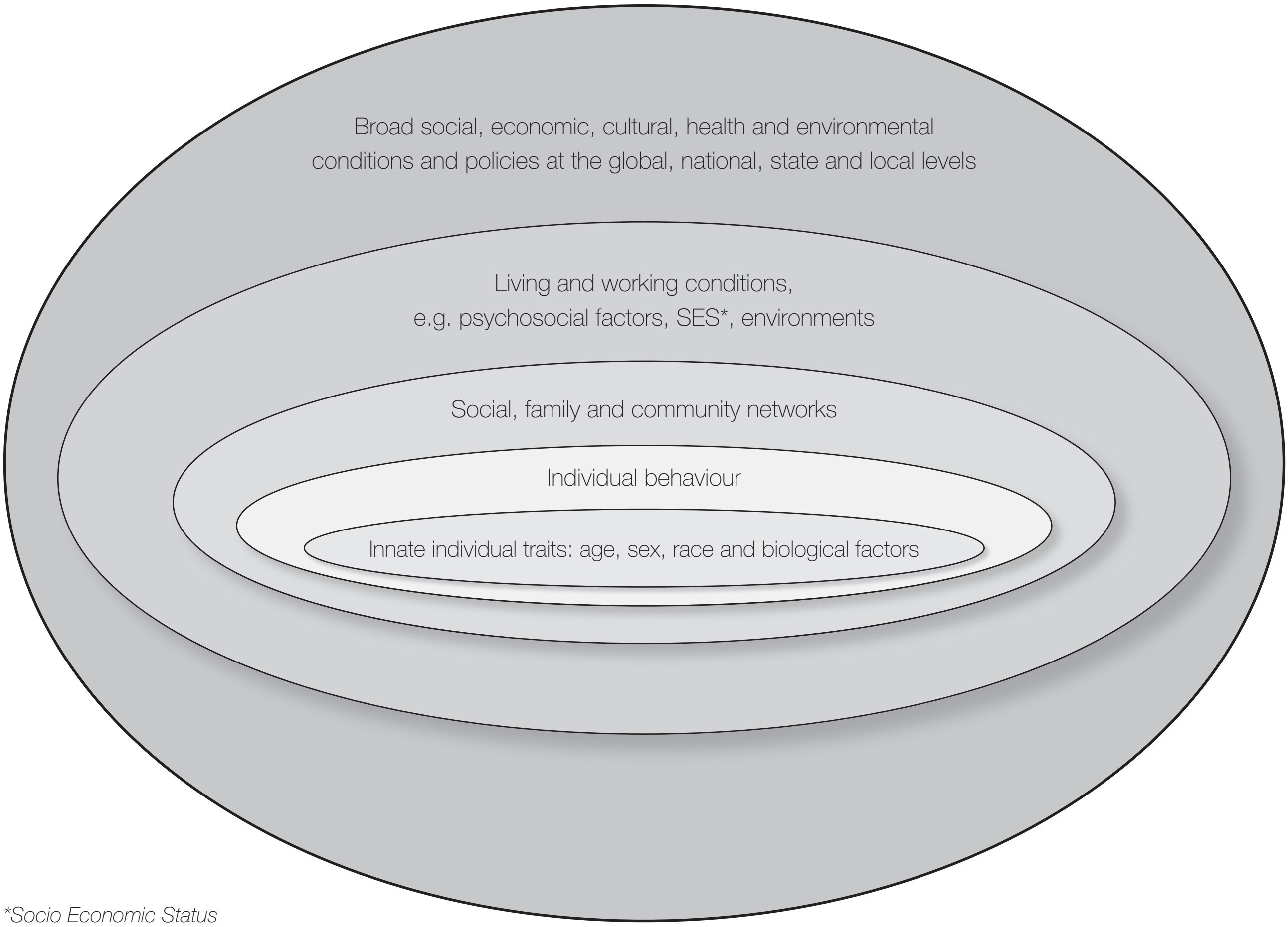
McRae and colleagues begin their treatise on what works in the education of Indigenous students with the statement that: 'Reconciliation of the Indigenous and non-Indigenous peoples of Australia is not a moment or single event. It requires a larger change in attitudes and practices' (2002:i).

Much change is required because, to paraphrase Tsey *et al*. (2003), the *educational* determinants of health are complex and multi-layered, and addressing those determinants needs multi-level thinking and action. In the multi-level representation in Figure 2, possible sites for action exist at inner, middle and outer levels. There must also be action at the interfaces between the levels: working from the inside-out and from the outside-in. As Luke (2004) argues, analysis techniques in many areas of the social sciences have tended to focus on correlations or upon a few variables in linear and/or unidirectional relationships. Such methods have not adequately dealt with effects that occur at different levels of complex systems. A more productive approach to analysis will differentiate between broad level effects, site-specific effects and individual effects. We have nominated possible sites for action in regard to the education–wellbeing relationship in the different levels included in Figure 2. Although beyond the scope of this chapter, it is also important to recognise the influence on education and wellbeing of other components of systems, such as meaningful employment opportunities and support structures.

Figure 2 illustrates that research designs and data analysis procedures must account for the multi-level nature of systems. For example, in school education, young students are nested in classrooms, which are nested in schools, which are nested in communities, which are nested in society. Techniques now exist that permit researchers to account for the effects of influences at different levels of systems. To ignore influences at different levels is poor quality research.

The representation in Figure 2 also shows that education is needed at all levels: for individuals, families, communities, bureaucrats and policy makers. The nested structure of Figure 2 further implies that there should be a high degree of coherence in education at the different levels. Approaches that lack such coherence run the risk of passing one another by, thus limiting their chances of generating any productive outcomes for the system.

FIGURE 2: Sites for action and a model for research and data analysis (adapted from Luke 2004)



**Socio Economic Status*

Educational effects at the inner level

The power of the individual

Uncle Badger's story makes it clear that individuals do have an effect. In that story, Kim was brave enough to talk with her uncle and he was wise enough to learn from her. We hope that we are open and reflective enough to learn from both of them. In other situations, it might be necessary for an individual to take positive action, a message made clear in the following story by Michael Coughlan.

Michael's story reminds us that the influence of individuals, both positive and negative, is always of significance. In this case, it was his determination to move beyond the resistance of some people in the system that led him to enlist the support of a 'big gun' who had a wider vision. As was the case in Uncle Badger's story, this story shows that individuals who have the determination to bring about change can wield great influence. Both Michael and the chairman of the company effected change. This raises the question of what 'guns', big or small, might bring about change in education?

Bringing in the 'BIG GUNS'

As told by Michael Coughlan, a Ngarrindjeri man from the Coorong in South Australia

In 1992, I was approached by the Chairman of Normandy Mining (now Newmont Mining) to join their team and assist them with gaining access for exploration and mining purposes on tracts of land subject to the Aboriginal Lands Right Act (NT) in the Northern Territory. The land is in and around Tennant Creek.

For many years these areas of land had been 'locked up' under the Lands Right Act due to mining and exploration being vetoed earlier by the Traditional Owners. From Normandy's point of view, without access to new areas to explore and mine, their Tennant Creek operations would not be sustainable in the short to medium term.

Major hurdles for Normandy included the attitudes of Traditional Owners to mining in Tennant Creek, the attitudes and behaviours of the Central Land Council towards mining companies in general, past history of conflict between previous mining companies and their pastoral companies with local Warrumungu and Walpiri peoples in Tennant Creek, local non-Indigenous treatment and attitude of Indigenous people, entrenched counter productive values of mining company workers towards Indigenous people and their plight, and other barriers to Indigenous people participating in the mining industry.

My objective for the Chairman was to overcome these barriers and gain land access. To assist, the Chairman accompanied me to Tennant Creek and introduced me to the local management team and to the key stakeholders in the community. The local management team was, clearly, highly loyal to the team leader (the Mine Manager) and the team, clearly, shared the leader's values and at the time appeared to be aligned to the ultimate leader, the Chairman.

After spending some time getting to know the underlying issues, I formed a 'coalface' point of view and subsequently was able to develop a partnership and stakeholder participation model for Tennant Creek with appropriate strategies for clearing obstacles and moving the negotiation positions forward. However, I had some obstacles and one of them was the local team leader who was making Indigenous issues a low priority, and would not lend any support when dealing with the other management team members.

This perplexed me and I started to question whether or not Normandy were serious about their objective, or were they just looking at doing some fancy window dressing. For most people who work or have worked in this field, they too always come to this point, and they either press on with faith, freeze, or flee and withdraw. I chose to press on, but with higher support. In a report to the Chairman I outlined my observations. The Chairman's actions were swift and decisive, he transferred the Mine Manager to a mine site that needed the technical skills of the Manager, and introduced a new Mine Manager who was properly briefed and prepped for the objectives at the Tennant Creek operations.

Instantly, things started making progress. The culture of the management team gradually changed and some of the players changed, the culture of the workforce changed and again so did some of the players. Local Indigenous employment at the mine soared, the attitudes of the Central Land Council changed for the positive, productivity lifted, the towns-folk followed suit and had at least on the surface changed their attitudes and behaviours toward Indigenous people. The subsequent negotiations for land access were a success, and all Normandy's applications were granted as well as other mining companies'. Unfortunately for Normandy, the land access issues were settled about one to two years short of their resources being depleted in Tennant Creek, and therefore they were forced to sell off the assets in 1997–98.

So it just goes to show that you can have all the 'best practices' models, all the latest technology on hand, but it only takes one influential or power broker in the chain to grind it to a halt. A few years after these events, I was watching the opening beach landing scenes to the movie Saving Private Ryan and my thoughts drifted to those days at Normandy, not Normandy beach, but Normandy the company, and I thought how we were like the soldiers undertaking the beach landing, dodging bullets, landmines, hand grenades and initially pinned down by enemy fire until the first bunker fell. Many of the soldiers appeared to be scared to move forward and would eventually die on the beach because of this, if it were not for the big guns pounding the bunkers, the soldiers would not have taken those bunkers on their own. I see Normandy's Chairman as my 'Big Gun'. We have too little [few] 'Big Guns' as leaders in this country, in my opinion, to deal with Indigenous issues the way they should be dealt with.

Students

The preceding description of constructivist approaches to learning assumes that students can develop a sense of agency that will drive change. In addressing this issue in research, one starting point would be to gather information on students' perspectives of their educational and health situations. To ignore the student perspective, and to deny the student voice, is to argue that they have no part in the education–wellbeing system that is designed to improve their situations. Such treatment is in conflict with the views of learning discussed earlier. The student perspective should be a key part of future research programs.

Teachers

In considering the production of change through education, we take as a fundamental principle that change can occur through teaching. Teaching is a powerful influence on educational outcomes:

> *When all other sources of variation are taken into account, including gender, social backgrounds of students and differences between schools, the largest differences in student achievement are between classes. That is by far the most important source of variation in student achievement is teacher quality (Rowe 2002:S1)*

Teaching actions in classrooms must be seen as a major site for attention in any research on the relationship between education and wellbeing.

Research in the area of cognitive strategy training provides one source of information about how such teaching effects might occur. Hattie, Biggs and Purdie (1996) found that strategy training interventions that focused on improving academic performance were associated with improvements in student learning outcomes of about half a standard deviation. This is regarded as an effect that is of practical significance in educational research.

A corollary of the argument about the importance of the quality of teaching actions is that preparing teachers for working in classrooms with Indigenous students must also be a site for attention. Thus, the content of the teacher preparation courses, the practicum experiences of the student teachers, and the induction of newly qualified teachers should all be considered as possible sites for action, and for research. Malin and CRCATH (2003) emphasise the importance of forging strong links between each of these components.

Educational effects at the middle level

Educational environments

Educational institutions, such as schools, are based around systems, and around systems within systems: these include political, cultural, community, home, school, year-level, classroom and peer groups, to name but a few. These various systems can interact with each other in supportive and non-supportive ways (Bateson 1972; Prigogine & Stengers 1984). Wilkinson and Marmot's discussion of two of the social determinants of health, stress and social support, points to the importance of the school system: 'Institutions that give people a sense of belonging, participating and being valued are likely to be healthier places than those where people feel excluded, disregarded and used' (2003:13).

A systems perspective proposes that people are viewed in terms of their relationships with each other, rather than simply being understood principally on the basis of their individual development (Slee 2002). In applying a systems perspective to education, an analysis of student behaviour can provide important insights into the various roles and relationships within the system. For example, Malin's (1994) study with Aboriginal children in reading classes in suburban Adelaide demonstrated that both the social organisation of the academic task, and the social relationship between the teacher and the student, played a crucial role in students' learning. Non-racist, inclusive environments are essential starting points in classrooms.

Systemic thinking is sharply at odds with some Western scientific thinking, which has emphasised remediation, deficits and weaknesses in individuals. In contrast to the 'deficit' approach, the systems approach emphasises how individual action is part of a transaction, and that all parts of the transaction need to be considered when change is being planned. Systemic thinking has potential for reconceptualising the place of Aboriginal students in the dominant culture school system.

Health promoting schools

Colquhoun, Goltz and Sheehan (1997) describe a radical or collective action model, which seeks to move away from 'victim-blaming' and to engage in socio-cultural change through collective action for health:

> *The rationale behind this approach is that health is primarily shaped by factors outside the control of individual citizens. These structural factors produce patterns of disadvantage within society, which correlate with poor health. The political decision-making processes which influences economics, working and living environments, service provision and social relations and, in turn, health, are the focus for the interventions based on this model. Critical consciousness-raising is the educational process involved in radical/critical health education (Colquhoun, Goltz & Sheehan 1997:8).*

One response to the need for radical or socially critical approaches in health is the idea of a health promoting school. The application of this concept has not always been consistent with its radical intent, yet it has at its core the notion of community engagement in visioning a healthy school community, identifying issues to be addressed and acting to achieve health-enhancing change. The model is interactive, involving curriculum, teaching and learning, the school ethos and environment, and partnerships with the wider school community to enhance health and education outcomes for students, staff and parents. The South Australian Department of Education, Training and Employment (DETE 2000) showcase Oak Valley School as an example of where the health promoting schools approach has demonstrated positive outcomes for the health and wellbeing of Indigenous students.

Educational effects at the outer level

Systemic change

A fundamental point of systems theory is that the impact of change in any one part of a complex system will be limited if there is resistance in other parts of the system. For example, a case study cited by Tsey and colleagues (2003) illustrates that although a family wellbeing empowerment program influenced the thinking of an individual participant, the participant's family circumstances blocked the potential for the participant to act in more empowered ways.

We have written about control and self at the individual level. However, control can also be influential at other levels of a system. Boughton (2000), following the writing of Freire, explains that an Indigenous person's perspective of lack of control, or lack of empowerment, may not be solely due to an individual's disposition or cultural beliefs, but can be a valid reflection of actual physical circumstances and life histories associated with the outcomes of particular policies. Clear illustrations of this at the systemic level are the government policies and practices that led to the forced removal of Indigenous children from their parents—the 'stolen generation'.

The overriding impact of the system upon the individual's wellbeing was illustrated by Marmot and colleagues' seminal Whitehall studies that identified relationships between employment status, job demand-control, stress and health (Marmot *et al*. 1999). Where poverty is not a factor, as with the civil servants at Whitehall, health remains unequally distributed according to social hierarchy, with

> *rank or relative position in social hierarchy [being] one of the most important determinants of health, and that addressing this must necessarily involve addressing existing power relationships at all levels of our work (Tsey et al. 2003:S35).*

Similarly, Gray and colleagues (2001) propose that Western secondary education could have a disempowering effect on Indigenous Australians, causing those students who entered the system but did not achieve success to become less self-efficacious and, therefore, less likely to take health-related action on behalf of their children. Although this explanation is untested, it is compatible with contemporary literature on self-efficacy, self-regulation and locus of control (Bandura 1997; Graham 1991; Graham & Weiner 1993; Zimmerman 1989). As a component of motivation, self-efficacy acts prospectively, affecting a person's readiness for action. Where levels of self-efficacy for a task are low, persistence in the face of difficulty is also likely to be lower.

The representation in Figure 2 suggests that sites for action, and research, in education exist at all levels of the system. The nested nature of these levels also suggests that the interactions between these levels should be sites for attention in future research. A clear implication of a systemic perspective, as depicted in Figures 1 and 2, is that in future research we do not just want to understand and enhance the capabilities (the minds and hearts) of parents, teachers and students: we also want to understand and enhance the capabilities of government ministers, of heads of departments and organisations, and of Indigenous and non-Indigenous administrators. A major step in enhancing capabilities is to discard previous conceptions that limit or impede positive action, and to adopt conceptions that lead to positive agency (Bandura 2001). This requires conceptual change.

Conceptual change

That fact that major problems continue to exist in Indigenous peoples' education and wellbeing suggests the existence of powerful and stable influences. This leads us to draw parallels with research in educational psychology, which has dealt with the powerful and stable nature of people's concepts, and the difficulty of achieving conceptual change even when certain concepts might be counter productive. We now have quite clear explications of three sources of difficulty in achieving conceptual change.

The first source is lack of knowledge, or the 'I don't know' response (Chi, Slotta & Leeuw 1994). Chi and colleagues observed that a common reaction by students, in situations where a change in conception about a phenomenon is invited, is to adopt the 'I don't know anything about that' defence. Thus, misconceptions about difficult concepts might be maintained due to lack of knowledge and lack of engagement, which makes the implementation of change that depends on such knowledge difficult to achieve. From an educational point of view, some progress might be made if suitable knowledge input was provided. It seems reasonable to consider whether simple lack of knowledge in organisations or by individuals—for example, about Indigenous peoples' perspectives on education or wellbeing—mitigates against change. The possibility that lack of knowledge might be a source of difficulty that limits progress reinforces our view that there is important research to be done in gaining detailed information about the situations and understandings of people at all levels associated with education–wellbeing systems.

A second source of difficulty related to conceptual change is where existing conceptions are long-standing, and so have considerable cognitive strength (Anderson 2000). For example, White and Gunstone (1989) point out that it is relatively easy for a teacher to promote a new belief about phenomena like gravity, electric current or natural selection. However, the development of knowledge about a new and more adequate conception of a phenomenon by students does not mean that they will abandon their existing beliefs about that same phenomenon. Different and conflicting conceptions of the phenomenon can be maintained over long periods of instruction, and it is often difficult to bring about a situation where students abandon their older, strong but less adequate conception in favour of a more adequate one (Gauld 1986). Posner, Strike, Hewson and Gertzog (1982) point out that conceptual change is unlikely to occur unless people are dissatisfied with their existing conceptions to the point where they will accept the advantages of a new conception. For organisations or individuals to undergo conceptual change, such dissatisfaction with the old, and acceptance of the advantages of the new, needs to be manifest. There needs to be an *imperative* for change. It is unlikely that people will be dissatisfied with their non-functional perceptions if perceptions that work to shore up their own position of superiority or their economic interests are not challenged. We see Michael Coughlan's story as an example of a situation where challenging of perceptions proved to be functional.

Further research questions emerge from consideration of this second source of difficulty in stimulating conceptual change. Why do key players in the wellbeing system believe that change is difficult to achieve? What challenges could be mounted in relation to these different sets of beliefs? What would these key players find attractive about a changed, more functional situation?

The final source of difficulty associated with bringing about conceptual change is described by Chi and colleagues (1994) as a problem of misclassification of a phenomenon to the wrong ontological category, such as classifying electric current as a 'thing', a type of matter, when it is actually a process. This analysis reminds us that things might be categorised in incompatible ways by Indigenous and non-Indigenous people. For example, non-Indigenous teachers' conceptions of land, schooling or health compared to their Indigenous students' conceptions might be problematic in this way. If this was the case, the problem of misclassification needs to be identified and explained so that the implications of the differences in classification can be made explicit.

Education leading to conceptual change is required at multiple levels at multiple sites, well beyond school classrooms. There is no hierarchy in deciding which sites for action should be targeted first. Rather, the attacks on misconceptions must occur simultaneously.

Summary and conclusion

We have proposed that it is fruitful to conceptualise the relationship between Indigenous peoples' education and wellbeing as a transactional system. From this analysis, we propose that education is required to achieve both the imperative for conceptual change, and conceptual change itself, at multiple sites throughout the system and at multiple levels—inner, middle and outer. In particular, we stress that education cannot be conceptualised as simply schooling, but rather that education occurs formally, informally and incidentally, with knowledge building and conceptual change leading to well-connected knowledge structures that are powerful for generating positive actions. Robust knowledge structures need to be generated, maintained and distributed between individuals, communities and organisations.

We do not claim that the above suggestions are necessarily new. However, our purpose has been to highlight how the educational literature can assist in refocusing attention upon key aspects of the multi-level transactional system that includes Indigenous peoples' education and wellbeing.

The situation of Indigenous peoples' education and wellbeing needs to be changed. There is a reasonable basis for expecting that an improvement in educational status could impact positively on wellbeing and that, in turn, would have a positive impact on educational status. Change is required in the overall conceptualisation of the education–wellbeing relationship, change that gives due recognition to the system of relationships that surround and influence outcomes. From an educational point of view, we suggest there is a need to make use of contemporary models of learning and teaching, both in informing practice and in directing research. Both of these suggestions for change point to the need to take action in educational practice and research at multiple levels and in multiple sites. Focusing attention just on schools or teachers or just on local communities would perpetuate the current inadequacies. The longevity of the problems in education and wellbeing suggest that new perspectives need to be investigated, one of which could be developed using recent research on conceptual change. Possible research questions derived from this and other perspectives are included in the following, final section of this paper.

Questions for consideration

We propose that there are a number of questions that emerge from our consideration of the education–wellbeing relationship for Indigenous peoples that warrant further research:

1) What are the knowledge structures about Indigenous peoples' education and wellbeing held by Indigenous and non-Indigenous peoples? What are the fundamental points of concurrence and difference between those knowledge structures? What is the potential power for positive action from those points of concurrence and difference?

2) What do key Indigenous and non-Indigenous people consider are specific components of education that transact with wellbeing in Australian Indigenous communities?

3) What priorities do Indigenous people attach to the education (at all levels, as in Figure 2) of Indigenous and non-Indigenous people?

4) What connections do Indigenous leaders see between constructivist philosophies of contemporary frameworks for schooling and Indigenous peoples' world-views and ways of education and creating knowledge?

5) What are the classroom processes that Indigenous children, adolescent and adult learners value that connect them to education? What do Indigenous students know about these processes and how to use them in their learning?

6) What factors promote and impede young Indigenous people's engagement with school?

7) How do representatives from the education–health network interact with and inform each other?

8) What components/features can be identified from successful partnerships that could provide models to facilitate the creation and maintenance of partnerships between organisations and between individual people?

9) What are areas of educational interventions that Indigenous communities regard as most urgent? How should these interventions be carried out?

10) In what ways can distributed knowledge (in organisations and communities) and the knowledge of Elders be conserved and shared?

Engaging in research that provides increased knowledge about these questions has the potential to better inform policy and practice.

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Chapter 5:

Aboriginality, Poverty and Health—Exploring the Connections

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Introduction

In the broader context, poverty and poor health are incontrovertibly linked. The research evidence of inequality of health between the poor and the non-poor is overwhelming. Moreover, this pattern equally applies in affluent countries such as Australia, where a clear and widening health gap exists between low and higher income groups (Mathers 1994; Walker 2000). Within these data, the disparity between Aboriginal[1] and non-Aboriginal Australia, in both health and income status, is also long established (Saggers & Gray 1991; ABS 2003). Using a social determinants of health approach, we might rationally conjecture that poverty is a core explanation for Aboriginal ill health.

The elemental role of social–structural determinants in population health is neatly summarised into ten core factors by Wilkinson and Marmot (2003). These are: the social gradient; stress; early life; social exclusion; work; unemployment; social support; addiction; food; and transport. A correlation is easily detected between each determinant and the relative position of Aboriginal people in Australia's socio-economic hierarchy. From the lowly position of the vast majority of Australian Aborigines on the social gradient the applicability of the social determinants of health to Aboriginal Australia appears obvious. These include the psychosocial stress inherent in Aboriginal people's lives; the low birth weights, poor maternal health and heavy burden of disease experienced by Aboriginal children; the historical and ongoing exclusion of Aboriginal people from social institutions and access to social resources; the high rates of unemployment and relegation of most Aboriginal workers to low-level, insecure market work; the high levels of addiction present in many Aboriginal communities; the inability of many Aboriginal communities and families to consistently access good food; and the limited transport options available to a majority of Aboriginal people.

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[1] This paper uses the term 'Aboriginal' when discussing Australian Aboriginal peoples in preference to the more commonly used terms 'Indigenous' or 'Aboriginal and Torres Strait Islander' in recognition of the fact that many Australian Aboriginal people find these terms problematic.

It is also not hard to identify poverty as a recurring theme. The above social determinants can be directly connected to poverty at the individual and population group level. Despite this obvious link, the association between these two concepts may not be that simple. There are grounds for questioning any presumption of a linear relationship between Aboriginal health and Aboriginal poverty. First, many of the concepts and assumptions inherent in current models of social determinants of health are not directly applicable to the cultural, social or political milieu of the lives of Aboriginal people (Hunter 1999; Morrisey 2003). Second, poverty is a complex phenomenon that encompasses a multitude of deprivations and is not the exclusive domain of low income or income inequality. Third, and more critically, the concept of poverty is significantly more complex when examined within the context of Aboriginal Australia.

In exploring the theoretical and empirical relationship between poverty and ill-health, this paper takes as its frame the multi-dimensional, and arguably different, nature of Aboriginal poverty. It is proposed that a core aspect of the analysis of Aboriginal health, within a social determinants of health model, is Aboriginality, itself. The term Aboriginality is used in this paper in the wider sociological sense, referring to the lived experience of being an Aboriginal person in contemporary Australia and the broader impact of that lived experience on individual and group life chances and life options. Contemporary theoretical debates on the nature of the link between income inequality and health are also examined for their relevance and possible contribution to broadening our understanding of the relationship between Aboriginal poverty and health inequity.

Measuring and defining Aboriginal poverty

In Australian studies of poverty, definitions of what constitutes poverty and who is poor are not straightforward. Poverty is variously defined, conceptualised and operationalised across a broad range of measures. There are also significant methodological and/or ideological debates about how poverty is measured. Poverty indicators are, fundamentally, constructions based on subjective judgments rather than objective phenomena. As such they can be, and frequently are, contested, often along ideological lines (Saunders 2005). Irrespective of these debates, however, the over-representation of Aboriginal people among the economically deprived and the low level of material wellbeing in Aboriginal households and communities is undisputed. The literature suggests that Aboriginal poverty is widespread, deeply entrenched and probably underestimated (Western 1983; Graetz & McAllister 1988; Hunter 1999; Morrissey 2003). To provide context for later discussion, and to develop a picture of the depth and breadth of Aboriginal poverty, it is worth providing an overview of Aboriginal economic disadvantage from a range of poverty perspectives.

Income inequality comparison

While cash income is a blunt measure of poverty, direct income is a key component of household resources. From an income base, Aboriginal households are clearly much poorer than others in Australia. Recent data from the Australian Bureau of Statistics (ABS) (2005) confirm that the average weekly gross mean income for Aboriginal households remains at around 60 per cent of that of non-Aboriginal households. This basic comparison, however, does not reveal the depth of the comparative income deprivation of Aboriginal Australia. Hunter (1999), using a range of equivalence scales to adjust for both the larger size of Aboriginal households and the variability of equivalence scales, found that regardless of the scale used Aboriginal households were more than twice as likely to have incomes below 40 per cent of the national median than non-Aboriginal households[2]. Examining the same data from the individual income unit perspective, again using an equivalence scale to take account of the number of people dependent upon each income unit, a third of Aboriginal people had income below 40 per cent of the median compared to less than 10 per cent of all Australians. Also, the comparative income inequality of Aboriginal Australians does not appear to be improving. Altman and Hunter (2003) find that the disparity of Aboriginal to non-Aboriginal individual income actually increased in the decade 1991–2001.

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[2] Households' variation in size and composition impacts on the resources needed for economic wellbeing. Equivalence scales allow for the direct comparison of different households by weighting a household according to its members. Factors commonly taken into account in assigning the weighting values are the size of the household and the age of its members, such as whether the members are children or adults.

Socio-economic comparison

Widening the examination of poverty to include measures of socio-economic position, the comparative picture is no less bleak. As these and the additional data in Table 1 below indicate, on almost any measure of social or economic wellbeing Aboriginal people are significantly poorer than other Australians. On broader measures of socio-economic inequality, Aboriginal people are: more than fifteen times as likely to be imprisoned as adults; seventeen times as likely to be detained as juveniles; and have comparative rates of homelessness more than three times those of non-Indigenous Australians (Bareja & Charlton 2003; ABS 2004a; ABS 2005).

The employment indicators included in Table 1 should also be interpreted within the context of the broad segregation of the Aboriginal labour market across occupational type and employment sectors. Only 21 per cent of employed Aboriginal males hold professional/associate professional or managerial positions compared to 41 per cent of employed non-Aboriginal males. Within sectors, a far larger proportion of the Aboriginal workforce is in government employment (43 per cent compared to 17 per cent) and despite more than a decade of strong private sector job growth, Aboriginal employment in this sector has declined since 1991 (ABS 2001).

Absolute and relative poverty comparisons

In developed nations, a relatively high standard of living means that poverty literature concentrates on relative rather than absolute measures of poverty. The social determinants literature also tends to a relative view of poverty, proposing that in developed counties, such as Australia, health is related to relative rather than absolute income (Wilkinson 1999). However, using the United Nations (1995 cited in Harris, Nutbeam & Sainsbury 2001:260) definition which defines absolute poverty as 'severe deprivation of basic human needs, including food, safe drinking water, sanitation facilities, health, shelter, education and information. It depends not only on income but also on access to services', the evidence suggests that a significant number of Aboriginal people experience absolute poverty. For example, nearly two-thirds of discrete Aboriginal communities are reliant on bore water for their water supply. In 2001, 35 per cent of those communities experienced water restrictions, 26 per cent had water supplies that failed testing for water safety and a further 8 per cent did not even have their water tested (ABS 2003). The existence of absolute poverty is also evidenced by the commonality in many Aboriginal communities of easily treatable diseases associated with inadequate basic sanitation and living conditions such as scabies and diarrhoea (Saggers & Gray 1991).

TABLE 1: **Socio-economic indicators: Aboriginal and non-Aboriginal populations**

	Aboriginal %	Non-Aboriginal %
Unemployment rate	20	6
Employed in non CDEP job*	38	74
Apparent year 12 retention rate	39	77
Hold a Bachelor Degree or above	5	21
Rent social housing	38	6
Homeowner/purchaser	31	70
Has welfare payments as main source of income	52	27
Would be unable to raise $2000 within a week	54	14
Proportion with income in lowest and second quintiles	72	39
Proportion with income in the highest quintile	5	20

Sources: ABS 2002; ABS 2004b; ABS 2005

** CDEP (Community Development Employment Program) jobs are welfare payment linked positions.*

Given the previous table outlining the comparative position of Aboriginal people in Australia's socio-economic hierarchy, relative poverty as defined below, obviously applies to a significant proportion of the Aboriginal population:

> *… being unable to afford the goods, services and activities (eg, housing, food, clothes, recreation, social obligations) that allow people to play the roles, participate in the activities and relationships and follow the customary behaviours that are considered normal in society and expected of people by virtue of their membership of society (Townsend 1993 cited in Harris, Nutbeam & Sainsbury 2001: 260).*

The absolute and relative dimensions of poverty are also important in how Aboriginal poverty is interpreted and understood. Altman (2004) demonstrates this key difference in an examination of measures of Aboriginal poverty between 1972 and 2001. In *absolute* terms, Aboriginal socio-economic indicators show improvement in the areas of housing and education. However, in the same period, unemployment rose and the proportion of the Aboriginal population aged older than fifty-five years remained static. Comparative analyses of those same statistics relative to those of non-Aboriginal Australia provide different results. Comparatively, the gap between Aboriginal and non-Aboriginal unemployment has decreased, as have the indicators around education. However, comparative mean income has remained at about 60 per cent of the non-Indigenous population, employment indicators have also remained static and the comparative proportion of Aboriginal to non-Aboriginal people aged older than fifty-five has actually declined. While both analyses confirm on-going Aboriginal poverty, the interpretation of whether Aboriginal socio-economic conditions are improving or declining, and in what areas, can depend on whether the focus is on exploring absolute or relative improvement.

Dimensions of poverty versus measuring poverty

The well-established statistical relationships between health inequality and income inequality can lead to poverty being viewed in somewhat simplistic terms (Harris, Nutbeam & Sainsbury 2001). A key reason is that the common indicators of poverty, such as low income or socio-economic status, tend to limit our conceptions of what poverty is. The problem here is that such indicators are just that—proxies of poverty that enable some limited aspects of poverty to be measured in statistically comparable ways. Recognising this essential difference between measures of poverty and poverty itself is important in avoiding the common pitfall of confusing proxies of poverty for literal definitions of 'poverty'. Poverty is a much more complex phenomenon than any of its individual proxies can indicate.

How then might we develop a more detailed picture of poverty? Given that poverty, in general, refers to 'lack' it might be easier to examine poverty in terms of what it is not: material wellbeing. Material wellbeing, defined by Richardson and Travers (1993:1), is 'that aspect of human well-being which can be affected by a change in produced goods and services' and is essentially concerned with a material standard of living. A brief look through the literature on this topic reveals the following list of what might be considered as factors in material wellbeing: cash income; home production; non-market work; non-cash government benefits; indirect tax concessions; home ownership—imputed rent and capital gains; standard of housing; value of leisure; government services (i.e. health and education); infrastructure; social cohesion; family and social networks; and autonomy (Richardson & Travers 1993; Harding 1998; Johnson 1998). In addition, material wellbeing also incorporates aspects of living that are not easily named or measured, such as quality of life or opportunity for future prosperity. For Aboriginal people, we might add dimensions such as cultural recognition, choice of lifestyle, capacity to self-determine, community control and land rights, to name just a few. The list, therefore, is almost endless, and this is the point. Just like material wellbeing, its opposite—poverty—is multi-factorial and is contributed to, and impacted upon, by an almost endless list of factors.

Conceptual problems in applying standard measures of poverty to Australia's Aboriginal peoples also hinder our ability to gain an accurate picture. Valid information on Aboriginal poverty is relatively scarce, limited until recently to census data and the more unreliable data from administrative sources such as government departments or community agencies. Demographic factors such as age structure differentials, geographic distribution of the population, significant differences in household structure and size, and cultural aspects such as the role of non-market work, constrain the comparability and understanding of the data that are collected. Additionally, many of the variables used within the ABS standard index of socio-economic disadvantage 'do not provide unambiguous and/or culturally appropriate measures of socio-economic disadvantage for Aboriginal Australians' (Gray & Auld 2000:v). For example, while Hunter (1999) uses a variety of equivalence scales to improve comparability between Aboriginal and non-Aboriginal households, all current equivalence scales are based on presumptions about the Western, nuclear family. Further, as Hunter, Kennedy and Biddle (2002) discover, the choice of equivalence scale can significantly reduce or increase the comparative level of Aboriginal poverty. Gray and Auld (2000) also conclude that while constructing a composite index of Aboriginal relative socio-economic disadvantage is possible, the usefulness of such an index is severely limited first, by the changeability of outcomes according to the variables included in the index, and second, by the place-specific relevance of many standard indicators such as education or employment.

The multi-dimensional nature of Aboriginal poverty

For Aboriginal Australia we need to rethink the dimensions of poverty. Hunter (1999) empirically establishes that Aboriginal poverty is multi-faceted with facets that are not directly related to income or lack of it. In this analysis overcrowding in housing is an issue for relatively advantaged Aboriginal families, as well as those on lower incomes; negative interactions between Aboriginal people and the criminal justice system are a common feature of Aboriginal life regardless of household income, with members of high-income Aboriginal households being nineteen times more likely to have been arrested than their non-Aboriginal counterparts; and dislocation from traditional lands is a common experience in Aboriginal households, irrespective of income. Most importantly for this paper, in the area of health high-income Aboriginal families are nearly as likely to experience long-term health problems as low-income Aboriginal families. Hunter's analysis, while limited by data availability, emphasises both the multi-dimensional nature of Aboriginal poverty as well as its essential differences from the poverty of other poor Australians.

From a social determinants perspective, to understand why this is so we need to ask the question within the context of the socio-political and material reality of Aboriginal people's lives. Not only is Aboriginal poverty different but so is Aboriginal material wellbeing. In the non-Aboriginal population, higher income tends to be intergenerational, reflecting a whole of life-course material advantage. Conversely, for Aboriginal people higher income is, to use medical terminology, almost entirely late in onset and often self-attenuating. That is, while some Aboriginal households record annual incomes in higher level brackets in cross-sectional data collections, such as a census or NATSIS (National Aboriginal and Torres Strait Islander Surveys), these data cannot be assumed to be both an indication of life-course advantage or as a proxy for other middle-class attributes, such as better health or educational outcomes. Without longitudinal data it is impossible to estimate what proportion of Aboriginal households retain their higher income status over data collection periods. Given that much Aboriginal higher income employment is located in Aboriginal-specific positions, such employment is often temporary in nature. Unlike other Australians in higher income brackets, loss of that employment will likely lead directly back to low income, rather than another job with another employer at similar or higher wages.

The domain of Aboriginality and Aboriginal poverty

Bill Tyler (1990) notes that Aboriginality occupies an ambiguous position within the dominant discourse on Australian studies of poverty and social stratification. While Aboriginal material disadvantage is regularly described, the literature rarely includes any causal exploration of why Aboriginal people consistently occupy the lowest rung of the Australian socio-economic hierarchy. Rather, Aboriginal poverty tends to be treated as another category of the poor, along with other traditionally disadvantaged groups such as migrants and sole parents. Poverty analyses are usually limited to a survey of historical inequalities and economic factors such as continuing education, employment and housing inequities. Aboriginality, as a causal element, is primarily unaddressed. Aboriginal people, families, households and communities do not just happen to be poor. Just like socio-economic advantage, socio-economic deprivation accrues and accumulates across and into the life and related health chances of individuals, families and communities. Data relating to Aboriginal poverty must be placed and analysed within their present and past social-structural context—a context that is uniquely Aboriginal. The then and the now are connected. The historic and contemporary consequences of Aboriginality impact on an individual's or a family's ability to access the economic, social, cultural and human capital resources of our society.

The key question here is whether being an Aboriginal person in Australia is a structural component, in itself, that impacts on an individual's life and health chances. This proposition does not mean that factors such as low income, low educational attainment and limited employment options are not important—just that they must be understood within a framework of Aboriginality. Crucially, Aboriginality is not just an added component—these factors plus Aboriginality. Rather, Aboriginality is the central core with other aspects of poverty intimately interwoven and interpreted through that Aboriginality. The domain of Aboriginality encompasses Aboriginal poverty. This dynamic might be expressed, albeit inadequately, in equation terms as:

Aboriginal poverty = The Domain of Aboriginality*
(low income + low education level + limited work skills + …)

The interrelationship of Aboriginal arrest, employment and poverty rates provide an illustration of this concept. In a recent study, Hunter and Borland (1997) found that following the experience of arrest the chance of Aboriginal males finding employment was reduced by up to 20 per cent. Data from New South Wales also found that in 2001 nearly one in five Aboriginal men, or two in five for those aged twenty to twenty-four years of age, were charged with a criminal offence (Weatherburn, Lind & Hua 2003). Therefore, while arrest is also likely to have negative employment consequences for non-Aboriginal men, the rate of arrest among Aboriginal males turns a private issue into a population-level, poverty-inducing problem.

Aboriginal poverty as a causal factor in Aboriginal health

Does the unique nature of Aboriginal poverty mean that a social determinants approach has no relevance in explaining Aboriginal health inequality? The answer, in short, is that we do not know. There is no empirical base from which to assess the applicability of social determinants models to Aboriginal health. As discussed in Hunter's analysis, no statistical association was found between income level and health—Aboriginal people had poor health across all income distribution levels. Theoretically, however, the complex multi-factorial nature of Aboriginal poverty and the role of Aboriginality itself mean that existing models can only ever offer, at best, partial explanations of the complexity of the interaction between Aboriginal poverty and health. As proposed, Aboriginality adds a dimension or, more accurately, a frame that cannot just be plugged into existing mainstream models. Although these limitations are formidable, broader theoretical work can still provide valuable insights for Aboriginal-specific research and theory development. The following section examines a range of health and poverty theoretical frameworks and how these might apply to understanding the social determinants of Indigenous health.

The role of culture in poverty and health outcomes

Ethnicity or cultures are only briefly considered within the broader social determinants of health literature. For example, Shaw, Dorling and Davey-Smith (1999) pursue ethnicity as a separate, but interrelated, determinant of health, while Eckersley (2001) points to the influence of Western cultural determinants as the missing factor in social determinants of health literature. Neither discussion includes Indigenous references. Outside the social determinants literature, however, Aboriginal culture and cultural practices as factors in both disparate health and poverty outcomes are the subject of theoretical and political debate. As such, two different perspectives on culture are discussed below: one revolves around the role of Aboriginal culture in producing poor health outcomes and the other looks to culture as an explanatory factor in current discourses around Aboriginal poverty.

A poverty of culture?

The first perspective theoretically pairs Aboriginal culture and poor health by pointing to the impact of cultural practices on health outcomes. For example, Sutton (2005:8), arguing against what he terms the 'politicisation of disease', states that 'culturally transmitted behaviours and attitudes lie at the centre of the huge differences between Aboriginal and non-Aboriginal health outcomes'. The argument's base is that Aboriginal cultural practices deriving from the 'pre-existing social and economic organisation of the people concerned' clash with contemporary Aboriginal environmental circumstances (2005:3). For instance, Sutton links overcrowded housing and unhygienic sleeping conditions with previous camping patterns of semi-nomadic Aboriginal residential groups.

On one level, Sutton's argument on the impact of culture on Aboriginal health has social determinants merit. Poor living conditions and overcrowding are undoubtedly associated with a higher burden of disease. However, positing these living conditions as primarily the result of culturally inspired choice, rather than related to poor infrastructure and lack of choice, is not empirically established by Sutton. On the other hand, health-related lifestyle factors—such as misuse of alcohol and other drugs, smoking and poor diet or resistance to incorporating healthy lifestyle practices into daily living—can be directly connected to poor health outcomes. But while these behaviours may have cultural elements, do they specifically derive from Aboriginal culturally embedded practices? Such behaviours are certainly not exclusive to Aboriginal people or universal within Aboriginal populations. Eckersley (2005), for example, points to the role of modern Western culture in alcohol and drug abuse at the broad community level. The diversity of Aboriginal cultures and lifestyle of populations also complicate any positioning of Aboriginal culture as a key explanatory factor in health inequality. Nearly one-third of Aboriginal people reside in Australia's larger cities (ABS 2005) and poor health outcomes are endemic (as is poverty) across specific cultural practices, belief systems and geographic location.

More critically, the positing of Aboriginal culture and cultural activities as a central causal explanation for Indigenous health inequality is not theoretically sustained. The key critique is the flexible use of the concept of Aboriginal culture to encompass a myriad of differentially occurring factors that may impact upon Aboriginal health. For example, in outlining problematic culturally embedded Aboriginal practices, Sutton (2005:2) conflates specific health-damaging activities such as poor diet, poor personal hygiene and substance misuse with infrastructure issues such as domestic sanitation and housing density. He then also adds the nebulous concepts of Aboriginal care of children and the elderly, general relationships, conflict resolution, cultural norms to do with the expression of emotion, and attitudes to learning new information to the one undifferentiated list. The arbitrary designation of specific health issues, structurally embedded factors, and undefined attitude and value items as 'culture' results in a confusion and conflation of cultural practices, structural conditions and the social, cultural, political and economic environments in which Aboriginal people live their lives. The squeezing of such a plethora of areas into the 'culture' bag stretches the concept of culture almost to meaninglessness, depriving it of its heuristic validity. While some Aboriginal cultural practices unquestionably contribute to poor health outcomes, empirical research is required to identify and determine the relevance and role of Aboriginal culture to a social determinants of Aboriginal health perspective.

A culture of poverty

Sutton's thesis, discussed above, links broadly into theories proposing culture as a causal explanation for poverty. Initially developed during the 1960s by American anthropologist Oscar Lewis, the culture of poverty is defined as 'a sub-culture with its own structure and rationale, as a way of life which is passed down from generation to generation along family lines' (Lewis 1967:xxxix cited in Lister 2004:106). The thesis, therefore, links poverty to the social and cultural attributes, attitudes and value systems of the poor. Although Lewis emphasised that this culture functioned as an adaptation and reaction of the poor to their marginal position in unequal societies, the concept of a 'culture of poverty' that is developed and maintained generationally by the poor themselves, and who are different in their values and attitudes and beliefs from the non-poor, found widespread public and political appeal. As such, variations have regularly reappeared in popular and political discourses around poverty. During the 1980s and early 1990s it was the concept of a cycle of deprivation which focused on the intergenerational transmission of deprivation through the transmission of attitudes, values and behaviours. The current expressions of the culture of poverty thesis are the related notions of an underclass and welfare dependency (Lister 2004).

For Aboriginal people, the concept of welfare dependency has a particular relevance. In what Altman (2004) refers to as discourse of crisis, Aboriginal people are now labelled as problematically welfare dependent and welfare dependence is linked causally with Aboriginal poverty. As in the broader discourse on welfare dependency, dependency is negatively linked with personal deficits such as passivity, laziness, drunkenness and poor parenting (Smiley 2001). For Aboriginal people, culturally linked values about the relevance of employment as well as the social dysfunction apparent in many Aboriginal communities are added. The outcome is Aboriginal-specific welfare reforms implemented with the stated intention of 'breaking the welfare cycle in many Aboriginal communities' (Lewis 2005:2). The focus on eliminating welfare dependence incorporates an assumption that removing dependence on welfare payments will result in the opposite of dependency: autonomy, personal responsibility and function.

The critical question here is not whether levels of Aboriginal reliance on welfare payments are acceptable. With more than half of all Aboriginal people (52 per cent) listing government benefits and pensions as their main source of income (ABS 2005), such reliance is obviously problematic. The often ambivalent relationship between Aboriginal people and the welfare system has also long been a topic of concern among Aboriginal activists (see Pearson 2000; Yu 1994; Perkins 1990, for example). Moreover, critiquing the application of the welfare dependency label to Aboriginal people living in poverty is not an argument against welfare reform *per se*. Instead, the critical question is whether welfare dependence is the core explanation for the deeply entrenched and unrelenting nature of Aboriginal poverty. There are currently no data available to ascertain the extent to which persistent Aboriginal inequalities reflect Aboriginal choice (Rowse 2002). And, as Lister notes (2004:110), as with the earlier culture of poverty and cycle of deprivation theses, the mainstream empirical research does not support welfare dependency as either the creator or intergenerational maintainer of poverty (for an Australian example see Pech & McCoull 2000).

Structure or agency or both?

The two theses discussed above, despite their deficits from a social determinants perspective, do raise the central question of the role of personal agency. Examining culture in tandem with health or poverty-related behaviours alerts us to the danger of seeing all Aboriginal health and poverty outcomes in purely structural terms. A social determinants perspective can risk what Kowal and Paradies (2005:1352) refer to as over-structuration, whereby the role of structural factors is over-emphasised and the role of individual agency is under-emphasised in choosing specific practices and behaviours. The question to be asked, then, is to what extent can poverty and ill-health, as social outcomes, be defined as a product of the autonomous, purposive action of human agency, or as a product of social, economic and political processes and structures?

The answer to this basic structure/agency question is irretrievably complicated by the embeddedness of individual behaviour in the broader socially structured environment. Choices at the individual level are not made in a vacuum. The social, political and economic milieu in which an individual, or a group of people, lives enhances or constrains their capacity for social agency.

According to Giddens (1991), the key to ascertaining the respective roles of agency or structure as an explanatory factor in social phenomena such as poverty or ill-health is found in the extent to which a group has the power to exercise control over their own lives despite their subordinate position in wider hierarchical political, economic and social power relationships. The evidence presented in this paper on the depth and breadth of Aboriginal deprivation in contemporary Australia, and the uniquely constraining nature of Aboriginality on the capacity of Aboriginal people's individual and group life- chances and options, indicate little opportunity for Aboriginal people to be what Giddens refers to as 'authors of their own biographies' (1991:127). Therefore, just as over-structuration can over-emphasise social structure, theories that focus on individualised explanations, such as personal or cultural inadequacies, can result in an over-reliance on personal agency as an explanation of health or poverty inequalities. Without the power to change life circumstances or to overcome or eliminate structural constraints, allocating the cause of poverty or health disparities to personal agency or cultural choices risks pathologising poor Aboriginal people, adding stigma and shame to unyielding inequality.

The positioning of cultural deficits and poor individual decision making as central explanatory factors also highlights the fact that, as a concept and as a lived reality, poverty is a social relation. As such, the politics of representation is a crucial element in poverty discourses (Lister 2004:110). For example, equating high levels of welfare payments among Aboriginal people with problematic welfare dependency can represent Aboriginal people as the stigmatised 'other', morally and practically complicit in their own high levels of poverty and health inequality. The specific targeting of Aboriginal people as welfare dependent, and welfare dependency as a root cause for intractable Aboriginal poverty, also renders the complex and multi-dimensional nature of Aboriginal poverty less visible. Poverty is effectively individualised and the social, economic and political contexts in which that poverty is embedded are obscured. Relevant to the case of Aboriginal poverty and Aboriginal health disparities, is Lister's (2004:102) suggestion that such 'othering' of the poor is most marked where inequality is sharpest.

Social determinant theoretical perspectives

Also of relevance in understanding the role of poverty in health disparities are two recent social determinants theoretical perspectives that move beyond examining the income inequality and health connection. These models incorporate a broader understanding of poverty and its links to poor health, alternatively proposing a psychosocial or a neo-materialist explanation. The caveat here, as Turrell (2001) cautions, is that much of the evidence comes from the United States or the European Union and is not necessarily able to be transposed to the Australian situation. Their applicability to the Aboriginal Australian situation is even more tenuously proposed.

The psychosocial perspective

From the psychosocial perspective, Wilkinson (1999; 2002) suggests that in the developed world social determinants have their major effects through psychosocial pathways rather than exposure to material hazards. The biology of stress and key psychological risk factors such as social affiliations, early emotional development and social status are interlinked. Within this, it is relative inequality—that is, income inequality as a marker of social status rather than as an indicator of material wellbeing—that explains the social gradient of health. Negative social status comparisons, quality of social relations and early childhood emotional experiences, it is argued, lead to chronic stress and subsequent health inequalities. The solution, according to Wilkinson (1999), is to implement employment, income and education policies that reduce the overall burden of disadvantage. Reducing relative societal inequality, that is the gap between those with lower and higher incomes, will enhance a population's psychosocial welfare and thus improve health inequalities.

From an Aboriginal social determinants of health perspective, psychosocial theory offers a plausible explanation for at least some Aboriginal health inequality. Ongoing psychosocial stress is a significant aspect of Aboriginal lives. The central concept of the theory—that an individual's socio-economic situation reflects their social prestige and that this status is reinforced in daily interactions which, in turn, influence psychological and physiological wellbeing throughout the life-course (Veenstra 2005)—has resonance with an Aboriginal social determinants perspective. Being an Aboriginal person in contemporary Australia adds an extra negative dimension to the experience of low social status and prestige as well as low material wellbeing. This whole-of-life course negative experience of social inequality and low social prestige translates, via psychosocial pathways, into poor health and a high burden of disease at the individual and group population level.

The applicability of the psychosocial perspective to an understanding of the social determinants of Aboriginal health, however, is limited by its individualist focus. The theory fails to address the 'whole-of-community' dimension of Aboriginal poor health and poverty. To increase its relevance, the theory would need to be widened to examine group inequality and the impact of that inequality on the sub-population's health outcomes. Additionally, greater income equality within Australia, as a whole, is unlikely to impact upon Aboriginal health unless such income equality is extended to cover Aboriginal people. Based on previous discussions of the manifestly different nature of Aboriginal poverty, this is an unlikely outcome into the foreseeable future.

The neo-materialist perspective

Of more relevance are those recent theoretical frames that 'bring back the social'. As Lynch *et al.* (2000) state, income inequality cannot be the starting 'social fact' of health inequalities discourse. The shape and extent of inequality comes from somewhere and a neo-materialist approach explicitly recognises the influence of the political and economic processes that generate income inequality (Lynch 2000). Hence, interpretations of the links between income inequality and health must begin with the structural causes of inequality, not just perceptions or measures of relative disadvantage. From the neo-materialist perspective 'health inequalities result from the differential accumulation of exposures and experiences that have their sources in the material world' (Lynch *et al.* 2000:1202). The effect of poverty on health is a reflection of the effects of negative exposures and lack of access to resources for individuals combined with a systematic under-investment across a wide range of human, physical, health and social infrastructure. In other words, income inequality is just a proxy for the multi-level impact of neo-material conditions that affect populations and population health.

The neo-material interpretation critiques psychosocial relative deprivation interpretations on four basic grounds. First, Lynch *et al.* (2000:1201) argue that the psychosocial/social cohesion interpretations conflate structural sources of inequality with their subjective consequences. Second, the perspective underplays the ambiguity of health consequences of tight social networks, with evidence suggesting that while network ties can enhance health, they can also be detrimental. Third, a mostly horizontal definition of social capital ignores the crucial role that vertical institutional social relations have in structuring the social environment in which informal relations exist. Fourth, the decontextualised nature of the psychosocial approach can be appropriated into political agendas, leading to claims that poor communities' health and income inequalities result from social or other deficits within a community and that communities must solve their own problems. These critiques are all relevant to any analyses of the link between Aboriginal poverty and Aboriginal health.

Coburn (2000; 2004) takes a more definitive neo-materialist stance, looking to the rise of neo-liberalism to explain rising levels of health inequality in the developed world. By neo-liberalism, he means the phenomenon of economic ideologies that include a commitment to minimising the role of the state and maximising that of the market. Also critiquing the psycho-social approach, he argues for a change of focus away from possible social/psycho biological mechanisms to a concentration on the social, political and economic context of the health/inequality relationship. To develop a complete understanding of the income inequality health link, Coburn (2000:41) states that the central place of social forces such as neo-liberalism, the changing welfare state and 'most generally, the relationship between class structures, economies and human wellbeing' must be acknowledged. Neo-liberalism, in particular, leads to both higher levels of inequality and lower levels of social cohesion, and its rising influence across the developed world has also resulted in a decline in the inequality-ameliorating role of the welfare state (2004:53).

Critically, Coburn notes that increases in inequality have been more pronounced in countries like Australia that have been classified by Esping-Andersen (1990) as liberal welfare state regimes. These countries have also been the most stringent in adopting neo-liberal, market-oriented political ideologies and policies. The welfare state, with all its defects, does operate to lessen the impact in inequality, and the decline of the welfare state is removing even the limited buffers such as income support measures and public infrastructure around health and education. Coburn's critique on the likely effect of the downgrading of the welfare state on inequality has significant implications for Aboriginal Australia.

Discussion: Advancing the research agenda

Despite the neo-materialist criticisms of the psychosocial pathways to disease thesis, the two theories—neo-materialism and psychosocial explanations—are more complementary than they are competing. Turrell (2001), in his analysis of both theoretical frames, argues that neo-material factors are the primary determinants of the relationship between health and income inequality, with psychosocial and social cohesion effects just one consequence of these social structural processes. Both theories, therefore, are important in developing an Aboriginal social determinants of health perspective.

The specific value of the neo-materialist approach to an Aboriginal social determinant of health research agenda, however, lies in its recognition that the relationship between health status and poverty is more sociological than epidemiological. The underpinning theses, that income inequality is a manifestation rather than a cause of a wider set of historical, political, cultural and economic factors, resonates with understandings of Aboriginal poverty as different, multi-faceted and fundamentally related to Aboriginality. Under the neo-materialist model, income inequality is only a proxy for wider social conditions that operate through individual, collective, communal and material pathways. Moreover, social and economic determinants are the products of social, political and economic processes, not social facts in themselves. A connection, therefore, might be drawn between the lack of attention paid to Aboriginality as a causal factor in Aboriginal low socio-economic status and income inequality, and the lack of attention paid to the macro context of health inequality. In both cases, associations and relationships among particular social variables tend to be drawn out without consideration of the broader social, political and economic context in which they are embedded. Aboriginal poverty and Aboriginal health inequality both have social structural underpinnings and both are compounded by, and inextricably interwoven with, the impact of Aboriginality.

A neo-materialist perspective also offers a way forward in our thinking about Aboriginal poverty and health. Placing the breadth of issues and concepts relevant to making sense of this relationship within a broad neo-materialistic framework allows us to move beyond the paralysing complexity of the linkage. As Anderson (2001:248) notes, there is currently no existing theoretical or empirical work that is specific to the 'social and historical context of Aboriginal health in Australia'. In developing what Anderson refers to as a more culturally appropriate model of the social epidemiology of Aboriginal health, we need to explore new research and theoretical paradigms. Conceptualising Aboriginal health from a neo-materialist perspective makes it clear that the major determinants of Aboriginal health inequalities occur in sectors other than those directly and immediately related to health.

From a research perspective, this means an explicit focus on determining the broader social, political and economic nature of the relationship between Aboriginal health and Aboriginal poverty. Given the previous discussion, the pathways and mechanisms that link income inequality with health are likely to be very different for Aboriginal Australia than for non-Aboriginal Australia. Specific research projects might examine Aboriginal health from the perspective of wider structural variables such as levels of government services, and investments such as transport services, road conditions, recreation facilities, health and social infrastructure, quality primary health care, and capacity to access employment and education options. Concepts and constructs such as Aboriginal community control of resources and infrastructure, health, social housing and the environment also need to inform the research framework.

Work is also required to develop different ways of conceptualising, operationalising and understanding the dimensions of Aboriginal poverty. The most commonly used methods both of measuring and analysing poverty are likely to be unsuitable, and, more critically, inaccurate when applied to Aboriginal people and Aboriginal poverty. Any understanding of the link between Aboriginal health and Aboriginal poverty requires appropriate methods for capturing the scope and extent of that poverty. For example, specific equivalence scales are needed to allow a genuine comparison of Aboriginal and non-Aboriginal households. Other indicators and measures of poverty and material wellbeing that can take into account the social, economic and political milieu of Aboriginal lives, as well as those aspects of life that are fundamental to Aboriginal material wellbeing, are also required. The paucity of reliable, comparable and available data on Aboriginal health and manifestations of poverty underscore the difficulties inherent in these and other related tasks. Census data are limited and administrative collections from places such as hospitals, housing and welfare agencies and criminal justice systems are prone to high levels of inaccuracy. Additionally, 'small percentagisation'—whereby the Aboriginal sample of even a large-scale national health and social survey is often too small to generate reliable results or results that can be disaggregated below national level—is also problematic. Separate ABS surveys, such as the NATSIS (1994; 2002), overcome some of these issues but are still prone to low data comparability with non-Indigenous survey data.

Research from a neo-materialist perspective would also be timely. Australian social and economic policy is increasingly treating Aboriginal people as if they were just another group of poor Australians. What is needed is an evidence-based research program that examines the mechanisms by which poverty and health inequities are interwoven for Australian Aboriginal people.

Conclusion

From whatever perspective poverty is measured, Aboriginal people are heavily over-represented among the poor of Australia. Given this, there is little doubt that the desperate state of Aboriginal health must have an association with embedded Aboriginal poverty. Untangling this link between Aboriginal health and poverty, however, is not straightforward. Considerable exploratory work—using research and theoretical paradigms that incorporate within their foundations the social, political and economic consequences of being an Aboriginal person in contemporary Australia—is required. The various perspectives on the socially determined links between poverty and health outlined in this paper offer possible ways to move this research agenda forward.

Endnote
Elements of this paper arise from a joint presentation developed by the author and Associate Professor Sherry Saggers for the Social Determinants of Indigenous Health Short Course Program, Menzies School of Health Research, 8–12 March 2004, Darwin, Northern Territory.

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Chapter 6: Labour Force Participation as a Determinant of Indigenous Health

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Introduction

It has long been recognised that social inequalities are associated with health inequalities (Marmot & Wilkinson 1999). Extensive research has shown that income, employment, education and community connectedness impact both on the health status of individuals and on the community more generally (Baum 1998; Wilkinson & Marmot 1998).

The positive link between employment, resultant income and health status is generally acknowledged and accepted. Employment is the means by which financial income is generated, which in turn provides the means to purchase the essential prerequisites for good health, such as adequate housing and nutritional food. This cycle is further embedded, since income may facilitate the opportunity for further education and attainment of knowledge and skills, which potentially secures a type of upward spiral of economic mobility.

The labour force characteristics of Indigenous Australians have been steadily documented over the years, providing some indications of the nature of Indigenous labour force participation and its consequences. It is thus widely known that the Indigenous population in Australia is broadly characterised by high unemployment, low employment and employment in low-skill jobs.

The ongoing low labour-market status of Indigenous people is due to a variety of interdependent factors that can be summarised as historical (including the failure of successive policy regimes), locational and cultural. The history of Aboriginal Australians differs significantly from other Australians, most notably in regard to their exclusion from the mainstream provisions of the Australian State until the late 1960s (Hunter 2001). Sixty-nine per cent of the Indigenous population lives outside the major urban areas and around 25 per cent live in remote areas of Australia where the lack of a developed labour market and the limited availability of services reduce the opportunities for mainstream employment (ABS 2004). Cultural factors are also a major determinant of labour force status. Indigenous peoples in remote areas may be unwilling to migrate for employment because they have other important cultural priorities. On the demand-side, there is also the likelihood that employer discrimination impacts on Indigenous labour force participation, and this is an area that is in much need of research.

The health status of Indigenous Australians has also been a subject of much research and policy concern. It has been consistently documented that Indigenous Australians have the poorest health of any subsection of the Australian population (RACP 1999). Substantial inequalities exist between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians, particularly in relation to chronic and communicable diseases, infant health, mental health and life expectation. It is also well established that Indigenous Australians have relatively poor education attainment levels, poor housing, and high crime and incarceration rates. Australian Aboriginals are disproportionately concentrated in deprived areas and also suffer the consequences of racial discrimination, barriers in accessing services, and language and cultural barriers to accessing information and services (Hunter 1997; Taylor & Hunter 1998).

Although there are a number of studies that explore matters related to the labour force status of Indigenous Australians, such studies really only scratch the surface of the *nature of the linkage* between labour force participation and Indigenous health. This paper reviews a body of literature related to labour force participation trends and the resultant socio-economic and health status of Indigenous Australians. This overview is set against a critique of the methodology used in the vast majority of the sourced studies. Current studies using Western-centric understandings and measures of health and work do not allow for a clear relationship to be detected between the two factors in the Indigenous Australia context. This is primarily a result of the continued application and use of Western understandings (and measures) of concepts, which do not accurately reflect the cultural specificity of the Indigenous Australian context. Thus there is little attempt to 'unpack' the nexus between labour force participation and health, since this is a vexed issue and the causal direction is entirely unclear. This reinforces the need for a different type of methodology in any future research. Throughout this paper it is argued that notions of work and health in the context of Aboriginal Australia need to be reconceptualised in a more Indigenous-specific and informed way if we are to truly understand the meaning both of 'work' and 'health' (appropriately defined) and the complexities of the relationship between the two.

Labour force participation of Indigenous Australians: Context

Standard economic theory assumes that labour force participation is determined in a two-stage process. First, individuals 'decide' whether or not they are going to supply their labour to the market. Following this, a number of factors determine whether or not individuals are employed, including incentives to search for work, willingness to accept any job offers and labour demand conditions. The conventional economic models of labour supply (the first stage) are limited in that they allow only a minor role for social environmental factors. In such models, social factors only affect labour supply through their effect on an individual's or a family's preference for leisure versus 'work'. As Hunter (2000) correctly states, such assumptions are not warranted in the Indigenous population, where a history of social exclusion from the mainstream institutions of Australian society due to beliefs of racial inferiority have had long-lasting and direct implications for behaviour and the desire to 'work' in the market economy.

The study of Indigenous labour force status is thus rendered complex by Indigenous-specific cultural/social and historical factors, the behaviour and preferences of potential employers, and the interaction between these supply and demand side factors. For example, although gainfully employed, Aborigines pursuing traditional hunter–gather lifestyles in remote areas are not counted among the officially employed, since they do not conform to the standard criteria for employment as working for pay or profit (Altman & Taylor 1989), even though they themselves may take the view of being self-employed within the confines of standard criteria.

Employment is the major factor determining economic security enjoyed by most Australians. The fundamental importance of the provision of decent and realistic work opportunities for those who wish to participate cannot be underestimated. However, before uncritically importing notions such as the fundamental importance of work into an analysis of labour force status and its impact on Indigenous health, it is necessary to consider the *meaning of work* in a cross-cultural context.

At the outset it is important to note that while the overwhelming majority of Indigenous Australians want employment opportunities (Gray & Hunter 1999; Hunter 2002), there are legitimate historical and cultural reasons why some may choose to opt out of mainstream or Western work structures. As Graham (1996, cited in Sully 1997 and in Probert & Macdonald 1996) points out, attitudes to work are affected by the historical experience of work. Traditionally, Indigenous Australians defined work in quite different ways to the colonially imposed 'Protestant work ethic'; the identity of Indigenous people was not bound up in work to the extent that it was for Europeans—success was broader than success at work, and it encompassed art, spirituality and other community activities.

It should thus be considered that *not* having any employment in the Australian labour market may actually empower and free many Indigenous people to hunt, fish, paint and live on the land. Indeed, the extra hours of 'spare' time may facilitate more extensive participation in ceremonial activities, thus increasing what may be defined as 'social capital' (Hunter 2000). Nor should employment be viewed as automatically contributing to social capital, since some forms of employment actually diminish the extent of shared values and trust. Work that involves or leads to frequent movement of the workforce, such as some types of casual or seasonal work, could uproot the worker's family and thus weaken links to the local community (Hunter 2000).

Past experiences are also likely to impact on the choice of Indigenous Australians to participate in mainstream Western employment. Aboriginal labour history, while being slow to emerge as a distinct field of study (Curthoys & Moore 1995), has started to provide accounts of Indigenous Australians' experiences as workers. These accounts, while differing in their interpretations of the nature of the employment interaction between Aboriginal labour and the wider society, all commonly emphasise the brutal and humiliating conditions under which Indigenous Australians worked.

For example, Evans, Saunders and Cronin's (1975) *Exclusion, Exploitation and Extermination: Race Relations in Colonial Queensland* provides an examination of racial thought, expression and behaviour by colonial Australians to the racial minority groups of Aboriginals, Chinese and Melanesians in the nineteenth century. Their account highlights the use of violence in the management of Aboriginal labour to ensure their economic usefulness. Aboriginals were engaged only in '… tasks considered demeaning and arduous by whites—such as scrub clearing or the traditional hewing of wood and drawing of water' (Evans, Saunders & Cronin 1975:110). They were unable to rise any higher in occupational status than this and '… received only the roughest and cheapest food and clothing for work at which they were [as] competent as any white man ' (Evans, Saunders & Cronin 1975:112).

Another history emerging is the experience of Indigenous women who were removed from their homes and families on Aboriginal reserves and set to work as domestic servants for white families. A number of labour historians (Huggins 1987 & 1995; Walden 1995) have provided informed accounts of the experiences of the women subjected to government policies of the day, which viewed domestic service as a fitting vocation for Aboriginal women (Huggins 1987) and one in which assimilation into white society could be facilitated. These women worked extremely long hours undertaking tasks ranging from manual, physical labour to cleaning and childminding and rearing. They were often subjected to both physical and sexual abuse by their white employers and punished severely for perceived incompetence. While a variety of individual State and Territory legislation existed that provided a framework for the determination of wage payment to Indigenous workers (see, for example, Williams 1992:91), the majority of Indigenous women domestic service workers did not receive a wage (Huggins 1987; Haskins 2005).

Indeed, one of the striking features of the history of Indigenous employment (one that is quite recent) was the widespread practice of not rewarding their labour with the payment of wages (see, for example, Williams 1992). The lack or insufficient payment of wages to Indigenous employees throughout history has commonly been linked to the exclusion of Aboriginals from the wage-setting system in Australia.

McCorquodale (1985), analysing all major Conciliation and Arbitration Commission decisions in Western Australia and New South Wales between 1922 and 1968, reminds us that throughout Australian history, employment legislation has been enacted to exclude Indigenous Australians from employment and/or subverted industrial action to those who did gain employment. Legislation included:

> 1842 *Breach of Contract Act* which was used with the 1849 *Aboriginal Native Offenders Act* 'to provide a whipping got up to two dozen lashes in lieu of or in addition to imprisonment if an Aboriginal worker objected to his/her employment conditions or who absconded; the *Wine, Beer and Spirit Sale Act* (1880) in Western Australia which allowed any person to give

> liquor to Aboriginal people in place of wages; … the 1901 *Post and Telegraph Act* which restricted mail contracts to non-Aboriginal Labour the Workmen's Compensation Ordinance of 1923 in the Northern Territory, which excluded people from receiving workers' compensation… (Williams 1992:91).

The effect of these and other legislation was no accident. They were deliberate attempts to marginalise Indigenous Australians from the mainstream economy. As McCorquodale (1985:3) states:

> *[T]he edifice of legislative discrimination and repression was no mere oversight, or momentary aberration of government. It was systematic, continuous, organized, and designed to remove and eliminate forever any prospect of a reservoir of peons, cheap black labour.*

Such historical institutional processes lead Williams (1992:93) to conclude that, '… Australian Aboriginal "unemployment" was a built-in feature of Australian economic history…'

A potentially complex interplay of supply and demand side factors is thus involved in understanding Indigenous labour force participation, since historical, racial and institutional discrimination not only influence the probability of available employment (Altman & Daly 1993), but also impact on whether or not the choice is made to enter employment.

In addition to impediments posed by the potential misunderstanding of what 'work' and 'employment' mean for Indigenous Australians, and alongside the complex interaction of supply and demand issues, Indigenous-specific institutional features such as the Community Development Employment Projects (CDEP) scheme need to be taken into account. The CDEP scheme poses a crucial difference between the Indigenous and mainstream labour market, and complicates comparative analysis. According to the latest statistics from the Australian Bureau of Statistics (ABS 2004) 25 per cent of Indigenous employment is in the CDEP scheme. Under the CDEP scheme, Indigenous communities get a grant of a similar magnitude to their collective unemployment benefit entitlement to undertake community-defined 'work'. The recipients are then expected to work part-time for their entitlements.

Historically, the CDEP scheme was available on a one-in-all-in basis for each community. The current policy, which evolved gradually in the mid 1990s, means that when the CDEP scheme is provided in a community, the unemployed have the choice as to whether or not they participate (Sanders 1993). Often viewed as the first 'work for the dole' program in Australia, the CDEP scheme has been regarded as an extremely effective way of facilitating the movement of Aboriginal people into mainstream employment. However, given the limited employment opportunities in rural and regional areas and the racial discrimination faced by urban Indigenous job-seekers, the CDEP scheme quickly became a destination for Aboriginal employees. Since 2005 the conservative-led Federal government has implemented major reforms to the CDEP scheme—such as requiring its participants to register with a formal job network provider and limiting the participation in the scheme to twelve months—in an attempt to get more Aboriginal people into 'real jobs' (DEWR 2005). Such reforms have been viewed negatively by Aboriginal lobby groups, which argue that the reforms are based on the flawed assumption that there are both jobs available to Indigenous Australians and employers that wish to hire Indigenous Australians. They argue that the reform serves an assimilation strategy and marks the destruction of yet another Indigenous Australian initiative (Graham 2006).

One of the earliest explorations of labour supply decisions in an Indigenous context was undertaken by Altman and Nieuwenhuysen (1979:201–04). They presented a standard neo-classical model of labour supply that explored the implications of Indigenous preferences. They identified that something akin to (what eventually would become) the CDEP scheme would serve as a potential means to boost Indigenous labour supply, mainly by the introduction of flexible working arrangements that would appeal to remote Australian communities.

Another seminal study was conducted by Daly (1995), who attempted to explain labour force participation of individual Indigenous males and females in terms of a basic set of education, marital status and geographic variables. Daly's findings are consistent with the basic human capital model, and while the importance of Daly's work is not denied, a more Indigenous-specific approach may be more appropriate (Hunter 2000). For example, a more culturally appropriate and sophisticated analysis of labour supply might focus on collective models of family labour supply that explore the interaction between household production and labour provided to the labour market (Blundell & Macurdy 1999, cited in Hunter 2000). Unfortunately the data required to test such models does not exist in the Indigenous context.

As noted above, Indigenous-specific cultural factors are particularly important in determining labour force status. In an attempt to understand the relationship between cultural factors and labour force participation, Hunter and Gray (2001) explored a number of variables, notably access to traditional lifestyles, whether a person spoke an Indigenous language, or engaged in hunting and gathering. While their study is some distance from a truly Indigenous understanding of work *per se*, the study did yield some interesting findings. It found that the access of an individual to traditional lifestyles and whether a respondent speaks an Indigenous language or engages in hunting and gathering are associated with significant reductions in labour supply and declines in the desire to work in the mainstream labour market. The study also found that a high proportion of Indigenous female workers reported childcare and other family responsibilities as the major reason for not looking for work. While this result may be surprising given the extensive family networks and high rates of informal care typical of Indigenous families, there is evidence that these networks are often not well suited to providing the reliable and predictable childcare that is required for participation in paid employment (Hunter & Gray 2002).

Health and labour force status

The notion of '(good) health' typically involves objective measures such as morbidity, mortality and limitations in activity. While the usefulness of such considerations may appear to be self-evident, the notion of 'health' can be culturally determined. The World Health Organization, adopting a holistic and multi-faceted view of health, defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (cited in Devitt, Hall & Tsey 2001:1).

The National Aboriginal Health Strategy (NAHS) Working Party also adopts a holistic approach, but extends the definition by proposing that wellbeing is an attribute of communities, as well as of the individuals within a community. In this way, cultural wellbeing, along with social and emotional wellbeing, is identified as being equally central to health. In the NAHS definition, health is thus recognised as having physical, mental, social and spiritual components:

> *Not just the physical well-being of the individual but the social, emotional and cultural well-being of the whole community. This is the whole-of-life view and it also includes the cyclical concept of life–death–life (NAHS Working Party 1989).*

Using the conventional conception of 'health', Indigenous Australians suffer a clear health disadvantage relative to their non-Indigenous counterparts, with lower life expectancy and higher morbidity and mortality in all jurisdictions with adequate data quality (ABS & AIHW 1997). Part of a broader approach to measuring health, however, is to ask people to assess the state of their own health. Subjective health assessment has become a critically important component of contemporary health research (Albrecht 1994), which some argue is as reliable as, and perhaps even more reliable than, biomedical measures (Epstein 1990). It should, however, be remembered that this measure is dependent on an individual's awareness and expectation of their own health. As such, it may be influenced by factors such as access to health services and health information.

Until recently, little was known about Indigenous peoples' subjective assessment of their own health. The 1994 National Aboriginal and Torres Strait Islander Survey (NATSIS) included a global question on health and thus provided the first population-based information on the self-assessed health status of Indigenous Australians.[1]

The NATSIS 1994 survey found that labour force status was significantly associated with self-assessed health status, even after adjusting for age. For both females and males, people who were unemployed or not in the labour force were significantly more likely to report fair or poor health than those employed in mainstream jobs (that is, jobs other than CDEP jobs). Females who were employed in CDEP scheme jobs were more likely than those in non-CDEP jobs to report fair or poor health. Although the opposite was true for males, the difference was not statistically significant after adjustment for age (Cunningham, Sibthorpe & Anderson 1994).

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[1] Overall, about 17 per cent of Indigenous Australians reported their health as fair or poor. This is similar to observations made in the 1995 National Health Survey (NHS) for all Australians, but this overall similarity obscures differences in self-assessed health status within particular age groups. A large difference was observed between the two surveys among people aged thirty-five to sixty-four years, with Indigenous Australians in those age groups in the NATSIS about twice as likely to report poor or fair health than non-Indigenous Australians in the NHS.

Hunter (2000) also analysed and interpreted the 1994 NATSIS data on a range of social indicators including labour force status (specifically, in this case, unemployment) and health. Analysing only the self-assessed health status category of 'long-term health condition', he found overall that among Indigenous people there is little or no relationship between ill health and labour force status. For example, Hunter (2000) found that unemployed males and females in non-urban households are between 9 and 4 percentage points less likely to have a long-term health condition than workers in mainstream employment. However, in urban households, there is no significant difference between the health outcomes of the unemployed and those in mainstream employment. This is consistent with existing studies, which show that Indigenous labour force status appears to be largely unrelated to health outcomes (Hunter & Gray 1999). The only group that consistently has poorer health than the unemployed are those in the 'not-in-the-labour-force' (NILF) category, many of whom may not be participating in the labour force because of a health condition.

While only focusing on one response category of self-assessed health, the findings reported by Hunter (2000) above contradict those of Cunningham, Sibthorpe and Anderson (1994). Hunter (2000) himself argues that the result of finding little or no relationship between ill health and labour force participation is consistent with the literature on the health effects of unemployment. The international literature appears to indicate that marginalised groups may respond realistically to their disadvantaged labour market position and experience lower levels of anxiety, financial strain and concern over being unemployed than do the employed.

Hunter (2000) did, however, find that health problems are issues in Indigenous households where there are several unemployed residents. He found that households with a concentration of unemployed tend to be unhealthier than those where only one person is out of work (although this pattern did not hold for males in urban areas). This may highlight the culture-specific emphasis on 'community', since each household could be construed as a community or sub-community, a point that Hunter neglects to consider. Other findings included that among the urban unemployed, the long-term unemployed are more likely to have a long-term health problem.

It is somewhat curious against the backdrop of these results that Hunter maintains that the 1994 NATSIS data reveal that there is little or no relationship apparent between ill health and labour force status. He does, however, qualify this conclusion (Hunter 2000:24)

> *Notwithstanding the apparently weak relationship between unemployment duration and health, the result is worthy of further discussion. Length of time out of work is frequently found to be unrelated to affective well-being and employment commitment, but job search attitudes remain significantly less positive among people who have been unemployed for prolonged periods. The explanation sometimes provided for this observation is that health improves after a person accepts their circumstances, in particular that the possibility of getting a job is small. Notwithstanding any positive side effects, these fatalistic attitudes and other adaptive behaviours are themselves an elusive cost and an impediment to enhancing job search intensity and, ultimately, Indigenous employment outcomes.*

Hunter (2000) goes on to conclude that if it were possible to control for this 'downward levelling of norms' (or psychological adaptation), the health impact of being unemployed for more than twelve months would be larger.

In a later study that analysed the Department of Employment, Workplace Relations and Small Business's (DEWRSB) data from a longitudinal survey of Indigenous job seekers, Hunter *et al.* (2000) found that health issues negatively impacted on prospects of gaining and retaining employment. This study revealed that health-related factors are much more important for Indigenous job seekers than was indicated in the 1994 NATSIS data. The main reason for this is that the DEWRSB survey data specifically identified that the health condition is related to an individual's capacity to perform work. This is the first study to explicitly highlight the effect of poor Indigenous health on labour force status. Given that health problems are defined in this study as 'those which affect the ability to perform one's job or get work in the first place', it is not surprising that health is associated with job retention. Hunter, Gray & Jones (2000) found that 10 per cent of males who have held the same job for at least twelve months had a health problem, while more than a quarter of male non-retainers had a health problem that may effect their work performance or capacity to find work (28.2 per cent). The importance of poor health in explaining poor Indigenous employment outcomes is confirmed in this study by a regression analysis. Having poor health is estimated to decrease the probability of employment for males and females by 20 and 13 percentage points respectively.

The recently released 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) data (ABS 2004) provide us with an up-to-date snapshot of labour force participation and Indigenous health, and a comparison with the 1994 NATSIS data.[2] The current data reveal that there has been some shift in reporting health status from 'good' to 'fair/poor' since 1994, with a higher proportion of people assessing their health as 'fair/poor' in 2002 (up from 17 per cent to 23 per cent). When the employment trends are examined, the increase in 'fair/poor' self-assessed health goes against the traditional linkage between employment and health outcomes.

The NATSISS data reveal that while the total proportion of the number of Indigenous Australians in the labour force remained constant, at approximately 60 per cent in both 1994 and 2002, there were marked changes in employment status at time of interview. The proportion of employed people increased from 36 per cent to 46 per cent over the eight-year period. The CDEP scheme increasingly contributed to Indigenous employment, accounting for one in four jobs held in 2002, and the proportion of Indigenous Australians employed in mainstream jobs also increased (from 28 per cent to 34 per cent). Between 1994 and 2002 the proportion of unemployed Indigenous people at the time of interview fell from 22 per cent to 14 per cent. These proportions translate to unemployment rates of 38 per cent in 1994 and 23 per cent in 2002. Improvements in long-term unemployment were also evident. In 1994 about half of all unemployed Indigenous people had been unemployed for one year or longer; by 2002 this proportion had reduced to one-quarter. Given this apparently (slightly) more positive account of Indigenous labour force participation, the higher self-reporting of 'fair/poor' health poses a number of questions, mostly related to the type of employment that is being generated, and the way it is being experienced by Indigenous people. This issue will be explored in greater depth later in this paper. For now, a closer look at labour status and health is warranted.

Table 1 displays self-assessed health status according to labour force status. Mainstream employed Indigenous Australians are more likely to report their health status as 'excellent/very good', while the unemployed and those not in the labour force are much more likely to report their health as 'fair/poor'.

The NATSISS data on income source at time of interview echo the changes in employment status. CDEP and non-CDEP wages and salaries combined accounted for a larger proportion of Indigenous Australians' main income source in 2002 (39 per cent compared to 33 per cent in 1994). Government pensions and allowances was the main source for 50 per cent of Indigenous people in 2002 (compared to 55 per cent in 1994). Mean equivalised gross household income has risen from $345 per week in 1994 to $387 per week in 2002.

When 2002 data are recalculated for the population aged eighteen or over (the population age target of most general social surveys), this is a mere 55 per cent of the relevant income level for non-Indigenous persons ($665 per week). Income data from the 2001 and 1996 population censuses in *Population Characteristics, Aboriginal and Torres Strait Islander Australians 2001* (Cat No. 4713.0) confirms that

TABLE 1: Health and disability by labour force status 2002

Health status	CDEP %	Non-CDEP %	Unemployed %	NILF %
Excellent/very good	47.6	54.2	46.3	33.6
Fair/poor	14.4	13.9	20.2	35.1
Has a disability or long-term health condition	31.2	24.4	35.2	48.8

Source: ABS (2004) National Aboriginal and Torres Strait Islander Social Survey 2002, ABS cat. no. 4714.0

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[2] Caution needs to be taken when interpreting results from the comparison of the 1994 and 2002 data, as the sampling frame of the 1994 survey differed slightly to the 2002 survey.

TABLE 2: Health and disability by income quintile 2002

Health status	Lowest %	2nd %	3rd %	4th and 5th %
Excellent/very good	38.0	42.8	49.2	56.7
Fair/poor	29.7	23.0	16.5	12.4
Has a disability or long-term health condition	43.5	33.3	30.5	25.3

Source: ABS (2004) National Aboriginal and Torres Strait Islander Social Survey 2002, ABS cat. no. 4714.0

while Indigenous mean equivalised gross household income has increased, the gap between Indigenous and non-Indigenous incomes has not narrowed.

Table 2 displays health status against income quintile. From the table, it can be seen that with a higher income there is a greater likelihood of a positive health self-assessment. Conversely, Indigenous people in the lower quintiles have much lower self-assessed health, and are far more likely to have a disability or long-term health condition.

Table 3 displays labour force status by income quintile, and reveals that Indigenous employees in mainstream employment are much more likely to be in the upper-earnings grouping. While CDEP workers are clustered in the middle quintiles, the Indigenous unemployed and those not in the labour force are (not surprisingly) in the lower-income grouping.

Table 4 displays the variables of health, labour force status, income and job search factors by location (remote versus non-remote). The data reveal that Indigenous people in non-remote locations assess their health as lower (that is, fair/poor) than those in remote Australia, and that Indigenous Australians in non-remote locations are more likely to be unemployed or in mainstream employment than those in remote areas. Indigenous people in remote areas have greater difficulty finding work due to the lack of jobs and/or the lack of 'appropriate' jobs than Indigenous Australians in non-remote areas and are more likely to be in the lower income quintiles. While it is difficult to translate this sort of 'splintered' data into a coherent story, the data does suggest some support for Hunter's (2000) suggestion of the 'downward levelling of norms' (or psychological adaptation) of Indigenous Australians in remote areas. This can be seen in their more favourable self-assessed health status against the backdrop of comparatively less employment opportunity (aside from CDEP employment) and earnings. The data also suggest that there may be some link between higher levels of self-assessed health and CDEP employment, with the majority of those participating in CDEP being located in remote areas.

Having viewed labour force participation from an aggregate perspective and exploring some of the differences between the various labour force status groupings, the focus will turn now to those qualitative studies that have looked at the experience of Indigenous Australians who are in employment. At the outset it needs to be said that there is a dearth of literature in this area. There is a great need to undertake qualitative ethnographic research, which can help us understand what 'work' means to Indigenous Australians, how they perceive their employment experiences and the resultant impacts on health.

The experience of Indigenous Australians at work

In a study of Koori workers, Sully (1997) attempted to identify some of the specific work and family cultural needs of Koori workers. Sully was particularly interested in the composition of Aboriginal families and the roles of family members, the differences between Aboriginal and non-Aboriginal communities in terms of values, and the consequences of these differences for the workplace, as well as any associated difficulties balancing work and family needs. The study also attempts to explore employment practices designed to assist workers with family responsibilities, positive benefits of family-friendly practices and any barriers to their introduction.

TABLE 3: Labour force status by income quintile 2002

Labour status	Lowest %	2nd %	3rd %	4th and 5th %
CDEP	9.3	17.8	11.5	3.4
Non-CDEP	8.9	33.6	61.5	84.8
Unemployed	20.8	11.2	7.9	4.7
NILF	61.0	37.3	19.1	7.1

Source: ABS (2004) National Aboriginal and Torres Strait Islander Social Survey 2002, ABS cat. no. 4714.0

TABLE 4: Characteristics of Indigenous Australians by remoteness 2002

Health status	Remote %	Non-remote %	Total %
Excellent/very good	44.2	44.0	44.1
Good	35.1	31.4	32.4
Fair/poor	20.0	24.5	23.3
Has a disability or long-term health condition	35.4	36.9	36.5
Labour force status			
CDEP	32.5	4.5	12.1
Non-CDEP	19.2	39.7	34.1
Unemployed	5.9	16.7	13.8
NILF	42.5	39.1	40.0
Unemployed—difficulty finding work due to:			
No jobs at all	29.4	8.2	10.7
No jobs in local area or line of work	18.3	10.5	11.4
Own health or disability	3.9	6.0	5.8
Racial discrimination	0.7	2.4	2.2
Income			
Lowest quintile	40.5	43.2	42.5
Second quintile	37.4	25.3	28.3
Third quintile	12.8	14.5	14.0
Fourth quintile	5.9	10.3	9.2
Fifth quintile	3.5	6.7	5.9
Personal stressor experienced in past 12 months:			
Not able to get a job	24.8	27.8	27.0
Involuntary loss of job	4.9	9.7	8.4

Source: ABS (2004) National Aboriginal and Torres Strait Islander Social Survey 2002, ABS cat. no. 4714.0

Sully (1997) rightly proposes that the issues of family responsibilities take on a particularly interesting and challenging aspect when considered in relation to the employment of Aboriginal people. This is especially pertinent, since multi-family households are more common in Indigenous households, and Indigenous families are generally larger than non-Indigenous 'nuclear' families. These differences in terms of family composition and roles can have direct implications for employment. Sully noted that leave provisions did not accommodate kinship expectations in relation to bereavement or assistance to family members. For Indigenous employees in the public sector, for example, grandparents have not come under the definition of 'immediate family' for the purposes of paid bereavement leave.

Moreover, the basic values, mores and laws of Indigenous and non-Indigenous communities can be contradictory. Sully (1997) posits that Indigenous people stress the importance of the group, while non-Indigenous Australians emphasise individual achievement and individual development. The values of Indigenous people may thus clash with the typical culture found in mainstream employment. Family obligations (attending funerals, for example) can often be a higher priority for Indigenous people than work. Huggins (1987:10), for example, states:

> *to Aboriginal people, the deep, religious and spiritual significance of funerals places a huge onus on relatives and friends to attend these important events. A funeral is viewed as paying final respects to a worthy and cherished person. No matter whether the deceased is a close relative or community acquaintance, attendance is unassumably [sic] commanded.*

Given that mortality rates are also much higher in the Indigenous community, the requirement to attend funerals may, in some cases, be greater than that experienced by other employees.

Sully also suggests that methods of communication are qualitatively different. It can be culturally inappropriate to force eye contact, or to touch an Indigenous Australian unless you are well known to the person. The significance of this for a multicultural workplace situation cannot be underestimated, since the emphasis on politeness and non-verbal communication may be misconstrued as 'shyness or rudeness, hostility or lack of knowledge' by the white observer in interpersonal interactions (Sully 1997).

The cultural differences in the interaction patterns and societal norms that Indigenous people bring to the workplace can often be compounded by stereotyping, tokenism and the racist remarks of other staff. As Sully (1997) asserts, the consequences for Indigenous employees of working for employers or supervisors who hold these stereotypes are not insignificant. Indigenous employees may be seen as tokens rather than individuals who bring specialised and useful skills to the organisation. This tokenism in turn can lead to feelings of isolation, strong pressures to succeed and exclusion from organisational groups. All of these factors contribute to an extremely complex and challenging situation for employers who seek to create a workplace that responds to the work, family and cultural needs of Indigenous people, and in so doing creates a quality of work-life relatively free of stressors that may impact negatively on health.

Using data from the Australian Workplace Industrial Relations Survey 1995, Hunter and Hawke (2000a; 2000b) attempted to explore how Indigenous Australians experienced their workplaces and conditions of employment. The study provides us with some insight as to how some Indigenous Australians may experience 'mainstream' employment. The main findings relating to Indigenous workers for the purpose of the discussion here reveal that Indigenous employees experience significant disadvantage in the workplace. They were more likely to be short-term employees than other workers in workplaces with Indigenous employees, and were more likely to prefer more hours of work per week. Similarly, Indigenous employees were less likely to get holiday pay and paid sick leave, and were more likely to be on a fixed-term contract. While more likely to be able to get permanent part-time work, Indigenous employees were less likely to be able to access maternity/paternity leave or bonuses for job performance than non-Indigenous respondents. Indigenous employees were more likely than other workers to have days off work because of work-related injury and illness. Indigenous employees were consistently less likely to report that they had control over their working environment, and were less likely to indicate that they had been consulted about any work-related changes in the previous twelve months. They were more likely to indicate they had no influence over the type of work or how it was done, their start and finishing times, pace of work and other decisions that affect workers.

These last points—work-related injury/illness and a limited locus of control in the workplace—are likely to be related and warrant further attention. Indeed, several European studies (see, for example, Marmot *et al*. 1997, Peter *et al*. 2002) have shown that people's health suffers when they have limited opportunity to use their skills and/or have little control over the way they undertake their work. In the absence of Indigenous-specific data, one can only speculate as to the nature and causes of the workplace injuries and illnesses that are being experienced by Indigenous employees and, again, this is clearly an area for further research and data collection. Possible reasons for the occurrences may be work-related stress due to the lack of locus of control, and perhaps also as a result of direct or systemic discrimination in the workplace, as well as a lack of training so as to avoid injury. Again, this is an area in which further qualitative-based research is sorely needed.

Conclusion and recommendations

This paper reviewed a number of studies that explore matters related to the labour force status and associated health of Indigenous Australians. The aggregate-level quantitative studies reveal that unemployed Indigenous Australians and those not in the labour force are more likely to experience ill health than those who are employed, and that the extent of the impact on health is qualified by locational factors. The literature also suggests, however, that Indigenous people who are in employment may be subject to certain 'risk' factors for health in the workplace. While the reviewed research sheds some light on labour force participation and health, such studies really only scratch the surface of the *nature of the linkage* between the two. The nature and direction of the causal nexus between labour force participation is a vexed issue and current understandings of health and work do not allow for a clear relationship to be detected. This is primarily a result of the continued application and use of Western understandings (and measures) of the concepts of 'work' and 'health' in the context of Indigenous Australia.

As we have tried to show throughout the paper, the concepts of health and work for Indigenous Australians can be quite different than those for non-Indigenous Australians. If we are truly to understand the meaning of both 'work' and 'health' (appropriately defined) and the complexities of the relationship between the two, we then need to hear about the experiences and meanings of these concepts from Indigenous Australians themselves. It is only by understanding the meaning and significance of work and non-work to Indigenous Australians that an essential starting point can be made in the identification of casual relationships. There is thus a great need for ethnographic research to illuminate the *meaning of work* for Indigenous people, and how this in turn may impact on health.

Qualitative and ethnographic research would facilitate a richer understanding of Indigenous perspectives of labour force status and its impact on health. For example, such an approach would help us understand how Indigenous Australians view the *experience* of employment, unemployment and job searching, as well as why decisions are made as to whether to enter the labour force or otherwise. While further quantitative data is also needed, it is exploratory qualitative research that should inform existing and future quantitative data related to labour force participation and Indigenous health to ensure the accuracy of the collection of Indigenous-specific data. This interdependent relationship between the two methodologies will ensure that future surveys incorporate measures of 'work' and 'health' that are both appropriate and meaningful to Indigenous Australians. Both types of research are necessary, but in order to understand the complex *linkage* between work and Indigenous health, there is now a crucial need for a more culturally appropriate and sophisticated ethnographic approach.

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Chapter 7:
Framework for Research on Aboriginal Health and the Physical Environment

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Executive summary

The Cooperative Research Centre for Aboriginal Health (CRCAH) has identified environmental health and health-related infrastructure as priority areas for research. The aim of this project is to provide a framework that will assist in the development of a focused and strategic research program in the area of Aboriginal health and the physical environment.

The research framework was developed through a survey of CRCAH partner organisations and other stakeholders involved in research or service delivery in the area of Aboriginal health. The aim of the survey was to identify current and future research interests and elicit views on how research into the physical environment and Aboriginal health could make a meaningful contribution to policy, planning and the delivery of services. A review of the published and unpublished literature on the physical environment and Aboriginal health looked at research that has been conducted to date and pointed to gaps in activity and knowledge.

The survey findings were categorised into three broad areas of research, and respondents ranked these categories closely. The categories were:

A) research that enhances our understanding of Aboriginal people's perceptions and behaviour in relation to the physical environment;

B) research aimed at understanding the determinants, outcomes and relationships between environmental factors and health outcomes; and

C) research that enhances the development and assesses the impact of programs and interventions.

Category A research was given the highest priority by CRCAH industry partners. In contrast to this, respondents from research organisations nominated Category B as the top priority.

The current research activities reported in the survey showed that most of the research related to the physical environment is being conducted in the area of housing. There are also projects underway in the areas of hygiene, water supply,

migration and the environment in a broader sense. The majority of these research projects were consistent with the research priorities identified in the survey and the review of the literature.

The review summarised research in each area of the physical environment and highlighted recommendations for research identified in the literature. It encompassed: environmental health, the urban environment, housing, maintenance, crowding, hygiene, water supply, waste disposal and drainage, swimming pools, dog health, roads and transport, energy, communication, climate and temperature, dust, pests and feral animals, land management, food supply, environmental health workforce, and trauma.

The survey and review found that research priorities should be in the urban environment, housing and areas directly related to housing, and water supply and sanitation. Many of the interventions reported in the literature are not based on either good evidence or good knowledge of Aboriginal people's perceptions and needs. This points to the importance of setting research priorities based on existing Category B evidence, and further investigating Aboriginal people's perceptions and needs in order to develop health strategies and actions based on Category A research.

The proposed research framework is based on the three categories of research in each identified area of the physical environment. Because of the complex nature and the multiple factors that influence each component, it may be useful to take an ecological approach to research in Aboriginal health and the physical environment. The ecological approach is guided by appropriate causal concepts based on universal laws (Category B), with the realisation that health and disease are mediated by specific social behaviours at the individual, population and global level (Category A). The best hopes for making an impact through interventions (Category C) in any of the areas identified in the framework rests upon a coherent strategy that is based on sound research in both Categories A and B. The importance of a more holistic approach to research is evident in the high priority placed on all three categories in the survey and on the expressed need to take a multi-disciplinary approach to research.

The research framework is intended as a guide to setting research priorities for the CRCAH in the area of Aboriginal health and the physical environment.

Background

The importance of the living environment, particularly housing, for the health of populations has been well established in the public health literature over the past 100 years.[1] There is an increasing body of evidence showing an association between housing quality and morbidity from infectious diseases, chronic illnesses, injuries, poor nutrition, and mental disorders.[2] The NHMRC, through the Aboriginal and Torres Strait Islander Research Agenda Working Group (ATSIRAWG) Road Map, has clearly identified the requirements for a healthy environment and lifestyle that are missing from many communities. These include housing, clean water, sewerage and safe surroundings.[3]

The CRCAH has thus identified environmental health and health-related infrastructure as priority areas for research. The significance of housing and the physical environment as a determinant of health, and the relatively undeveloped state of local and international research in this area, attests to the potential impact of a strong research program. This project aims to provide a focused research framework for Aboriginal[4] health and the physical environment.

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[1] D. Mara & G. Alabaster 1995, An Environmental Classification of Housing-related Diseases in Developing Countries', *Journal Tropical Mededicine and Hygiene*, vol. 98, no. 1, pp. 41–51; T. Agbola & O. A. Akinbamijo 1995, 'Housing and Health Characteristics: An epidemiological study of a tropical city', in B. Folasade Iyun, Y. Verhasselt & A. Hellen (eds), *Health of Nations: Disease, Medicine, and Development in the Third World*, Ashgate Publishing Ltd, Aldershot, UK; M. Shaw, M. 2004, 'Housing and Public Health', *Annual Review of Public Health*, vol. 25, pp. 397–418.

[2] J. Krieger & D. Higgins 2002, 'Housing and Health: Time again for public health action', *American Journal of Public Health*, vol. 92, no. 5, pp. 758–68.

[3] Aboriginal and Torres Strait Islander Research Agenda Working Group of the National Health and Medical Research Council (NHMRC) 2004, *The NHMRC Road Map: A Strategic Framework for Improving Aboriginal and Torres Strait Islander Health through Research*, NHMRC, Canberra.

[4] We use the term Aboriginal to represent Aboriginal and Torres Strait Islander peoples in this review.

Methods

The research framework was developed through:

1. A survey of CRCAH core and associate partners in order to:

- elicit views on how research into the physical environment and Aboriginal health could make a meaningful contribution to policy, planning and the delivery of effective and efficient services;
- identify current and previously unreported work carried out by relevant CRCAH partners; and
- identify current and future research interests in the area of the physical environment and Aboriginal health.

2. A review of the published and unpublished literature on the physical environment and Aboriginal health.

Survey

Contact was initially made with the ‘link’ people in all CRCAH partner organisations. They were asked to identify individuals in their organisation with an interest in Aboriginal health and the physical environment. CRCAH’s intranet email contact list was then used as a basis for circulating the survey to a wide range of stakeholders across Australia. A survey questionnaire was drawn up that asked respondents:

- to list research priorities in order of importance;
- to identify documents that contributed to their rationale;
- to describe the basis on which they had listed the priorities;
- to outline the nature of their interest in this research;
- to provide a description of their planned, current or funded research in this area;
- to identify any publications they have authored that are relevant to Aboriginal health and the physical environment; and
- to identify any additional literature that they see as important to this area of research.

A preliminary analysis of the survey led to the identification of three major themes, or categories, within which the specific research topics could be grouped. The preliminary findings were then disseminated through the original contact list. Recipients were requested to complete a second survey which asked them to:

- prioritise the three listed categories;
- indicate the top three research topics within each category;
- identify any gaps in the preliminary findings; and
- provide additional comments.

The analysis of the second survey involved counting the number of respondents who identified each category as the first, second or third priority. Once the categories had been prioritised, the topics within each category were assessed by counting the number of times each topic was listed as a first, second and third priority. A summary table was drawn up to assess which topics received the most number of nominations for each priority ranking. This provided an overview of the survey findings for all respondents.

Further analysis was conducted to compare the priorities of CRCAH partner versus non-partner organisations, and service providers versus research institutions. To this end, the respondents were divided into four groups: CRCAH partners involved in research; CRCAH partners involved in service delivery; non-partners involved in research; and non-partners delivering services. The above method of analysis was then followed for each group. From the summary table comparisons were drawn between all respondents belonging to research organisations and those who were service providers. There were also comparisons drawn between partner organisations and non-partner organisations.

The gaps in research priorities identified by respondents were listed and additional comments summarised so as to draw attention to areas that were not highlighted in the original survey.

Literature review

The literature review on Aboriginal health and the physical environment commenced with a broad reading of the literature on environmental health in the Indigenous Australian context. The main aspects of environmental health were identified and grouped into the following three categories:

1. The built environment, that is, all aspects of the environment that are constructed by humans. The built environment encompasses housing, water supply, communication, transport, roads, drainage, waste disposal, energy and swimming pools.

2. The natural environment, that is, the surrounding environment in which people live. Humans have an influence over the natural environment, but are not always responsible for direct modification and control. The natural environment includes climate, temperature, land management, pest and feral animals, dust and dog health.

3. The social environment, in this instance, refers to the human relationships that mediate the health outcomes resulting from the built and natural environments. These include social capital,[5] environmental health workforce, crowding, maintenance, food supply, trauma and hygiene.

This structure allowed environmental health to be approached broadly by including the immediate living environment as well as the surrounding natural environment. It also allowed consideration of the social processes that are both a product of and an influence on the built and natural environments.

A review of the literature was conducted for the subsections in each category. A search of the in-house database at Menzies School of Health Research, Darwin, was conducted initially to pick out any relevant literature that had already been collected. A search of the electronic databases PubMed and APAIS, as well as the Charles Darwin University library catalogue, was then carried out using a mixture of the following keywords:

- Subsection keyword (i.e. housing, water supply, climate)
- Health
- Aborigin*
- Indig*
- Remote
- Australia

A broad search of each subsection was refined until a manageable number of relevant search results were obtained. The articles that were applicable to the topic of Aboriginal health and the physical environment, both in the urban and rural/remote context, were entered into a standard bibliographic database. Review articles pertaining to the same topic in similar contexts internationally (i.e. New Zealand, Canada and America) were also included. References that were identified as important in the survey were also added to the database.

Due to the small amount of literature on environmental health in the urban context, a further search was done of APAIS and PubMed, using the keywords Urban, Health and Aborigin*.

Social capital is an important aspect of the social environment, and there is a growing literature on social capital and health (e.g. I. Yen & S. Syme 1999, 'The Social Environment and Health: A discussion of the epidemiologic literature', *Annual Review of Public Health*, vol. 20, pp. 287–308. Another group in the CRCAH is reviewing this literature in the context of the social determinants of health.

Findings

Survey

Overall ranking of research priorities

There were sixteen responses to the first survey. A thematic analysis of the research priorities showed that the identified topics fell into three broad categories. These were:

Category A: Research that aims to enhance the understanding of Aboriginal people's attitudes, perceptions, values and behaviour relevant to health and the physical environment.

Category B: Research that aims to enhance the understanding of the determinants, outcomes and relationships between environmental factors and health outcomes.

Category C: Research that aims to enhance the development of, and assess the impact of, programs and interventions.

There were five specific research topics identified under Category A, ten topics under Category B, and twelve under Category C. The second survey generated twenty-seven responses. An analysis of all responses to the request to prioritise the three categories revealed that they were ranked closely.

Within Category A the top three research priorities were:

1) prioritisation and definitions of need;

2) the use of housing by Aboriginal people; and

3) Aboriginal people's conceptions of the physical environment and public space.

Other lower ranked priorities included hygiene and the effect of dispossession and grief on the perceptions and use of public space.

Within Category B the most important research priorities were considered to be:

1) understanding the environmental influences that romote a healthy start to life;

2) location and context and how these affect access to health services; and

3) research into the environmental influences on lifestyle, for example, smoking, obesity and physical activity.

This third preference was followed closely by environmental influences on alcohol and other drug use. Other priorities, in order of preference, were environmental influences and infectious disease, water quality and quantity, environmental influences and nutrition, the health of the ecosystem, environmental influences and injury, dust and air pollution.

The three most highly ranked research priorities within Category C were:

1) self-determination, community control and capacity development interventions relevant to the environment and health;

2) broad health/public policy approaches relevant to the environment and health (e.g. healthy settings approaches that address air, water, shelter, sanitation, chronic disease, schools, mental health); and

3) strategies to overcome structural barriers to environmental health improvements, including political and economic barriers.

Other research priorities in this category included, in order of nominated preference, behaviour change and skills development, basic infrastructure and related technology, effect of infrastructure aimed at improving child and youth health, workforce initiatives, housing management systems, economic analysis, methodological issues and research capacity, information systems and 'caring for country' programs.

Gaps in the research priorities

Respondents to the second survey identified a number of specific gaps in the research priorities listed under each category. In Category A, the effect of land ownership by some, as opposed to no land rights by most, was thought to warrant further investigation. In Category B, it was suggested that research into the physical environment, social capital and connectedness was required. Four gaps were identified within Category C, the most frequent relating to information. Although there was an existing topic of information systems, the issue of information access and feedback was considered sufficiently different to warrant separate inclusion. The gap in research in the urban context was highlighted. While location/context in Category B encompasses this, it is important to note that research priorities may be different in these diverse areas. The other two gaps were individualism versus collectivism and leadership within the community.

Some respondents also provided additional comments in the second survey. These comments strongly promoted a trans-disciplinary approach to research, involving social scientists, physical environment specialists and health professionals. This should allow for an equal emphasis on qualitative and quantitative data. There was also a strong call to focus on issues that are context and location specific. It was further noted that the influence of the wider community should be taken into account in order to explore ways in which the council, health centre, community store and wider political environment impact on health. Cultural rationality and human rights were highlighted as potential approaches that could be used to determine research priorities into Aboriginal health and the physical environment.

Ranking of research priorities by organisation

A further analysis of the second survey was conducted to compare the views of CRCAH partner organisations and non-partner organisations. Table 1 classifies the organisations that responded to the survey, and provides an overview of their responses.

There were seventeen responses from partner organisations and ten responses from non-partner organisations. The categories were ranked closely by both groups. The priorities ranked within each of the categories were also similar for both groups and consistent with the overall ranking of research priorities.

Further analysis was conducted to compare the results from service providers and research organisations. There were fifteen respondents from service provider agencies

TABLE 1: Survey response by type of organisation

Organisation type	CRCAH partner	Non-partner	Category ranking
Research organisations	Flinders University Menzies School of Health Research LaTrobe University University of Melbourne Australian Institute of ATSI Studies University of Queensland	Australian National University	Priority 1 = B Priority 2 = C Priority 3 = A
Service organisations	Aboriginal and Torres Strait (ATSI) Services Department of Health and Community Services (NT) Department of Community Development, Sport and Cultural Affairs (NT) Department of Education, Employment and Training (NT) Department of Health and Ageing (Commonwealth)	Department of ATSI Policy (Qld) Wide Bay Division of General Practice (Qld) TAFE (Qld) Mawarnkarra Health Service Aboriginal Corporation (WA) Thursday Island Coordinating Council (Qld) Department of Health and Human Services (Tas)	Priority 1 = A Priority 2 = C Priority 3 = B
Category ranking	Priority 1 = A Priority 2 = C Priority 3 = B	Priority 1 = B Priority 2 = A Priority 3 = C	Priority 1 = A Priority 2 = C Priority 3 = B

TABLE 2: **Current research activities reported by CRCAH partner organisations**

Category A:	**Category B:**	**Category C**
Understanding Aboriginal people's perceptions and behaviour	Relationship between the physical environment and health outcomes	Developing and assessing interventions
• Water supply and use in Aboriginal communities in South Australia. • Living along the Murray: Nunga perspectives. • Living along the lower Murray River and Coorong: Nunga perspectives. • Feedback of information from the Community Housing Survey. • Indigenous mobility in discreet and rural settlements. • Analysis of Indigenous migration from 2001 census data.	• The living environment, child health, human rights and public health legislation. • 2006 Community Housing and Infrastructure Needs Survey (CHINS). • Water supply and child health. • Input to, and review of,the Indigenous Disadvantage Reports. • The Hygiene Study: childhood infectious disease in remote Aboriginal communities in the NT. • Socio-economic and Environmental Determinants of Health in NT Aboriginal Communities (SEEDH).	• Housing needs analysis. • Research into the design of kitchens and wet areas. • Review of national framework for design, construction and maintenance of Indigenous housing. • Do housing infrastructure improvements reduce child exposure to bacterial pathogens? • Housing Improvements and Child Health (HICH). • Improved hygiene measures for reducing skin, respiratory and diarrhoeal illness in Aboriginal children: a randomised control trial • Microbial outcome measures for evaluating the impact of hygiene interventions on Aboriginal child health.

and twelve from research organisations. Service providers showed a clear preference for research on Aboriginal people's perceptions and behaviour (Category A), while this was the third priority for research organisations. The association between environmental factors and health outcomes (Category B) was given top priority by research organisations, but was third preference for service providers. CRCAH industry partners rated Category A research particularly high.

It is interesting to note that CRCAH partners involved in service delivery identified most of the gaps listed above. Most of the additional comments were provided by CRCAH partners, particularly respondents from research organisations.

Current research activity

The first survey asked respondents to provide a description of their planned, current or funded research in the area of Aboriginal health and the physical environment. There were nineteen current research activities reported by CRCAH partner organisations (Table 2).

Table 2 shows that current reported research into Aboriginal health and the physical environment is evenly spread across Categories A, B and C.

Literature review

To date, Australian research into Aboriginal health and the physical environment has focused on establishing associations between various aspects of the environment and health outcomes (Category B), and then developing and evaluating the impact of interventions to reduce associated morbidity and mortality (Category C). However, while there is currently a significant gap in Category A research, there is a slow but growing recognition that the development of successful programs and interventions requires an understanding of Aboriginal people's world view and behaviour. There were specific areas in the literature review where gaps in knowledge surrounding Aboriginal perceptions were identified. These areas included research on water supply, waste disposal, swimming pools, the urban environment, energy, trauma and hygiene. Despite this, the recommendations for research stemming from the literature review continued to focus on Category C research.

Discussion

Comparing survey and literature review findings

Priorities identified through the survey compared with those identified through the literature review

The most striking difference between the survey and the literature review was the priority given to research that enhances the understanding of Aboriginal people's attitudes, perceptions, values and behaviour relevant to health and the physical environment (Category A). To the survey participants, this type of research was as important as that which aims to enhance the understanding of the relationship between environmental factors and health outcomes (Category B), and research that aims to enhance the development and assess the impact of programs and interventions (Category C). CRCAH industry partners rated the need for more investigation of Aboriginal people's perceptions and behaviour particularly highly.

The literature review, on the other hand, revealed a significant gap in Category A research and provided few recommendations for further research in this area, focusing instead on further research into the development and assessment of interventions (Category C). The only exceptions to this were found in research into water supply, waste disposal, swimming pools, the urban environment, energy, trauma and hygiene, where a few researchers acknowledged that an understanding of Aboriginal people's values, priorities and actions could be used to inform and develop more effective health strategies.

A comparison of the literature review and survey also highlights some important considerations regarding future research into specific aspects of the physical environment. The limited research into Aboriginal health in the urban environment appears to be of particular concern given that the majority of the Aboriginal population lives in urban areas. Unlike research in remote areas, the studies conducted in urban settings have focused more on perceptions and behaviour in relation to the physical environment, and there have been few documented interventions. This points to a significant need for further research into environmental health in the urban context.

Housing and the maintenance of houses, particularly in remote communities, has received a substantial amount of attention in the Australian literature. The research priorities highlighted by international reviews on housing and health suggest that further research is required into the precise mechanisms by which housing affects health. On the other hand, the Australian literature has prioritised interventions, based on the assumption that the health–housing connection does exist. If adequate housing is one prerequisite for health, then there is a need for effective strategies to ensure that Aboriginal people have access to safe and affordable housing. Effective strategies are likely to be those based on a good understanding of Aboriginal people's priorities, needs and use of houses. Therefore, it is important that these needs and behaviours are explored in the first instance and are used to inform appropriate housing programs.

It has been difficult to establish a causal association between crowded living conditions and poor health outcomes. Further research in this area was not seen by survey respondents as a priority, neither was research into interventions to change behaviour. There is a perceived need, however, to look at ways in which housing and the wider environment can better meet the needs of Aboriginal families. Although this has been recognised for more than two decades, there seems to have been little action taken.

Hygiene is an important health issue at the interface between housing and people. Both the literature and the survey results indicate that research efforts in this area should be focused on Aboriginal people's perceptions and behaviours in order to change the approach to interventions. Previous attempts at teaching people a different way of thinking have been relatively ineffective, therefore, a stronger emphasis on skills development rather than behaviour change would appear appropriate.

There has been a relatively large amount of literature on the technical aspects of liquid waste disposal in remote areas. This is in stark contrast to the lack of importance placed on solid waste disposal. Given that solid waste is a prominent and visual problem in many communities it is interesting to note the lack of research and interventions in this area. Only one study was identified that looked at Aboriginal people's perceptions of solid waste and this research did not extend to recommendations for interventions. Considering the mainstream unacceptability of solid waste pollution, it would seem that there may be considerable benefit from research into programs and interventions aimed at reducing solid waste pollution in the environment. It is interesting that this was not reflected in either the literature or the survey findings.

There has been a lot of attention given in recent years to dog health programs in remote Aboriginal communities. Yet a substantial amount of research attempting to link dog health with human health has failed to show a clear association. Dog programs designed to improve human health may thus be a waste of health resources. Addressing the underlying causes of human ill-health is more likely to show long-term benefits for both dogs and humans than addressing dog health in isolation.

Energy is an issue that deserves further consideration, as it facilitates many healthy living practices such as cooking and storing food, having hot water to wash, controlling temperature in the home, and enhancing general safety and functioning after dark. Technical energy supply issues have been dealt with in the literature, but there seems to be a lack of information around the use of electricity by Aboriginal people. Research in this area could, therefore, be of benefit.

Nutrition is at the core of human health. There are myriad social issues around food and its supply that require exploration in order to understand Aboriginal people's perceptions and behaviour, and to use this knowledge to develop interventions. However, the social aspect of food is outside the scope of this review. Food in relation to the physical environment is intimately linked with other areas such as energy, water supply, housing and waste disposal. Therefore, research into these areas will have a flow-on effect and may have benefits for food supply, storage and intake.

Within the survey, social issues of trauma were highlighted primarily in terms of domestic violence and alcohol use. Although this is not directly related to the physical environment, it is important to note that these issues were raised and continue to be a concern for many people involved in Aboriginal health.

Notably, there is only a small amount of literature linking health with roads and transport, communication, climate and temperature, dust, and pests and feral animals. These areas were also not given priority by survey respondents. This is not surprising given the magnitude of health problems associated with the more important aspects of the physical environment. In the future, as broader health issues are resolved, these areas may become increasingly important.

Research activity compared with identified priorities

The first questionnaire asked respondents to provide a description of their planned, current or funded research in the area of Aboriginal health and the physical environment (see section 'Current research activity'). When these research activities were mapped against research priorities identified in the survey it showed that current research activity was being conducted equally across categories A, B and C. This is consistent with the close ranking that the three categories received in the second survey.

There was noticeably more research being conducted into housing than any other area, with seven studies underway at the time of the survey. The review identified research into effective health hardware and housing technology as a priority and two current research activities in this area were reported in the survey: research into the design of kitchens and wet areas, and a review of the national framework for design, construction and maintenance of Indigenous housing. The literature also identified a need for longitudinal studies evaluating housing interventions, while the survey identified two current studies examining housing improvements in relation to bacterial pathogens and child health.

Management systems relevant to housing and the community were nominated as fifth priority in Category C. In relation to this priority, there is current research into the feedback of information from the Community Housing Survey. The first Category A priority identified by the survey was prioritising and assessing needs in Aboriginal communities. Two research projects addressing this area were reported: the housing needs analysis, and the Community Housing and Infrastructure Needs Survey (CHINS). Environmental influences and a healthy start to life was nominated as the top priority for research in Category B, with research in this area involving a study into the living environment, child health, human rights and public health legislation.

Three research projects on hygiene were reported, each focusing on child health in relation to hygiene, consistent with the top Category B research priority—environmental influences and early life.

Three research projects considered the environment from a broad perspective, with two of them examining Nunga perspectives consistent with the priorities outlined in Category A. The third, on socio-economic and environmental determinants of health in Aboriginal communities, encompassed all of Category B, and was, therefore, in line with priorities identified by survey respondents.

There were two studies on water supply identified by CRCAH partner organisations: a study on water supply and use in Aboriginal communities, identified as a Category A priority in the survey; and a study on water supply and child health, identified as a top priority in Category B, as it examines the environmental influences on child development.

There are two studies identified by CRCAH partners that do not fit neatly within the priorities identified in the survey or those highlighted in the literature. Both of these studies focus on Indigenous mobility and migration.

Current project activities identified in the survey tend to be consistent with nominated research priorities, with a strong focus on housing in both the literature and projects. This indicates that although housing is important, there is definite scope to expand future research into other areas associated with the physical environment.

Limitations of the methods

The scope of this review, as well as time and budget constraints, limited the depth of information and analysis on specific topics. The literature on this broad area, particularly the international literature, is immense. Consequently, for non-Australian research, we restricted our search to review papers and did not examine reports of primary research. This will have reduced the sensitivity and specificity of our review, particularly with respect to the international literature. The amount of peer-reviewed Australian Aboriginal literature in this area is relatively small. The extent of grey literature, such as government reports and discussion papers, research theses, consultants' reports, and unpublished community reports, is likely to be much larger but outside the scope of this paper due to time and resource constraints.

The survey was sent to a general and untargeted mailing list, and many of the recipients would have little knowledge or interest in this specific research area. This approach was designed to provide opportunity for input from a wide potential audience, and could be seen as a 'call for expressions of interest'. Given the primary aim of this project and the intention to obtain input from as wide a group as possible, it was not appropriate, nor possible, to construct a sampling frame or a complete list of individuals or organisations that we knew would, or should, provide input. It was expected that many survey recipients would not respond, and it was perceived to be more important that the survey was distributed as widely as possible to scope out the range of views of interested stakeholders. Approximately 10–15 per cent of people on our mailing list responded to the call for input. The exact number could not be calculated because a number of emails were sent to group email addresses. Thus, the findings are based on the responses of those who had sufficient interest in the subject of this survey.

Despite these methodological limitations we feel that our review of the literature has provided us with an overview of research in the area, and an indication of research priorities as perceived by a range of interested parties. The information contained in this scoping project should be a useful guide to the CRCAH in further developing a research agenda for Aboriginal health and the physical environment.

TABLE 3: Framework for research on Aboriginal health and the physical environment

Aspects of the physical environment	**Category A:** Aboriginal people's attitudes, perceptions, behaviour	**Category B:** Understanding the relationship between the environment and health outcomes	**Category C:** Development and impact of programs and interventions
Environmental health			
Housing			
Maintenance			
Crowding			
Water supply			
Waste disposal and drainage			
Hygiene			
Swimming pools			
Dog health			
Urban environment			
Communication			
Roads and transport			
Energy			
Climate and temperature			
Land management			
Pests and feral animals			
Dust			
Environmental health workforce			
Food supply			
Trauma			

Proposed framework for CRCAH research

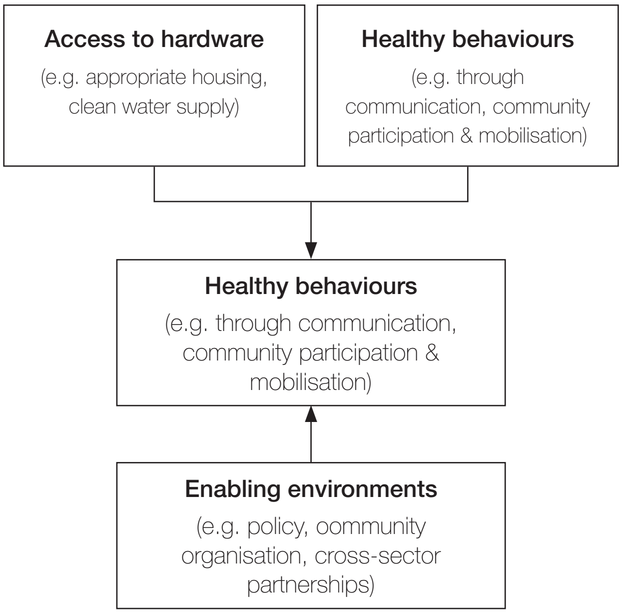
Table 3 provides a framework for research into Aboriginal health and the various aspects of the physical environment. Categories A, B and C were developed by drawing out themes from research priorities identified in the first survey. Aspects of the physical environment were identified through the broad literature on environmental health in the Indigenous context.

This framework highlights the different components of the physical environment and outlines the three types of research that might be undertaken under each component. The review of the literature and the results from the survey show that priority is not distributed equally within the framework. The lack of research in the urban setting is recognised in the survey, indicating that this is a priority issue. Similarly, housing and the components related to housing (such as crowding, maintenance and hygiene) are emphasised in the literature as well as in the survey, which attests to the potential benefits of a strong research program in this area.

Although this research framework is reductionist, in order to allow for consideration of the many aspects that make up the physical environment, it is important to recognise the complex, interwoven nature and the multiple factors that influence each component. Thus, it is useful to take an ecological approach to research in Aboriginal health and the physical environment. Ecologism attempts to deal with the true complexities of the biological world through an awareness of the interaction between biological, human and social systems.[6] The ecological approach is guided by appropriate causal concepts based on universal laws (Category B), with the realisation that health and disease are mediated by specific social behaviours at the individual, population and global level (Category A). The best hope for making an impact through interventions (Category C) in any of the areas identified in the framework rests upon a coherent strategy that is based on sound research in both Categories A and B.

Figure 1 outlines the Health Improvement Framework (HIF), which is an integrated approach to research, linking health hardware and behavioural determinants with enabling institutional and policy environments. While the ecological approach allows consideration across all three categories of research, the HIF is important when considering the multiple factors that impact upon interventions aimed at improving health.

FIGURE 1: Health Improvement Framework[7]



The importance of the ecological approach, and the usefulness of a framework that encompasses the multiple factors that impact upon health, are highlighted by survey respondents placing high priority on all three categories of research. The call for multi-disciplinary research evident in the survey is also consistent with this ecological approach. It highlights the need to make use of medical scientists, epidemiologists, statisticians, social scientists, economists, political scientists and administrators in the domain of public health. This allows for a broader exploration of the biological mechanisms, the social processes and the most appropriate and effective health strategies in order to make the most gains in Aboriginal health.

Conclusion

Survey and review findings prioritised research in the urban environment, housing and areas directly related to housing, and water supply and sanitation. The evidence base for interventions has not been given priority in the survey or the Australian literature to the same extent as it has in the international literature. Many reported interventions are not based on either good evidence or good knowledge of Aboriginal people's perceptions and needs. This points to the importance of setting research priorities based on existing Category B evidence, and further investigating Aboriginal people's perceptions and needs in order to develop health strategies and actions based on Category A research.

The proposed framework for research on Aboriginal health and the physical environment is based on the three categories of research in each identified area of the physical environment. While the framework is reductionist by nature, it is important to take an ecological approach to research synthesis and the application of findings. For example, even in highly focused studies it is essential that contextual factors are taken into account, with consideration of how the findings from the research fit with broader health issues. The HIF may be a useful tool for the development and implementation of interventions. The importance of a more holistic approach

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[6] M. Susser & E. Susser 1996, 'Choosing a Future for Epidemiology: II. From black box to Chinese boxes and eco-epidemiology', *American Journal of Public Health*, vol. 86, no. 5, pp. 674–7.

[7] Adapted from Environmental Health Project, UNICEF Water Environment and Sanitation, US Agency for International Development, World Bank/Water and Sanitation Project, Water Supply and Sanitation Collaborative Council 2004, *The Hygiene Improvement Framework. A Comprehensive Approach for Preventing Childhood Diarrhoea*, Joint Publication No. 8, Environmental Health Project, Washington, DC.

to research is evident in the high priority placed on all three categories in the survey and on the expressed need to take a multi-disciplinary approach to research.

It is important to note that the proposed framework is not intended to be prescriptive. It does not encompass every aspect of the environment and other areas may deserve consideration. The framework is intended as a guide to setting research priorities for the CRCAH in the area of Aboriginal health and the physical environment.

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Chapter 8: Social and Emotional Wellbeing of Aboriginal and Torres Strait Islander People within the Broader Context of the Social Determinants of Health

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Introduction

The social and emotional wellbeing of Aboriginal and Torres Strait Islander people is affected by a range of social determinants of health. These determinants include forms of State violence and inter-generational trauma, imbalanced power relations and limited access to services within the mainstream population, and systemised and individualised discrimination and racism. These contribute greatly to the perpetuation of lower income and standards of living, including poor quality and overcrowded housing and community infrastructure, and poorer outcomes in health, education, employment and the justice system. Indigenous Australians continue to experience higher levels of poverty, incarceration and ill health than the rest of the Australian population. Given these experiences, and the resulting disadvantage they exert on Aboriginal and Torres Strait Islander people's employment opportunities, it is not surprising that welfare payments originally designed as safety nets for the small minority, that is 5–10 per cent of the mainstream population that become unemployed at any given time, have become a trap for some Aboriginal and Torres Strait Islanders, where up to 80 per cent of residents live on some form of welfare. The pervasive effects of inter-generational welfare on such communities are clearly visible and continue to entrench the 'downtrodden image' of Aboriginal and Torres Strait Islander people in the media. The experience of these inequities promotes adoption of risk behaviours such as smoking, inhalant use and harmful drinking, as well as poor nutrition and the morbidity associated with chronic diseases such as diabetes, cardiovascular disease, renal disease and mental illness, and many infectious diseases (ABS & AIHW 1997, 1999, 2001, 2003, 2005).

A number of reports outline the factors that influence/determine the social and emotional wellbeing of Aboriginal and Torres Strait Islander people. These include: Dunlop 1988; NAHSWP 1989; RCIADIC 1991; Burdekin 1993; Swan and Raphael 1995; HREOC 1997; and Zubrick *et al.* 2005. The Commonwealth Department of Health and Ageing (DHA) has published a

Social and Emotional Wellbeing Framework policy document (hereafter the *Framework*) using a population health model for national action against the high incidence of social and emotional wellbeing problems and mental ill health among Aboriginal and Torres Strait Islander people (DHA 2004). The *Framework* is based on a holistic Aboriginal definition of health (NAHSWP 1989; Swan & Raphael 1995), and uses nine guiding principles extracted from the *Ways Forward* report (Swan & Raphael 1995) to emphasise this holistic view. The development of the *Framework* was based on widespread consultations, the available literature and some specific research (e.g. OATSIH 2002), and was created in response to the growing need to manage mental health issues in a more appropriate manner.

There is a feeling among Aboriginal and Torres Strait Islander people that the term mental health has some stigma associated with it, and that they may prefer the less 'loaded' term—social and emotional wellbeing. This term has the advantage of alluding to the social and historical nature of human wellbeing as against the perceived individualistic nature of the term 'mental health'. This feeling is shared by other populations: for example, Patel (1996) suggests dropping the word 'mental' when discussing mental disorders in primary care in African countries. On the other hand, the increasing recognition of the significant burden of disability and loss associated with mental health disorders all over the world, the growing influence of consumers over services and public discourse, the placing of mental health within a human rights framework, plus efforts to reduce stigma, are all leading to greater acceptance of the word and adoption of its broader meaning.

The literature about social and emotional wellbeing in general, and individual mental health and mental ill health in particular, is broad in scope. We have, therefore, focused our review on the social determinants of Aboriginal and Torres Strait Islander health, as directed by the Cooperative Research Centre for Aboriginal Health (CRCAH).

We would like to acknowledge at the outset that any future research in this area must recognise the critical importance of engaging and collaborating with Aboriginal and Torres Strait Islander people and communities so that their needs and priorities are properly addressed by the research, and that practical outcomes flow from such investigations. This approach should also ensure that the heterogeneity of Aboriginal and Torres Strait Islander people is captured.

This review has four main sections:

1. the social determinants framework of health;

2. social and emotional wellbeing;

3. measuring and assessing social and emotional wellbeing; and

4. towards a research agenda in social and emotional wellbeing.

Each section has a short introduction and summary.

We have used a variety of sources for this review, including electronic library databases, Health*InfoNet*, Google, websites of government and non-government agencies, and discussions with colleagues. The information on Aboriginal and Torres Strait Islander wellbeing available in academic journals was relatively limited compared to the wealth of material found in the various types of 'grey literature', such as unpublished reports, conference proceedings and websites. This indicates that the area is highly interactive, evolving and attracting substantial attention.

As this literature review was limited both by time and resources, our aim has been to capture a summary of the emergent themes in the current discourse, rather than to complete a systematic and exhaustive review. The rationale was thus to identify the major documents, to highlight the main themes and to provide a rich resource for further exploration of specific issues.

The social determinants framework of health

Introduction

In this section we explore the literature on social determinants of health from both an international and Aboriginal and Torres Strait Islander perspective.

International understanding

Although questions have been raised as to the applicability of internationally accepted social determinants of health to Aboriginal and Torres Strait Islander people (e.g. Morrissey 2003; Dance *et al*. 2004:29), we will use such determinants as a guide to our understanding of Aboriginal and Torres Strait Islander health, until research provides evidence to the contrary.

The importance of social factors on health outcomes is convincing internationally (e.g. WHO 1986; Marmot & Wilkinson 1999, 2006; RACP 1999; Yen & Syme 1999; Eckersley, Dixon & Douglas 2001; Berkman & Kawachi 2001; Siegler & Epstein 2003; Wilkinson & Marmot 2003; Marmot 2004; Wilkinson 2005). There is also a substantial international literature on the association between social factors and health throughout the life-course (e.g. Kuh *et al*. 1997; Blane 1999; Wadsworth 1999; Lynch & Kaplan 2000; Cashmore 2001; Vimpani 2001; Ben-Shlomo & Kuh 2002; Gilman 2002; Harper *et al*. 2002; Gilman *et al*. 2002; Wadsworth & Butterworth 2006).

Yen and Syme (1999) broadly describe the social environment as neighbourhoods, groups to which we belong, workplaces, and policies that governments and others create to order our lives. Shaw (2004) suggests how housing can affect wellbeing through 'the meaning of home'. A range of authors also discuss the association between the social environment and morbidity and mortality risks independent of individual risk factors, and the influence of the social environment on disease pathways, including mental ill health (Yen & Syme 1999; Faris & Dunham 1960; Gunnell *et al*. 1995; Payne *et al*. 1993; Yen & Kaplan 1999). Najman (2001) considers that not only are these social origins of health substantial and persistent, but that they offer the greatest prospect for improvements in population health.

Psychosocial interventions are used widely in nursing, social work, behavioural science, psychiatry, and sociology (Glass 2000). Cashmore (2001) explores pathways that children follow to particular physical, social, emotional and cognitive developmental outcomes throughout their development, and discusses risk and protection mechanisms, vulnerability and resilience, and preventive interventions. O'Dea and Daniel (2001) discuss psychosocial characteristics in the context of the social gradient in health, such as depression, hostility, psychological stress, and their associated health outcomes. The social gradient in health refers to social inequalities in health whereby life expectancy is shorter and most diseases are more common further down the social ladder in each society (Wilkinson & Marmot 2003; Marmot 2004).

Socio-economic factors throughout the life-course can affect adult physical and mental health and disease in two main ways. First, these factors can expose individuals to circumstances that cause or increase the risk of injury and disease, and reduce protective factors during gestation, infancy, childhood, adolescence and young adulthood. Secondly, through learned behaviours, social chains of risk operate throughout the life-course resulting in adult socio-economic circumstances that increase disease risk through exposure to causal factors in later life (Kuh *et al*. 1997). Cullen and Whiteford (2001:21) discuss two associations between mental disorders and poor social circumstances. The first is that mental disorder impairs psychological and social functioning leading to downward 'social drift' (Goldberg & Morrison 1963; Jones *et al*. 1993). The second is that individuals in socially disadvantaged situations are exposed to more psychosocial stressors, and these stressors trigger the onset of symptoms of ill health and the loss of psychological abilities for social functioning (Bebbington *et al*. 1993).

Wilkinson and Marmot (2003) suggest a number of factors that help to explain the sensitivity of health to the social environment. Such factors include the social gradient, stress, early life, social exclusion and social support, addiction, and work and unemployment. Within each area, behavioural issues around parenting, nutrition, exercise, and substance abuse, and structural issues around unemployment, poverty and experience of work are discussed. For example, the report points out that stress and psychosocial risk factors such as social isolation, lack of control over work and home life, low self-esteem, insecurity and anxiety may lead to mental ill health.

Aboriginal and Torres Strait Islander understanding

There is a substantial body of literature on Aboriginal and Torres Strait Islander health and social disadvantage (e.g. ABS & AIHW 1997, 1999, 2001, 2003, 2005). The determinants of mortality and morbidity in Aboriginal and Torres Strait Islander health are complex and multidimensional, and evidence from social epidemiology indicates that social factors are implicated in the production and persistence of health inequality (Anderson 2001). More recent publications provide a framework to better understand the complex issues (for example, policymaking, education, employment and welfare, history, housing, racism, concepts of health and illness) that make up the social determinants of Aboriginal and Torres Strait Islander health (McDonald *et al*. 2006; Carson *et al*. 2007).

Morrissey (2003:31) considers that much of the research into the social determinants of Aboriginal and Torres Strait Islander health 'is indifferent to social theory and dominated by a simplistic quantitative positivism which is incapable of capturing the complex aetiology and pathways of chronic disease', and moreover, 'strips away the essential political elements'. Morrissey argues for an alternative research methodology, both qualitative and quantitative, based on a transdisciplinary and complex perspective (Higginbotham , Albrecht & Connor 2001; Higginbotham, Briceno-Leon & Johnson 2001). We agree that a transdisciplinary approach is necessary and that the research needs strengthening. However, significant work has focused on the complexities of the social, historical, political, economic and cultural factors affecting Indigenous health and wellbeing—although not always in 'social determinants' jargon. This perspective is reflected in the holistic Aboriginal and Torres Strait Islander definition of health as embodied in key health policy documents: for example, in the National Aboriginal Health Strategy (NAHSWP 1989), in the pioneering work of Swan and Raphael (1995), in the *Bringing Them Home Report* (HREOC 1997), in the underlying issues sections of the various Royal Commission into Aboriginal Deaths in Custody Reports, and in the philosophy and operation of community-controlled comprehensive primary health care services.

Further, the work of Dunlop (1988), Sheldon (2001) and Cox (2000) make important contributions to an understanding of the complexity of this field. Cox's ethnography addresses 'the social sources of suffering' with a study of everyday life, while all three authors give accounts of how the various local Aboriginal and Torres Strait Islander groups perceive and describe social and emotional distress and how this fits (or not) with mainstream psychiatric perspectives.

In her exploration of an Aboriginal and Torres Strait Islander community's perceptions of current difficulties, Cox (2000) found that various traumatic events and forms of distress (suicide, interpersonal violence, homicide and sickness) were understood in the light of salient moral domains that originated from local priorities and sensibilities. These demonstrated the residents' human need for meaning and control. These findings led to an exploration of the historical erosion of local forms of power and control during periods of exploitation, protection, removal, integration, and assimilation. This erosion of power is also manifest in contemporary social processes such as self-management, land rights and native title. Thus past and present forms of marginalisation are deeply implicated in present tensions in local governance and in the problem of establishing legitimate forms of authority at the community level. This level of analysis is crucial in establishing the dimensions of Aboriginal and Torres Strait Islander social and emotional wellbeing, and identifying the factors that undermine or enhance it.

Summary

There is a large and compelling international literature, mainly from work in developed countries, describing the complex and multidimensional nature of the social determinants of health. A much smaller body of work describes, not always in 'social determinants jargon', the importance of social factors in the health inequality experienced by Aboriginal and Torres Strait Islander people.

Social and emotional wellbeing

Introduction

The concept of social and emotional wellbeing is sometimes used interchangeably with the term mental health. However, as mentioned above, the term wellbeing is preferred by many Aboriginal and Torres Strait Islander people, partly as a way of subverting the stigma associated with mental illnesses. Indigenous definitions of health reject the biomedical view of disease as the result of damaging physiological events that disrupt normal physical or mental processes. These definitions are also inconsistent with the Cartesian mind–

body split on which separate care pathways for social and emotional health, and physical and mental disorders, have been based.

Whichever term is adopted, it is critical that the many issues that underlie Aboriginal and Torres Strait Islander people's health and wellbeing be recognised as associated with what Swan (1988) referred to as 'reality factors'. These factors have not been effectively included in health service research and provision, on the basis of being too broad, encompassing everything and therefore being too impractical. Their significance, however, is demonstrated by the inability of a health system that focuses on individuals to achieve significantly better mental health and wellbeing outcomes for Indigenous people despite decades of effort and biomedical advancement. We believe that whole-of-government and community-driven approaches are needed that encompass all aspects of life including economic, political, social and cultural dimensions.

Aboriginal and Torres Strait Islander specific issues

Aboriginal and Torres Strait Islander people have suffered terribly from the consequences of colonisation and evolving forms of social, bureaucratic and legislative marginalisation for more than 200 years. Although it is outside the scope of this review to detail this suffering and its profound effects on Aboriginal and Torres Strait Islander people's social and emotional wellbeing, we are able to highlight some of the major issues raised in the broad anthropological and cross-cultural psychiatric literature that documents these effects (e.g. Eastwell 1977 a, b; Gault *et al.* 1979; Reid 1982, 1983; Kamien 1976a, b; Cawte 1969, 1972, 1973, 1974, 1976; Hunter 1993a, b, c, d, e, f, g, h, i, j; Reser 1991; Mobbs 1991; Cox 1997, 2000).

There is a growing literature on important issues around the removal of children and forced separation (ABS & AIHW 2003, 2005; HREOC 1993, 1997; Kendall 1994; King 1997; Kinnear 2000; Koolmatrie & Williams 2000; Read 1981, 2000; Petchovsky & San Roque 2002; Zubrick *et al.* 2005), inter-generational trauma (Raphael *et al.* 1998), violence (ABS & AIHW 2003, 2005; Anderson 2002; Atkinson 1990a, b, 1991, 1992; Blagg 1999; Bolger 1990; Eckermann & Dowd 1988; Memmott *et al.* 2001; Reser 1990b; Smith & Williams 1992), self-harm and suicide (e.g. Cox 2002; Gunnell *et al.* 1995; Radford *et al.* 1999; Tatz 1999, 2001), and alcohol and drug use (Mathews *et al.* 1988; Harold 1989; Brady 1995a, 1998, 2000, 2002; Dance *et al.* 2004).

The peer-reviewed literature in this area of research primarily highlights the fact that governments at all levels, health care professionals, non-government organisations, the private sector, and other groups and individuals in our society have failed to produce significant improvements in Aboriginal and Torres Strait Islander wellbeing. The government's minimal interest and commitment in health and welfare issues specific to Aboriginal and Torres Strait Islander people are highlighted by a number of sources (Jonas 2003; Read 2000; SNAICC 2003), with some reports focusing on common legacies of distress (HREOC 1997; Kinnear 2000; MHCA & CAA 2001), which government agencies have thus far failed to address. The peer-reviewed literature is also essential in reiterating the true nature of Aboriginal and Torres Strait Islander dimensions of wellbeing, the legitimacy of which is often attacked by members of Parliament (HR 2000) and the media (Jonas 2003).

There are a number of important government-initiated or sponsored reports on Aboriginal and Torres Strait Islander wellbeing issues, the principal being the *Bringing Them Home: Report of the National Enquiry into the Separation of Aboriginal and Torres Strait Islander Children* (HREOC 1997). This report is a comprehensive review of testimonies collected from individuals who were removed under government-initiated policies. It discusses the effects of such policies and what reparations are required for survivors of these removals and their families to begin the process of healing. We note the actions the Commonwealth Government took to set up the National Regional Centre Program for social and emotional wellbeing under the *1996 Emotional and Social Wellbeing (Mental Health)* Action Plan (DHA 1995; Urbis Keys Young 2001) following the *Bringing Them Home* and *Ways Forward* reports (HREOC 1997; Swan & Raphael 1995). The activities of several of these regional centres are in the broader literature (e.g. Urbis Keys Young 2001; Anon 2002; Dukes *et al.* 2004; KAMSC 2003; Frith *et al.* 2007).

What is social and emotional wellbeing?

Social and emotional wellbeing is a much broader concept than mental health (Mobbs 1991; Reser 1991). Swan and Raphael (1995) recognise this by advocating a holistic view of Aboriginal and Torres Strait Islander mental health that should be understood in the context of the impact of colonisation, loss of traditional lands, loss of culture, separation of children from their families, racism, social inequity, trauma and grief. Social and emotional wellbeing is determined by a wide range of factors, and an understanding of these factors varies between cultural groups and individuals, as well as along the age and development spectrum (DHA 2004).

The factors that diminish social and emotional wellbeing—including grief, loss, trauma, abuse, violence, substance misuse and physical health problems—are well known. Conversely, the positive and stabilising influences that promote self-care and self-defined recovery for all kinds of illnesses, addictions and traumatic experiences are similarly recognised (DHA 2004).

The historical origins of barriers to social and emotional wellbeing experienced by Aboriginal and Torres Strait Islander people are highlighted by the Human Rights and Equal Opportunity Commission (HREOC 1997). Hunter (1998b) describes five levels of activity required to address social and emotional health problems. These are: political (reconciliation and social equity); community development (including health promotion and prevention initiatives); appropriate mainstream services; adapted mainstream approaches (such as the adaptation of narrative therapy to Aboriginal and Torres Strait Islander needs); and Aboriginal and Torres Strait Islander therapies.

Cox (2000) provides a historically and culturally contextualised comparison of interpretations of certain phenomena, understood by Aboriginal people as spiritual and pathologised by Western psychiatry (see Cawte 1974, 1988). The problem of misdiagnosis is also covered here and is further discussed by Indigenous authors such as Swan (1991), O'Shea (1996) and Gulash *et al.* (1999)—the latter in terms of a discussion of the inappropriateness of Western diagnostic tools when applied to Aboriginal and Torres Strait Islander populations.

The relatively small research literature on the social and emotional wellbeing of Aboriginal and Torres Strait Islander people focuses on the following broad aspects: perspectives on social and emotional wellbeing, healing, sharing and regeneration; social health in urban settings; individual and family wellbeing; personal and community development; Aboriginal stories about kidney disease; psychosocial problems of adolescents; Aboriginal self; wellbeing in the context of drug and alcohol use; resilience and vulnerability; the social meaning of petrol sniffing; disturbed behaviour, environment and social stress in traditionally oriented Aboriginal societies; early interventions for social and emotional wellbeing; issues affecting adults removed as children; healing traditions; unresolved grief and the removal of children; training in Aboriginal and Torres Strait Islander social and emotional wellbeing; the socio-cultural context of wellbeing, illness and healing; better medication management for Aboriginal people with mental health disorders and their carers; measuring social and emotional wellbeing; and the control factor and taking control, empowerment, and stress and coping. (See Adams 2002; Anderson 1996; Atkinson & Edwards-Haines 2003; Atkinson 1994; Brady 1992a, b, 1993, 1995a, b, c, 1998, 2000, 2002; Brice 1994; Brice et al. 1992; Bushby & Moodjit 2002; Cawte 1973; Cox 2000; Daly *et al*. 2004; Davidson *et al*. 1978; de Crespigny *et al*. 2005; Deemal 2001; Devitt & McMasters 1998a, b; Dunlop 1988; Finlayson & Anderson 1996; Fredericks & Atkinson 1997; Gault *et al*. 1970; Gray *et al*. 1995; Gridley 2000; Gulash *et al*. 1999; Hamilton 1975; Harnett *et al*. 1998; Heil 2003; Holmes *et al*. 2002; Hunter 1998b; Kowanko *et al*. 2003a, b, c, 2005; Kendall 1994; Kirmayer *et al*. 2003; Koolmatrie & Williams 2000; Lowe & Spry 2002; Lynn 2001; McGuire 1999; McMahon & Reck 2003; Mobbs 1991; NACCHO 1993; 2003; Radford *et al*. 1999, 1991a, b, c, 1990 a, b; Raphael *et al*. 1998; Reid 1982, 1983; Robson & Silburn 2002; Toby 2000; Tsey & Every 2000 a, b, c; Tsey 2000; Tsey *et al*. 2002, 2003 a, b, c, d, 2004; Vino *et al*. 1996; Wanganeen 1994).

Health and wellbeing

Examples of the holistic notion of Aboriginal and Torres Strait Islander health are provided by the National Aboriginal Health Strategy Working Party (NAHSWP 1989:ix–x), the National Aboriginal and Islander Health Organisation (NAIHO), the National Aboriginal Community Controlled Health Organisation (NACCHO), and definitions cited by Swan and Raphael (1995, Part 1:14), while Heil (2003:22–5) explores the history of contemporary meanings of the concepts inherent in 'Aboriginal and Torres Strait Islander health and wellbeing'.

Aboriginal and Torres Strait Islander people do not make the Platonic and Cartesian divide between mental and physical being (i.e. they have a holistic view of being), and have to struggle with the dominant (Western) culture's language of health and illness (McDonald 2006; Cox 2000). Anderson (1996) discusses how Aboriginal people have used various definitions of health with an analogous range of meanings. The core elements of these definitions include 'the physical, social, emotional, cultural and spiritual wellbeing not only of the individual but the whole community' (Anderson 1996:68). He describes how the 'Ngaringman mob' from the Northern Territory have a word *punya* with a range of meanings including 'wellbeing', and explains '… like *punya,* wellbeing connects people, place and Law, and is a whole-of-life view including the traditional concept of life-death-life as well as the relationship to the land' (Anderson 1996:68). Nathan (1980, cited in Mobbs 1991) gives more detail on how some urban Aboriginal and Torres Strait Islander groups conceptualise health.

The link between wellbeing and community features strongly in a number of international descriptions of health and wellbeing that are relevant to the holistic Aboriginal and Torres Strait Islander concepts (e.g. WHO 1986; Bristow 2003). In a study of health and wellbeing of Indigenous people from diverse parts of the world, family connections, community relations, peace, spirituality, environmental factors and control of services are highlighted as important components of wellbeing, with happiness and health repeatedly recognised by respondents as essential components of wellbeing (Bristow 2003).

A New Zealand Maori model of health and wellbeing is Whare Tapa Wha, visualised as a 'four-sided house': Taha Wairua (spiritual)—capacity for faith and wider communion; Taha Hinengaro (mind)— capacity to communicate, think and feel; Taha Tinana (physical)—capacity for physical growth and development; and Taha Whanau (extended family)—capacity to belong, to care, and to share. The link between these four components is fundamental. 'A person's synergy relies on these foundations being secure. Move one of these, however slightly, and the person may become unwell' (Durie 1998, cited by McPherson *et al*. 2003:444).

Mental health and mental ill health

The holistic Aboriginal and Torres Strait Islander understanding of mental health also influences interpretations of personal states (Swan & Raphael 1995, Part 2:29). It is well recognised that the response to distress and interpretation of 'different' behaviours can vary across cultures. Thus, interpretations of 'mental health' and 'mental illness' that are framed from Western medicine are limited (Reser 1991; Cox 2000). Swan and Raphael (1995, Part 2:29–33) review the literature of explanatory frameworks of mental illness, illness experience and aberrant behaviour from Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander perspectives, including the work of Dunlop (1988).

The term 'mental health' is defined holistically in the *National Mental Health Plan 2003–2008* (AHM 2003) as quoted in the DHA Framework document (DHA 2004:7). For Aboriginal and Torres Strait Islander people, this mainstream definition must incorporate strengths—such as the importance of land, culture, spirituality, ancestry, family and community—and acknowledge inherent resilience (DHA 2004:7). The DHA Framework document also discusses 'mental ill health', where mental health problems and mental illness are differentiated on the basis of severity, duration, as a temporary or expected reaction to life stressors, and whether presenting problems meet the criteria and threshold for a diagnosis according to classification systems for mental disorders (DHA 2004:8).

Some of the mental health literature boundaries that separated research in psychiatry from research in social and emotional wellbeing are fading (Hunter & Tsey 2003). Psychiatric research has shifted emphasis from developing and establishing the most effective therapies for specific mental illnesses to identifying the 'common factors' across therapies that effect the most change (Rosenzweig 1936 cited in Hubble *et al*., 1999; Frank 1961; Lambert 1992; Hubble, Duncan & Miller 1999; Bertolino 2003). These 'common factors' include change in non-clinical aspects of a person's life (e.g. family and career, housing, employment/ meaningful occupation, recreation) that assist individuals towards connectedness and wellbeing (Lambert 1992; Bertolino 2003).

The importance of a collaborative partnership between clinicians, primary health workers and the carer and family, who enhance a person's wellbeing on a daily basis, is clear (O'Kane & Tsey 1999; MHCA & CAA 2000). At the same time, mental health consumers have pioneered new ways of looking at severe mental illnesses. Common stages and experiences detailed in accounts of illness indicate that consumers can successfully redefine themselves and their lives, despite the continued presence of the illness, in ways that represent personal definitions of recovery. A group of Maori consumers from New Zealand have described the core elements of their recovery journeys in a document titled ‘Tuituia’. This document highlights the importance of cultural identity and the concepts of ‘Whanau Ora’, which encompass the notions of inclusiveness, collectivity and interdependence in relationships within family and Maori society (MH-SMART Tangata Motuhake/Whaiora Roopu 2005).

From the social and emotional wellbeing perspective, people with mental illness are often among the least empowered individuals in any community. There is little documentation detailing levels of stigma among Aboriginal and Torres Strait Islander communities. However, Dunlop (1988) and Cox (2000) provide evidence that in some such communities there is a high degree of tolerance for individuals experiencing difficulties, and that those who experience social and emotional distress tend to remain integrated in community and family life. The underlying social disadvantage in these communities—lack of employment opportunities, environmental problems such as overcrowded housing, limited access to mental health services, and the availability of drugs and alcohol—profoundly affect the lives of people who must face the additional challenges of managing mental illness (Hunter 1998b). When traumatic events occur in the community, consumers are often deeply affected and may experience a severe relapse, which, in turn, may further add to the communities’ grief and lack of control.

The relatively large research literature about mental health and mental ill health among Aboriginal and Torres Strait Islander people focuses on the following broad aspects: overviews of mental health; mental health service programs and practice; mental health promotion; mental ill health prevention; early interventions for mental health; suicide; depression; distress; violence; self-mutilation; resilience; vulnerability; psychiatric disorders; social and cultural influences on mental health; ethno-psychiatry; spirituality; forced separation and its psychiatric sequelae; child development; Aboriginal and Torres Strait Islander perspectives on mental health; and mental health workers (Bianchi *et al*. 1970a, b; Biernoff 1982; Bonner 1980; Brady 1987; Brideson 1998; Brown 1999, 2001; Bullen 2001; Cantor *et al*. 1995; Cawte 1965a, b, c, d, 1969, 1976, 1988; Davidson *et al*. 2000; Eastwell 1977a, b; Fagan 1991a, b; Gunnell *et al*. 1995; Hennessy 1996; Higgins 1996; Hoban 2002; Hunter & Garvey 1998; Hunter 1988a, b, c, 1990a, b, c, d, 1991a, b, c, d, e, 1992a, b, 1993a, b, c, d, e, f, g, h, i, ,j, 1994a, b, c, 1995a, b, c, 1997a, b, 1998a, b, 1999, 2002, 2003; Hunter *et al*. 2001; Jones 1972; Jones & Horne 1972; Kamien 1975, 1976a, b; Kessler *et al*. 2002, 2003; King 1997; Kinnear 2000; Kyaw 1993; Laugharne *et al*. 2002; McKendrick 1990; McKendrick & Thorpe 1994; McKendrick & Charles 1992, 2001; Mushin *et al*. 2003; O’Kane & Tsey 1998, 1999; O’Shea 1996; Parker 2003; Petchkovsky & San Roque 2002; Radford *et al*. 1991a, b, c, 1999; Reser & Morrissey 1991; Reser 1990a, b, 1991; Sheldon 1997, 2001; Sheehan *et al*. 2002; Swan 1991; Tatz 1999, 2001; Troth & Grainger 2000; Turale 1992, 1994; Zubrick *et al*. 2000).

Resilience

Resilience is a multifaceted characteristic of the wellbeing of individuals and communities that helps protect against the risks associated with adversity. Resilience is particularly important for Aboriginal and Torres Strait Islander people given their continuing experience of colonisation and their relative socio-economic and cultural disadvantage by most indicators.

International understanding of resilience

A generalised definition of resilience is the process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstances (Masten *et al*. 1990). Masten and colleagues (1990) identify three kinds of resilience: (1) ‘overcoming odds’, which is commonly used to refer to the belief that individuals have a particular quality or personal strength that enables them to withstand adversity; (2) coping in the face of sustained and acute negative circumstances (e.g. continuous family conflict); and (3) recovery from trauma (e.g. death of a sibling or parent).

The general literature on childhood and adolescent resilience is quite extensive (e.g. Compas *et al*. 1995; Howard *et al*. 1999; Serbin & Karp 2004). Rutter (1984, 1985, 1987) has discussed protective factors and mechanisms in children that promote psychosocial resilience. These include factors that reduce both risk exposure or impact and negative chain-reactions following bad events or experiences, as well as those that promote self-esteem and self-efficacy through achievements. Positive relationships and new opportunities that provide needed resources or new directions in life also enhance resilience.

Aboriginal and Torres Strait Islander and broader Australian understanding of resilience

Little is known about resilience among Aboriginal and Torres Strait Islander people (e.g. Brady 1992a, 1993, 1995c; Harnett *et al*. 1998; Hunter 1990c, 1993a:240; Toby 2000; Cadd 2002; Holmes *et al*. 2002; Westerman 2003; Robson & Silburn 2002). However, it is worth remembering that Aboriginal and Torres Strait Islander people are likely to use different terms for this concept, such as strength or survival as in Bart Willoughby's song *We Have Survived* released in 1982 by the Australian band No Fixed Address.

International and Australian research into resilience includes family and community, not just the individual. The Australian literature on resilience frequently concentrates on preventative/intervention programs often aimed at parenting skills (Jenkin & McGenniss 2000; Scott 2000; Gauntlett *et al*. 2000; McDonald & Hayes 2001; Silberberg 2001; RPR Consulting 2004a, b). However, few of these programs are Aboriginal and Torres Strait Islander specific or designed to transcend cultural differences. Gauntlett *et al*. (2000:23) noted that 'many discussions of prevention and early intervention strategies specifically for Indigenous communities emphasise very similar problems to those of mainstream Australia', but went on to say that 'there is a recognised need to have programs and studies that are focused specifically on the wellbeing of Indigenous communities'. RPR Consulting (2004b) reviewed the Early Intervention Parenting program and Good Beginnings Prototype, the two main subcomponents of the Child Abuse Prevention program. With respect to Aboriginal and Torres Strait Islander communities, the consultants stressed the importance of a whole-of-community approach, as in the Indigenous RAP-P (Resourceful Adolescent Program for Parents) Program and the Strong Men, Strong Families project in Roebourne (RPR Consulting 2000b:8). Gauntlett *et al*. later noted that

> *the current needs of Aboriginal and Torres Strait Islander people are a consequence of having their strengths destroyed through processes of colonialism. Strategies to promote stronger Aboriginal and Torres Strait Islander communities, to develop their resilience and to foster social capital within them clearly have to start from this premise (2000:24).*

There is some evidence to suggest that Aboriginal and Torres Strait Islander people in remote and urban locations have developed resilience strategies to survive the range of social and health problems that affect them. The potential for achieving gains in mental and physical health and wellbeing through enabling Aboriginal and Torres Strait Islander people to practise cultural knowledge in natural resource management, 'caring for country', gathering and eating bush tucker, market gardening and living on outstations to reconnect with their country has been described in many reports (Bear-Wingfield 1996; CAT 1996; Mills, Pensio & Sailor 1997; McDermott *et al*. 1998; Brown *et al*. 2001). Toby (2000) found that Aboriginal female prisoners developed protective factors to help them cope with the stress of being in prison. The various works of Tsey and colleagues with Aboriginal and Torres Strait Islander people on family wellbeing, control issues and with men's groups has also improved our understanding of resilience issues. This research has demonstrated that participation in family wellbeing programs and men's groups resulted in high levels of personal empowerment, including an increased sense of self-worth, resilience, ability to reflect on root causes of problems and problem solving ability, ability to address immediate family difficulties as well as belief in the mutability of the social environment. Evidence also suggests a ripple effect of increasing harmony and capacity to address structural issues within the wider community. These issues include poor school attendance rates, workforce development, debates about contemporary Aboriginal and Torres Strait Islander spirituality, the critical housing shortage, endemic family violence, alcohol and drug misuse, higher levels of chronic disease and over-representation of Aboriginal and Torres Strait Islander men in the criminal justice system (Tsey 2000; Tsey & Every 2000a, b, c; Tsey *et al*. 2003a, b, c; Tsey *et al*. 2004).

Brady (1992a) discusses the social, geographical and historical factors influencing the prevalence of petrol sniffing, from its commencement in the 1950s to the early 1990s, and suggests that young Aboriginal men involved in the cattle industry have been able to develop independence and self-esteem that helped them resist taking up petrol sniffing. Brady (1995b) also discusses the causes of Aboriginal and Torres Strait Islander vulnerability to drug and alcohol problems resulting from social and economic marginalisation.

Work by Chandler and Lalonde (1998) with First Nations tribes in British Columbia has focused on similar issues in relation to youth suicide. They have demonstrated that cultural continuity and local community control are linked to low rates of suicide, and transcend the impact of remoteness and social and economic disadvantage to promote a sense of purpose and identity in their young people.

The National Health and Medical Research Council (NHMRC) has identified research on Aboriginal and Torres Strait Islander resilience and wellness as one of six priority research themes, and supported the recent International Collaborative Indigenous Health Research Partnership Grant Program on Resilience that aims to stimulate research in this area (NHMRC 2004a, b).

Summary

The second section on social and emotional wellbeing has summarised some of the literature and perspectives on the concept of social and emotional wellbeing among Aboriginal and Torres Strait Islander people. It gives an overview of definitions and concepts before moving into a brief summary of the main topics addressed by the literature in this field. The concept of resilience, another term that focuses on social rather than individualistic approaches, was also discussed. We considered some international perspectives on this topic as well as its relevance among Aboriginal and Torres Strait Islander groups.

Measuring and assessing social and emotional wellbeing

Introduction

This section explores what we know from the available literature, both Australian and international, of how social and emotional wellbeing can be measured, how such measures can be used, and their relevance to the health of Aboriginal and Torres Strait Islander people.

What we know

There are hundreds of tools that have been developed to measure and assess various aspects of social and emotional wellbeing, quality of life and related concepts (e.g. see http://acqol.deakin.edu.au/instruments). These tools are used for many purposes, including monitoring clinical care, measuring the impact and outcomes of interventions, identifying priority groups for resource allocation, identifying individuals at risk of mental health problems, assessing the economic benefit of various programs to justify expenditures, and so on. The vast majority have been developed for mainstream populations, with very few developed or validated for use with Aboriginal and Torres Strait Islander people (Westerman 2003). As a result, Aboriginal and Torres Strait Islander programs and services have faced greater difficulty in demonstrating their outcomes in quantitative terms in the absence of appropriately validated tools.

The whole issue of measuring social and emotional wellbeing, especially that of Aboriginal and Torres Strait Islander people as a sub-group within the larger Australian population, raises difficult and sensitive issues. Any quantitative measure of health can be experienced by Aboriginal and Torres Strait Islander people as disempowering. Given the magnitude of health disadvantage experienced by Aboriginal and Torres Strait Islander people, statistics can be presented in a way that reinforces the perception that the situation is hopeless and any efforts to change it are futile. On the other hand, strengths-based approaches to measurement that capture subtle incremental change towards larger improvements can enable people to gain confidence and hope, and ensure that positive change, not harm, occurs. Although few such tools are widely used at present, a number are in developmental stages (e.g. Kingi & Durie 2000; NACCHO 2003).

However, there are many technical issues to consider in quantification. The Australian Government agencies responsible for health data collection and analysis have stated that the measurement of the social and emotional wellbeing of Aboriginal and Torres Strait Islander people continues to be limited by a number of constraints including the following:

> *A lack of data definitions, standards, and data collection instruments that encapsulate the holistic nature of social and emotional wellbeing in a culturally appropriate way while allowing for statistical measurement needs to be met;*
>
> *Inaccuracies in available data as a result of misdiagnosis of people with symptoms of social and emotional distress. Certain behaviours, which might be appropriate in terms of Indigenous culture, may be diagnosed as mental illness in non-Indigenous terms (HREOC 1993). The use of psychological tests based on concepts alien to Indigenous culture is another potential source of inaccurate diagnosis. Misdiagnosis may also occur because of language problems, particularly in the elderly (HREOC 1993);*

> *Under-reporting of mental and behavioural disorders and associated conditions because of the under-identification of Indigenous people in administrative records such as hospital and death records;*
>
> *National surveys have not had sample sizes sufficiently large and/or geographically representative of the Indigenous population to produce results about mental health for Indigenous people… However, even if the survey[s] had been able to produce results for Indigenous people, the questions used may not have been appropriate (ABS & AIHW 2001:143).*

The Australian Bureau of Statistics (ABS) has developed a background document on measuring wellbeing (ABS 2001) that acknowledges wellbeing as a complicated concept that is influenced and affected by a range of internal and external factors:

> *From birth to death, life enmeshes individuals within a dynamic culture consisting of the natural environment (light, heat, air, land, water, minerals, flora, fauna), the human made environment (material objects, buildings, roads, machinery, appliances, technology), social arrangements (families, social networks, associations, institutions, economies), and human consciousness (knowledge, beliefs, understandings, skills, traditions). Wellbeing depends on all the factors that interact within this culture and can be seen as a state of health or sufficiency in all aspects of life (ABS 2001:6).*

The ABS has identified eight areas for measurement: family and community (support and nurture through family and community); health (freedom from disability and illness); education and training (realisation of personal potential through education); work (satisfying and rewarding work both economic and non-economic); economic resources (command over economic resources, enabling consumption); housing (shelter, security and privacy); crime and justice (personal safety and protection from crime); and culture and leisure (time for and access to cultural and leisure activities). The areas are highly inter-connected, and objective and subjective measures can be used within each area, although assessment may be difficult. The usefulness of this approach for measuring the wellbeing of Aboriginal and Torres Strait Islander people is unknown.

Following a national workshop in Canberra in 2003[1], co-hosted by the two Australian Government agencies, a process began whereby, in consultation with NACCHO[2], the ABS developed a 'social and emotional wellbeing' module for use in the 2004/2005 Indigenous Health Survey (IHS). Results of this survey were released in 2006 (ABS 2006). A follow-up workshop was co-hosted by the two Australian Government agencies in Canberra in November 2006, and the findings from this workshop may provide a useful guide for further research into the measurement of social and emotional wellbeing.

Information is available in the literature from a number of research projects exploring the measurement of Aboriginal and Torres Strait Islander mental health/social and emotional wellbeing (e.g. Brice 1994; Clayer & Divakaran-Brown 1991; Radford *et al.* 1990a, b, 1999; Hunter 1990a, b, c; Hunter *et al*. 1991; McKendrick *et al*. 1992, 2001; Turale 1992, 1994; Adams 1996; KAMSC 1999; Bullen 2001). These discuss the importance of community ownership, community involvement, community spiritual oversight, community-based ways of seeing, action-focused approaches, layers of community control, and cultural validation of survey instruments in the development of methodological approaches. They also identify pitfalls in the application of standard instruments, and urban versus non-urban inquiry methods. Further important work defining the issues involved in the application of mainstream mental status and outcomes assessment tools to Aboriginal and Torres Strait Islander populations in clinical contexts was undertaken by Gulash *et al*. 1999, Westerman 2004, Haswell-Elkins and Wargent 2005, emphasising and demonstrating the importance of family, Indigenous health workers and community informants.

Other Australian projects such as the *Western Australian Aboriginal Child Health Survey* using the Strengths and Difficulties Questionnaire (SDQ) (Zubrick *et al*. 2005), the New South Wales Health Survey using the Kessler 10-Psychological Distress Scale—unmodified (NSWHD 2000),

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[1] A workshop on measures of social and emotional wellbeing of Aboriginal and Torres Strait Islander people was hosted by the Australian Institute of Health and Welfare and the Australian Bureau of Statistics, Thursday 14 August 2003, Canberra. A background paper for this workshop was prepared by Gavin Stewart of New South Wales Health (Stewart 2003).

[2] NACCHO prepared a draft review and discussion paper during this period (NACCHO 2003).

and the ABS 2004/2005 Indigenous Health Survey (ABS 2006), highlight the methodological difficulties involved in measuring the social and emotional wellbeing of Aboriginal and Torres Strait Islander people.

International projects of relevance to understanding how the social and emotional wellbeing of Aboriginal and Torres Strait Islander people is measured include:

(i) A Canadian project—The First Nations and Inuit Regional Longitudinal Health Survey—managed by the Assembly of First Nations Chiefs' Committee on Health. The instruments and methods used were developed by the National Aboriginal Health Organisation and included structured interview schedules designed for computer analysis and mental health questions.

(ii) A United States of America project—American Indian Services Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project (AI-SUPERPFP). A variety of instruments were used (e.g. SF-36 and a modified version of the Composite International Diagnostic Interview), data collection was computer assisted, and the AI-SUPERPFP lay interview included assessment of risk factors such as life events, recent events, chronic strains and traumas, and protective factors such as ethnic identity, social support, coping, mastery and self-esteem. Details of this project are available on line (http://www.uchsc.edu/ai/ncaianmhr/dac.htm). Brice (1997) describes a 'Baseline Measures' project in the USA using tribally defined health status indicators and work in progress towards establishing a national Indigenous health database. The community-driven approach provides a holistic framework for action to advance Native American health, including mental health.

(iii) A New Zealand model of health and wellbeing called Whare Tapa Wha, and Hua Oranga—a Maori measure of mental health outcome (Kingi & Durie 2000). This work formed the basis of much focus on Indigenous issues within national approaches to mental health in New Zealand. For example, the Maori Monitoring and Review Group, which has responsibility for ensuring responsiveness of Maori in all aspects of New Zealand's national initiative, MH-SMART has developed a set of principles and training vignettes to guide the use of the Health of the Nation Outcomes Scale (HoNOS) with Maori consumers (Levy *et al.*, 2005a, b) that have both informed and been informed by work in Australia (Haswell-Elkins & Wargent 2005).

Summary

Given the issues raised in the second section that perpetuate the inter-generational loss of social and emotional wellbeing among Aboriginal and Torres Strait Islander people brought about through colonisation, it is clear that defining and measuring Indigenous wellbeing requires great care. We have briefly identified problems that arise in the selection and development of appropriate tools for measurement, their implementation, and the interpretation and use of the data collected. We also describe a number of recent initiatives in Australia, Canada, New Zealand and the USA that are beginning to show the benefits of appropriately developed and used measurement tools in holistic action frameworks for the promotion of mental health and wellbeing.

Towards a research agenda in social and emotional wellbeing

Introduction

This section pulls together the main findings of the literature review, and makes recommendations on the practical measures that researchers and other stakeholders—such as practitioners, educators, policy makers and planners—can take in partnership with communities to help improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people.

A research agenda

The approach

We would like to reiterate what we wrote in the introduction to this review: that is, the critical importance of involving Aboriginal and Torres Strait Islander people and communities right from the start in all research activity, and the need to clearly link research outcomes to government policy-making and implementation to achieve measurable improved health outcomes. We would also like to emphasise the critical importance of recognising (and allowing for) the dominant Western perspective (bias) that most of us bring to our research activities (e.g. Stanfield 1985; Scheurich & Young 1997). The concept 'social and emotional wellbeing' is not easily defined, but is a critical part of the holistic concept of health. We have reviewed some of its important components, and suggest in what follows a potential focus for future research in a social determinants context. No single discipline, used in isolation, will be able to influence the search for new and effective ways of promoting social and emotional wellbeing. Transdisciplinary and multi-level research frameworks are needed to understand and address the complex social determinants of Aboriginal and Torres Strait Islander social and emotional wellbeing, including power, control, political parity and genuine self-determination.

The policy context

We described in the Introduction and in the second section of this review how the DHA has recently developed a national strategic framework for social and emotional wellbeing for Aboriginal and Torres Strait Islander people (DHA 2004). In this document, the fifth strategic direction is to 'improve quality, data and research', with a key result area of 'developing and publishing culturally appropriate data and research that reflects Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing and that underpin improved service delivery'. The rationale for this key result area lists six action areas—including culturally sensitive data collection methods, support for community research initiatives, recruitment and retention of Aboriginal and Torres Strait Islander statisticians and researchers, and ethical conduct of research—to progress improvements in social and emotional wellbeing (DHA 2004:50–3). However, research and recommendations alone are not sufficient to achieve improvement. It is already known that under-resourcing, short-term funding, and the poor attitudes and behaviour of health professionals remain major barriers to Aboriginal and Torres Strait Islander people accessing effective services. Available evidence indicates that institutionalised racism and discrimination is evident in the vagaries and constraints of funding availability in relation to the actual needs of Aboriginal and Torres Strait Islander social and emotional wellbeing services and programs, thus inhibiting the effectiveness of such programs (Henry *et al*. 2004 cited in Kreger *et al*. 2004). Recommendations made by Swan and Raphael (1995) ten years ago for an additional $50 per capita to increase accessibility to mainstream specialist mental health care services, and a further $150 per capita for Aboriginal and Torres Strait Islander organisations to provide 'social and emotional wellbeing' programs, have not been met. A national social and emotional wellbeing policy review found that there was an expectation of achievement from Aboriginal and Torres Strait Islander community-controlled health sectors disproportionate to their under-resourcing. Such organisations are required to do 'too much' in 'too short a time'(Roxbee & Wallace 2003).

We recommend that researchers, communities and other stakeholders develop in partnership research projects around the fifth strategic direction and key result area described above, including resource allocation for Aboriginal and Torres Strait Islander social and emotional wellbeing services and programs.

Measurement

We have shown in the third section that there are currently no generally accepted tools for measuring the social and emotional wellbeing of Aboriginal and Torres Strait Islander people. The lack of valid and reliable tools to guide interventions and policies that seek to promote social and emotional wellbeing seriously disadvantages efforts to keep this a high priority in the broader public health agenda, where there is strong competition for resource allocation by more easily measured phenomena. We consider that an important research focus in the longer term would be the development of social and emotional wellbeing measurement tools that take into account the complexities of Aboriginal and Torres Strait Islander culture, language, history and inter-subjectivity against a background of inequality and power differential through which people define their holistic wellbeing.

We recommend that, in the shorter term and as a practical measure, researchers, communities and other stakeholders consider the instruments used in the ABS Indigenous Health Survey 2004/2005, and the *Western Australian Aboriginal Child Health Survey*, together with qualitative approaches, to undertake local priority research in social and emotional wellbeing.

Resilience

We demonstrated in the section on resilience that there is little information in the literature on resilience among Aboriginal and Torres Strait Islander people, and that research in this area is a NHMRC priority. This situation may reflect both the short time frame and limited resources available for our review, and the inapplicability of Western concepts and language of resilience to Aboriginal and Torres Strait Islander communities. Researchers need to understand related concepts of resilient behaviours and language within an Aboriginal and Torres Strait

Islander context. Resilience has been an important aspect of the ability by Aboriginal and Torres Strait Islander people to survive more than 200 years of colonialism, and remains an important factor in determining good health and social and emotional wellbeing. We are currently living through a period of globalisation with rapid social and other changes in many aspects of our lives. Resilience is an important characteristic to help all age groups navigate these changes with good health and wellbeing outcomes. The practical research work of Tsey and colleagues with Aboriginal and Torres Strait Islander people in north Queensland is a good example of research in this area.

We recommend further research to understand what resilience actually means in Aboriginal and Torres Strait Island communities, and how this understanding can be used to strengthen individuals and communities.

Healing and spirituality

We found in our review that the literature on healing and spirituality prominently featured both a number of Aboriginal and Torres Strait Islander scholars (Atkinson & Edwards-Haines 2003; Atkinson 1994, 2001, 2002; Atkinson & Ober 1995; Goreng Goreng 2004; Wanganeen 1994) as well as non-Indigenous scholars (e.g. Reid 1982, 1983; Cox 2000). Aboriginal and Torres Strait Islander healing and spirituality is an important aspect of social and emotional wellbeing research, particularly in the context of the history of colonisation in Australia. However, there was relatively little literature about healing and spirituality in the context of Aboriginal and Torres Strait Islander social and emotional wellbeing. We consider this a specific area for further research.

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Chapter 9: Community Development and Empowerment—A Review of Interventions to Improve Aboriginal Health

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Abstract

'[T]he question of where to start addressing social determinants of health in Indigenous settings remains a real issue for practitioners in the field' (Tsey *et al.* 2003). This paper contributes to the development of a research agenda on the social determinants of health by focusing on interventions that have engaged Aboriginal communities in tackling social inequalities. A review of published literature was conducted in order to explore the limits and potential for community development interventions to contribute to improved Aboriginal health. The objectives of the review were to: identify community development interventions to improve and maintain health and wellbeing in Aboriginal settings that have been documented or evaluated; explore and define the theoretical underpinnings of 'community development' as it is described in the literature; describe identified interventions including how community development principles are conceptualised, challenges faced and lessons learned, particularly those relating to factors critical to their success and sustainability; and identify appropriate methodologies for evaluating community development interventions in Aboriginal settings.

Key findings include:

- the mainstream literature describing community development and empowerment interventions to improve health in Aboriginal Australia is extremely limited, particularly in terms of Indigenous perspectives. This may be because community development is generally *done*, rather than theorised, evaluated and written up;
- a small number of studies comprehensively discuss the theory and application of community development approaches and demonstrate that empowerment outcomes and increased control can be fostered using this approach; and,
- key factors critical to the success of community development and empowerment in Aboriginal settings are identified in the available literature.

This suggests that long-term research is required to determine the potential for different community development interventions to contribute to empowerment and improved health outcomes. There is a need to develop appropriate, practical evaluation

methodologies capable of assessing and explaining community development and empowerment processes and outcomes, and how they contribute to improved health.

Social determinants of health and community development theory

The conceptual relationship between social determinants and community development

The complex nature of the social determinants of health and the broad range of interventions labelled 'community development' amplify the need for conceptual clarity about these terms and their relationship, before reviewing the community development literature. Research on 'the social gradient of disease' shows that relative rather than absolute disadvantage is the main cause of health disparity (Marmot 2000; Wilkinson 2002). Exploration of the 'social gradient of disease' suggests that one of the most critical psychosocial factors is 'the control factor', which refers to the amount of control people have over their lives, including whether they are part of an integrated social network and whether they have access to supportive relationships (Syme 1998). Despite the undeniable links between social class and population health disparities, public health interventions that directly address social class as a risk factor are hard to find (Syme 1998). The complexity of class as a social phenomenon, and the notions of social revolution often associated with the concept, are likely contributing factors to public health practitioners preferring to focus their interventions on individual lifestyle risk factors.

Syme (1998) argues that a possible 'solution' lies neither in social revolution nor medicalising social problems for health service intervention. Rather we should focus on aspects of social class that are amenable to change, such as 'control of destiny', and empower individuals and communities to develop the capacity to exert greater control and influence over their social circumstances (Syme 1998, 2004). A key point in Syme's and other similar analyses is that there is no single entry point for tackling health inequalities and that policies and strategies need to be multilevel and multifaceted, underpinned by long-term research (Oldenburg *et al*. 2000; Syme 2004). In other words, interventions that promote empowerment and control are just one of a raft of approaches that should be implemented as part of an overall strategy to reduce health inequalities.

Specific social determinants of the poor health of Aboriginal Australians include the history of colonisation, poverty, racism, unemployment, lack of education and training, and a lack of access to appropriate health services. Social inequality and relative powerlessness have long been identified as major factors in Aboriginal health and wellbeing (Devitt *et al*. 2001; Scrimgeour 1997). However, there is a chronic lack of knowledge of what can be done to tackle health inequalities experienced by extremely disadvantaged population groups such as Indigenous Australians, and it is difficult to find tested and validated empowerment programs in the Indigenous health literature (Tsey *et al*. 2003). The twin constructs of 'empowerment' and 'control of destiny' have been identified as potentially useful analytical tools for understanding and addressing the social determinants of Indigenous health (Oldenburg *et al*. 2000; Tsey *et al*. 2003). Indigenous leaders also view 'empowerment' initiatives that will assist Indigenous people to take greater control and responsibility for their situation as a possible 'solution' to the ongoing deterioration of many aspects of Indigenous health and wellbeing (Pearson 2000). In particular, Aboriginal community-controlled health services, government departments, and public health practitioners and researchers have identified community development as a useful approach for improving Aboriginal health as it promotes the development of locally appropriate health interventions and fosters individual and community empowerment (Bell 1996; Biven 2000; Feather *et al*. 1993; Ife 2002; THS 1999). Despite the logical connection between the 'control factor' and Indigenous disempowerment, it is less clear how 'control' operates at the individual, group and community level, and in different cultural settings, and how empowerment can best be fostered, including through the use of community development approaches.

In the context of Fourth World Indigenous populations, analysts have been concerned that contemporary measures of social determinants may not be appropriate for the socio-cultural frameworks of health because these measures and indicators have been developed almost entirely in Euro-cultural contexts (Elias 2003). Morrissey (2003) has been critical of the social determinants of health literature in relation to Aboriginal Australians. Some of his key criticisms are: the uncritical application of findings from overseas studies to the

Aboriginal Australian context; its theoretical 'barrenness' or lack of social science theoretical grounding; the dominance of simplistic quantitative positivism that is incapable of capturing the aetiology of chronic diseases; and the failure to centre Aboriginal people as the dominant partners in research involving them (Morrissey 2003). These justified criticisms highlight the need to explore the relationship between community development interventions and empowerment in the Australian Aboriginal setting, the theory and concepts underpinning interventions, and the range of methods used to explore and evaluate such interventions.

Community development concepts

There is a great deal of confusion and contention in the literature about the term 'community development' and its constituent concepts of 'community', 'participation', 'involvement', 'power', 'capacity' and 'empowerment'. The following definitions were informed by a review of community development in the international and national health literature.

A community development approach

Labonte's (1993) definition of community development is consistent with the way it has been defined in the Indigenous Australian context: a process of working with communities, in an environment that advocates the full and active participation of all community members, to assist their members to find plausible solutions to the problems they have identified, so that Indigenous people understand and acquire skills to develop culturally appropriate programs and services for their communities (Sherwood 1999). Two types of outcomes can be fostered by a 'community development' approach: (1) improvement in health outcomes by effectively addressing a health issue, and (2) increased individual and community empowerment, which leads to healthier and more equitable power relations (Baum 2002; Labonte 1994).

Community

The recognition that socio-economic status is linked to health outcomes has meant that 'community' has become one of the chief arenas within which to tackle these inequalities (Billings 2000). In the public health and community development literature, 'community' is generally used to refer to categories of people based on identity, geography or issue (Freeman *et al*. 1997; Ife 2002; Kenny 1999; Labonte 1997; Wass 2000). While this definition recognises that communities can take different forms, much of the literature on community development interventions in Aboriginal Australia describes processes conducted with *geographical* communities. Geographical communities are rarely characterised by harmony and shared values on all issues, and individuals differ in the extent to which they identify with their particular community (Baum 2002; Wass 2000).

Participation

The health development literature describes two types of participation:

- participation as a 'means'—ensuring local people's cooperation/collaboration with externally introduced programs or processes to facilitate the effective implementation of such initiatives and to achieve a set of objectives; and
- participation as an 'end'—the empowerment of people to take greater responsibility for their development through their acquisition of skills, knowledge and experience.

In community development processes participation is valued both as a means *and* an end (Kahssay & Oakley 1999).

Power refers to 'the ability to affect change, not the power to exploit or dominate others' (Ife 2002). Structural and post-structural views of power are most useful in empowerment research. A structural view sees power as being of a limited nature, and empowerment being about challenging and overcoming structural forms of disadvantage and dismantling dominant structures. From a post-structural view, empowerment is considered to be a process of challenging and changing the discourses that support the maintenance of power, and deconstructing discourses that are based on claims of knowledge and expertise (Baum 2002; Ife 2002).

Empowerment

Empowerment consists of 'personal, group and social aspects of power and capacity ranging from leadership, resources and strengthened networks to critical thinking, trusting relationships and increased group participation' (Labonte 1999:430). In the community development context 'empowerment' has been described as a social action process that promotes participation of individuals, organisations and communities in gaining control of their lives both in their community and in the larger society (Wallerstein & Bernstein 1988). Empowerment can operate at the level of the individual, the organisation or the community (Israel *et al*. 1994). Community empowerment has also been described as a process that progresses along a dynamic continuum of: individual empowerment; small groups; community organisation; partnerships; and political action (Baum 2002; Laverack 2001).

Methodology

Data sources

We searched the CD–ROM databases Australian Medical Index, MEDLINE, APAIS and Sociofile for the period 1994–2004. The following key words were used in combination: *Indig*, Aborigin*, Australoid*, Torres Strait Islander, native*, Indian*, Maori*, Inuit, community development, community participation, community involvement, capacity building, empowerment and participatory action research*. We also searched the Australian Indigenous Health*Info*Net and the Australian Institute of Aboriginal and Torres Strait Islander Studies Bibliography.

Study selection

To ensure the review remained manageable yet could successfully identify relevant studies, we developed a set of inclusion and exclusion criteria. Articles were excluded if they were published before 1994, if they were not available in English, if the study population was not Indigenous, or if the study did not describe an intervention that utilised a community development approach with a view to directly addressing a health issue and contributing to empowerment. 'Indigenous' was taken to include Aboriginal populations in developed countries such as Australia, New Zealand and Canada, due to their shared history of colonisation and dispossession and the ongoing marginalisation of such groups. This is not to suggest that Indigenous people in different countries have experienced colonisation and its impacts in the same way. Rather, that community development interventions implemented with Indigenous groups are likely to have more relevance to Indigenous Australia than those conducted with disadvantaged non-Indigenous people in 'developed' countries or other low socio-economic status groups in Australia. A large proportion of the original 335 studies identified were excluded because they described interventions that involved community consultation or sought some level of community participation, but were inconsistent with our definition of community development as having an explicit empowerment objective. The identification of only seventeen studies highlights the lack of published literature on the use of community development processes to improve Aboriginal health.

Data analysis

The data were extracted and analysed according to the following five categories: theoretical underpinnings; nature of the intervention; implementation and evaluation methodology; outcomes; and critical success factors.

Methodological limitations

We intended to include the so-called 'grey' literature in this review as many community development interventions are implemented in Aboriginal settings by government departments and non-government organisations, but few are written up in the published literature. Aboriginal community-controlled health services in particular are likely to have extensive experience with community development. However, due to time constraints we did not review the 'grey' literature. A related limitation of this review is the lack of Indigenous commentary that we identified in the mainstream literature on community development. Indigenous researchers and practitioners publishing more on community development would be a significant contribution to the literature in this area.

Discussion

As stated previously, a relatively small number of publications detailing community development processes aimed at improving Indigenous health were identified in the literature review. This reflects the likelihood that community development is *generally done*, rather than theorised, evaluated and written up in the mainstream literature. This section discusses and analyses the seventeen publications (see Table 1) that we identified under the following headings:

- Theoretical underpinnings
- Nature of the intervention
- Implementation and evaluation methodology
- Outcomes
- Critical success factors.

TABLE 1: Authors and title of reviewed papers

Author	Title
Adam & Spratling 2001	Keepin Ya Mob Healthy: Aboriginal community participation and Aboriginal health worker training in Victoria
Braun *et al.* 2003	Empowerment through Community Building: Diabetes today in the Pacific
Campbell & Stojanovski 2001	Warlpiri Elders Work with Petrol Sniffers
Con-Goo 2003	Self-Development in Order to Improve Community Development: An evaluation of a personal empowerment pilot initiative in Far North Queensland Indigenous communities
Hunter *et al*. 1999	An Analysis of Suicide in Indigenous Communities of North Queensland: The historical, cultural and symbolic landscape
Lawson & Close 1994	'New Public Health' Approaches among Isolated Rural Aboriginal Communities in New South Wales
McCormack *et al*. 2001	Learning to Work with the Community: The development of the Wujal Wujal guidelines for supporting people who are at risk
Midford *et al*. 1994	The Care of Public Drunks in Halls Creek: A model for community involvement
Mitchell 2000	Yarrabah: A success story in community empowerment
Moran 2003	An Evaluation of Participatory Planning at Mapoon Aboriginal Community: Opportunities for inclusive local governance
Rowley *et al*. 2000	Effectiveness of a Community-Directed 'Healthy-Lifestyle' Program in a Remote Australian Aboriginal Community
Salisbury 1998	A Health Service and Aboriginal and Torres Strait Islander Partnership to Develop and Plan Mental Health Services
Smith *et al*. 2002	Community Action to Promote Child Growth in Gapuwiyak: Final report on a participatory action research project
Tsey *et al*. 2002	Indigenous Men Taking Their Rightful Place in Society? A preliminary analysis of a participatory action research process with Yarrabah Men's Health Group
Tsey *et al*. 2004	A Microanalysis of a Participatory Action Research Process with a Rural Aboriginal Men's Health Group
Voyle & Simmons 1999	Community Development through Partnership: Promoting health in an urban Indigenous community in New Zealand
Warhaft *et al*. 1999	'This Is How We Did It': One Canadian First Nation community's efforts to achieve Aboriginal justice

Theoretical and conceptual underpinnings of community development and empowerment

Many of the references identified in the initial literature search described interventions labelled as 'community development' and with 'empowerment' objectives, but did not include any detail on the meaning or application of such terms. In most cases these publications described processes that appeared to be consistent with pursuing participation as a 'means' to developing appropriate health strategies and improving health, but not as an 'end' in itself, through fostering empowerment. For example, an article by Canuto *et al*. (2000) reflects the use of a community development approach as a means to reduce injury-related harm within Woorabinda through support for the community to develop and maintain a community-owned injury control strategy. In other cases, statements were made that 'empowerment' had been achieved, but there was no detail as to what empowerment was nor on what basis it was considered to have been fostered. Such references were considered of limited value in this scoping exercise.

Of the seventeen papers selected, a limited number explicitly made the link between community development as a tool for fostering empowerment and control and addressing the social determinants of Indigenous health. Voyle and Simmons (1999), for example, set out the need for using a community development approach in terms of the impact of social determinants on Maori health, and the importance of self and collective efficacy to good health. In their paper, on a partnership to address diabetes in New Zealand, they define community development as the process of organising and/or supporting community groups in identifying their health issues, planning and acting for change and gaining increased self-reliance and power as a result. Empowerment is defined as a social action process that promotes participation of people, groups and communities towards the goal of increased control (Voyle & Simmons 1999).

Other authors made the case for using community development approaches in Indigenous health on the basis that Indigenous people have a *right* to self-determination and to control their own health and futures. For example, the Victorian Aboriginal Community Controlled Health Organisation used a community development process to develop a health worker training course 'based on the conviction that Aboriginal people know what is best for them' (Adams & Spratling 2001:116). In a paper on the use of a community development approach to develop guidelines for supporting Indigenous people at risk of suicide, the use of the approach was based on 'the belief that there must be more opportunities for Aboriginal and Torres Strait Islander people to control their own destiny' (McCormack *et al*. 2001:20). Similarly, the use of a community-driven process to address violence in a Canadian Aboriginal community was described as key to the Aboriginal struggle for self-determination (Warhaft *et al*. 1999).

Other papers rationalised the use of a community development approach for several different reasons. In their report on a community development process to promote Indigenous child growth in a remote NT community, Smith *et al*. (2002) describe the approach as an effective way to address a health issue through the development of appropriate community-based strategies (participation as a means), as well as a means of addressing the social determinants of health by fostering empowerment (participation as an end) and promoting Indigenous self-determination (participation as a right).

While each of the selected papers provided some information on the empowerment and community development theory underpinning the intervention described, this was done to varying degrees. In their paper 'Empowerment through Community Building' Braun *et al*. (2003) provide a detailed argument on how community building was used to empower coalitions to take action around diabetes in Pacific countries, although the focus is on the mechanics of empowerment rather than the nature of power and changed power relationships. They include a useful logic model that demonstrates how community building steps (gaining access to the community, transferring knowledge and skills, building coalitions and providing technical assistance) relate to empowerment outcomes. In turn, a link is drawn between these empowerment-related outcomes and the long-term goal of improving health. Other papers provide limited detail on the concepts themselves and the conceptual relationship between community development, empowerment and health. In many cases it is argued that defining, analysing and acting on one's problem is evidence of empowerment, which is said to be health promoting (Salisbury 1998). While this definition is often used and consistent with the one presented by Labonte in the previous section, it is difficult to appraise and learn from such interventions because of the lack of detail on the theories and concepts underpinning them.

A small number of the interventions reviewed described community-initiated responses to community-identified problems. In these cases, the theoretical and conceptual underpinnings of the process were generally not set out. This does not imply that such responses were not based on sound reflection on the problem and the best way to deal with it, rather the focus was on taking action, not justifying the use of one approach over another. For example, a paper by Campbell and Stojanovski (2001) describes the response of Warlpiri Elders from the Northern Territory community of Yuendumu to the problem of youth sniffing petrol. The strategy was developed and implemented by Elders on a voluntary basis to address this problem. While empowerment objectives were neither articulated nor evaluated, the implementation and sustainability of a community strategy is evidence of Aboriginal people taking control of community health and wellbeing. This suggests that community development processes may be occurring and successfully contributing to Indigenous empowerment in many communities, but they are not being theorised, evaluated and written up in the mainstream literature.

Nature of interventions

Some studies described the use of community development processes to address particular health issues in Indigenous communities. Most of these processes were initiated and facilitated by agencies outside of the community, generally in response to community members expressing concern about the particular issue. Smith *et al*. (2002) describe a two-and-a-half-year community development process implemented by a government health department to address the problem of poor child growth in a remote geographical community in the Northern Territory. This process involved local people defining 'the problem', exploring possible solutions, forming partnerships, mobilising resources and taking steps to implement their solutions. A similar process was implemented by the Cairns District Health Service in the remote Queensland community of Wujal Wujal to support the community to address suicide (McCormack *et al*. 2001).

Several studies described a community-initiated response to a specific health issue, rather than the facilitation of a community development process by an outside agency. The Yarrabah community's response to suicide followed a similar process to those set out above but was driven by the community, which only sought outside involvement when they needed it (Hunter *et al*. 1999; Mitchell 2000). Similarly, a Canadian violence project involved community members defining the problem and developing a program to treat sexual abuse victims and offenders. Outside involvement was sought when funding was required to implement the community-designed program (Warhaft *et al*. 1999).

Community development approaches were used in some studies to establish 'appropriate' health services for Indigenous communities. For example, in Halls Creek a government department initiated a process to involve local people in decision-making about setting up a sobering-up centre to address alcohol-related problems in the town (Midford *et al*. 1994). In another case, the Tweed Valley Health Service and the 'Aboriginal and Torres Strait Islander community' (presumably a community of interest) developed and delivered a mental health service through a partnership based on participation and empowerment (Salisbury 1998). This process involved the health service supporting a local Indigenous health council to trial and to seek solutions to promote mental health.

Two studies detailed processes designed to improve community health more generally, rather than focusing on a specific issue. A 'new public health' program was implemented by the New South Wales Health Department (NSW Health) in ten disadvantaged Indigenous communities from 1986 to 1990 (Lawson & Close 1994). An Aboriginal health promotion officer was employed and trained and a health committee was established in each pilot site to support a range of activities aimed at improving the physical environment, health promotion, and self-esteem and pride. Another community development process undertaken to improve the general health of a community was the development of a five-year resettlement plan for the remote Queensland community of Mapoon (Moran 2003). This participatory planning process took eighteen months and resulted in a plan to promote the physical and social development of the community, with the overall goal of promoting community health.

Finally, several interventions were more directly concerned with building capacity and promoting empowerment than with supporting a community to address a health issue. A number of papers were reviewed that describe the use of a community development approach to support a men's group in Yarrabah (Con Goo 2003; Tsey *et al*. 2002; Tsey *et al*. 2004). The process is being undertaken with a small group of community members with an initial focus on promoting individual empowerment and self-development. This is being done through the delivery of a Family Wellbeing Program being piloted in Indigenous communities in North

Queensland, which is described in several studies (Con Goo 2003; Tsey *et al*. 2002). This empowerment program first builds the capacity of individuals and then supports the empowered individuals to participate in community-level change. Another study described a project that is forming and building the capacity of coalitions in seven Pacific countries with a shared history of colonisation (Braun *et al*. 2003). While the overall goal is for the coalitions to take action to address diabetes, the project itself is clearly concerned with capacity building and empowerment.

Intervention and evaluation methodology

Most studies would best be described as case studies implemented in a single Indigenous setting without control groups. One exception to this was the 'new public health' program undertaken in ten pilot sites in NSW (Lawson & Close 1994). The program process was evaluated by comparing each community before and after, as well as comparing the ten participating communities with four comparative communities where no intervention had taken place. The authors are careful to spell out that 'the use of the term "comparison" is meant to imply a lesser degree of exactness than the more common term "control"' (Lawson & Close 1994:28). Two other exceptions describe interventions where the primary goal was to build individual and group capacity, rather than to address a community-identified health issue and contribute to empowerment as a result of the community development process. Con Goo (2003) evaluates the piloting of the Family Wellbeing Program in six pilot sites, while Braun *et al*. (2003) describe a capacity-building diabetes program that was implemented in seven different countries with eleven different coalitions. Further, one study compared biochemical markers and behavioural risk factors for community members who participated in health promotion activities in a remote geographical community and for those who did not (Rowley *et al*. 2000).

According to the National Health and Medical Research Council's 'levels of evidence' the evidence we collected—no randomised control trials (RCTs) and few comparative studies—is low level and has a high potential for bias (Rychetnik & Frommer 2002). However, it can be argued that community development and empowerment interventions are generally not compatible with these 'high level' study designs because they involve a community responding to an issue of concern. These approaches are predicated on community motivation to address health problems and, therefore, do not fit well with the concept of randomly allocating groups of people into case or control groups. As Rowley *et al*. (2000:143) argue:

> *A truly 'randomised' design is unlikely to be a useful model for community-based interventions, since communities and individuals choose whether or not to undertake such programs: there is no apparent reason to expect that interventions imposed from outside the community should necessarily receive support from community members.*

On the other hand, more comparative studies of similar community development and empowerment processes are required if decision-makers in health agencies are to be convinced of the value of these approaches.

Formative or process evaluations were undertaken on many of the interventions to improve them as they were being implemented. The analysis of the Halls Creek alcohol project includes a useful discussion on the contribution of the formative evaluation to the overall success of the sobering-up service that was established (Midford *et al*. 1994). The evaluation process was key to delineating the purpose, type and possible measures of each subsequent evaluation of the sobering-up centre. The model encouraged flexibility and distinguished between short-term impacts and longer term outcomes. The point is made that outcomes from community development processes take a long time to manifest in quantifiable terms, but subtle changes lay the foundation for further change. The challenge is to design sensitive ways of measuring early change and of 'involving the community in identifying appropriate measures can go some way towards dealing with this problem' (Midford *et al*. 1994:8).

A number of other studies also measured process outcomes rather than quantifiable health outcomes, which take a long time to manifest and are difficult to measure. Lawson and Close (1994) describe a comprehensive process evaluation strategy involving questionnaires and interviews. They justify their focus on process rather than health outcomes due to the difficulty in establishing a causal link between public health programs and health outcomes. Further, they argue that a key priority for Aboriginal communities is to develop programs that are acceptable, affordable and implementable: therefore, it is essential to evaluate process (Lawson & Close 1994).

Participatory action research (PAR) was used in three of the studies and is described as a useful methodology for implementation and evaluation. The Yarrabah men's group is being supported to plan, implement and evaluate activities through a PAR approach. This allows community members to act as researchers exploring priority issues affecting their lives, to recognise their resources, to produce knowledge and to take action to improve their situation with support from researchers (Tsey *et al*. 2002). PAR is being used to undertake a formative or process evaluation of the empowerment intervention, as well as contributing to empowerment outcomes. A system of ongoing reflection and action has been developed which is based on participant observation, informal discussions and in-depth interviews (Tsey *et al*. 2004).

Smith *et al*. (2002) also used a PAR methodology because of its compatibility with community development. They argue that PAR shares the same process and empowerment principles as community development, but involves a method of systematic investigation. In this case, the PAR framework is described as both contributing to and constraining the community development approach. On one hand, the power sharing, critical reflection and action-orientation of the methodology supported the achievement of project outcomes. On the other, conducting the community development process within a research framework created a set of requirements that were not conducive to fostering community control and participation. For example, the need to articulate a detailed research plan in order to secure funding, and the use of standard research methods and instruments undermined the capacity of community members to set the agenda.

The fact that this issue was described in other studies suggests it is not directly related to the PAR methodology but more to do with how community development interventions are generally researched and evaluated. The diabetes partnership project analysed by Voyle and Simmons (1999) aimed to evaluate both the project process and outcomes. While their paper outlines the process evaluation, they refer to the impact of the outcome evaluation (which focused on quantitative assessment of diabetes risk factors) on the project process. The 'medical model requirement for quantitative pre- and post-programme measures' had two negative effects on the process (Voyle & Simmons 1999:1043). First, it limited the discretionary power of the partnership committee who wanted to provide health education before screening but were restricted by the evaluation design. Second, the minimum sample size required to attach significance to the scores took nine months to meet. This created a time gap that meant a loss of momentum and the departure of some Maori staff trained by the project before the health promotion intervention commenced. It is concluded that while quantitative methods are useful they should not be 'superimposed in a manner that interferes' with community development or empowerment (Voyle & Simmons 1999:1046).

Few studies sought to evaluate empowerment outcomes comprehensively. As noted in the section on theory, in many cases empowerment was defined as local people taking action on problems and this was evaluated by assessing the presence or absence of community action. Conversely, those studies that comprehensively set out what empowerment was and how it could be fostered also sought to evaluate empowerment outcomes. A good example of this are the studies on the Family Wellbeing Program (Con Goo 2003; Tsey *et al.* 2002). The researchers supporting the PAR process are undertaking a ten-year research program to explore how empowerment can be used to understand and address the social determinants of health. This long-term approach involves regular group discussions, interviews, critical reflection and feedback to promote and assess empowerment.

Outcomes

Involving Indigenous participants in designing and implementing health initiatives

Most studies reported on the successful use of a community development process to involve community members in developing and implementing locally appropriate health initiatives. For example, one successful outcome of a Cairns-based suicide prevention project was Indigenous community members developing 'culturally appropriate guidelines' for working with people at risk of suicide (McCormack *et al*. 2001). It is anticipated that these guidelines will promote community-owned responses that will increase self-reliance. However, the success reported on to date is the development of the guidelines themselves. Similarly, Voyle and Simmons (1999) report on the strong participation of Maori in establishing and then taking control of their own health group and diabetes program as successful outcomes.

Changed health behaviour

Several studies described both the establishment of a community health initiative as well as the positive impact of the initiative on health-related behaviour as evidence of success. In one case, petrol-sniffing activities run by Warlpiri Elders led to a decrease in the number of young Indigenous people sniffing petrol (Campbell & Stojanovski 2001). Similarly collective action taken by members of the Yarrabah community to address youth suicide resulted in a marked halt in youth suicide and a substantial reduction in self-harm (Hunter *et al.* 1999; Mitchell 2000).

Empowerment

In most cases, the development and implementation of a health initiative by Indigenous community members was described as evidence of empowerment. Indigenous participants developing an acceptable and well utilised mental health service is cited as evidence of empowerment in a rural area in Queensland (Salisbury 1998). Other examples of this type of reporting on empowerment include the successful establishment of a sobering-up service in Halls Creek in Western Australia and the development of a health worker training course in Victoria, both of which relied on strong Indigenous participation (Adams & Spratling 2001; Midford *et al.* 1994).

Several papers refer to empowerment as evidenced by the establishment of a health initiative with Indigenous involvement, as well as specifying the aspects of community action that are considered to be evidence of empowerment. For example, a diabetes project conducted in seven Pacific countries increased individual competence, enhanced community capacity, reduced barriers and improved supports for diabetes control (Braun *et al.* 2003). These aspects of empowerment are discussed in detail and examples are provided to support the empowerment claims made. Another body of empowerment research to report comprehensively on empowerment outcomes is that of Tsey and colleagues on the Family Wellbeing Program. Their papers help operationalise the concept of empowerment by describing the specific outcomes of the program at the individual, group and community level. They describe significant changes in the behaviour of the men involved and an increased sense of self-awareness, self-confidence and hope for the future. The men's group is also showing signs of empowerment by supporting each other to address their problems collectively. Further, there are signs that the problem-solving skills individuals are acquiring are having a ripple effect as people work together to affect community change (Tsey *et al.* 2002).

Improved health

Only two studies sought to assess changes in physical indicators of health as a measure of the success of the community development approach. Rowley *et al.* (2000) describe modest, sustained improvements in biochemical and behavioural risk factors as a result of the Looma Healthy Lifestyle Project conducted in a remote community in Western Australia. They suggest that participation in the project may have contributed to community members having a greater sense of control over events. This, in turn, may have meant that participants were more likely to undertake and sustain intervention strategies, resulting in metabolic improvements in relation to the comparison group. While the possibility of a relationship existing between increased control, empowerment and physical changes is flagged, increased control and empowerment were not assessed.

A study in which the primary author was involved sought to evaluate improvements in child health, in addition to the establishment of a health initiative and empowerment outcomes (Smith *et al.* 2002). Analysis of the quantitative data collected (which was not reliable due to inadequate coverage) did not show an improvement in child growth according to weight over the two-year project period. This was primarily attributed to the inadequate project time frame and the unrealistic expectation that there would be a measurable health outcome in two years. Despite demonstrating that the community development process contributed to the development of a locally appropriate and sustainable child health strategy, as well as empowerment at the individual and group level, the success of this project was questioned by some staff from the implementing health agency as quantifiable health improvements were not demonstrated. In this instance, seeking to evaluate health outcomes prematurely undermined the value attributed to the community development process by detracting from the less tangible empowerment outcomes achieved (Smith 2003).

It is not possible to draw conclusions about the empowering potential of the different interventions reviewed and to make recommendations about the value of one over another. The conceptual ambiguity surrounding empowerment means that the study authors have given different meaning to the term, which affects how they seek to foster empowerment and how they evaluate it. Developments that might be taken as signifying empowerment under one conceptualisation might not be considered as so significant under another. This highlights the need to develop a workable concept of community development and empowerment that can be implemented and evaluated in the Aboriginal health setting. It also highlights the need for long-term community development processes combined with evaluations that have the potential to demonstrate significant outcomes.

Critical success factors identified in the literature

Community ownership of the problem and solution

Community definition and ownership of the health problem being addressed by the project was repeatedly identified as key to the involvement of local people in designing and implementing health strategies. The Yarrabah community is described as having progressed through a series of stages before entering a state of full ownership of the suicide problem (Mitchell 2000). This full ownership stemmed from an understanding that lasting solutions could only be found within the community itself, which manifested a widely shared community commitment to action. This process was described as slow and accompanied by much pain and grief over a long period of time, but pivotal to the community's success in reducing youth suicide and self-harm.

Existing community empowerment and local setting

Existing community empowerment and the local community context were also critical success factors. The Warlpiri response to petrol sniffing was partly attributed to community members having already been empowered by a previous family counselling program that equipped people with the skills to cope with any ongoing problems (Campbell & Stojanovski 2001). The Yarrabah community's ability to address the alarming rate of suicide was partly attributed to changes in the community context including the establishment of a community council (Hunter *et al.* 1999). This empowered community members and contributed to an increased sense of community responsibility. In turn, the community-driven process led Yarrabah residents to take greater control over decision-making about health and a community-controlled health service was established. This health service then established the men's group described by Tsey *et al.* (2002), which is now contributing further to individual and community empowerment.

The employment of local facilitators

Employing local Indigenous people as team members and training them in community development skills and processes contributes to successful community development. A NSW public health program employed Aboriginal health promotion officers who completed an associate diploma in health and community development as part of their work (Lawson & Close 1994). The combination of the professional skills they acquired from this training and the personal characteristics they brought to the program (mature interpersonal skills, knowledge about health promotion, and commitment to and participation in the affairs of the community) enabled them to play a leading role in health promotion. Similarly, employing community-based liaison workers was key to the success of the New Zealand diabetes project (Voyle & Simmons 1999). Conversely, the lack of training provided as part of the Mapoon participatory planning process was identified as limiting capacity building (Moran 2003). A number of studies argue that more attention should be given to identifying the types of skills needed and how these skills can be taught, so that local people can use community development approaches to bring about social change in Indigenous communities (Smith *et al.* 2002; Tsey *et al.* 2004).

The role of outsiders

'Outsiders', or external community development facilitators, play an important role in providing information about health problems and possible strategies to address them. While the Yarrabah response was community driven at all stages, researchers and visiting health professionals provided information on suicide and stimulated critical reflection among community members on its underlying causes, a process that contributed to the community taking ownership of the problem (Hunter et al. 1999). Similarly, in Halls Creek local people were concerned about alcohol-related problems but had limited knowledge of possible solutions (Midford *et al.* 1994). The research team involved provided information on the range of possible services that could be established, contributing to the community taking action.

Establishing trusting partnerships

A related factor that promoted success was the establishment of trusting partnerships between Indigenous community members and outsiders over time. Voyle and Simmons (1999) describe the lack of trust that existed between Maori community members and non-Maori or dominant culture members at the start of their project. They attributed this to the history of colonisation, the experience of government agencies subverting self-determination by tying funding to compliance, the activities of previous researchers in not returning research benefits to communities, and the perception of self-servicing agendas on the part of bureaucrats, particularly health managers (Voyle & Simmons 1999). The reluctance of Maori to be ‘used’ again—a common theme in these factors—was addressed by adjusting the project time frame to allow trust to build. Over time, Maori participants saw that the project team was genuine in its commitment to developing a respectful partnership where power was devolved from health professionals to Indigenous people. The Gapuwiyak Child Growth Project similarly found that the deeply embedded power inequalities between Indigenous community members and the non-Indigenous researchers and health professionals made it difficult to work in partnership in the early stages (Smith *et al*. 2002). A productive partnership was established over time as relationships developed and the supportive, rather than directive, role of the researchers became evident from their practice.

Establishment of a local committee

The formation of an Indigenous committee that took a leadership role in community development processes contributed to the success of several interventions. In the Halls Creek project an advisory group, consisting of both local people and government workers, acted as a conduit for community perspectives, provided a means of liaison with relevant government agencies and was responsible for keeping the communities informed about progress (Midford *et al*. 1994). In Gapuwiyak, the local action committee developed and implemented a strategy to promote child care and development (Smith *et al*. 2002), while a partnership committee of Maori and health professionals played a leading role in the New Zealand diabetes project (Voyle & Simmons 1999). Key to the effectiveness of this committee was operating with a framework of values centred on empowerment, mutual respect, self-determination, and incorporating cultural community knowledge and strengths.

Adequate internal and external resources

Finally, adequate internal and external resources are central to the success of community development processes (Braun *et al*. 2003). Even where processes were initiated and driven by community members, appropriate resources from inside and outside the community contributed to their positive outcomes (Hunter *et al*. 1999; Warhaft *et al*. 1999).

Conclusion

There is limited mainstream literature on the theory, implementation and evaluation of community development and empowerment interventions in Aboriginal Australian settings. In particular, there is a lack of Indigenous commentary in the mainstream literature. The general lack of community development discourse in the Australian academic literature cannot be attributed to a decline in community development practice. To the contrary, it has been argued that while ‘community development has virtually disappeared from academic and bureaucratic discourse, it has remained alive and well in a thousand guises in the field’ (Onyx 1996:101). Hunter (1998) notes that across Indigenous Australia there are now many examples of community development projects, which have had varying degrees of success, yet only a limited number of these have been written up in the mainstream literature. Community development is generally done by practitioners rather than theorised by academics. However, to improve both the theory and the practice, community development intervention should be implemented and evaluated in order to investigate their potential to improve Aboriginal health through participation and empowerment processes.

Few published articles comprehensively and critically describe and evaluate community development processes. Many papers identified in the initial search either detailed aims and objectives, without mention of the actual outcomes, or made sweeping claims about people having been empowered without describing the process and the evidence of this outcome. The Australian community development literature generally has been criticised for its tendency to make grand claims about the transformatory nature of such work, none of which are supported in the programs reported on (Mowbray 1996).

Only six of the studies we reviewed comprehensively explore the concepts of community development and empowerment and their relationship to health, describe the community development intervention in detail, include an evaluation strategy, and clearly set out how they were judged to have contributed to empowerment. These studies provide much insight into community development processes and their potential to contribute to empowerment outcomes. Similarly, detailed studies of community development interventions are needed to assist us to understand and address the social determinants of Indigenous health through fostering empowerment. Ideally, such studies would start with a shared concept of community development and empowerment, because differences in the meaning given to these concepts by practitioners and evaluators affect their operationalisation and, therefore, judgments about the empowering potential of such schemes (Bridgen 2004).

Factors critical to the success of community development interventions in fostering empowerment in Aboriginal settings include: community members owning and defining their problems and solutions; existing community capacity and empowerment and a context that supports local involvement in promoting health; employing local people and training them in community development skills and processes; the role of outsiders in providing information about health problems and possible action strategies, as well as in stimulating critical reflection; the formation and active involvement of a local committee in all aspects of the community development process; the development of trusting, respectful partnerships between Aboriginal community members and outsiders over time; and adequate resources both from within and outside the community. The evaluation of long-term community development interventions would generate further evidence to confirm the importance of these factors.

The literature we reviewed suggests that long-term research is required to determine the potential for different community development interventions to contribute to empowerment and improved health outcomes. More work is required to develop appropriate, practical methodologies for evaluating interventions that seek to understand and address the social determinants of health by promoting empowerment and control through community development processes. A starting point for developing practical evaluation methodologies is making clear how the term ‘empowerment’ is being understood and, on this basis, establishing the indicators of community development on which judgments about success will be based.

Both community development interventions and evaluation methodologies should be flexible enough to be responsive to community direction. At the same time, evaluation methodologies should be comprehensive enough to evaluate the range of outcomes generated by empowerment interventions. Methodologies should evaluate both processes and impacts on health behaviour, such as increased use of health services. Health outcomes should not be evaluated until measurable health improvements can realistically be expected. Appropriate evaluation methodologies are likely to draw on a range of methods, both qualitative and quantitative. While qualitative evaluation is the key to understanding processes and assessing empowerment, the measurement of quantifiable health outcomes is likely to be central to influencing policy-makers in health agencies. A transdisciplinary approach involving teams of people from different disciplinary backgrounds may prove the most effective way to implement and evaluate community development interventions. The involvement of industry partners in such teams would maximise the likelihood of research findings being translated into health service practice. Participatory Action Research is one approach that appears to be useful in the implementation and evaluation of community development projects and processes, largely because it shares a similar process and set of objectives. At the same time, like other evaluation methodologies, care must be taken to ensure that PAR is not constrained or made too cumbersome by research requirements. If this occurs, the evaluation may undermine community development processes aimed at generating community action and empowerment.

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Chapter 10:
Governance, Indigenous and Non-Indigenous, as a Social Determinant of Aboriginal Health

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Introduction

Governance involves processes, systems, and institutions, both formal and informal, by which social groups constitute themselves, devise values and policies, carry out joint objectives, distribute power and authority and hold their members accountable to one another. The field of governance studies is important for understanding the social determinants of health by reference to both Indigenous and non-Indigenous governance systems. On the Indigenous side, informal governance arrangements among groups and across regions are as important as formal organisations for community administration or health delivery. On the non-Indigenous side, there are impediments to meeting Aboriginal health needs both because of confusion at the interface of Indigenous and non-Indigenous governance, and also because of lack of clarity over governance arrangements within and between health services and related agencies.

Processes of governance affect health outcomes in a number of ways. Community governance can influence perceived health goals in relation to other community purposes, it can affect people's understanding of health determinants and the intentions of health program deliverers, and it can aid or inhibit health education and health programs. Governance is implicated in this whether it is understood as sets of institutional structures or as a series of self-replicating informal processes. In fact, it can be seen as both of these, since stable processes harden over time into institutions, and institutions themselves harbour governance processes that are often unintended and formally unacknowledged but, nevertheless, influential.

The complexity of governance issues in any particular Indigenous situation is an important influence on health outcomes. Most obviously the governance instruments in place affect how Aboriginal groups may be communicated with, how research projects can be managed with consent, and how compliance with good health practice can be encouraged and monitored. Perhaps less obviously, good governance leads to relative community harmony and a sense of wellbeing, and thus both to the conditions for better health and receptiveness to health programs.

The field of Aboriginal health involves cross-cultural mediations where the formal and informal processes of non-Indigenous health delivery institutions meet up with and share a common ground with the formal and informal processes for Indigenous governance. This paper looks at processes and institutions in a number of subject areas: Aboriginal political life and custom; the governance organisations in place for ordering aspects of Aboriginal life; and, on the non-Indigenous side, at the culture of organisations that affects their ability to be effective, and how cultural constraints may limit cooperation in whole-of-government programs. The paper introduces each of these topics with a discussion of the key issues and provides a summary of some of the major writings in the field.

Aboriginal political life and custom

Two important observations about Aboriginal political life are often missed in policy planning. Aboriginal communities are not a social vacuum or *tabula rasa* of governance processes. Non-Indigenous interventions in Aboriginal life will always encounter a pre-existing system of governance. It may be informal and will have been altered by colonisation, but it continues to assert a strong influence on people's lives and their relations with non-Indigenous people and organisations. Secondly, Aboriginal authority, in such areas as decision making or dispute management, is always diffuse. It varies according to the nature of the players in any particular interaction, the social context, and the nature of the issue at hand. There is no 'one stop shop' for governance and authority in an Aboriginal setting.

Aboriginal authority does not operate through a strict hierarchy of people holding particular offices or a particular status. For this reason, Aboriginal politics has been called a state of 'ordered anarchy' (Hiatt 1998). Although there are prominent people in any group, they rarely have the authority to speak for everyone. At best they may be the group's choice for contact with outsiders and liaison with appropriate community members for particular issues. Frequently, also, they will represent powerful factional interests, not least themselves. Aboriginal leaders, in general, do not have the power to bind others to a course of action. There is a strong ethic of personal autonomy in Aboriginal groups (Myers 1986). However, the principle that puts the 'order' into 'ordered' anarchy is that of 'relatedness' (Myers 1986), and it is this dynamic of autonomy in tension with relatedness that characterises Aboriginal political life. Autonomy has an important corollary—the attenuation of responsibility for the actions of another. Communities may have concern for the actions of individuals—this is part of relatedness—but their members have little available to them in Aboriginal cultural practice to control or regulate the behaviour of another in secular matters. This follows from an individual's autonomy.

Relatedness expresses itself through custom. While this is often called customary law it does not have the same characteristics as Western law. It is rather the customary way that people are supposed to relate to each other and to the space in which they live, informed by mores of kinship and sanctioned by religion and myth. It is also the customary way of dealing with breaches of these expectations. Like political life itself, custom is fluid and negotiable in operation, varying according to the nature of the authorities invoked, the nature of the actors, the circumstances and the context. Of course, there is another significant variable—the impact of colonisation.

Colonisation has had an impact in two ways, firstly by tending towards codifying, simplifying and rigidifying the fluidity and complexity of pre-colonial practice, and secondly, by challenging, modifying and frequently undermining Indigenous systems of authority. These two somewhat contradictory tendencies go hand in hand. Examples of the first would be the broader society condoning spearing in the leg for an offence, such that it may now be seen by a particular community as the only appropriate punishment for a range of serious offences, whereas in the past ostracism or fighting may have been among the responses. This supports those in the group who are in favour of spearing and undermines dissenting voices, and it usually impacts most heavily on young men. Indeed, physical retribution by older men against almost anyone in a community, if couched in terms of custom, usually attracts more favourable outside attention than similar action by women or by youth. This is only one instance in which the values of the coloniser have influenced the practice of the colonised.

Yet non-Indigenous support for certain Aboriginal customs does not depend on it reflecting non-Indigenous practice. Rather, it depends on an idea of how Aboriginal people ought to behave, even if this is radically distinct from non-

Indigenous practice. Similarly, the second tendency, the undermining of Indigenous authority, depends also on the outsider's views of correct behaviour. This is most noticeable when acknowledged authority figures within a group refuse to cooperate with an advised course of action or a project. Their position is fragile in relation to outsiders, and they are often easily circumvented and their views marginalised. While this means a project can often go ahead, at the same time customary authority within the group is undermined and demoralisation of the whole group can be the result. Demoralisation and social malaise often then mean that the project itself meets a dysfunctional community and becomes a waste of effort and resources.

How can these seemingly insoluble tendencies be reconciled with the urgent need for intervention in health practice? On the one hand, attempts to recognise and institutionalise customary practice result in simplification, advantaging one set of interests against others, and perhaps sanctioning abhorrent practices from a non-Indigenous point of view. On the other hand, ignoring customary authority further undermines already vulnerable families and communities, results often in stubborn resistance to apparently beneficial programs, and produces social behaviour that just perpetuates the problems intervention programs are designed to address.

Clearly, one answer, recognised by most social welfare agencies, is to provide the group with the support and the conceptual tools to adapt their practice to contemporary circumstances in ways that they find congenial. Currently, this is called 'capacity building', but there is no consensus about how it should be undertaken and there has been little effort to date in Australia to view these problems within an international comparative framework. Secondly, there must be a willingness to enter a dialogue with Aboriginal groups aimed at doing more than convincing them of a program's worth. There may be inhibitors to the program that the potential participants are well aware of. Or there may be cross-cutting programs that lie in the domain of another agency but have higher priority in the group's own estimation.

Frequently, the need to get 'runs on the board' leads to overriding these concerns since there is apparently nothing to be done about them. Attention to the problems of governance raised above requires the assessment of non-health inputs, those which need to be sourced outside of the health field. An understanding of these problems in any particular case could also provide arguments to support a decision of non-intervention where it could be a wasted or even harmful effort. A more immediately practical approach to dealing with the constraints of informal community governance is to leave it to community organisations to handle, and to work through these organisations themselves, however imperfect they may be, rather than attempting to go directly to 'the community' itself. This idea of 'community' is often a construct of outsiders and cannot be assumed to exist as a social entity simply because people are co-residents of a settlement (Sullivan 1996:5–42; Holcombe 2004:163–84).

Aboriginal organisations

Many Aboriginal community organisations have been in operation for more than two decades. They perform many functions—health service, art group, women's refuge, outstation support, progress association, land rights application or administration, or communal civic services. The organisational matrix for any given area is often complex. In many instances, service organisations support each other, often acting in coalition and dividing responsibilities. They may share membership and there can be considerable overlap of personnel on the various governing boards. In other instances, organisations may be captured by particular interests such as family groups or hold policy stances with little apparent basis, from an outsider's point of view, that have become historically entrenched. In all cases, the members and significant individuals in community organisations will have much more intimate ties across organisations, a fuller knowledge of their linked histories and longer term commitments to relationships (good or bad) with each other than any outsider can hope to have. This means that outsider interventions need to proceed cautiously and with respect, yet without freezing all activity at the first sign of conflict, dissension or crossed purposes, since this does not do justice to Aboriginal needs and expectations. Community groups need to be carefully studied in order to set a course between the extremes of working only with one apparently powerful organisation, thus marginalising others, and working with none because it is apparent that power is distributed, diffused and contested. Such study should be able to identify where functional power and influence lies, how formal structural authority can be aligned with this and where shared interests allow for the brokering of cross-organisational alliances.

All Aboriginal organisations, like non-Indigenous organisations, have a formal constitution. They may be incorporated under the *Aboriginal Councils and Associations Act 1976* or they may be incorporated under one of the state associations acts. In some cases they are incorporated under corporations law appropriate to large-scale business, but these are rare. In the vast majority of cases an organisation follows standard non-Indigenous governance forms in its administrative structure. There is a membership formed around a set of objectives of the association that establish the community of interest. There is a governing council or board and the rules establish how this is to be constituted, how it is to be appointed or elected, and the criteria for board membership. The membership controls the organisation by election of the board at the annual general meeting and can control the board from time to time by a special general meeting. The appropriateness of the structure and rules, and the conduct of the organisation in meetings and elections, is scrutinised and regulated either by the Commonwealth Registrar of Aboriginal Corporations or the various state offices for the regulation of incorporated associations. Organisations are usually formed to receive grants from government. These grants come with conditions for disbursement and accountability that further limit the sphere in which an organisation can assert autonomy.

Two things are apparent from this brief discussion. Aboriginal organisations are not Indigenous in structure and are not entirely under Indigenous control, yet they have been adapted by Indigenous people to Indigenous purposes and they intersect with unincorporated Indigenous governance processes. Outsiders need to practice a delicate balancing act in their dealings with community organisations. On the one hand, they cannot assume organisations to be inauthentic and illegitimate simply because they follow non-Indigenous governance guidelines. Clearly, they have been both adopted by, and adapted to, Indigenous community processes. However, nor can they be assumed to have unquestionable legitimacy in the eyes of the members, and beyond this the constituents and clients, nor effectiveness in good governance and community service outcomes. Indeed, there tends to be a contradiction between these two elements of organisations, because non-Indigenous processes of good governance have proved to be the most instrumentally efficient but may lack legitimacy in Aboriginal culture. Congenial organisations in the eyes of staff and council members may be lacking in efficiency. Attempts to address the legitimacy question by importing apparent Aboriginal cultural forms often results both in a poor reflection of culture (which is too complex to be treated in this way) and resiling from good governance principles.

Many of the structural difficulties encountered by organisations established for community governance and service delivery have been canvassed in the recent review of the *Aboriginal Councils and Associations Act (ACA) 1976*, under which many Aboriginal organisations are incorporated (Corrs Chambers Westgarth 2002). The ACA Act is the vehicle specifically intended by the Commonwealth for the incorporation of Aboriginal associations. The recent review points out that there are 3000 associations incorporated under the Act, and these organisations have a key role in the delivery of government services at both state and federal levels. The last amendment to the Act took place in 1992. Past reviews of the Act have raised important issues to do with law reform and the current review notes that these concerns have not been dealt with by Parliament. The review identifies current issues that affect the efficiency of the incorporation statute. Since enactment in 1976, Indigenous people have undergone a change in circumstances. Changes in the legal environment have impacted upon corporate regulation and 'the recognition and enforcement of Indigenous legal rights' (Corrs Chambers Westgarth 2002:1). The current Corporations Act is not geared to the needs of Indigenous organisations across the board, but rather is most suitable for organisations operating as commercial enterprises. The enactment of the Native Title Act (NTA) has also affected the legal environment since it requires that Native Title can only be managed by ACA Act corporations (Mantziaris & Martin 2000; Sullivan 1995).

The conclusions of the report can be summarised as follows. The needs of Indigenous people are not being met by current legislation concerned with incorporation. Needs related to incorporation have to be addressed by a change in the legislative environment. It was the purpose of the ACA Act in 1976 to provide a 'general statute of incorporation' for Indigenous people. The report found that as a consequence of amendments since enactment, the ACA Act no longer fulfils its purpose. Indeed, the legislative purpose of 1976 reflects now-outmoded concepts in the regulation of corporations more generally. The report also notes that the understanding of Indigenous culture in the Act is no longer appropriate to the altered circumstances of Indigenous people since 1976. Currently, the Act serves to undermine, rather than assist, Indigenous people in terms of socio-economic benefits. This is not confined to concerns with the legislation itself, but is also reflected in the Act's administration.

Non-Indigenous organisational culture

Most development intervention in Aboriginal communities requires cooperation between government agencies, Aboriginal non-government organisations (NGOs) and the community itself. Clearly this requires an understanding of intercultural interaction. This has been an interdisciplinary study in the humanities for many years. In practical terms, it means managing the interaction of Indigenous and non-Indigenous systems. Conceptualising the interface, however, is a matter for considerable contention in this field and a new approach is slowly emerging.

The old, and dominant, view is based on an understanding of intersecting spheres of cultural activity—Indigenous on the one side, non-Indigenous on the other—with intercultural activity occurring in between. Some NGOs, such as Aboriginal medical services, could be characterised as inhabiting this ambiguous and polyvalent intercultural space (Sullivan 1996:73–81).

The emerging view finds these characterisations unhelpful. There is as much diversity within Aboriginal groups and across Aboriginal Australia as there is in non-Indigenous Australia. Pan-Aboriginality is as tenuous a concept as its opposite, the mainstream. On the other hand, non-Indigenous and Indigenous activities are inextricably mixed with each other and mutually dependent. From this point of view health interventions, like others, do not exist in two worlds which need translation one from the other, but occur within the same field and upon the same ground. The 'inter' in intercultural in this sense means not so much 'between' as 'among' (see Merlan 2005). The consequences of this view are challenging, as they require an approach that embraces the idea of culture permeating both Indigenous and non-Indigenous institutions in any given situation.

In the previous section, we addressed the possibility of Aboriginal organisations being constituted like non-Indigenous organisations, but operating in a culturally congenial manner. This means that the board, staff, members and clients respond to cultural values and modes of behaviour that are not reflected in the formal structure. Non-Indigenous organisations do this too, though this is rarely recognised by the organisation itself. Rather like the speculation that we cannot taste water because we are born with it in our mouths, culture is often not apparent to those immersed in it. The anthropology of organisations (see Wright 1994) attempts to make visible and analyse the dynamics that occur in the interstices of formal organisational structure or apparent due process (see Lea 2002). This approach can be useful in understanding why government service delivery organisations are not more successful at meeting Indigenous disadvantage, and could have much to say about the impediments to whole-of-government cooperation across agencies and sectors.

Government organisations have a formal distribution of authority reflected in the agency flow-chart. They have formal mission statements elaborated into strategic plans and operationalised through business plans. They have agency policies that promote activities directed through these plans and implemented through the structure with, additionally, requirements for reporting, monitoring, assessment and accountability. Routinely, they set themselves the task of improving Indigenous disadvantage in their area of intervention, and routinely they fail to do so, sometimes significantly. Nevertheless, impeccable procedures are followed through standard institutional structures and these allow for reporting that all is well with the organisation and its officers at least, despite its lack of impact in the world. It is common in Indigenous circles to attribute this to a lack of care, bad faith or incompetence, but this is unfair and simplistic. If, however, we accept that motivated, skilled and intelligent people have undertaken Aboriginal development programs for the past forty years in organisations with world 'best practice' standards in terms of administrative arrangements, we clearly must look elsewhere for their lack of success.

There are practical reasons and reasons that derive from organisational cultures. We will argue that the second of these has not received enough attention. Firstly some practical difficulties: Indigenous problems are often multi-factorial so one agency's programs may fail, or not get off the ground, because of uncoordinated activity by another agency. Indigenous interventions are costly not only because of their complexity, but also because they occur off a low base, and usually in areas that are hard to service. Lack of knowledge may also be a factor. High staff turnover and historical ignorance of Aboriginal issues in Australia in general can result in policy formulation and program implementation being put in the hands of people who are fumbling in the dark.

Yet these factors have been around for a long time and many attempts have been made to address them. Inter-agency coordinating committees and ministerial councils have long been a feature of Indigenous affairs planning. Budget allocations fluctuate, and there is no doubt that more money has often led to improved outcomes, but also much funding is misapplied or swallowed up in unproductive processes. Similarly, lack of knowledge about how to do Aboriginal development is difficult to understand. So much research and subsequent discussion has occurred continuously over this period that it is often hard to justify calling for more. Although these factors are, no doubt, influential, it is likely there are other impediments that have not yet received adequate attention, and that these concern the internal processes of development agencies (investigated in the Australian context by Lea 2002).

Some of the organisational drivers that an anthropologist would look for within the formal structure are lines of authority, responsibility, control over resources, flows of information and the means of dominating the organisation's symbols and discourse. Despite formal positions of authority, the power to direct any individual or section is attenuated by subordinates' power to resist. Conflicting aims and needs come into play as well as conflicting assessments of what is required. Resistance may come about by being responsive to other drivers: for instance, directing an individual to take risk without protection for failure produces resistance. Yet the person directing may not be in control of such a guarantee. There are, then, other lines of authority, direction or influence that can lead to a confusion or dilution of clear principles of management. This is a small example of the manner in which similar cross-cutting interplays of power and resistance within an organisation could be described and analysed. A common means of dealing with multiple pressures is to reinterpret the goal such that it seems to meet all requirements. Thus, a clear intention at one level of the organisation is implemented in an unforeseen manner at another. Often, the least powerful in such an interaction is the client, leaving the service personnel able to sign off on an achievement, variously reinterpreted at all levels, while the client is no better off.

This is only a preliminary attempt to indicate a fruitful area of study, not a developed thesis in itself. It does show how complex such an analysis could quickly become. Complexity is increased when cooperation is required across agencies, as it is with the current government policy of whole-of-government service delivery in Indigenous affairs (Shergold 2004). Here multiple lines of authority or influence are more clearly tied to control over resources and levels of responsibility. No one in a government agency is likely to be happy redirecting 'their' resources to another's project, still less when they may be required to share responsibility without commensurate control. This is not simply a matter of selfish behaviour. It is commonsense when no protection is provided from sanction over negative outcomes nor reward for positive ones. Consequently, cooperation tends to take place in symbolic behaviour such as meetings and position papers, apparently implementing policy without deeply changing normal practice. These insecurities, which are real not imagined, are greater when cooperation is required across formal boundaries such as state/Commonwealth lines or the government/non-government sectors.

Control of information flows is also an important part of any cultural analysis of organisations. Each person or workgroup at every level of an organisation is subject to their own configuration of information, whether coming from their interaction with a client group, from policy planning forums, or from cruder political drivers such as sensitivity to Aboriginal health indicators in the field of broad public debate. How information is controlled, how meanings are transformed as information passes from one set of interests to another, and how policy is formed as much in response to an agency's internal needs as to external factors, are equally subjects that could bear a good deal of examination.

Factors like those outlined here add up to consistent behaviours and unarticulated values that form the culture of an organisation or agency. Newcomers are inducted into the culture as 'the way we do things here' through both formal and informal means. Advancement depends to a significant extent on absorption and reflection of the culture, and when employees move on or cross to other agencies one of their first tasks of adjustment is to jettison the old culture and absorb a new one. Culture conflicts across agencies and between government agencies and NGOs can be another significant barrier to whole-of-government service delivery.

Approaches to organisational culture

In the remainder of this chapter we discuss some sources for the study of organisational culture and whole of government service delivery in Indigenous affairs.

Wright (1994) offers a useful overview of anthropological approaches to organisational culture. In the introductory chapter of *Anthropology of Organisations* she gives a historical account of the anthropological study of public and private organisations. This account incorporates discussion of the research, its analytical methods and a context for later chapters outlining approaches to culture as a concept. For the study of culture and organisations she shows how anthropological approaches to culture have contributed to organisation studies.

Wright argues that the need for this approach has been generated by changing ways of organising in an environment of structural adjustment both in the West and elsewhere. She suggests that these changes have been brought about by the reordering of capital and the recognition of the shortcomings of the Western model of bureaucracy. She says that changes in ways of organising have been influenced by, and have influenced, Indigenous management, gender inequality and development discourse stressing the 'empowerment' of clients. Wright develops and endorses a notion of culture that emphasises social relations in processes of domination. She suggests that in doing this we can garner an understanding of how it is that people make and contest meaning in an organisational context. Furthermore, Wright sees that in a period characterised by change and reorganisation of capital the 'claim to "culture" is itself ideological' (1994:27), stressing that culture is being perpetually renegotiated and contested. Deployed as an analytical concept, she says, culture allows us to problematise the idea of what an organisation is in a particular set of circumstances.

In his contribution to Wright's collection, Marsden makes a useful contribution to the study of Indigenous management (Marsden 1994:41–55). He looks at the current situation in development studies that emphasises the need for local initiatives to drive project development. In contrast to previous models, which stressed the importance of non-local specialist knowledge to initiate and develop projects, current thinking privileges the 'knowledge' of local communities. The apparently neutral vocabulary of management has, according to Marsden, now taken over from the previous vocabulary of economics. In this chapter, he seeks to look behind this terminology and see what assumptions it rests on and indeed what it stands for.

One assumption is the belief that flexible management approaches which involve people in their design and implementation will be more successful than top–down approaches (Marsden 1994:42). In building capacity in development projects, techniques like participatory appraisal and evaluation have become commonplace. The aim of such projects is to focus not just on end results (products) but also processes. This, according to Marsden, is where the appeal of 'Indigenous management' lies. If local people are going to drive local schemes in a bid for self-reliance, then the terminology of 'Indigenous management' is seductive.

But Marsden problematises the notion of 'Indigenous management' suggesting that, in development discourse, it is deployed in three particular ways. These are: reference to 'Indigenous peoples', the process of indigenisation, and 'insider knowledge' and its use (Marsden 1994:42). Marsden expands each of these uses, with a particular focus on the problematic 'insider knowledge', and stresses that the political dimension of knowledge cannot be ignored, particularly in its use.

In pulling together the various threads of his argument, Marsden considers issues such as oral and written tradition and the related issues of the relegation of Indigenous knowledge systems to an inferior position based on modes of communication. He attributes various other techniques for relegating Indigenous 'traditions' to functionalist accounts of cultural situations progressed in the early part of the last century. In questioning the rhetoric of development discourse, Marsden draws out the current emphasis on sustainable development and capacity building through the strengthening of local institutions. He suggests that in so doing there is a tendency to ignore or misjudge the cultural and historical contexts that have produced such rhetoric. He has pointed out some of the dangers of relying on concepts of 'insider knowledge' and particularly emphasised the political nature of such knowledge.

Herzfeld (1992) is another significant contributor to the anthropology of organisations. He is concerned with the impulse of Western thinkers to assume that Western societies are more 'rational' than other societies. He argues that it is impossible to ignore local understandings of social relationships, responsibility, personal character and chance in assessing national bureaucracies. Formal systems and informal activities rely on both symbolic practices and idiomatic language to establish boundaries that then allow the distinction to be drawn between insiders and outsiders. The delineation of such boundaries facilitates the expression of prejudice and the justification of social disregard. This then allows the most generous of societies to produce at a structural or national level legitimised indifference.

Herzfeld asks:

> *how and why can political entities that celebrate the rights of individuals and small groups so often seem cruelly selective in applying those rights? Indifference to the plight of individuals and groups often coexists with democratic and egalitarian rights (1992:1).*

The book uses examples from modern Greece as well as European social forms to explore this idea, following the development of modern bureaucracy and of looking at relationships—often mediated through social form—between individuals and the state over time. Herzfeld uses historical and cultural information to examine what he sees as binding humans together, while simultaneously setting them against each other through time. He also looks at the ways that laws and formalised systems are altered through the forces of social process, changing their original meanings.

Whole-of-government coordination of service delivery

Herzfeld's perspective can be usefully applied to whole-of-government administrative policy. This field itself has a developed literature. The integration of national administrative systems has been referred to variously as 'joined up' government in the United Kingdom (UK), in Canada as horizontalism, in Australia as whole-of-government, and elsewhere as holistic governance. While there are some differences in emphasis in the literature, these terms refer to the allocation of resources, and to the coordination of thinking and action within government. These approaches supposedly bring together stakeholders in various areas of government to lead ultimately to the provision of more streamlined services for citizens, consumers or clients. There is a developing international experience of whole-of-government policy approaches (Ling 2002:19–21). The literature from the UK is particularly useful for analysing the Australian example (e.g., Pollitt 2003; Ling 2002). In literature from both countries there is a good deal of attention paid to the idea that a joined-up approach is not new, rather that it has been present in UK and Australian government policy development for many years.

In Australia, whole-of-government has gained a key position in recent public administration reform. The secretary of the Department of Prime Minister and Cabinet (effectively the head of the public service), Peter Shergold, introduced the Australian Government's commitment to a whole-of-government approach in Indigenous affairs in 2004. He suggested that the provision of 'Indigenous-specific programs and services' in a whole-of-government way would be 'the biggest test of whether the rhetoric of connectivity can be marshalled into effective action' (Shergold 2004:10). He stressed that 'no new edifice is to be built to administer Aboriginal affairs … [that this whole-of-government approach] is "the antithesis of the old departmentalism"' (Shergold 2004:10). Shergold goes on to detail the five characteristics of the whole-of-government approach to Indigenous affairs—collaboration, regional need, flexibility, accountability and leadership. Noting that 'knowledge is the key to cultural change' and that whole-of-government is 'the public administration of the future' (2004:15) Shergold is optimistic about the capacity of whole-of-government to resolve social issues in a 'new era' of public administration.

The report that Shergold introduced in April 2004, 'Connecting Government' (MAC 2004), had been commissioned by the Australian Public Service Management Advisory Committee and is a management policy document. In comparison with the international literature it shows that within public administration in Australia, an understanding of the implications of a whole-of-government way of doing business is underdeveloped. It is clear from the report that the authors are ambivalent about how the principles of effective 'joined up' government might be applied to the Australian Public Service (APS). The authors of this report define 'whole-of-government' in the APS as follows:

> *Whole-of-government denotes public service agencies working across portfolio boundaries to achieve a shared goal and an integrated government response to particular issues. Approaches can be formal or informal. They can focus on policy development, program management and service delivery (2004:1).*

In broad terms, the findings of the report are that a whole-of-government approach presents a serious challenge to public administration in Australia. The authors contend that dealing with this challenge can best be done through an emphasis on structures and processes that support whole-of-government work, culture and capability, information management, infrastructure and budget, and accountability and making connections outside the APS. These general areas are the headings of chapters in the report.

In the chapter concerned with structures and processes, the authors of 'Connecting Government' draw attention to existing management practices at a senior level of government, adding that they are efficient and provide leadership. The need to create suitable structures for the implementation of whole-of-government work is seen as critical. Some suggestions are made in this chapter for improving current structures—like taskforces, interdepartmental committees and agencies that contribute to decision-making and implementation—and discusses them in the context of a whole-of-government approach.

Culture and capability are seen as key factors in this report, even to the point that they 'shape the success of whole-of-government activities' (MAC 2004:43). Recommending a 'horizontal overlay' for issues that 'transcend traditional boundaries' the authors point to a collaborative approach, and commitment to policy and decision-making, which takes account of divergent perspectives. There are some suggestions about how this might occur through existing structures. It is characteristic of this chapter, and of the report as a whole, to be somewhat vague and lacking innovative suggestions for structural reform. For example, in relation to resolving cultural differences, the report observes that 'Australian Government field employees involved in the Wadeye project hold barbecues once a month as a networking mechanism to exchange information' (MAC 2004:51). How or why this works is not made clear. This kind of statement is common in the report, suggesting perhaps a lack of engagement between the establishment of whole-of-government policy and a working understanding of implementing that policy.

The next chapter, which looks at information management and infrastructure, rests on the comment that, 'as whole-of-government approaches become more common in the way agencies conduct their business, information sharing plays a critical role in generating better decisions' (MAC 2004:60). Undoubtedly, there is truth to this, but the report does very little to detail this process. There are some examples of agencies that are involved in information sharing. There is, however, little or no analysis of how information sharing works or why. The rest of the report, which addresses budget and accountability, relationships outside the APS and managing crises, continues with much the same ambivalence between commitment to innovation and endorsement of current practice. The report is a taxonomy of issues rather than a 'how to do it' manual for whole-of-government policy implementation. However, Appendix 2 in the report does have a table setting out issues and responses and a column devoted to lessons learned, which might provide a useful checklist of achievements to date or, perhaps, provide some guide for practitioners as to how to address particular circumstances.

Conclusion

This paper began by pointing out that Aboriginal groups and communities are not governance-free zones to which good governance instruments need to be brought. By this point, it will be evident that Aboriginal people live in a highly complex governance environment in which their own un-incorporated processes intermingle with Aboriginal and non-Aboriginal institutions and organisational cultures. Cultural processes permeate this governance environment influencing it at all levels. It is a difficult and often frustrating area to work within, particularly when interventions are focused on clear practical goals and outcomes.

Yet the governance environment is a significant social determinant of Aboriginal health. It demands attention if practical programs are to be productive and sustainable. Studies of good governance for Aboriginal communities are needed to increase both Indigenous and non-Indigenous knowledge in this area. Such studies should not be confined to local or community governance. Intersecting spheres of Aboriginal political and administrative organisation exist at regional and national levels also. The relationship of the local to the regional and national, the assertion of rights and the need for effective administration, are integrated concerns for future research. This paper has shown that attention to the cultural aspects of governance is necessary both within and outside of organisational structures. They are neither obstacles to be beaten down, nor impediments to be circumvented. Rather, it is the sea in which we swim, and we need to be attentive to its currents, rips and tides as well as to our own momentum and direction.

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Chapter 11:

Social Capital and Aboriginal and Torres Strait Islander Health—Problems and Possibilities

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Introduction

The concept of social capital has gained widespread currency within public health. Social isolation has long been understood to be detrimental to health, hence it is not surprising that there should be interest in the value of social connections for health. Explorations of the role of social capital in creating healthy communities now encompasses an international literature concerned with redressing health inequality within both rich and poor countries. Numerous definitions abound concerning social capital, however, at its core, social capital refers to the ability of people to secure benefits by virtue of membership in social networks or other social structures (Portes 1998).

Social capital research encompasses a wide spectrum of topics within the broad field of social and economic inequality. Health inequality is now an important part of this field. Studies largely within the area of social epidemiology have described significant associations between levels of social capital and levels of health status. Despite burgeoning enthusiasm for the concept, how to operationalise it in health policy and programs is by no means clear. Firstly, there is scepticism about whether there is really anything new about social capital. Secondly, social capital remains conceptually immature, hence open to vagueness and ambiguity. Thirdly, measuring social capital is fraught with many methodological difficulties. Fourthly, and perhaps most importantly for this paper, social capital is to a large extent a cultural construct, and, as such, may possess quite different meanings in different cultural contexts. For Aboriginal and Torres Strait Islander communities, already too familiar with ethnocentric research, the concern about constructing 'another' non-Indigenous representation of their issues is very real.

To date, there has been little research effort using the social capital concept within Aboriginal and Torres Strait Islander health. Therefore, this review seeks to describe *potential* application of the concept rather than a summative account of social capital within Indigenous Australia. The purpose of the review is to discuss problems and possibilities in operationalising the social capital concept within Aboriginal and Torres Strait Islander health. The review has been compiled from published data with a focus on social capital, health and Aboriginality. A range of sources were searched including:

- electronic library databases
- Australian Government websites
- Australian university and research centres
- international websites concerned with social capital research
- Google search using key words.

Approximately 400 references were located and they form the basis of this review.

Theorising social capital

Definitions: what are we talking about?

Lyda Judson Hanifan (1920), quoted in Feldman and Assaf (1999:2), is credited with the first use of the term describing social capital as

> *those tangible assets [that] count for most in the daily lives of people: namely goodwill, fellowship, sympathy, and social intercourse among the individuals and families who make up the social unit.*

Mignone (2003) collected seventeen definitions of social capital in order to track the trajectory of ideas behind social capital, but there are many more versions available. Portes and Sensenbrenner (1993) have described different types of social capital definitions corresponding to four different theoretical trajectories from (1) Marx and Engels, (2) Simmel, (3) Durkheim and Parsons, and (4) Weber. This is not the place to describe in detail these different trajectories, however it is important to acknowledge the diversity of definitions available and the consequent lack of conceptual consistency. Putnam's definition of social capital is arguably the most quoted in contemporary literature and defines social capital as:

> *features of social organisation, such as networks, norms and social trust that facilitate coordination and cooperation for mutual benefit (1995:35–36).*

Often social capital is referred to as the 'glue' that keeps communities together. The simplicity of this is appealing, but there is also, as Schuller *et al.* (2000) argue, an 'over-versatility' of the concept that has allowed it to be applied to almost any social situation and to mask potentially important differences in its use. Baum (1997), for example, has noted diverging understandings of the role of the state in the creation of civil society and social capital. The libertarian slant promotes the idea of social capital as 'beyond' the capabilities of government, while the communitarians would acknowledge the importance of an 'activist state'.

Woolcock (1998) has argued it is important to distinguish between what social capital is and what it does. This is a particularly important distinction in relation to Aboriginal and Torres Strait Islander health. Here we must ask what kinds of social capital are actually valuable to Indigenous people? A starting point for answering this question might be to first acknowledge the different levels of social interaction studied within the social capital literature. Macinko and Starfield (2001) have argued that there are four levels of social space in which social capital is used: a macro level (countries, regions); a meso level (neighbourhoods); a micro level (social networks); and an individual psychological level (attitudes such as trust). All of these levels have relevance to the social formations of Aboriginal and Torres Strait Islander Australia.

Putzel (1997) has argued that there is a profound theoretical confusion in the social capital arena created by 'failing to distinguish between the mechanics of trust (the operation of networks, norms etc.) and the political content and ideas transmitted through such networks and embodied in such norms'. As Ostrom (1997) has noted, cartels and organised crime groups can display substantial social capital. This 'dark' side of social capital is often obscured by the concern to idealise the value of social connections. Putnam (1995), in particular, has idealised the American family as well as community association membership. The idea that families can be oppressive social instruments, or that many of the associations in the USA with declining memberships may hold deeply conservative and exclusionary roles, is ignored by Putnam (Putzel 1997).

The big picture: is there a role for social capital in theorising Aboriginal and Torres Strait Islander health inequality?

The enormity of Indigenous health inequality in Australia implores us all to consider its nature and potential solutions. While there can be no dispute that a history of colonisation, dispossession and discrimination have formed the conditions from which poor health has resulted, there remains a vacuum in our understanding of how we place ideas about poor health causation within a theoretical framework. In particular, the struggle to reconcile social accounts of poor health with the dominant biomedical emphasis on individual agency has unfortunately attracted little interest.

Brady (1999) has argued the need for a 'syncretic approach' that integrates both structural and socio-cultural levels of explanation. The social capital literature generally acknowledges the need to address structural issues, but nevertheless downplays class relations and focuses predominantly on social policy remedies around facilitating social cohesion rather than economic and political change (Germov 2002:89). Muntaner *et al.* (2002) have argued that the social capital literature around health has a tendency to 'blame the victim' by suggesting that the source of health problems of deprived groups is their lack of social networks and initiative. The role of social capital in helping to theorise Aboriginal and Torres Strait Islander health inequality has yet to be articulated, although Hunter has observed that: 'Social Capital theory is articulated at a level abstract enough to encompass the experiences of many Indigenous Australians', but adds more critically that 'unless more attention is paid to modelling exactly how these social exchanges add (or subtract) economic value to individuals or groups, then the term social capital is little more than a metaphor' (2000:38).

A logical starting point for considering the uptake of social capital within Indigenous Australia would be to consider the broader theorising of ethnicity within social capital research. However, Carlson and Chamberlain (2003) argue that, at present, the exploration of ethnicity within social capital research remains both conceptually and methodologically immature. For example, in the study by Kawachi *et al.* (1997) that analysed racial difference between black and white Americans, it was found that social mistrust highly correlated with being black, low income and low education. However, these studies also found that the health outcome for black Americans explained by social mistrust was significantly less than for white Americans. The theoretical implications of these findings remain unexplored (Carlson & Chamberlain 2003). Some useful work on the relevance of social capital to the health and wellbeing of First Nation communities has emerged in Canada, shedding light on the nature of social capital in an Indigenous context (see Mignone 2003; Matthews 2003; Matthews *et al.* 2005).

We should not be surprised to find mistrust of institutions among Aboriginal and Torres Strait Islander Australians, but whether this constitutes an 'independent' source of health inequality or whether such mistrust is the result of many deeper injustices needs careful thought. These theoretical issues are not only related to questions of academic rigour, but also connect to very real political issues that are the consequence of our understanding of Aboriginal and Torres Strait Islander health inequality. There is already an alarming number of descriptions of Aboriginal and Torres Strait Islander communities in terms of dysfunction and disease (Brough 2001). Before another potential descriptor of dysfunction is constructed, it is crucial that the validity of the description be thoroughly examined. For example, at a very basic level, there seems to be an assumption within some of the social capital literature that if low social capital produces poorer health, then communities with poor health, logically, must have low social capital. If this were the case, then we could assume right now, without any empirical research, that Aboriginal and Torres Strait Islander communities must have low levels of social capital, since poor health status is not in question. Perhaps, instead, we need to reverse the hegemonic logic of measuring how 'well-connected' Aboriginal and Torres Strait Islander people are to non-Indigenous Australia, and instead ask how well connected is non-Indigenous Australia to Aboriginal and Torres Strait Islander Australia?

Active citizenship: by whose standard?

A common idea within social capital literature (particularly the line of inquiry evolving from Putnam (1993, 1995) is concerned with the extent to which individuals display civic habits conducive to healthy communities. This line of thinking fits particularly well with 'third way' social policy thinking of mutual obligation and other anti-welfare-dependency strategies. This kind of social policy logic has gained significant ground in Australia and has received additional momentum in terms of Aboriginal and Torres Strait Islander social policy through the analysis of the Aboriginal social commentator Noel Pearson. Pearson (2001) has argued that the passive welfare system is ultimately to blame for many of the social and health problems facing Aboriginal and Torres Strait Islander communities. Like many working under the banner of the 'third way'—social capital, social entrepreneurship, and community building—Pearson argues the importance of active citizenship in finding solutions to long-standing social problems.

Civic participation may well be a useful idea to encourage, but the problem remains as to whose standards this should be measured by. It is unlikely Pearson's imagination of Aboriginal civic responsibility is the same as conservative liberal imaginations. Hunter (2004) notes this too, arguing that disadvantaged people may find resonance in social capital, but are nevertheless still likely to be talking about very different experiences to their political leaders.

A major stumbling block in theorising 'healthy' citizenship for Aboriginal and Torres Strait Islander Australians must be an acknowledgment that citizenship itself has been an excluding and socially divisive political ideal within Australian colonial and post-colonial history. Turner's commentary on the problematic nature of citizenship for Indigenous people is relevant here:

> *In particular, in the modern period, if citizenship has emerged primarily within the nation-state, then citizenship simultaneously excludes and subordinates various Aboriginal groups within so-called white-settler societies (especially Australia, Canada, New Zealand and the United States). These aboriginal groups are faced with the choice of either separate development within their own 'state' or some form of assimilation into existing patterns of citizenship (1993:14).*

For Aboriginal and Torres Strait Islander people who have struggled against assimilationist policies and programs, often in order to create healthier outcomes for their communities, the idea of measuring 'civic participation' against a benchmark set by 'mainstream' Australia would not only be theoretically and methodologically flawed, but, more importantly, politically and historically insulting. Moreover, does being an active member of the Aboriginal and Torres Strait Islander community confer the same possibility of benefit as being an active member of other communities?

Part of the difficulty in taking a universalist view of social capital is that it does not acknowledge the possibility that social capital clusters around particular social spaces, some of which may sit in opposition to each other. As Portes has argued, sometimes group solidarity is cemented by a common experience of adversity and opposition to mainstream society:

> *In these instances, individual success stories undermine group cohesion because the latter is precisely grounded on the alleged impossibility of such occurrences. The result is downward levelling norms that operate to keep members of a downtrodden group in place and force the more ambitious to escape from it (1998:14).*

Measuring social capital

Social epidemiology

There is a growing body of public health research considering the interconnection between social issues, economic indicators and wellbeing for both neighbourhoods and individuals. Cross-disciplinary studies investigating social capital have emerged recently which provide new perspectives from urban planning, community development and psychology to enrich the health debate (Grootaert & van Bastelaer 2002; Mohan & Mohan 2002; Gilson 2003; Jackson 2003; Robison & Flora 2003).

Some population studies by Baum and others link social dimensions with health outcomes providing practical suggestions for structural health interventions or policies (Tijhuis *et al*. 1995; Baum 1999a, b, c; Baum *et al*. 1999; Wallis & Dollery 2001). Focused studies, such as for children, injecting drug users or mental health, offer suggestions for public policy (Lovell 2002; Jutras 2003; Stewart 2004). Programs such as that by Glass *et al*. (2004) develop population health through social approaches, such as intergenerational programs. These studies are welcome, as human services research and policy more commonly focuses on deficits or matters needing improvement than on strengths and wellbeing. Social issues and wellbeing indicators, while recognised as linked and important, have been less well researched than biomedical factors and ill health, and likewise are less well resourced in health services (Gorski 2000).

Social capital generally shows weaker associations with population health indicators than economic inequality. While social capital has been embraced as a model to help explain connections between the social environment and health, some suggest the notion of class remains a more valid measure to explain differences in health status (Muntaner *et al*. 2002; Kennelly *et al*. 2003; McCulloch 2003). Muntaner and colleagues (2002) suggest a closer relationship between health outcomes and poverty rather than social capital, where strong welfare states are associated with lower rates of both infant deaths and injury mortality for workers.

The nature and context of relationships is poorly developed in current research with a presumption that middle-class Western values and systems apply in other situations. There seems to be no 'one size fits all' for social indicators, and research results are often contradictory (Hyden 2001; Lindstrom & Ostergren 2001; Lynch *et al*. 2001; Moss 2002; Edmondson 2003). Social background seems to have different effects on health outcomes. For instance, people living in poor neighbourhoods who knew few neighbours displayed lower levels of anxiety and depression than others living in more affluent places (Caughy *et al*. 2003). McMichael and Manderson (2004) suggest that while social capital is a useful concept for understanding some aspects of adaptation to a new environment for Somali women resettled in Australia, the institutions of social capital are politically and culturally loaded. The impact of social connectedness may depend both on class and socio-economic background, or social norms may have various impacts depending on customary behaviours. Saggers and Walter (2004) suggest a dynamic relationship between Indigenous status and the socio-economic, cultural and political arrangements of a society, and that this underlies the differences in health outcomes for Indigenous people.

Challenges in measurement

The nature of the association between social connectedness and health is poorly understood (Berkman & Glass 2000; Kawachi & Berkman 2000; Veenstra 2000; Cattell 2001; Cullen & Whiteford 2001; Scanlon 2004). One important reason for this is the difficulty in measuring social connectedness. Epidemiology, as the traditional quantitative discipline of public health, must come to grips with this measurement, especially in the crucial area of Indigenous health and wellbeing. More generally, Leeder and Dominello have thrown down the gauntlet:

> *There is no claim that epidemiology has been successful in illuminating fully the association between socio-economic status and health, but then who has? So, are we seriously to believe that a concept such as social capital—defined differently by many people who use it, burdened with middle class fantasies and nostalgia for the picket fence and mum at home cooking the evening meal—will see us out of that fix?*
>
> *For social capital to find a place at the social policy table, it must be given some stability and… be subject to quality epidemiological research, not too dissimilar to that which has underpinned epidemiology's immense success in public health over the decades (1999:428).*

Morrow suggests we conceptualise social capital

> *not so much as a measurable 'thing', rather as a set of processes and practices that are integral to the acquisition of other forms of 'capital' such as human capital and cultural capital (i.e. qualifications, skills, group memberships etc.) (1999:744).*

Shortt (2004) has briefly reviewed the lack of international consensus around the measurement of social capital, including attempts to design a generic social capital assessment tool. Baum and Ziersch (2003) observe that most studies measuring social capital have done so quantitatively, often using measures such as per capita membership in voluntary groups and levels of inter-personal trust, but that there have been fewer in-depth qualitative studies that may be fruitful in the way they examine the contexts in which social capital operates and its multi-dimensional nature.

Hughes and Stone (2001) consider social capital measurement to be an emerging field, and identify four key principles to help avoid past pitfalls in measuring social capital in empirical research (Portes 1998; Stone 2001; Stone & Hughes 2001). These are that: (1) social capital measurement and 'practice' needs to be theoretically informed; (2) social capital should be understood as a resource to collective action; (3) empirical work must recognise that social capital is a multi-dimensional concept; and (4) a recognition that social capital will vary by network type and social scale.

Social capital research requires multi-level analysis. Should we measure it at the group level if we agree that social capital is a collective characteristic? Kawachi and Berkman (2000) consider there are two possible approaches, one using aggregate variables (aggregating individual level data), and the other using integral variables (direct observation at the group level). We must be mindful of the well-known 'ecological fallacy' that associations at the group level (e.g.

family, community, town, city, country) could differ from the corresponding associations at the individual level within groups of the same population (Robinson 1950). Firebaugh (1978) has shown that under certain conditions aggregate level data can provide unbiased estimates of individual level relationships. Ecological studies are the only studies that can measure group effects, however, they have several methodological problems that may limit causal inference, especially biologic inference (Morgenstern 1998). Van Deth (2003) has discussed various pitfalls around the measurement of social capital, including the use of aggregate measures for collective phenomena.

Social capital theory can provide an explanation for local contexts, although Shortt (2004) observes that social capital tends to ignore context. A validation of social capital indicators in different settings is, therefore, required (Van Deth 2003; Hunter 2004). While there is no single test to establish the causality of an observed association between an exposure and an outcome, we can use various guides to assist in determining whether an association is causal (Bradford Hill 1965; Susser 1991; Lucas & McMichael 2005).

Hughes and Stone (2001) describe a study in which existing survey data from a random sample of 1500 Australian households (with at least one person aged eighteen years or older)[1] were used to develop and test three approaches to measuring social capital, using statistical techniques such as cluster and factor analysis—a network-based approach, an overall measure approach and a typology-based approach. Measures of informal social capital used included 'trust in family', 'reciprocity within family', 'trust in friends' and 'reciprocity among friends'. Measures of generalised social capital used included 'trust in people around here (local area)', 'reciprocity among people around here (local area)', 'trust in people in general', and 'number of group memberships (individual item, actual number)'. The authors concluded that while the three approaches to measurement had statistical validity and reliability, further research was required to determine their validity and usefulness. Although the measurement approaches used in this study may not apply to Aboriginal and Torres Strait Islander Australians, they are worth exploring further.

The Australian Bureau of Statistics (ABS) has recently published an information paper with a broad conceptual framework for statistics on social capital and a set of possible indicators for measuring aspects of social capital (ABS 2004). Four main elements of social capital are identified: network qualities, network structure, network transactions and network types. Further, sub-elements within each of the four main elements have sets of possible indicators. For example, within the main element of network qualities, indicators of trust and trustworthiness are listed as: generalised trust; informal trust; institutional trust; generalised trustworthiness; feelings of safety using public transport; feelings of safety walking in the street; and feelings of safety at home after dark. An indicator of generalised trust is listed as 'the proportion of people who feel that most people can be trusted', and data items are 'most people can be trusted' and 'cannot be too careful dealing with people'. There is no discussion in this ABS information paper about the applicability to Aboriginal and Torres Strait Islander Australians of the social capital conceptual framework, elements or indicators. This framework will need to be looked at critically, taking into account the complex issues of kinship, before applying these empirical measures of social capital to Aboriginal and Torres Strait Islander people.

Onyx and Bullen (2000) measured social capital in five communities in New South Wales—Deniliquin, Greenacre, Narellan, Ultimo and Pyrmont, and West Wyalong—which included rural, outer metropolitan and inner city communities. The final non-random sample consisted of 1211 people, aged between eighteen and sixty-five, interviewed face-to-face. Using factor analysis and the thirty-six best social capital items, they concluded that eight elements appeared to define social capital: participation in the local community; pro-activity in a social context; feelings of trust and safety; neighbourhood connections; family and friends connections; tolerance of diversity; value of life; and work connections. In their 2004 USA study, O'Brien *et al*. (2004) used a random telephone survey adaptation of the Onyx and Bullen (2000) non-random, face-to-face interview questionnaire, and concluded, using exploratory factor analysis, that the Australian-based instrument deserves further attention as a practical tool for health researchers interested in measuring social capital. Again, careful work would be required to determine if this non-Indigenous based questionnaire instrument is relevant, valid and reliable for measuring social capital in Aboriginal and Torres Strait Islander communities and populations. The development and testing stages prior to operationalisation of large- surveys will be crucial.

It is worth noting that Matthews *et al*. (2005) are examining aspects of social capital in First Nation coastal communities in British Columbia. The study has generated successful methods for collecting data on social networks inside Indigenous communities. Measures for individual and institutional trust have been trialled as well as indicators of community commitment and attachment. This Canadian work presents potential openings for researchers in Australian Aboriginal and Torres Strait Islander health to consider.

Complicating these issues of measurement, both those specific to Aboriginal and Torres Strait Islander Australia and to broader epidemiological rigour, is the current atmosphere of apprehension towards research and researchers in Aboriginal and Torres Strait Islander communities and neighbourhoods, which has seen a strong move towards action research rather than purely descriptive or analytical studies. Indeed, one of the unexpected benefits of an explicit focus on social capital among researchers involved in Aboriginal and Torres Strait Islander health, could be the encouragement of a concern for how the research process itself either builds or erodes social capital.

Social capital in public health practice

The burgeoning literature defining, applying and referring to social capital demonstrates the term's increasing usage by both theorists and practitioners alike. While debates about the clarity and rigour of social capital research abound, there has nevertheless been a heavy investment in the concept by practitioners and policy-makers. References to social capital now cross a range of geographical locations and populations. What was initially a concept applied in the USA or Europe has become a global phenomenon applied in regions and countries that differ socially, culturally and economically. They can range from a Los Angeles neighbourhood (Arefi 2003) or the state of California (Twiss *et al*. 2003) to the Ivory Coast (Aye *et al*. 2002), Jamaica (Honig 1998), Russia (Rose 2000) or Australia (Baum 2000). Social capital has been used in programs in rural areas particularly in those areas either developing or declining (Bossert 1998; Narayan & Pritchett 1999; Williams 2003). There is also an emerging urban social capital literature in Australia (Baum 1997, 1999a,b, 2000; Baum *et al*. 1999; Leeder & Dominello 1999) and elsewhere such as in the USA (Putnam 1995; Aday 1997; Cohen 1998; Bartelt & Brown 2000; Hutchinson 2004).

Social capital research now spans an enormous mosaic of populations including age groups (Sun 1998; High *et al*. 1999; Bazemore 2001), work groups (Butler 1999; Marger 2001), linguistic groups (Hyyppa & Maki 2001; Silverman 2001), religious groups (Candland 2000), those 'at risk' (Aday 1997; Knowlton 2003), those with low socio-economic status (Runyan & Wanda 1998; Grootaert 2001; Drukker *et al*. 2003), migrants (Liang 1994; Campbell & McLean 2002) young people (Sun 1998; Earls & Carlson 2001; Campbell & MacPhail 2002, Douglas 2005), women (Gittell & Ortega-Bustamante 2000), and sex workers (Campbell & Mzaidume 2001).

Social capital and community work

There is an expectation that 'societies with a rich web of relationships and widespread participation in community organisations will flourish at many levels including the economic' (White 2002). Hence, it is not surprising to find the social capital concept being operationalised in areas such as community development, capacity building, social development and community building. The connection between social processes, economic outcomes, health and wellbeing—both for individuals and at a whole neighbourhood level—have been highlighted in many studies (Baum 1999a, b, c; Veenstra 2000; Denner *et al*. 2001; Lindstrom & Ostergren 2001; Lynch *et al*. 2001; Subramanian *et al*. 2001; Kennelly *et al*. 2003; Wen *et al*. 2003; Altschuler *et al*. 2004). Many writers acknowledge the link between neighbourhood social processes, individual empowerment and improved health and wellbeing (Campbell & Jovchelovitch 2000; Semenza 2003; Twiss *et al*. 2003; Guareschi & Jovchelovitch 2004), although it is agreed evaluating the connections is problematic (Billings 2000).

At a neighbourhood level, social capital was reported as basic infrastructure for community development (Flora 1998) and, more specifically, community building in the inner city (Cohen 1998). A public health study in Adelaide established links between urban civic infrastructures and opportunities for people to connect (Baum & Palmer 2002). Roseland (2000) explored the connections between social and natural capital in an environmental framework, and the implementation of participative governance for achieving sustainable development in communities. Temkin and Rohe (1998) propose a theoretical model linking social capital to neighbourhood stability, while other studies suggest that social capital contributes to increases in neighbourhood prosperity (Arefi 2003) and quality of life in poor neighbourhoods, particularly in public housing (Lang & Hornburg 1998).

Altschuler *et al*. (2004) examined the impact of environment on health and the effect of bridging and bonding capital in an urban neighbourhood with varying socio-economic status (SES). Bonding capital refers to links with close-knit peer and family groups, while bridging capital refers to connections outside of these immediate social networks. They found that while bonding capital may be more uniform across neighbourhoods of varying SES, bridging capital (and consequently improved health outcomes) tends to be found in greater amounts in higher SES areas (Altschuler *et al*. 2004).

Among the literature espousing the positive implications of social capital, there are few examples of its negative effects that are often referred to in theoretical papers. While Ostrom (1997), for instance, suggests some organised crime groups display characteristics of social capital, many more authors refer to it in the context of crime prevention (Carson 2004; Hughes 2004; Lee & Herborn 2003).

Social capital and public health

Several projects have set out to test the hypothesis that increasing social connections could show improvements in health. Litwin found that physically active people had better social connections (Litwin 2003). Cattell discovered that different kinds of social networks had an impact on individual health along with perceptions of neighbourhood and poverty and social exclusion (Cattell 2001). Building local connections between older adults and children is believed to have health benefits for both (Glass *et al*. 2004). Likewise, building relationships between women to improve play opportunities for children was believed to improve outcomes both for overall social functioning and for health (Jutras 2003). A community building project in the USA involved local residents constructing public art in a major civic intersection (Semenza 2003). A similar process was used in California to establish community gardens, which showed public health benefit while strengthening community building skills (Twiss *et al*. 2003). A study in the Netherlands found that the higher the degree of social control in a neighbourhood, the better the children's mental health (Drukker *et al*. 2003).

Holtgrave and Crosby (2004) found a highly predictive relationship between social capital and tuberculosis. McCulloch (2003) conducted an analysis of social disorganisation in Britain and found connections between individual health outcomes and neighbourhood structural characteristics such as population density, concentration of affluence and residential instability. The effect of social capital has been explored in several studies focusing on HIV and STDs. Holtgrave and Crosby (2003) demonstrated clear links between social capital, economic inequality and STDs and suggest the need for structural interventions designed to increase social capital in communities. Clearly, finding an association between social capital and a variety of health outcomes has not proven difficult. However, some authors have been concerned that deeper social divides may be more fundamental to health inequality. A study of peer education of sex workers in a deprived community in South Africa found it difficult to translate the theory of social participation into improved health outcomes because of the dominant structural conditions of poverty (Campbell & Mzaidume 2001). A French study considered social capital and access to reproductive technology, and concluded that social class is more influential on behaviour than social capital (Tain 2003).

Social capital and culture

The role of the culture concept within social capital has not been deeply explored, although a large body of research now describes international social capital in a large range of cultural contexts. There remains the question of whether social capital is relevant only to Western, neo-liberal societies (Szreter 1999; Edmondson 2003), or if it has application in Indigenous communities (Gasteyer & Flora 2000).

A study of the Roma population in Hungary considered the relationships with ethnic minorities in terms of institutional social network resources. It concluded that there was a higher institutional capacity where the Roma population demonstrated high levels of social cohesion, where social networks had norms of trust and cooperation, and where there were effective links with external organisations (Schafft & Brown 2000).

Several studies have considered links between social capital and economic outcomes for ethnic groups (Fox & Gershman 2000). The possible nexus between social capital, cultural background and health status has been examined in a variety of locations, particularly in Europe and North America. A study in Finland found differences in the onset of disability and in self-reported health between Swedish- and Finnish-speaking residents in the same locality. The authors suggest these differences can be explained by social capital (Hyyppa & Maki 2001). A British study explored the impact of ethnic identity for African–Caribbean people on organisational participation and health outcomes, and concluded that institutional racism meant participation was unlikely (Campbell & Mclean 2002). A study in Chicago found higher social capital associated with better health outcomes for whites, although the association was not as strong for African Americans (Lochner *et al.* 2003). While these kinds of studies make links between ethnicity and social capital, there is still a lack of conceptual clarity concerning the ways in which social capital is itself a cultural product.

What we already know about social capital in Aboriginal and Torres Strait Islander Australia

Social capital has yet to attract a concerted interest within the study of Aboriginal and Torres Strait Islander Australia. To date, interest has largely been restricted to the study of economic development and education. Predominantly through the works of the Centre for Aboriginal Economic Policy Research (CAEPR) researchers, a series of findings have emerged that point both to potential and problems in the use of social capital as an analytical device in understanding economic and to educational inequality.[2]

Martin (1995) has argued the importance of connecting socio-cultural understandings of Aboriginal and Torres Strait Islander 'economic' values and practices in order to understand the nexus of culturally constructed ideas about exchanges of food, goods and cash. In this kind of analysis, Aboriginal and Torres Strait Islander Australians face a choice between participation within the dominant social spaces or within the socio-cultural spaces of their own communities. Similarly, Schwab's discussion of Aboriginal and Torres Strait Islander participation in higher education took up this point:

> *Clearly, for many Indigenous people, participation in higher education is an attempt to acquire cultural capital that is convertible to economic capital in the dominant economy, but it is worth considering to what degree that same cultural capital is convertible in the Indigenous community (1996:12–13).*

Here, Schwab (1996) found that Aboriginal and Torres Strait Islander people often weigh up the costs and benefits of education in terms of their own particular social and cultural circumstances. The 'cost' of education, for some Aboriginal and Torres Strait Islander people, can be a loss of connection to their own community and can bring with it substantial new responsibilities to their extended families and communities.

This theme resonates with the tensions Aboriginal and Torres Strait Islander people can face in 'choosing' between bonding and bridging capital. A qualitative study of social capital within an urban Aboriginal and Torres Strait Islander community (Shannon *et al.* 2003) found that people can face this 'choice' in a more generic sense, often having to decide which aspect of their identity they feel they should or can emphasise in a particular circumstance. Stories of not feeling trusted by non-Indigenous people and institutions were common, leading many Aboriginal and Torres Strait Islander people into situations of having to 'manage' the presence of their identity on a day-to-day basis. A recent survey of social capital and health in a rural town with a significant Aboriginal population (23 per cent) also found that Aboriginal people were more likely to think about their identity than their non-Indigenous counterparts (Gilles *et al.* 2004). Indeed, one-third of Aboriginal and Torres Strait Islander respondents had in the previous four weeks felt negative physical or emotional symptoms as a result of how they were treated because of their identity. Under such circumstances it is not surprisingly that Giles *et al.* (2004) also found lower levels of civic participation among Aboriginal and Torres Strait Islander participants than non-Indigenous participants.

Civic participation may, of course, hold different meanings within an Aboriginal and Torres Strait Islander context. For example, Shannon *et al.* (2003) found that many Aboriginal and Torres Strait Islander people did not consider work they did for the community as 'voluntary'. Rather, they described such community work as 'just what you do', with some seeing it in terms of their identity—their shared responsibility. This is supported quantitatively in the National Aboriginal and Torres Strait Islander Survey findings concerning voluntary work, in which Aboriginal and Torres Strait Islander people were found to be more likely to volunteer than their non-Indigenous counterparts (Smith & Roach 1996).

What is clear from these few studies of Aboriginal and Torres Strait Islander social capital is that it is difficult to separate an understanding of social capital from an understanding of lived identity. The diversity of Aboriginal and Torres Strait Islander people's cultural practices and social contexts around

Australia is well known. Social organisation and kinship are complex subjects that must be taken into account when measuring social capital in relation to the health outcomes of Aboriginal and Torres Strait Islander people. We must be mindful that much of the literature about social capital has a Western, colonial focus, and there is an important need to develop and test reliable and valid measures of social capital for Aboriginal and Torres Strait Islander Australians.

Implications for the development of an Aboriginal and Torres Strait Islander social capital research agenda

The way forward in social capital research in Aboriginal and Torres Strait Islander health is by no means clear-cut. The theoretical, methodological and political challenges (and even dangers) of social capital research have been openly canvassed within this review. Based on these concerns, it would not be appropriate to conclude that social capital offers a panacea to the development of a more 'social' perspective within the study of Aboriginal and Torres Strait Islander health inequality. However, neither would it be wise to conclude that social capital does not have something valuable to offer.

The poor health of Aboriginal and Torres Strait Islander people has long been argued to be the result of social forces, yet there is little research on how exactly these social forces affect health. Social capital is neither inherently 'good' nor 'bad' for health status. Hence, we need to imagine the possibilities of a research agenda that points towards an understanding of the production of health and wellbeing, and not simply 'another' way to describe poor health status. In their review of social capital in health promotion, Hawe and Shiell (2000:880) argue that the growing importance of place within health promotion involves

> *the recognition that people's experience of themselves as persons with meaning, dignity, power to act on their own behalf and care respectfully for others, happens in a social context and properties of that context can either encourage human interaction, connection, growth and respect or conversely, foster alienation and despair.*

It will be important to describe a variety of macro, meso, micro and individual contexts, from which a variety of perspectives can be produced about social capital in Aboriginal and Torres Strait Islander communities.

At the very least, social capital provides an alternative to the dominant biomedical, risk-factor approach that has failed to contribute substantially to an improvement in Aboriginal and Torres Strait Islander health status. An understanding of social capital in an Aboriginal and Torres Strait Islander context might not only contribute to a better understanding of traditional risk factors, but also offer the possibility of exploring the direct relationship between the social environment and health. Perhaps the single largest contribution that social capital research might make to the Aboriginal and Torres Strait Islander health field is to provide a space in which the dynamics involved in the social determinants of health can be critically examined. It is in the debate about the usefulness of these dynamics in explaining Aboriginal and Torres Strait Islander health that progress might be made. Acknowledgment of the Aboriginal and Torres Strait Islander voice in the description of Aboriginal and Torres Strait Islander circumstances will be important in this debate. This voice will be needed to ensure that the research addresses the value and meaning of social capital from an Aboriginal and Torres Strait Islander perspective. The research questions here are not just about describing what kinds of social capital presently exist in Aboriginal and Torres Strait Islander Australia, but, more importantly, what kinds of social capital do Aboriginal and Torres Strait Islander people desire? The current trend in social policy towards building social capital in marginalised communities seems often simply to assume a match between policy and community agendas. The ultimate test of the social capital concept will be whether it resonates with Aboriginal and Torres Strait Islander voice and experience.

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Chapter 12: Law as a Determinant of Indigenous Health—Some Constitutional Issues

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Introduction

It has long been recognised that illness and its problems are rarely randomly distributed across communities—in so many cases they are skewed towards the disadvantaged. The poorest in our community, those with the least opportunities, are also our sickest. Thus it is crucial that we recognise and take account of how the social dimension influences patterns of ill health if we are to address this problem in any useful way. Indigenous health presents a particularly marked pattern of disadvantage, and the social contexts have become the principal way of explaining that disadvantage. Indeed, the comparison between Indigenous and non-Indigenous health in Australia is so stark that the social context is the most meaningful way of explaining those differences.

Those social contexts are defined and shaped by a number of factors including law, which can play a significant role in influencing health outcomes. In the case of Indigenous health outcomes, the law has a complex and longstanding role. Sometimes it has supported Indigenous communities, but often it has legitimated their social disadvantage and authorised and sustained policies, such as the separation of families, or allowed, and even required, unequal treatment and discrimination. In Australia our most fundamental law is the Constitution, which is the foundation of the Australian Commonwealth and which sets the scene for the relationships between citizens and their State. But how can the Australian Constitution influence Indigenous health? Potentially it can: for example, it is the case that Indigenous health in other broadly comparable countries, New Zealand, Canada and the United States of America (USA), though bad, is not as bad as in Australia. It is also the case that those countries have constitutional arrangements that are different to Australia's insofar as they acknowledge and take account of a prior Indigenous relationship with the land. Potentially these constitutional differences might offer one explanation for the health differences. We might speculate that where constitutional arrangements reflect and support Indigenous rights and interests, health outcomes potentially might be better. With this possibility in mind, the relationship between Indigenous Australians, the Constitution and possibilities for constitutional reform are examined, especially in the context of rights.

Indigenous Australians were constitutionally ‘invisible’ until 1967

The Constitution was drafted against the beliefs that traditional Indigenous communities were dying out. One of its founders, Alfred Deakin, was an idealist—a man concerned about safety in factories, a man who wanted to eliminate the ill-use of animals. He also approached the business of Federation with lofty visions and high morals. Yet in 1905, he wrote this about Indigenous Australians:

> *These rights of property in land and stock about which the earliest [European] settlers are of necessity most keen among themselves are incomprehensible... to [an Indigenous] race whose ideas upon such questions are of the rudest and most archaic (Deakin 1968:147).*

His comment demonstrates the gulf between Europeans and Indigenous Australians at the time.

When it came into being, the Constitution made Indigenous Australians invisible and specifically prevented the Commonwealth from making laws that might apply to them. Section 127 read, ‘In reckoning the numbers of the people of the Commonwealth, or of a State or other part of the Commonwealth, aboriginal natives shall not be counted’ (Atwood & Marcus 1997:2).[1] Section 51 (xxvi) gave the Commonwealth power to make laws with respect to ‘the people of any other race other than the aboriginal race in any State for whom it is deemed necessary to make special laws’ (Atwood & Marcus 1997:2).[2]

Both these provisions were changed by popular referendum in 1967. Section 127 was repealed and the phrase ‘other than the aboriginal race’ was deleted from section 51(xxvi). Since that date the Commonwealth has used its power to pass a range of laws relevant to Indigenous issues, including funding, protecting heritage, Native Title, and establishing the now defunct Aboriginal and Torres Strait Islander Commission (ATSIC).[3] Mainly these have been for beneficial purposes, advancing Indigenous interests, though there is no reason why the Commonwealth could not use the power to make laws that are not beneficial to Indigenous Australians. Arguably, the 1998 amendments (which introduced the ‘10 Point Plan’) to the *Native Title Act 1993* were not beneficial, as the essential effect was to make Native Title more difficult to claim. Neither was the act that abolished ATSIC in 2005. In the Kartinyeri case the High Court was split on the point: two judges argued that there was no reason why detrimental law could not be made by the Commonwealth, one judge argued that detrimental law could not be made, and a fourth judge offered a test of proportionality against which a Commonwealth law could be tested.[4] It is most likely that a future court will allow detrimental legislation under the power, with the only limit being that the law could not be a ‘manifest abuse’ of power. What that might mean in practice remains unclear.

The scope of the race power is thus an issue that needs further consideration, particularly in light of the Kartinyeri case.

The preamble and a case for change

Preambles are the lead-in to constitutions. Often expressed in grand and memorable language, they set the tone and express the values, although they may not be followed through in the rest of the document or in practice. Mostly a preamble has a symbolic function, unless courts decide

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[1] This ‘exclusion from counting’ related to the allocation of parliamentary seats and the distribution of funds to the States, both measured by the States’ populations.

[2] It is often believed that the 1967 amendment allowed Indigenous Australians to vote. The changes did not address this issue.

[3] ATSIC was a representative authority of appointed and elected members established by Commonwealth legislation in 1989, with funding and administrative functions. It was abolished in 2005.

[4] *Kartinyeri v. Commonwealth* (1998) 195 CLR 337: the judgments of Gummow and Haines JJ, Kirby J and Gaudron J respectively.

that they will use it as an aid to interpretation. The preamble currently in the Australian Constitution is merely a bland statement of intent to federate.[5]

There is an argument that a preamble that properly reflects the past histories and seeks to reconcile the future relations between Indigenous and other Australians should replace the original version. A model that can provide guidance is the 1999 Draft Declaration for Reconciliation of the Council for Aboriginal Reconciliation. It reads as follows:

> *Speaking with one voice, we the people of Australia, of many origins as we are, make a commitment to go on together recognising the gift of one another's presence.*
>
> *We value the unique status of Aboriginal and Torres Strait Islander peoples as the original owners and custodians of traditional lands and waters.*
>
> *We respect and recognise continuing customary laws, beliefs and traditions.*
>
> *And through the land and its first peoples, we may taste this spirituality and rejoice in its grandeur.*
>
> *We acknowledge this land was colonised without the consent of the original inhabitants.*
>
> *Our nation must have the courage to own the truth, to heal the wounds of its past so that we can move on together at peace with ourselves.*
>
> *And so we take this step: as one part of the nation expresses its sorrow and profoundly regrets the injustices of the past, so the other part accepts the apology and forgives.*
>
> *Our new journey then begins. We must learn our shared history, walk together and grow together to enrich our understanding.*
>
> *We desire a future where all Australians enjoy equal rights and share opportunities and responsibilities according to their aspirations.*
>
> *And so, we pledge ourselves to stop injustice, address disadvantage and respect the right of Aboriginal and Torres Strait Islander peoples to determine their own destinies.*
>
> *Therefore, we stand proud as a united Australia that respects this land of ours, values the Aboriginal and Torres Strait Islander heritage, and provides justice and equity for all (Council for Aboriginal Reconciliation 1999).*

The 'republic' referendum in 1999 also contained a proposal for a new preamble, which included the following words: 'honouring Aborigines and Torres Strait Islanders, the nation's first people, for their deep kinship with their lands and for their ancient and continuing cultures which enrich the life of our country' (AEC 1999:32). Along with the republic option, the proposed preamble was defeated in the referendum.

Would a new preamble incorporating language similar to the above draft declaration be significant? Would it have symbolic value, as an often repeated and potential rallying point?[6] More particularly, would an accurate and prominent statement of the past and a valuing of the Indigenous contribution help to right the wrongly held assumptions of Deakin and so many others in 1901? Those who argue for a new preamble would say that as our most important and distilled national statement, and also as the lead-in to our most important document, a preamble has huge symbolic value and that an honest description of the realities of European settlement and its impact on Indigenous Australia should be made for that reason alone.

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[5] WHEREAS the people of New South Wales, Victoria, South Australia, Queensland, and Tasmania, humbly relying on the blessing of Almighty God, have agreed to unite in one indissoluble Federal Commonwealth under the Crown of the United Kingdom of Great Britain and Ireland, and under the Constitution hereby established: And whereas it is expedient to provide for the admission into the Commonwealth of other Australasian Colonies and possessions of the Queen: Be it therefore enacted by the Queen's most Excellent Majesty, by and with the advice and consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the authority of the same, as follows: *Commonwealth of Australia Constitution Act 1900* (63 & 64 Victoria chapter 12). Available at http://www.aph.gov.au/senate/general/constitution/.

[6] For example, the well-known commencement to the USA Declaration of Independence: 'We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty, and the pursuit of Happiness.'

A case for 'positive' rights

Among Western democracies, Australia is most unusual in not having a Bill of Rights, a comprehensive statement of the rights of citizens. Typically these are rights to privacy, to associate with other citizens, the right to free speech and rights to due process in the courts. The Australian Constitution contains little by way of rights. There is a tentative right to religious freedom and a right to be treated as a national citizen. Property rights are also protected to some extent. Beyond this the High Court has, since 1992, implied some rights into the Constitution, but these are limited and controversial and most significantly apply to 'political' communication as a necessary component of the democratic process.[7] For Indigenous people, there are no rights in areas important to them—to equal treatment, to free association and to retain their culture.[8]

However, it should also be said that there is no guarantee that these rights, even if they had been in place during the twentieth century, would have altered the course of Indigenous policy. They are never taken as absolutes and many of the policies were paternalistic, believed by their creators to be in keeping with the good social policy of their day. Furthermore, it would also have been the case that most Indigenous Australians would not have been in a position to enforce these rights even if they had them.

Rights involve complex analysis, with individual rights sometimes conflicting and a particular right never interpreted absolutely. However, we suggest that a community with these rights may be in a better position to protect its citizens from arbitrary procedures than a community without them.

But there is also another set of rights that should be considered. These are positive rights, which entitle citizens to health services or to a clean environment, as opposed to rights that protect them from an overbearing State. International documents do recognise these kinds of rights. Indeed, they are embedded in some of our most significant documents. For example, article 25 of the Universal Declaration of Human Rights (1948)[9] provides that:

> *Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.*

The International Covenant on Economic, Social and Cultural Rights (1966)[10] also expresses a right to health in article 12 (HRI n.d.).

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

> (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
>
> (b) The improvement of all aspects of environmental and industrial hygiene;
>
> (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
>
> (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.[11]

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[7] *Lange v. ABC* (1997) 145 ALR 96. See also *Coleman v. Power* (2004) 209 ALR 182 and *Mulholland v. Australian Electoral Commission* (2004) 209 ALR 582. A useful discussion of the law in this area is to be found in Arcioni 2005.

[8] *Kruger v. Commonwealth* (1997) 146 ALR 126.

[9] Adopted and proclaimed by the United Nations General Assembly resolution 217 A (III) of 10 December 1948. Available at http://www.universalrights.net/main/declarat.htm.

[10] Adopted and opened for signature, ratification and accession by United Nations General Assembly resolution 2200 A (XXI) of 16 December 1966. Available at http://daccessdds.un.org/doc/RESOLUTION/GEN/NR0/005/03/IMG/NR000503.pdf?OpenElement.

[11] There are also regional statements of rights. The *Charter of Fundamental Rights of the European Union* (2000/C 364/01) provides for the following in the preamble: 'Conscious of its spiritual and moral heritage, the Union is founded on the indivisible, universal values of human dignity, freedom, equality and solidarity; it is based on the principles of democracy and the rule of law. It places the individual at the heart of its activities, by establishing the citizenship of the Union and by creating an area of freedom, security and justice.' Some relevant substantive provisions are Article 3 Right to the integrity of the person; Article 35 Health care; Article 37 Environmental protection.

These declarations do not imply binding obligations on signatory states to pass legislation providing these rights, and citizens cannot demand them in the clear absence of legislation providing the right.[12] The Constitution of the World Health Organization (WHO) (1946) also provides an underpinning for public health policy expressed in the language of rights. The Constitution's preamble makes the point that 'the enjoyment of the highest attainable standard of health' is 'one of the fundamental rights of every human being… The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States'.

This document is particularly significant for health policy in Australia. In 1947 the Commonwealth Parliament 'approved' Australia becoming a member of the WHO by passing a short act (*World Health Organization Act 1947* (Cth)). This act allowed the making of regulations necessary for carrying out and giving effect to the Constitution of WHO and the actions taken under it. However, nothing significant appears to have followed from this enactment, and in their actions Australian governments do not seem especially influenced by the terms of the WHO Constitution.

Some jurisdictions have expressed rights in a more significant and binding way by incorporating these kinds of positive rights into their constitutions. One example is the South African Constitution which provides for the following rights, particularly significant to Indigenous communities in Australia.

Section 24 Environment

Everyone has the right—

(a) to an environment that is not harmful to their health or well-being; and

(b) to have the environment protected, for the benefit of present and future generations, through reasonable legislative and other measures that—

(i) prevent pollution and ecological degradation;

(ii) promote conservation; and

(iii) secure ecologically sustainable development and use of natural resources while promoting justifiable economic and social development.

Section 27 Health care, food, water and social security

(1) Everyone has the right to have access to—

(a) health care services, including reproductive health care;

(b) sufficient food and water; and

(c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

(3) No one may be refused emergency medical treatment

(Constitution of the Republic of South Africa 1996).

Constitutional rights such as these should direct government action in particular ways, but, as section 27(2) (above) illustrates, will not demand that they be given paramount attention at all costs. In relation to the right to an environment that is not harmful, the South African Supreme Court has required that the government authority, in considering whether or not to approve a mining application, accord 'appropriate recognition' to the right:

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[12] In the *Minister of Immigration and Ethnic Affairs v. Teoh* (1995) 183 CLR 273, it was said that, 'a treaty which has not been incorporated into our municipal law cannot operate as a direct source of individual rights and obligations' (Mason & Deane:286). But in cases of ambiguity the court was prepared to adopt a construction that favoured the international obligations. The case was controversial for this last point and is of limited effective significance in this area, especially as the decision may not be followed by a later High Court.

> *The enormous damage which mining could do to the environment and ecological systems militated in favour of an application of the rule. When application was made for the issuing of a mining licence, it was necessary to ensure that development which met present needs would take place without compromising the ability of future generations to meet their own needs. The Constitution, by including environmental rights as fundamental, justiciable human rights, by necessary implication required that environmental considerations be accorded appropriate recognition and respect in the administrative process.*[13]

In another case, relating to the constitutional right to housing, the Supreme Court concluded that:

> *neither section 26*[14] *nor section 28*[15] *[of the South African Constitution] entitled the respondents to claim shelter or housing immediately upon demand… However, section 26 did oblige the State to devise and implement a coherent, co-ordinated programme designed to meet its section 26 obligations.*[16]

Overall, the South African experience indicates the importance of positive rights, since these are triggers for achieving adequate standards of environmental health and health care. If they are pursued and actively enforced by courts, positive rights will prompt the environmental and social changes that so often are the causes of ill health within populations. They might provide the central pillar of public health law and the source from which many reforms might come.[17]

How might positive rights be relevant to Indigenous communities in Australia? We are a wealthy country and have the resources to provide a good level of healthcare for all of our citizens. More particularly, the deficits in Indigenous health are so great that a 'rights-based' approach would demand more be spent on Indigenous health. Indeed, there is evidence that the current rate of spending is not great, particularly in light of the size of the problem. In 2002 the South Australian Coroner reported that the levels of government spending in the Anangu Pitjantjatjara lands amounted to 'around $15000 per capita' when Community Development Employment Projects and Centrelink payments were discounted: he concluded that this 'does not seem a particularly high figure', particularly in a community with as many problems as this one (South Australian Coroner 2002:para 9.4). A constitutional right to health would provide a forum for an applicant, representing an Indigenous community, to take the matter to court and to seek an order that his or her constitutional right was not being met. In this model resources would no longer be the exclusive preserve of government policy makers, but would become a public issue, a right that individuals and communities could pursue in the courts.

Regional Indigenous autonomy

The question of Indigenous autonomy within regions of Australia is particularly divisive and unclear. It can be pictured as 'separate development' in the apartheid sense or as the creation of another nation within Australia. In practice, autonomy can mean many things. For example, across Australia local governments all enjoy a measure of autonomy in the sense that they can make by-laws, exercise statutory powers, raise revenue and regulate the use of the public lands vested in them. But they exercise these powers subject to the States' local government acts and can be disbanded or their powers changed. Furthermore, local councils and their inhabitants are not 'sovereign' (in the sense of being independent entities), since the general laws of the State and the Commonwealth continue to apply within the areas.

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[13] *Director, Mineral Development, Gauteng Region and Another v. Save the Vaal Environment and Others* Supreme Court of Appeal 1999 (8) BCLR 845 (SCA).

[14] Section 26 Housing
(1) Everyone has the right to have access to adequate housing.
(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right.
(3) No one may be evicted from their home, or have their home demolished, without an order of court made after considering all the relevant circumstances. No legislation may permit arbitrary evictions.

[15] Section 28 Children
(1) Every child has the right—
(a) to a name and a nationality from birth;
(b) to family care or parental care, or to appropriate alternative care when removed from the family environment;
(c) to basic nutrition, shelter, basic health care services and social services;

[16] *Government of the Republic of South Africa and Others v. Grootboom and Others* 2000 (11) BCLR 1169 (Constitutional Court).

[17] See the discussion in Gostin (2000:32–4) and commentary in Caldis (2002) and Loff (2002).

Indigenous autonomy may mean no more than the creation of local council-type entities and the vesting of certain powers (for example, to regulate the sale and possession of alcohol) in them. There are examples where this has happened, often as a consequence of land rights legislation, which vested a measure of local control over these lands.

Land rights and the creation of Indigenous community bodies as their managers have allowed some degree of Indigenous empowerment. The first is the ability of communities to regulate access to their lands and the resource use that occurs on them, notably mining. The second relates to their regulation of activities to do with the ongoing use of the land, such as possession of alcohol. Indeed, it is generally the case that land rights brings with it some acceptance of the rights of self-management, though the extent to which this can equate to the powers of local government varies. In South Australia the Aboriginal Lands Trust has a power to impose control over alcohol in Trust Lands, but it must have been proposed by the Indigenous communities on whose land it will apply.[18] In Queensland the *Local Government (Aboriginal Lands) Act 1978* first created two communities as councils operating under the *Local Government Act 1993*. This was subsequently extended to other Aboriginal and Torres Strait Islander communities.[19] This allows the communities to make by-laws in the range of public health activities that local councils administer (sanitation, housing and land-use controls). In Western Australia the *Aboriginal Communities Act 1979* also vests by-law making powers in areas that are brought under it.[20]

It is important that local communities have adequate infrastructure to maintain a healthy population. Some of the most dramatic and obvious failings in Indigenous health services relate to the lack of basic public health services, which were put in place in cities more than a hundred years ago and which were central in extending life expectancy and lowering infant mortality. Thus 'small scale' traditional public health issues relating to the effectiveness of community sanitary controls and local governance of public health are also important and should be part of the autonomy debate. They might also be seen as part of the 'big picture' issues, as a component of a constitutional right to health.

In 2002 the National Public Health Partnership published a survey of public health laws relevant to remote Indigenous and Islander communities, and the following issues were said to be important (National Public Health Partnership 2002:5; see also chapter 13):

> *The lack of clarity in some jurisdictions as to the application of public health and related laws to remote communities and the responsibility for monitoring standards and granting of necessary approval, particularly where remote communities are on Crown land or land vested in instrumentalities of the Crown.*
>
> *The lack of clarity as to the role of local government in relation to remote communities in some cases.*
>
> *The role of remote area guidelines in filling gaps left by the laws, and their use as conditions of funding.*
>
> *The opportunities being created by modernisation of public health laws to clarify the application of public health and related laws to remote communities.*
>
> *The need for greater clarity with regard to the powers and responsibilities of Aboriginal Community Councils in relation to local government type functions and maintaining public health standards, together with appropriate responses for these functions.*

Addressing these issues and vesting powers to regulate public health issues is sensible and sits within the framework of autonomy, which, given its limited nature, will not sustain the accusations of 'separate development'. But its limited scope should also be acknowledged. The powers given to communities exist in State statutes and can be taken, amended or withdrawn as governments see fit and their parliaments then allow. The ease with which ATSIC could be disbanded by the coalition government in 2005 illustrates this point.

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[18] *Aboriginal Lands Trust Act 1996* (SA): see the regulation-making powers, section 21.

[19] The two original communities were the Shires of Arakun and Mornington (section 9). More recently, see the *Local Government (Community Government Areas) Act 2004*. See also the *Community Services (Aborigines) Act 1984*, which also dealt with a number of non-local government management issues.

[20] Section 7, by-laws, which sets out a range of areas in which they can be made, including public health and safety. For a general survey see Way [undated].

More particularly, any measure of self-government or autonomy could only happen effectively if there are the skills and resources to make it happen. Autonomy should not be accompanied by reduced services or permit the creation of a judicial vacuum. The South Australian Coroner made the point about the need for effective policing in remote communities where violence and crime is often a serious and ongoing issue, marring the lives of many and corroding the fabric of the community. Yet policing is erratic and responses delayed on account of the distance from the nearest police station. In a call for the provision of local police services, he commented that the 'issue of the adequacy of policing goes beyond mere rhetoric about empowering local communities. There are real human rights issues involved which are not at present being addressed by [the SA police]' (South Australian Coroner 2002:para 11.5).

Autonomy as a constitutional arrangement—treaty arrangements

If Indigenous autonomy is to be taken seriously as an issue, it may need to be preceded by more fundamental change that establishes a permanent and fixed relationship between Indigenous Australians and Australians more generally. Much thought has been directed to these ideas and one proposal, considered by the Senate Constitutional and Legal Affairs Committee in 1981, involved an amendment to the Constitution, adding a new section 105B, to allow for specific agreement with respect to the States and to make provision for treaties.

The key element of this proposal is that the Commonwealth would be empowered to make a treaty with Indigenous persons or bodies recognised as representatives of Indigenous peoples relating to 'the status and rights' of Indigenous persons. The scope of these agreements would include restoring or compensating for land lost as a result of settlement; political status and matters of self-government and sovereignty; health and education; cultural and heritage matters; and the exercise of Indigenous laws. The proposal would then go on to provide that 'the [Commonwealth] parliament shall have the power to make laws for the implementation by the parties of such treaty or treaties' and that the laws passed under the section would be binding on the Commonwealth and States and Territories. Section 105B would itself be protected from amendment or repeal by a special requirement (S105B(6)) that it receive two-thirds majority support of Aboriginal and Torres Strait Islander peoples, and there is a treaty in place that permits such amendment or repeal and that the terms of the treaty are complied with (Dodson 2003:37).

Such a proposal, were it ever to be implemented, has the obvious strength of 'constitutionalising' the agreements between Indigenous Australians and the wider Australian community through the federal government. The programs and the governance arrangements that emerge from this process are protected from being overturned by the unilateral action of the government or through the parliamentary process. For example, if ATSIC was to be established under such an arrangement it could not be abolished without the agreement of Indigenous Australians. Implicit in this provision is the recognition that Indigenous Australia warrants a separate legal structure and, once created and agreed upon, the measure of independent constitutional legitimacy that section 105B envisages.

However, implementing such a provision requires two things. First, it requires a federal government willing to see Indigenous sovereignty as sufficiently important to warrant limiting its own constitutional sovereignty. The issue has been around since at least 1981 and there is no indication that the current Howard Coalition government would be remotely interested in furthering the proposal. Indeed, recent developments imply the opposite. Second, it requires the Australian electorate to support the proposal to the extent necessary to obtain a majority of States and a majority of electors overall (as required by section 128 of the Constitution). While the 1967 amendment did receive near-overwhelming support, it is more than likely that the section 105B proposal would be painted by its opponents as divisive, creating 'separate Australias', and thus generate a substantial level of opposition, as well as support. The history of referendums in Australia demonstrates that they are generally not successful and that a proposal that does not have the support of all major parties is most unlikely to pass.

The likelihood of a constitutional provision like section 105B coming into operation is, at this time, extremely remote.

Exploring the value of constitutional reforms—here and overseas

These constitutional or ‘big picture’ reforms might be undertaken for a number of reasons, one being that such changes more fairly and more properly provide a recognition of the past and a way forward. An argument grounded in fairness and a desire for reconciliation would alone make the argument for the constitutional changes canvassed above. But there is another reason to consider them. Structural changes may improve health and welfare outcomes. While the causes of Indigenous ill health are many, it is often said that dispossession and a failure to repair the legacy of colonisation is a substantial cause and that reforms to Indigenous health must also address these structural issues. This view needs to be considered carefully; in a sense our arguments for reform and change should be an application of ‘evidence-based law’. For example, it could be said that ‘land rights is the issue’. But if that was the case we would expect, after some thirty years of land rights, the health status of Indigenous Australians in the Northern Territory to be far better than it is. Similarly, after nearly twenty-five years of land rights in South Australia, we might also expect the social indicators for people in the Pitjantjatjara lands, a large area in the north-west of the State, to be far more positive than they currently are.

One way of assessing whether constitutional differences are relevant to health and welfare outcomes—and if they are relevant, why they are relevant—is to compare the health of Indigenous Australians with Indigenous populations in other parts of the world whose experiences of dispossession are broadly similar but whose constitutional arrangements are different. This is a promising field of inquiry, and comparative research is currently being undertaken, which may lead to identification of some important issues (see NHMRC 2002).

The work in Australia on Indigenous ill health is mirrored elsewhere and it is recognised that the health of Indigenous peoples is generally worse than that of the ‘dominant settler’ population. For example, it is reported that in New Zealand, ‘Maori die on average 10 years younger than people of Anglo–European descent’ (McPherson *et al*. 2003:443). In the USA it has been reported that, ‘a persistent gap in health status remains between American Indians and non-Hispanic whites’ (Anon 2004:935; see also Anon 2000:1415). In Canada, life expectancy for Indigenous peoples is 7.4 years less for males and 5.2 years less for females (Government of Canada 2000). There is also an over-representation for a range of disease. In a 2003 editorial, the *British Medical Journal* outlined the general poor health status of Indigenous peoples. In exploring this, it identified a first group of historical health risks that the settlers introduced (for example, measles, smallpox, tuberculosis and so on) and a second, contemporary group of risks from ‘lifestyle diseases’ (for example, injury, alcohol-related problems, obesity and so on). In identifying causes, the editorial focused on a range of issues, notably a group it called the ‘long-distance’ issues of ‘government policies and constitutional standing’ (Durie 2003:510). How might we ‘test’ Indigenous health outcomes against the idea that these long-distance issues do matter?

If we make Canada the point of comparison, it is the case that Indigenous health is improving. Taking life expectancy as an example, there has been an *improvement* of some 13 per cent in Indigenous Canadian health between 1980 and 2002. More significantly, Indigenous health in Canada is substantially better than in Australia. The following table of life expectancies for Indigenous people was compiled from Australian Bureau of Statistics and equivalent overseas data:

Australian Aboriginals (1997–99)	56	63
Maoris (1997–99)	68	73
Canada Aboriginals (1990)	67	74
US American Indian (1999)	69	78

Source: Australian College of Health Services Executives 2002

The difference in life expectancies between Indigenous and non-Indigenous peoples also indicates the difference is greatest in Australia. It has been estimated to be 19–21 years in Australia, 9–10 years in New Zealand, 5–7 years in Canada and 4–5 years in United States' (Ring & Brown 2003:404; see also New Zealand Ministry of Health 2003).

There may be many issues that explain these differences: different social structures before and after colonisation, different opportunities and different physical environments. But there are some important constitutional differences that may also be significant and are worth exploring as a potential basis for the different health outcomes.

The history of colonisation in both the USA and in Canada suggests that Indigenous rights were taken more seriously than they were in Australia. The independence of Indian tribes in the USA was reflected in the United States Constitution (Article 1, S8), where the commerce power allows regulation of commerce 'with foreign nations, and among the several States and *with the Indian tribes'* (authors' italics). In the 1821 case of *Cherokee Nation v. Georgia*, Chief Justice Marshall referred to the various Indian tribes as 'domestic dependant nations'.[21] While the Native American experience was not positive, with lands taken and communities dispossessed, the current position has been summarised as follows: 'US Indian Tribes exercise a wide variety of governmental powers. These powers extend well beyond the mere right to occupy reservation lands or enjoy subsistence hunting and fishing rights' (Myers 1998:3). It has also been said that:

> *[the] result of the legal relationships of tribes with the United States is that they continue to be ruled by their own laws. Today tribal governments exercise legislative, judicial and regulatory powers and it is clear that their authority is derived from their aboriginal sovereignty, not delegated from the federal government. Indian governments are rapidly expanding their operations to implement their police power through tribal courts, zoning ordinances, taxation bureaux, environmental controls, business and health regulation, and fisheries and water management codes (Getches et al. 1993, cited in Myers & Landau 1998:3).*

McRae *et al*. add that under USA law, 'Indian treaties are accorded the same dignity as that given to treaties with foreign nations. United States courts have developed rules of interpretation which, in case of doubt, favour the Indians' (1997:148). But it is possible for later federal laws to overturn a treaty if it specifically intends to do so without reference to the parties to the treaty. It is this possibility that a new section 105B in the Australian Constitution would seek to prevent.

In Canada the constitutional arrangements also incorporate Indigenous Canadians. Native title was first recognised in 1889, arising from The Royal Proclamation of 1763. It was expanded in 1973, in *Calder v. Attorney General of British Colombia*, when the Supreme Court concluded that 'when the settlers came, the Indians were there, organised in societies and occupying the land as their forefathers had done for centuries. That is what Indian title means.'[22] Treaties are also recognised in Canada and continue under the title of 'comprehensive land claim settlements' (McRae *et al*.:148). They are recognised in the *Constitution Act 1982* by section 35(3), which includes these rights as treaties given constitutional protection. There is continuing activity in Canada in this area. An Inherent Right to Self Government policy commenced in 1995 and 'recognises that self-government is an inherent right held by Aboriginal people that… attracts constitutional protection' (Behrendt 2003:23). This policy allows for an ongoing reworking of old agreements, envisaging that a range of issues could come within the scope of self-government, including education, health, marriage, child welfare and cultural traditions. Further areas are negotiable, including environmental and resource management, while areas such as defence, substantive criminal law, and postal and shipping services fall outside the scope of self-government (Behrendt 2003:23,24).

Overall, we can see in the USA, Canada and New Zealand (where the Principles of the 1840 Treaty of Waitangi influence many current statutes and the decisions made under them)[23] constitutional arrangements that recognise the prior rights of Indigenous communities and vest some formal levels of constitutionally protected governance in those communities.

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[21] *Cherokee Nation v. Georgia* 30 US (5Pet)1, 17–20 (1821).

[22] *Calder v. Attorney General of British Colombia* (1973) 34 DLR (3d) 145 cited in Myers and Landau (1998:4).

[23] Not discussed but see Myers and Landau (1998:5,6). It should also be noted that the status and the legal significance of the Treaty of Waitangi has been, and continues to be, the subject of much debate. See, for example, the discussion in Orange 1987.

Do these arrangements contribute to the fact that Indigenous health status is substantially better in those communities than it is in Australia, where, beyond some statutory provision of land rights and the limited potential to claim Native Title, nothing has happened?

There is value in comparative analysis: one study that considered this question was published in 2000. While tentative, and recognising that many issues might come into play, it could be argued that self-governance provides more resilient structures, which lead to better outcomes. The author concluded that the arrangements in Canada provide opportunities for better practice, for greater ownership and for empowerment 'at individual, community, regional and national levels' (Moran 2000).[24] The paper concluded that 'there should be a shift in existing attitudes, policy and programs in Australia away from implied assumptions of dependence, towards greater community control and economic empowerment' (Moran 2000).

We might speculate whether these opportunities, which seem to exist in the United States and Canada, and which may substantially explain the differences in health status, are more prevalent and more resilient *because they are grounded in a constitutional base* and are part of a tradition that has taken, and continues to take, the theory, if not always the practice, of Indigenous rights seriously. More investigation of this proposition needs to be undertaken, but it is a promising line of inquiry, emphasising the potential importance of the 'big picture', while seeing some useful links between the law and Indigenous health and welfare.

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[24] See also the work of Dr Dale Bramley, Waitemata District Health Board (New Zealand), and his conference paper at the Public Health Law Symposium (Bramley 2005).

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Chapter 13:

Healthy Change at the Micro-Level—Victoria's Koori Courts

Rosie Smith (Victorian Department of Justice in Courts and Program Development)[1]

Introduction

By contrast with our constitutional arrangements, which are 'big picture' and likely to impact negatively on Indigenous health, this case study examines the Koori Courts, a comparatively small pilot project that seeks to address injustices in the way Indigenous people interact with the criminal justice system. It is arguable that such a project impacts positively on the individuals involved and, through them, on their families and the broader community. This project could deliver health benefits in addition to better social justice. This paper does not take the next step to undertake an epidemiological study to measure any health outcomes from the Koori Courts project. It describes the project and suggests that such small projects are worthy of examination as health interventions in a social determinants framework, in the same way that Reynolds *et al.* (2004) argued that the Australian constitutional arrangements are similarly worthy of examination as part of a social structure that will have health consequences for those affected. While the concept of Indigenous courts is not in itself new,[2] Victoria's Koori Court project represents the most recent example of this type of court, and can be distinguished from other similar courts by the fact that the project is not only the result of direct requests by Victoria's Indigenous communities themselves, but also that it receives direct legislative recognition.[3]

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[1] Rosie Smith is a Palawa (Tasmanian Aboriginal) woman and a lawyer, and is currently overseeing several of the initiatives under the Victorian Aboriginal Justice Agreement, including the Koori Court pilot project. She has recently completed a Masters of Public Health at Deakin University.

[2] Indigenous courts have been established in other States for some time. See, for example, the Nunga Court in South Australia. Accessible at http://www.ocsar.sa.gov.au/docs/information_bulletins/IB39.pdf.

[3] See *Magistrates Court (Koori Court) Act 2002*.

The Koori Court

Introduced in 2002, Victoria's Koori Court is an innovative community-controlled project initiated under the Victorian Aboriginal Justice Agreement.[4] As already noted, one of the major impacts of the court is to change local conditions and influence the larger social system, which could have positive outcomes for the health and wellbeing of Indigenous Victorians.

Background

Over the past three decades three key reports have highlighted the problem of the massive over-representation of indigenous people in custody and within all levels of the justice system.

Recent statistics show that:

- Indigenous Victorians are twelve times more likely to be imprisoned than non-Indigenous Victorians;
- Indigenous offenders are more likely than non-Indigenous offenders to be remanded in custody (23.4 per cent compared to 13.8 per cent); and
- during 2000–01, Victoria Police processed 4676 Aboriginal people for alleged offences, an increase of 1118 people, or 31.4 per cent over the previous five-year period.

Historically, the legal system has been viewed with suspicion and mistrust by Aboriginal people, in part due to past government policies allowing the dispossession of land, the removal of children from families and communities, and the systemic racism within government and other institutions. As numerous reports have identified, the existing criminal justice system did not address such historical concerns. In particular, the report of the Royal Commission into Aboriginal Deaths in Custody made it clear that the legal system needed to be modified to make it less culturally alienating and more tailored to the needs of Aboriginal offenders. In addition, that report highlighted the need of the justice system to address the underlying reasons associated with offending behaviour; for example, issues relating to employment, health, education, community services, housing and economic development of Aboriginal communities—issues traditionally thought of as outside the scope of the criminal justice system.

The Victorian Aboriginal Justice Agreement is a direct response to these concerns and recommendations. It is a joint initiative by the Victorian Department of Justice (DOJ) in partnership with the Indigenous community and the Victorian Department of Human Services (DHS).[5] In developing the initiatives under the Agreement, extensive consultation was undertaken with Indigenous organisations, including the Aboriginal and Torres Strait Islander Commission, Aboriginal Affairs Victoria, Victoria Police and the DHS.

The success of the Agreement and its initiatives can be seen in the significant changes that have occurred for Indigenous people across Victoria's criminal justice system, such as improvements to Indigenous access to justice-related services and greater awareness in the Indigenous community of civil, legal and political rights.

In 2004, for the first time in Victoria, Indigenous people began employment in the development of policies and programs that affect Indigenous communities. These included local initiatives or other programs under the Regional Aboriginal Justice Advisory Committee (RAJAC) justice plan.[6]

During the consultation process strong community support was expressed for the establishment of a Koori Court, the aim of which was to ensure that the court sentencing process was culturally responsive to the needs of Indigenous defendants.

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[4] Victorian Aboriginal Justice Agreement, 2000. The following parties were signatories to the agreement: the Attorney–General, the Minister for Aboriginal Affairs, the Department of Human Services (DHS), the then Commissioner of the Aboriginal and Torres Strait Islander Commission, the chairperson of the Victorian Aboriginal Justice Advisory Committee, and the Chairperson of Binjirru and Tumbukka Regional Councils.

[5] VicHansard, Whole Speech, Magistrates Court (Koori Court) Bill, Second Reading, by Mr Hulls, 24 April 2002.

[6] There are six RAJACs in Victoria. All have a membership and partnerships with Aboriginal community service providers and the DHS, Police, Corrections, Courts and the Sheriff. All six RAJACs have developed their own Social Justice Plans that identify the needs in their regions and initiatives to address those needs.

The Koori Court model

In considering the operation of the Koori Court model, this paper will focus on the Koori Court both in regional Victoria and in metropolitan Melbourne.

Created under the *Magistrates Court (Koori Court) Act 2002,*[7] the Koori Court is a special sentencing division of the Victorian Magistrates Court. Essentially, the Koori Court is an alternative way of administering sentences so that court processes are more culturally acceptable and comprehensible to the local Indigenous community. The key emphasis is on creating an informal and accessible atmosphere, which allows greater participation by the Indigenous community in the court and the sentencing process.

(a) The aims and objectives of the Koori Court

From a criminal justice perspective, the Koori Court seeks to tailor sentences appropriate to the needs of Indigenous offenders, to reduce the number of failures to appear, to decrease breaches of court orders, to reduce recidivism, to provide general deterrence and to increase community safety.

From an Indigenous community perspective, the objectives of the Koori Court are to increase Indigenous participation in the administration of the law, most significantly by the appointment of Aboriginal Elders or Respected Persons and Koori Court Officers to the Koori Court; to increase positive participation by Koori offenders and their community; to increase the accountability of the Koori community, families and offenders; to promote and increase community awareness about community codes of conduct and standards of behaviour; and to promote and increase community awareness about the Koori Court generally.

(b) The role of the Aboriginal Elder or Respected Person

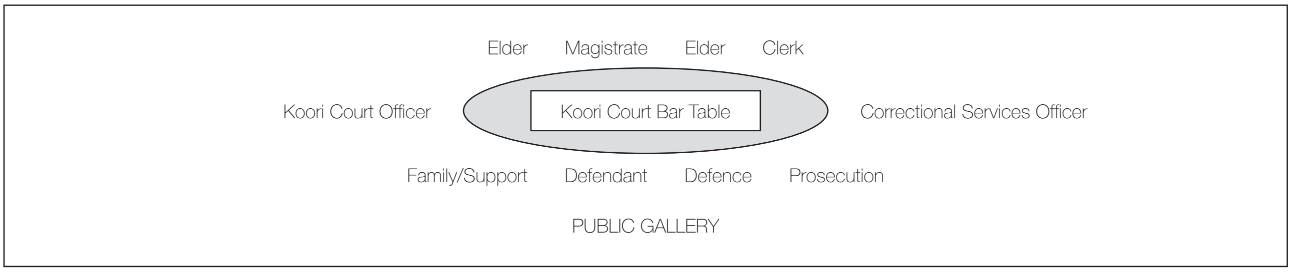
The Aboriginal Elder or Respected Person is an Aboriginal person of high standing within the Aboriginal community and is appointed by the Secretary of the DOJ. The Aboriginal Elder or Respected Person can assist the Magistrate with background information, is able to explain which family or kin the offender belongs to and, through personal life experiences, is able to describe how being involved with committing a particular crime can affect the whole Aboriginal community. The Aboriginal Elders or Respected Persons are strong advocates for respect to land and for respect to other people and culture, and often refer to other community protocols. They provide a sense of belonging and a sense of worth to offenders, who normally would go through the mainstream system and have no relationship with the Magistrate or anyone within the courtroom.

(c) The role of the Koori Court Officer

The role of the Koori Court Officer (KCO) is filled by a local Aboriginal person who is based within the Magistrates Court. KCOs are the linchpin to the success of the Koori Court process; they bring together all the significant players for each matter on the day, they provide the court with background information and, when appropriate, develop a plan suitable for the offender.

(d) The environment of the court and process

Compared with the usual formality of a Magistrates Court, the environment of the Koori Court is significantly different. The Magistrate does not sit at the bench, but sits between two Aboriginal Elders or Respected Persons at a specially built table. Aboriginal artwork adorns the walls of the court and three flags—Aboriginal, Australian and Torres Strait Islander— are displayed.



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[7] The *Magistrates (Koori Court) Act 2002* received bipartisan support. All offences can be heard in the Magistrates Court except family violence and sexual offences. The Aboriginal community made this decision, as there was concern in having an Aboriginal Elder or Respected Person in a position of conflict; it was also thought best to take it slowly.

In terms of court process, there are again significant differences between the process of the Koori Court and the process of the Magistrates Court. In contrast to the Magistrates Court, the Magistrate acknowledges the traditional custodians of the land,[8] introduces the Aboriginal Elder or Respected Person, and acknowledges other Elders and senior members of the community present in the court. The 'smoking of the court', a ritual that took place before the first sitting, is explained. This process is repeated at the beginning of each matter for the benefit of the defendant so he or she knows the court is truly acknowledging the traditional custodians and the Aboriginal Elder or Respected Person. Other participants around the table introduce themselves and explain their roles.

Once the plea is taken and the charge found, the Magistrate might ask the defendant to say something to the Aboriginal Elder or Respected Person. Regarding sentencing of the defendant, the decision-making is ultimately up to the Magistrate. However, the Magistrate may seek advice from the Aboriginal Elder or Respected Person or others within the court. To ensure transparency, all discussions about the appropriate sentence are conducted in the view and hearing of everyone in the court, not behind closed doors.

Only Koori defendants, in particular those who plead guilty to an offence and who have shown an intention to take responsibility for their actions, can elect to have their matters heard in the Koori Court (DOJ 2002). For many defendants, going before an Aboriginal Elder or Respected Person and other community members present in the court can be more daunting than appearing in the Magistrates Court.

Two case studies

The case studies that follow present a brief overview of procedures in the Koori Court. However, a full understanding of these procedures is best appreciated first hand by observation of court processes.

Koori Court—case study 1

One matter involving a young offender appearing for his first time before the Koori Court (however, he was not a stranger to the criminal justice system). The defendant presented himself with little, if any, interest in the process until prompted by one of the Aboriginal Elders to pay attention and participate in the hearing of his matter. The defendant came to court with his grandmother but little other support was present, as the offender had not previously been engaged with the Indigenous community. A representative of a local community organisation advised the court that the defendant was a talented artist and that his grandfather had made a significant contribution to local football.

After seeking advice from the Aboriginal Elder or Respected Person, the court adjourned the sentence for two months to allow development of a case management plan. The plan involved a full assessment to ascertain appropriate support for the defendant and programs that could become part of a Community Based Order (CBO).

On the return date, there was significant change in the appearance of the defendant; he willingly participated in the process and had several support people with him. The court heard that the assessment had identified intellectual disabilities and alcohol and drug problems, and appropriate support services were recommended. The defendant was linked up to Aboriginal service providers anddemonstrated a commitment to his own rehabilitation. He had tackled his drug abuse and regularly participated in football training and matches. The defendant was linked up with other role models in the Aboriginal community and has been invited to act as a role model for younger persons in the community. Before completing the hearing, the Magistrate asked if the defendant wanted to say anything to the Aboriginal Elder or Respected Person. The defendant thanked the Aboriginal Elder or Respected Person for taking the time to listen and giving him the opportunity to gain the support he is now receiving.

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[8] This could vary depending on where the Koori Court sits. In Broadmeadows, it is the Wurundjeri and the peoples of the Kulin Nations. In Shepparton, it is the Bangarang and the Yorta Yorta people. In Warrnambool, it is the Gunditjmara Kirrae Whurrong.

Koori Court—case study 2

A difficult matter at the Koori Court involved a defendant, who, while on a suspended sentence, was charged with an assault on another Aboriginal person. As the matter unfolded, the court heard that the defendant and his siblings had been abandoned by their parents, and that he had taken on the role of looking after and protecting them. He described the traumatic experiences of being separated and placed in foster homes. He also spoke of his gift of being a dancer and how his spiritual connection to land and culture kept him alive.

During the hearing, one of the Elders asked the defendant where it would be suitable for him to undertake a CBO. The offender replied that he wished to go to his grandmother's country. Although exceptional circumstances were demonstrated, the handing down of the sentence was adjourned for several months to allow the offender to re-establish himself in his grandmother's country. The court heard on the return date that the offender was working with a local Aboriginal community organisation, and was actively involved in a men's camp involving the RAJAC members, including the local Magistrate and members of the Victorian police. The Court heard that he was one of the leaders in taking Indigenous men out on the land, where drug and alcohol and anger management issues were discussed along with other cultural matters concerning Indigenous men. The defendant further advised the court that being involved with these activities was important to him as it not only gave him the opportunity to share his knowledge and wisdom on dance and other cultural business with other Indigenous men, but it was a real healing experience for him and something truly meaningful.

Due to the significance of the offence committed, the Magistrate was considering a sentence including an Intensive Community Corrections Order (ICCO),[9] but was persuaded by submissions put by the defendant's counsel, and the actual demeanour of the defendant himself, that a Community Based Order was more appropriate. The CBO required the offender to continue working with the men's group and in other community activities.[10]

Similarly to the first case study, this defendant thanked the Aboriginal Elder or Respected Person for listening to him and his struggles. The defendant took great pride in telling the Aboriginal Elder or Respected Person that he would carry on with the work he had been doing. He made a commitment to continue to share his knowledge of the land and other cultural business with local Indigenous youth and men in the community.

In this matter, the Koori Court not only achieved what the establishment of the Koori Court in Victoria intended, but also probably surpassed what the model originally envisaged. In appearing before the Elders and the Indigenous community, the defendant faced the difficulty of being, in a sense, tried twice.

Some observations

While it can be argued that the successful elements of the Koori Court model are due largely to the role of the Koori Court Officer and the Aboriginal Elders or Respected Persons in the court, there is no doubt that the opportunity for the defendant to speak and be listened to is significant in the process. As more mainstream and Indigenous services become available, the ability of the Koori Court to tailor sentencing options is improved.

The early success of the Koori Court has been significantly influenced by the leadership of Dr Kate Auty, a Regional Co-ordinating Magistrate until mid-2004. Magistrate Auty has been able to bring together all stakeholders within the court to ensure the Koori Court model achieves its objectives. The Koori Court also serves to highlight the gaps in the service provision and these concerns are being raised and discussed with appropriate agencies.

Accordingly, the evaluation completed in April 2005 (see below) suggested that the ongoing success of the Koori Court will depend upon the continuing active involvement of local Indigenous organisations, particularly in their capacity to provide culturally appropriate support services (Harris 2006).[11]

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[9] The CBO is a non-custodial sanction that has been developed for offences that might ordinarily involve a period of imprisonment. The structuring of CBOs is such that they are intended to have a punitive element (in the imposition of tasks or duties that take up the defendant's time), coupled with a rehabilitative dimension (the requirement that the defendant complete rehabilitation or counselling programs). An ICCO can be up to 12 months long. The ICCO is, as Freiberg (2001) observes, at the top end of the sentencing hierarchy, having been created as a major diversion option for those offences where the defendant is likely to receive a short term of imprisonment.

[10] The Magistrate will retain all sentencing alternatives, including the power to send defendants to prison, as in the conventional Magistrates Court. However, the primary goal of the Koori Court is to create sentencing orders that are more culturally responsive to Aboriginal offenders, thereby reducing the rate of re-offending. The Koori Court therefore benefits not only the Koori community but also the wider community.

[11] Since the introduction of the Koori Court there has been a significant increase in the number of service providers attending Koori Court sittings. It is important that stronger links between the Koori Court and service providers are made and maintained.

Is the Koori Court good for health?

The Koori Court is an example of the law operating to change the social structure to address substantial social justice issues. Such an initiative may also provide significant health benefits. Burris *et al*. (2002) suggest that such community involvement may also translate into positive health outcomes for all those involved by addressing the fundamental social determinants of health at the local level where they are embodied in actual lives, practices and environments.

It appears that the Koori Court is effectively identifying the underlying factors that lead to the presentment of persons before the court, in particular the broader societal factors of disadvantage caused by the dispossession of traditional lands and separation from family, community and identity.

The Koori Court applies culturally sensitive sentencing options involving existing Indigenous services, and identifies additional areas of need in community services. The role of the Aboriginal Elder or Respected Person in the Koori Court addresses social factors that may contribute to offending behaviours, such as social isolation and marginalisation. As illustrated by the case studies above, the Koori Court has a role in connecting Aboriginal persons to their community and identity.

People who come before the Koori Court generally have complex problems, often involving drug and alcohol and/or mental health issues; many have disrupted childhoods, low educational levels, limited employment experiences and few aspirations for the future. The CBOs handed down by the Koori Court have often required offenders to participate in initiatives under the Victorian Aboriginal Justice Agreement, such as the mentoring program in local communities,[12] or the wellbeing program sponsored by the local Aboriginal Co-operative.[13]

The Koori Court model was evaluated over a two-year period by independent evaluators to ensure that it is effectively achieving its intended outcomes. The evaluation was completed in April 2005 and was conducted by the La Trobe University Law School.

The assessment criteria of the evaluation included:

- a detailed qualitative analysis—examining the responses to the Koori Court of all participants including defendants and the Koori community, and
- a detailed quantitative analysis—examining a statistical breakdown of the impact of the court upon re-offending, breach of orders and the comparative costing of Koori Court proceedings.

The central focus of the evaluation was whether the Koori Court has an ability to reduce the over-representation of Indigenous people in the criminal justice system in Victoria (Harris 2006).

The final evaluation found that in virtually all of the stated aims of the Koori Court pilot program it has been a 'resounding success', including reduced levels of recidivism among Koori defendants. Specifically, the Shepparton Koori Court had a recidivism rate of approximately 12.5 per cent for the two years of the pilot program, and the Broadmeadows Koori Court's re-offending rate was approximately 15.5 per cent. Both these figures are significantly less than the general level of recidivism, which is reported at 29.4 per cent by the evaluator (Harris 2006).

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[12] The mentoring program came about during the Victorian Aboriginal Justice Agreement consultations held in the community, which revealed that young women, often with children, were not successfully completing community-based sentences of the Magistrates Court and orders of the Parole Boards, and were thus becoming enmeshed in the justice system. The aims of the program are to assist Aboriginal women on Community Corrections Orders to complete their orders successfully; to ensure the mentoring program provides a planned response to Aboriginal women on CBOs; to make sure that Aboriginal Elders are involved in the mentoring program so as to provide support, advice and cultural connection to program participants; and to ensure that the project officer operating out of Rumbalara Co-operative in Mooroopna fosters support, networking and the sharing of resources. (Involves women from the local community to act as mentors for woman offenders coming before the Koori Court.)

[13] Aboriginal Co-operative, Healthy Lifestyles Program, came about because Aboriginal footballers and netballers, together with the local Koori community, created the Football and Netball Club. The club's major objective is to strengthen the spiritual and emotional wellbeing of its people, promote recreation, and enhance public understanding of and reconciliation with Aboriginal culture. The club is a vehicle for addressing fundamental social issues, including health and employment, through the spirit of the sport. The Healthy Lifestyles Program is a health program to promote health holistically using the local facilities and programs and sport as a vehicle to convey health messages. It deals with youth issues, leadership and personal development, men's health, women's health, substance abuse, cultural awareness and fitness performance.

Accordingly, Reynolds *et al*. (2004) suggest that the Koori Court can play a pivotal role in helping to achieve more positive health outcomes for Indigenous Victorians and believe this is an area worthy of further exploration. Linking defendants into culturally appropriate support services can lead to better health outcomes.

It is time to apply social epidemiology to the law and legal initiatives to consider their effect as part of the social determinants of health, which are related to aspects of people's social environment, such as living and working circumstances and their lifestyles (Marmot & Wilkinson 1998). So far this discourse has identified a history of health, racism and marginalisation, poverty, social class, education, training, control over own health, powerlessness, employment, place, income, incarceration and the justice system, housing and infrastructure, family separation, land and reconciliation as social determinants of health (Anderson 1988; Anderson 2001; Tsey *et al*. 2003; Australians for Native Title and Reconciliation 2004).

The World Health Organization identified ten main social determinants of health: social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food and transport (Marmot & Wilkinson 1998)—all of which are relevant to Indigenous Australians.

However, these social determinants of health were not framed from an Indigenous viewpoint and do not take into account what happened more than 200 years ago to Aboriginal people. Indigenous people not only have lower mental health and general wellbeing but they are still struggling to overcome effects of intergenerational trauma that has existed since occupancy. Cultural dispossession, poor nutrition, overcrowded conditions, poor sanitation, lack of healthcare, welfare dependence, unemployment and poor education are all social determinants impacting on Aboriginal health today.

Vickery and Clarke (2007) claim that cultural survival is an important part of Aboriginal people's emotional wellbeing, and that it needs to be affirmed through cultural ceremony, oral history and site recognition, as well as self-determination and community control. They suggest it was the cultural wellbeing of Aboriginal people that was the impetus for seeking recognition of native title.

Brennan (2004:3) was of the view that changes in public policy can affect the social environment of a community in ways that are conducive to better health. He based his view on approaching health through its social determinants and environmental changes, which can lead to healthier individual behaviour. He further suggested that some of these changes could happen in the health sector; other changes lie outside health in the realm of law, politics and economic policy.

The area of Indigenous health is an important place to begin such considerations. In particular, Australia's refusal to recognise Indigenous people in its constitution, and early legal assumptions such as *terra nullius*, have had significant social consequences for our Indigenous community. We believe that there have also been health consequences from these policies and that those consequences are worthy of further examination within a social determinants framework.

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Chapter 14: The Meaning of Culture within Public Health Practice—Implications for the Study of Aboriginal and Torres Strait Islander Health

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Introduction

The purpose of this paper is to critically examine the conceptualisation of culture within public health practice, and consider its implications in our understandings of Aboriginal and Torres Strait Islander[1] health status. There is no doubt that culture is a popular concept within public health, particularly in describing health differentials between populations distinguished by race, ethnicity and culture. However, this popularity is not matched by critical self-reflection upon the ways in which the concept of culture has been constructed within this space.

Interest in culture has traditionally been the domain of anthropology, sociology and, more recently, cultural studies, rather than medicine and public health. Public health literature generally offers very little in the way of meaningful understandings of the culture concept. Instead, the idea of culture tends to be employed uncritically, with reliance on assumed understandings of culture and the cultural practices implicated in health.

Although arguments around definitions and explanations of culture persist, it is not the intention of this paper to enter the debate. Hall and Neitz (1993:4) argue that efforts to define the term would reify culture and fail to acknowledge the broadness and complexities of the concept. Fundamentally, the term culture refers to a way of life of a group of people, or society, that is shared and learned (Abercrombie *et al.* 2000:83). It is not a tangible or static entity, nor is it confined to what is observable, whether that includes behaviours or belief systems. Commonly, definitions of culture tend to emphasise the shared meanings and understandings behind what is observable (Hall & Neitz 1993:4–5). For example, Haviland (2002:34) defines culture as follows:

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[1] Aboriginal and Torres Strait Islander people are at times referred to as ‘Indigenous’ within this article. It is acknowledged that Aboriginal people and Torres Strait Islander people reflect two distinctly different cultural groups.

> *Culture consists of the abstract values, beliefs, and perceptions of the world that lie behind people's behaviour and that are reflected in their behaviour. These are shared by members of a society, and when acted upon, they produce behaviour that is intelligible to other members of that society. Cultures are learned, largely through the medium of language, rather than inherited biologically, and the parts of a culture function as an integrated whole.*

Hall and Neitz (1993:5) suggest that culture includes "(1) ideas, knowledge and recipes for doing things, (2) humanly fabricated tools, and (3) the products of social action that may be drawn upon in the further conduct of social life". Across different disciplines, it is evident that some of these elements of culture have been emphasised more than others, that is, an archaeologist may be more interested in recovering the physical materials of a society, whereas an anthropologist may be more concerned about uncovering their meaning (Hall & Neitz 1993:5).

It should be acknowledged that culture intersects with many different sources of identity including age, gender, sexuality, race and ethnicity, religion, lifestyle and occupation. This paper emphasises culture within the context of race and ethnicity as the foundation for public health's imagination of Aboriginal and Torres Strait Islander culture. Of particular interest here, is the use of the culture concept as an explanation, both stated and implied, of health and illness.

In thinking about the notion of ethnicity and culture, Fenton (1999) argues that what matters most, are the markers of culture that construct group boundaries. Ethnicity is described as a social process that is often articulated through ancestry, culture, dress and language. Here, he suggests that culture is not fixed, but instead is contested and variable so that one cannot "define the people in a way that says "this people" share "this culture" (Fenton 1999). Yet, public health's interest in Aboriginal and Torres Strait Islander culture rarely engages in these intricacies. Instead, public health literature tends to require a sense of fixedness enabling it to measure culture alongside other 'risk factors'. Here culture becomes essentialised in the interests of rationality (Peterson & Lupton 1996:34) and healthism (Richmond 2002:200). Ahmad (1996: 190) expresses the dangers of this restricted use of culture:

> *Stripped of its dynamic social, economic, gender and historical context, culture becomes a rigid and constraining concept which is seen somehow to mechanistically determine people's behaviours and actions rather than providing a flexible resource for living, for according meaning to what one feels, experiences and acts to change.*

We acknowledge the political complexities of representations of Aboriginality, and in particular the shifting ways in which categories like 'race' and 'culture' have been used within both academic and popular discourses. Like Anderson (2003:47), we fear the policing of Aboriginal authenticity, whether via an 'old' biological essentialism or a more recent cultural essentialism. Such essentialisms are woven into Australia's colonial history, exemplifying the unique political positioning of Indigeneity within the multicultural landscape of Australian society. The goal of this paper is not to assert a morally acceptable definition or use of Aboriginal and Torres Strait Islander culture, nor is it to demonstrate a definitive way in which culture might matter to Indigenous health. Instead, we wish to encourage a more critical discourse within public health around its engagement with Aboriginal and Torres Strait Islander culture.

Method

As part of this analysis, a recently constructed EndNote database of 4722 Indigenous health research papers[2] was searched for journal articles that explicitly used the term 'culture' in keywords, title and/or abstract. A total of forty-five papers were identified, although we reviewed many more that may contain discussions relevant to culture and health. However, for the purposes of this review we were keen to analyse only those papers that explicitly identified the

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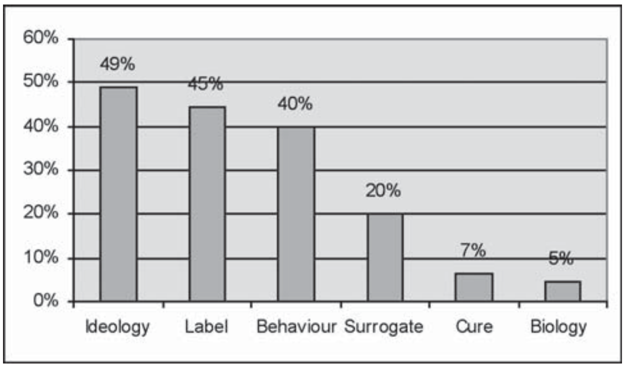
[2] The database was collected as a preliminary project for the Burden of Disease study in Indigenous Australians by the School of Population Health at the University of Queensland. The original database was compiled by searching for publications (journal articles, reports, etc.) containing the terms 'Indigenous', 'Aboriginal', 'Torres Strait Islander', 'health', and 'disease' from the period 1994–2004 from Australian Indigenous Health*Info*net, Curtin University and databases such as PubMed, Science-Direct, Informit, Proquest, and Blackwell Synergy.

FIGURE 1: **Applications of 'culture' within Indigenous public health and medical journal articles 1994–2004**[3]



term 'culture' as a keyword. These papers were analysed qualitatively to develop six themes that were then used to classify how public health research uses the concept of culture in Indigenous health research. The six broad themes are culture as biology, as label, as behaviours, as ideology, as a surrogate, and culture as cure. A discussion of each follows. Papers often invoked more than one theme area, but it appears from this analysis that Indigenous culture is most commonly referred to as either a label within epidemiological studies, as a set of belief systems or as a predicator of health behaviours (see Figure 1). This is an exploratory analysis only and further work is required to produce a more detailed study of so many research papers. Our goal here is to open up a line of inquiry, rather than to produce definitive findings.

Culture as biology

Although only 5 per cent of articles reviewed used the culture as biology theme, historically, biological explanations for health inequalities among different populations have been significant (Lee *et al*. 2001). Today, their significance remains, not in the validity of the practice, but rather in how the assumptions inherent within such thinking still feeds current discourses of ethnic health inequality.

A key feature of the culture as biology category, is the intersection between the terms 'race', 'ethnicity' and 'culture' and the associated political and intellectual climates that their use occupies (Marks & Worboys 1997:4–5). Historically, the term 'race', rather than 'ethnicity', was used to distinguish particular populations. Here the concept of race was thought to be biologically determined, and therefore health inequalities between different populations could be unproblematically attributed to biological differences and deficiencies (Williams D. 1999). Within Australia, biological notions of race underpinned the colonisation process. Health problems could go unnoticed or ignored, and Indigenous people could be treated as experimental objects of public health and medicine (Bhopal 1998). Indigenous health problems were expected and legitimised upon the premise that Aboriginal people were destined to die out (McGregor 1997).

The terms ethnicity and culture have since emerged to replace the term 'race' in order to avoid the "past abuses and biological connotations' that 'race' often invokes" (Marks & Worboys 1997:5). Ethnicity and culture both draw distinctions within the human population, not by perceived biological differences, but through social, economic, religious, political and cultural points of departure (Lee *et al*. 2001:38). While the terms race, ethnicity and culture have been used interchangeably, they clearly elucidate two very different meanings. However, Lee *et al*. (2001:39) accuse epidemiological and health service research of supplementing the terminology of race, with ethnicity and culture, while still retaining biologically derived meanings in explaining ethnic health inequality.

Critics of biological explanations of ethnic health inequality also suggest that genetic factors are not significant in explaining the observed ethnic/racial variations in health (Mays *et al*. 2003:85), particularly when other possible explanatory factors are taken into account, such as social, behavioural and environmental factors (Lee et al. 2001). Importantly, Lee *et al*. (2001:39) note:

> *Arguing against the legitimacy of race as a category of biomedical research is not meant to suggest that the social category of race is not real, or that race as a key dimension of stratified societies does not exist… Race is socially, not biologically meaningful; it is 'real' because we have acted as if certain people at certain points in time, were inferior.*

Indeed, today, we talk less about race, and more about culture and ethnicity. But we should still question whether or not the causal pathways we now rely upon still invoke racist and/or ethnocentric assumptions about 'us' and 'them'.

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[3] Of the 45 articles collected, 19 were classified according to more than one theme. The most common combination was articles that were classified as both 'ideology' and 'behaviour'.

Certainly, by continually emphasising how the culture of the 'other' determines ill health (Ahmad 1996:192), we have perhaps supplemented biological determinism with a cultural determinism that is no less oppressive in its ability to assert ideas of inferiority among already marginalised populations within our society.[4]

Culture as a label

Culture has become a standard feature of epidemiological inquiry that sits seemingly uncontested beside 'traditional' health risk behaviours of diet, substance use, physical activity and weight (McKenzie & Crowcroft 1994). However, in recent years the use of race and ethnicity as an epidemiological variable has been seriously challenged because of its methodological flaws and destructive consequences (Bhopal 1997; Bhopal & Donaldson 1998; Senior & Bhopal 1994; Anand 1999; Aspinall 1997; Shim 2002; Pfeffer 1998; Wright 1997).

One of the most potent arguments is that using cultural identity to explain health inequality amounts to what is termed 'black box epidemiology'. That is, despite demonstrating an association between ill health and cultural identity, epidemiological studies have still largely failed to articulate precise causal pathways (Bhopal 1997:1752). Instead, epidemiology trades off old assumptions around "innate characteristics related to "ethnic" or "racial" difference" (Karlsen & Nazroo 2002), thus fuelling racial prejudice and imaginings of the uncivilised, unsanitary and contagious 'other' (Lupton 1995).

In this instance, Shim (2002:130) argues that epidemiology participates in racial identity formation by constructing "particular knowledge claims about the health effects of racial, class and sex/gender differences". Peterson and Lupton (1996:55) note, that the construction of them and us, as normal/abnormal and healthy/unhealthy enables the low risk group to project their fears about "social order, death and disease" upon those deemed as high risk.

> *In Canada, and elsewhere, epidemiological portraits of Aboriginal sickness and misery act as powerful social instruments for the construction of Aboriginal identity. Epidemiological knowledge constructs an understanding of Aboriginal society that reinforces unequal power relationships; in other words, an image of sick, disorganised communities can be used to justify paternalism and dependency (O'Neil et al. 1998).*

Epidemiological studies formed a predominant feature of Australian Aboriginal health discourse in the 1990s, and account for approximately 45 per cent of all Indigenous health journal articles that explicitly use the term 'culture' (see Figure 1). Despite the successes in achieving greater social and political awareness of Indigenous health inequality, Brough (2000:80–81) has argued elsewhere that pervasive epidemiological descriptors have made it more difficult to imagine Aboriginality beyond the labels of disease and dysfunction. These depictions, while grounded in certain quantified 'facts' about Aboriginal health, are presented as uncontestable truths about Aboriginal people, families, cultures and communities. Here, we can see Aboriginality constructed as pathogenic and deviant through a largely behaviourist health promotion agenda (Richmond 2002:198; Nettleton & Bunton 1995; Brough 2000).

Culture as behaviours

Culture as behaviours refers primarily to the way in which health promotion and health education programs understand culture. Invoked through the discourses of risk, 'healthism' and rationality, culture here often refers to a series of unhealthy behaviours (Richmond 2002). Understanding culture as behaviour is a common approach within Indigenous health research, accounting for 40 per cent of cultural interest (see Figure 1). It is an approach that tends to be criticised for ignoring the broader structural forces that contribute to health inequalities in favour of an individualised approach that encourages victim-blaming, and further marginalisation (Nettleton & Bunton 1995). Nettleton and Bunton note the irony of health promotion rhetoric, which purports to empower the disadvantaged yet often benefits the privileged, a group more likely to be able to take up healthy behaviour messages.

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[4] The intersection between racism and public health 'authority' has been shown elsewhere to be highly influential in public policy. For example, the USA 1990 General Social Survey revealed that more than half of all white people believed black people to be prone to violence, to prefer a dependence on welfare and to lack motivation and will power to get out of poverty. Four out of five respondents rejected biological explanations for such phenomenon in favour of motivational and cultural differences (Williams, D. 1999).

Moreover, as Jones (1994) argues:

> *In focusing exclusively on modifying cultural practices in black and minority ethnic groups, they both imply that such culture is deficient and also ignore wider structural deficiencies and barriers, including racism.*

Pearson (1986:53) suggests that such constructions enable the causes and solutions to health inequalities among cultural minorities to become depoliticised and individualised. Here, culture, behaviour and lifestyle become blurred, hence behavioural 'remedies' can run dangerously close to cultural 'remedies'. Jones (1994), for example, describes the varying public health responses to rickets in the United Kingdom amongst Asian women and the general population. He noted that when it was found to be a problem among Asian women, attempts were made to change their diet, yet when it was a problem across Britain decades earlier, vitamin D was added to margarine. In Australia, we see Aboriginality constructed largely in terms of risk, and an emphasis on associating behaviours such as smoking, drug and alcohol use, violence, nutrition and self-harm with Aboriginality (Alati *et al*. 2003; De Costa 2002; Sweet 2002; Sutton 2001; Widders 2003; Busch 1998). Rarely is Aboriginal culture examined or defined in a way that highlights the positive or desirable behaviours and attributes associated with Aboriginality (Brough *et al*. 2004). Curiously here, the benefits of the broader health promotion rhetoric of empowerment (WHO 1986) seem to be denied to precisely those groups within society who could most gain from it.

Culture as ideology

Described as a culturalist explanation for health inequality, culture as ideology emphasises how different belief systems impinge upon interactions within the health care setting (Julian 2003). This popular approach challenges the ethnocentricity of the biomedical model of illness by examining the different meanings and associations attributed to issues such as health service access, communication and diagnosis, and perceptions of health, illness and treatment by different ethnic populations. Durie (2003) notes that cross-cultural understandings are required because misdiagnosis and non-compliance is said to be greater in situations where the doctor and patient have different cultural backgrounds.[5] Chu (1998) argues that greater awareness around the differences of language, illness explanatory models, and illness management are vital to enhancing the level and quality of health care service access among ethnic minorities.

As shown in Figure 1, this approach constituted almost half of all 'cultural' interest in Indigenous health. It is not without its critics, however, particularly for its somewhat ironic failure to acknowledge the heterogeneity of populations (Peberdy 1997). For example, Morgan *et al*. (1997) discuss Aboriginal philosophy and its impact upon health outcomes drawing on the sweeping generalisation of '*the* Aboriginal perspective'. Critics suggest that these approaches rely too heavily on 'traditional' or 'authentic' representations (Brady 1995) as well as the capacity to promote stereotypical representations and victim-blaming. As Pearson (1986:53) observes: 'Potted guides to culture, rarely written by minorities themselves, have become a vital source of instant 'expertise' on these cultures, which are thought to cause so many health problems'.

These depictions often result in "a catalogue of checklists of cultural stereotypes which are regarded as essential characteristics of particular cultural/racial types" (Ahmad 1996:195). In this instance, health care providers are thus enabled to engage in policing the boundaries of ethnic or cultural group membership within the health care setting according to one's compliance to the imagined checklist. Evidence also suggests that such understandings influence health care providers in a way that may result in inequitable health care treatment, which thus contributes to and/or compounds health inequality (Van Ryn & Fu 2003; Bowler 1993).

Rather than suggest that culture does not matter, Kelleher (1996:83) argues that there is a need for cross-cultural discourses to engage in the "complexity of identity formation" and the interplay of both agency and structure.

> *[P]eople from any ethnic background will have a number of structures giving relevance to their lives, with their culture and ethnicity being only one such structure which people utilise in making decisions about how to live and how to cope with problems of illness (Kelleher 1996:84).*

Certainly, there has been little attempt within Indigenous health research to elaborate possible connections with other social structures.

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[5] See Humphery *et al*. (2001) for a critique of the ethnocentric assumptions embedded in the compliance notion as used in Aboriginal and Torres Strait Islander health.

Culture as a surrogate

The category of culture as a surrogate refers to the research literature that seeks out structuralist explanations for health inequality, often using culture as a surrogate for socio-economic status, and applying these explanations to cultural spaces as if economic processes act independently of culture (Shim 2002). For instance, disproportionate rates of work-related injury among migrant populations might be attributed to the over-representation of migrant groups in hazardous working-class occupations (Julian 2003:148). Here, culture as a surrogate accounted for 20 per cent of publications collected (see Figure 1), and often emphasised the importance of socio-economic and environmental conditions upon health outcomes for Aboriginal Australians.

Theoretically, this position is often most favoured among 'anti-racists' who view public health's interest in culture as a decoy diverting attention away from the more profound issues of racism, poverty, educational disadvantage and unemployment, to name but a few (Pearson 1986; Ahmad 1996). Poverty is perhaps the single greatest determinant of ill health, with racism serving the cause of economic and health inequality among minority populations globally (Bhopal & Donaldson 1998; Harrell *et al.* 2003; McKenzie 2003; Sherman 2003; Bhopal 1998). However, there still remains a large gap in how we conceptualise the intersection between culture and poverty without having to draw on pejorative 'culture of poverty' ideas. Lacking in Indigenous health research is any substantial theorisation or testing of the extent to which Indigenous health inequality is the product of class and/or culture variables, and particularly how these two perspectives might contribute to each other.

Williams (D. 1999) notes that while socio-economic status can explain a large proportion of racial differences in health status, race and ethnicity still have an independent effect upon health outcomes. Hunter (2000) has found that Aboriginal Australians do not witness the associated improvements that the general population experiences with increased income. Julian (2003:148) argues for a more sophisticated approach in which we "view social location as a function of the intersection of a range of factors such as class, ethnicity, gender, age and immigrant status". This kind of sophistication has yet to substantially reveal itself in Indigenous health research.

Culture as cure

The category of 'culture as a cure' refers to texts that seek to demonstrate how the notion and/or practice(s) of culture may be employed to produce better health outcomes. Although culture is the most popular concept within global Indigenous/First Nation health discourses (Brady 1995), culture as a determinant for *better* health remains unexplored in public health research, representing only 6.5 per cent of journal publications examined (see Figure 1). This limited use of culture as a health resource, rather than as a barrier to health, reflects the dominant deficit model of public health inquiry.

The idea that 'culture' acts as a resource for better health has been articulated in a number of different ways: from incorporating cultural symbols and meanings within health promotional material (Brady 1995, Simmons & Voyle 2003); to asserting that a particular culture may be conducive to better health behaviours (Brook *et al.* 1998), that traditional cultural practices may remedy health conditions (Brady 1995; Spicer 2001), that strength in one's own cultural identity may protect against or treat negative health behaviours (Chandler & Lalonde [in press], Miller, 1999; Williams 1999a; Yancey *et al.* 2002; Williams R. 1999), or that the process of examining and exploring one's cultural identity might in itself be conducive to better health outcomes (Williams *et al.* 2003).

The concept of culture as treatment is most commonly found in the drug and alcohol literature regarding First Nation peoples (Spicer 2001). Brady (1995) is critical of this approach, suggesting that it produces a 'simplistic and static notion of culture', that it fails to see culture beyond the 'traditional' past, that it supports common myths about Aboriginality and invokes essentialist ideas of authenticity, and that it serves to deny individual agency within alcohol treatment programs.

In his study of abstinence among First Nation Americans, Spicer (2001) noted that drinking was commonly associated with cultural degradation, and that a stronger sense of one's own cultural identity was a common theme among those who became abstainers. However, within this study, there was not an argument for or against a specific mode of 'culture' or treatment, but a recognition of the cultural meanings associated with particular health behaviours. Spicer (2001) criticises anthropologies of alcoholism amongst American Indian communities and calls for more attention to be given to cultural meanings around abstinence.

The influence of culture in positive health outcomes is being increasingly described in research among Hispanic, Mexican, and Asian populations in the United States of America. There, increased immunisation rates, and decreased drug use have correlated with cultural identity, rather than assimilated identities (Anderson *et al*. 1997; Guinn 1998; Salant & Lauderdale 2003, Brook *et al*. 1998). On a different tangent, in his analysis of African–American health, Williams (D. 1999) notes that negative conceptualisations of one's own group have been linked with higher levels of psychological distress, alcohol use and poorer physical and mental health. Miller (1999) and Yancey *et al*. (2002) highlight links between positive racial socialisation and better health behaviours. This use of the culture concept in health research is yet to attract any real attention in understanding Australian Indigenous health.

Williams *et al*. (2003) present an interesting insight into culture as treatment by arguing that identity and culture are important individual and community resources for marginalised communities, engaging meaningfully, they suggest, with the empowerment agenda of health promotion. Here, culture is not measured according to quantifiable variables, but is instead recognised as a resource for the community; it is the process of enabling such communities to define, express and represent *themselves* that is empowering and conducive to better health outcomes.

Conclusion

This rather brief overview of public health applications of 'culture' within Indigenous health research is not an attempt to argue for a particular version of the culture concept. Culture matters to Indigenous health because it matters to Indigenous people. Conceptually, research remains restricted to the study of cultures, and rarely engages in the culture concept itself and how it matters to health. Without this deeper reflection, culture is static and stereotypical, disguising as much as it reveals. Much of the public health rendering of Aboriginal and Torres Strait Islander culture is not concerned with how it matters to Indigenous people, but rather how it matters to risk-factor epidemiology. Culture then becomes little more than a branding device to denote research among cultural 'others'. We have suggested a number of themes evident in the Indigenous health literature. We do not imagine these to be absolute categories and acknowledge there may be many other ways in which the culture concept is at work in Aboriginal and Torres Strait Islander health research. We are suggesting though, that Indigenous health researchers provide more critical reflection on how they use the culture concept in their work, so that a richer dialogue that resonates more fully with the lived experience of Aboriginal and Torres Strait Islander people may evolve.

Understandings of Aboriginal and Torres Strait Islander people, culture and health require an approach that acknowledges the fluidity, diversity, strength and vitality of Indigenous culture. Such an approach demands imaginings of Indigenous culture that extend beyond the stereotypical images of the 'traditional', the 'dysfunctional' and the 'pathogenic'. Instead, we need both a deeper engagement in the concept of culture as well as a recognition of the intersections between culture and broader social, economic, environmental and political conditions that continue to entrench health inequalities.

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Chapter 15:
Culture as a Determinant of Aboriginal Health

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Introduction

In this scoping chapter, we do not attempt to present a comprehensive literature review on culture and health, since to do so would take much more than could be contained in this chapter (if it could be done at all). Nor do we delve into the intricacies of cultural theory any further than is needed to provide a sufficiently robust conceptual basis for the purposes of this chapter. We also make no attempt to describe in any detail the cognitive and social structures and processes comprising the different cultures that might impact upon Aboriginal health, partly because, as we shall demonstrate later, the current literature provides no basis for such a task; but, also, mainly because of our argument that the static description, categorisation and comparison of cultures, which was the central concern of classical anthropology, should not be our main approach in any case.

This chapter begins by addressing, in an extremely minimal frame, some of the more prominent social science approaches to the concept of culture and also to the question of the link between health and illness, canvassing the sociology of culture, varieties of medical anthropology, cultural explanatory models and culture care theory. This is followed by an exploration of the Australian literature on culture and Aboriginal health, where we will show that there is a virtual absence of systematic theoretical and empirical work in this area. We will also demonstrate that in the rare instances where culture is examined as a health determinant there is a generalised indifference to the theoretical approaches discussed.

The second half of the chapter attempts to suggest how the ‘absences’ we expose might be remedied. First, we argue that appropriate methodology must be developed and deployed, and in this context we give some examples from the development of Indigenous psychological research in the Philippines and decolonising methodology in New Zealand. Then we suggest a (non-exhaustive) list of areas in which such a methodology might be deployed.

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Culture

Culture as social process

At the level of cultural theory, the major points we wish to make are that culture is an elusive concept and that it is impossible to understand *cultural processes* unless they are located in the context of *structures of power.*

Kroeber and Kluckhohn (1952) compiled from an extensive literature analysis no less than 164 different implicit or explicit definitions of culture that had been used by anthropologists. Following this, Williams (1983:90) described the word culture as 'one of the two or three most complicated words in English' and as having three main uses:

i. a general process of intellectual, spiritual and aesthetic development

ii. a particular way of life, whether of a people, a group, a period, or humanity in general

iii. the works and practices of intellectual and especially artistic activity (Williams 1983, p. 90).

A further distinction of immediate relevance is that:

> *In archaeology and in cultural anthropology the reference to* culture *or* a culture *is primarily to material production, while in history and* **cultural studies** *the reference is primarily to* ***signifying*** *or* ***symbolic*** systems*. This often confuses, but even more often conceals, the central question of the relations between 'material' and 'symbolic' production, which, in some recent argument… have always to be related rather than contrasted (Williams 1983:90–91, author's emphases).*

These are crucial distinctions for the purposes of this chapter because the concept of culture has been extremely pervasive in health policy for over fifty years as a vehicle for interpreting the health and behaviour of both Aboriginal people and migrants. Also, as we shall later show, the implied definition of culture in this discourse, almost without exception, has been one that emphasises 'signifying and symbolic systems' as opposed to 'material production'. Moreover, in terms of the three broad usages specified by Williams, the Australian discourse has leaned heavily to the first and third; and where it has included 'a particular way of life', this has almost always been restricted to the private, familial sphere (e.g. Castles *et al*. 1991).

What this boils down to is that the dominant discourse related to culture in Australia has been one that excises whole areas of the 'way of life'. Thus, dance is culture but the organisation of industrial production is not; cuisine is culture but the organisation of the welfare system is not; and 'traditional' health beliefs are cultural in nature but 'modern' medicine is not because it derives from a scientific paradigm that makes truth claims, which transcend individual cultures.

The complexity of these matters extends even further than this, however, since Aboriginal people generally do not enter these cultural negotiations on equal terms, but as the less powerful party by far. In such a situation it is the more powerful parties that set the limits of what Bourdieu calls a *field* in which what is, and is not, valued cultural capital can be defined according to the interests of the more powerful parties (Bourdieu 1977:70–78).

Worsley's book *Knowledges* (1997) attempts to synthesise Williams's work and that of other theorists in specific cultural contexts. He criticises Williams's use of the term 'cultural materialism' and substitutes a framework of what he calls 'dialectical sociology'. Thus:

> *one has to say that culture, since it deals in ideas and values, is not material. While material objects certainly exist… we cannot understand what an object from another culture is unless we understand what it means to those who produce and use it.*
>
> *The opposite, idealist, assertion is equally mystifying: ideas and values do not float about in the air, nor do all of them have the same significance for social behaviour… Social relations, then, have to be looked at in dialectical terms as an interplay between ideas and other kinds of constraints on behaviour, from hunger to social pressures (Worsley 1997:348–9).*

Culture, then, is not a static set of beliefs or mores but something that is continually reconstructed through social processes, which involve, among other things, unequal relations of power between the groups participating in these processes. Langton crystallises this point in the context of Australian visual media, highlighting the dynamic and historical nature of culture:

> *The most dense relationship is not between actual people, but between white Australians and the symbols created by their predecessors. Australians do not know and relate to Aboriginal people. They relate to stories told by former colonists (Langton 1993, quoted in Anderson 2000:429–30).*

Thus, in this process of cultural construction, the more powerful participant's definition of the culture of 'the other' is itself an important element, irrespective of its consonance (or lack of it) with any empirical reality. This is not only because it enables the relatively powerful to set the ground rules for what is legitimate or feasible, but also because of its effect in structuring the field in which the self-identity of 'the other' is formed (Karlsen & Nazroo 2002:4).

The preceding argument leads us to an important point, namely that the project of investigating the cultural dimensions of Aboriginal health is not in any way bounded by elucidating the content and practice of *Aboriginal* culture(s), enormous as that task might be. This is because Aboriginal health is deeply affected, not just by Aboriginal culture, but also by the exposure of Aboriginal people to non-Aboriginal cultures and subcultures of various sorts. In fact Aboriginal culture *itself* has been profoundly altered by these contacts (as the history of the last 200 years makes blindingly obvious), and probably continues to be altered in ways that are often not so obvious (see, e.g. Ross 1987; Goodall 1996; Rowse 1990; Bell 2002). This is unarguably true at Williams's 'material' level of culture. Later we argue that it is probably true in terms of 'signifying and symbolic systems' also.

Culture, social science and health

In this subsection we review very briefly some of the approaches through which the social sciences (especially anthropology and sociology) address the culture–health nexus and articulate the concept of culture to the study of health, illness and disease. It should be noted that it is our intention simply to map some dimensions of the field to form a backdrop to our examination of Australian literature. We make no judgments about preferred approaches and neither do we claim that our map is complete.

Medical anthropology

We take as our starting point a *The Lancet* article in which Helman describes the concerns of medical anthropology as follows:

> *Medical anthropology is the study of how people in different cultures and social groups explain the causes of ill-health, the types of treatment they believe in, and to whom they turn if they do get ill. The scope of medical anthropology also extends to how these beliefs and behaviours relate to biological and psychological changes during both health and disease (Helman 1991:1081).*

Specifically, medical anthropology has focused on the widening gap between medical and lay perspectives on ill health, that is, between 'disease' (the biomedical model with emphasis on physiological data, which is seen as more real than social or psychological data) and 'illness' (the subjective experiences of the patient and the meanings that are given to such experiences). The field is also concerned with body image, which concerns the way lay theories of anatomy and physiology may influence how people interpret and respond to physical symptoms. The field is also concerned with the culture of biomedicine.

Political medical anthropology and critical medical anthropology

The field of medical anthropology is monolithic. There are distinct theoretical and methodological schools within the discipline, probably the most important being what is variously known as political economic medical anthropology or critical medical anthropology. The approach of this school has been:

> *distinguished from conventional medical anthropology, not simply by its scope of analysis but more fundamentally by its priority of embedding culture in historically-delineated political-economic contexts. Accordingly, the relevance of culture is not restricted to ethnomedical conceptions but extends to issues of power, control, resistance and defiance surrounding health, sickness and healing (Morsy 1996:23).*

This critical perspective, which dialectically links culture and power relations, has had very little impact in Australia and virtually none in health research. What critical anthropologists and many third- and fourth-world scholars in other disciplines refer to as decolonising methodologies is a requisite for advancing understanding of the social determinants of Aboriginal health.

Explanatory models and the culture care theory

Some important examples of work in medical anthropology that emphasise the culture–health nexus are to be found in the work of Kleinman and Leininger.

Kleinman investigates the reasons for differences in perceptions of health and illness between healthcare professionals and patients, which he interprets by arguing that medical knowledges are socially constructed cultural systems. He uses the concept of explanatory models (EMs) to illustrate the potential conflict that may arise due to different cultural constructions of medical knowledge. EMs refer to 'the notions about an episode of sickness and its treatments that are employed by all those engaged in the clinical process. The interaction between the EMs of patients and practitioners is a central component of health care' (Kleinman 1980:105). 'EMs are responsible for the cultural shaping of clinical reality' (Kleinman & Mendelsohn 1978:320) through the categories and value orientations that patients and practitioners bring to the clinical process.

Kleinman (1980; Kleinman & Mendelsohn 1978) identifies three forms of medical knowledge—EMs that are cultural systems in themselves. Any health situation can involve (a) the EM of the professionals; (b) folk EMs (held by non-professional healing specialists); and (c) popular EMs (held by the patient's family and community). The popular EMs are likely to exert a great influence in the patient's social construction of the health problem, and yet this is the least studied.

The practical implication of the concept of EMs is obvious. Healthcare professionals/workers should show a willingness to understand the folk and popular EMs and work through what the best treatment will be.

But is knowing the EMs enough? Kleinman argues that the healthcare system should focus more on 'healing', rather than 'curing':

> *Healing, in one sense, is the sum of the core clinical tasks of the health care system. This implies that it is the cultural system as a whole which heals. This type of healing we shall refer to as* ***cultural healing*** *(Kleinman 1980:35).*

Like Kleinman, Leininger's culture care theory aims to 'discover human care diversities (differences) and universalities (similarities) and to use this knowledge to provide culturally congruent nursing care as a pathway to health and well-being or to help people face disabilities and death' (Leininger 1995:102).

Leininger argues that all cultures have their 'secrets' or ways of caring for others at different stages of life, during crises and under different human conditions. This is culture care (Leininger 1995:105). Within and across cultures or collectivities, there are variabilities and/or differences (diversity), as well as commonality and/or similarities (universality) in culture care and the challenge for healthcare providers is to discover what these are and how to use this knowledge to take action. The goal of discovering culture care is to provide culturally congruent and competent care, defined as:

> *those cognitive based assistive, supportive, facilitative or enabling acts or decisions that are tailor-made to fit with individual, group or institutional cultural values, beliefs and lifeways in order to provide or support meaningful, beneficial and satisfying health care or well-being services (Leininger 1995:106).*

The uses of culture in Aboriginal health research

The 'absence' of culture

In this section we review the ways in which the concept of culture has been deployed by health researchers and service providers in relation to Aboriginal people historically, and over the last fifteen years or so.

A good starting point is a comparison of two books published twelve years apart, both designed to provide overviews of the state of Aboriginal health, and research concerned with it. These are respectively *The Health of Aboriginal Australia*, edited by Janice Reid and Peggy Trompf (1991) and *The Health of Indigenous Australia*, edited by Neil Thomson (2003).

The most striking comparative feature of these two books is that the Thomson anthology is much more firmly set within the mode of traditional biomedicine and quantitative epidemiology than the earlier one. The Reid and Trompf volume contains several chapters that employ an anthropological perspective and directly address issues of culture in almost one-third of the total text.[1]

Such considerations are virtually absent from the Thomson collection. For example, Altman's (2003) chapter on the economic and social context of Aboriginal health devotes just over half a page to culture, this being mainly a list of factors that keep people out of the labour market. Hunter's (2003) chapter manages a thirty-page review of the literature on Aboriginal mental health in which he utilises the noun 'culture' only twice (pp. 145 & 146) and the adjective 'cultural' three times (pp. 128, 133 & 137). (This would seem a remarkable feat but it probably reflects the material he chose to review fairly accurately.)

The Thomson volume as a whole lists only three index entries for what it terms 'cultural factors' and in this it cleaves to at least one modality in Aboriginal health research, which is either to ignore socio-cultural factors completely or acknowledge their 'importance' and then proceed as if they do not exist.

This is exemplified by the chapter on diabetes, which states that 'diabetes, in a broad sense, is a disease that arises from a web of social and economic determinants' (Irvine, Kirov & Thomson 2003:98). The determinants then go unmentioned for the rest of the chapter except for the startling assertion that:

> non-modifiable risk factors include…
>
> - race/ethnicity…
> - degree of modernisation or 'Westernisation' (Irvine, Kirov & Thomson 2003:96).

It should be stressed that this comparison is illustrative rather than indicative. It illustrates that it is still possible to write a considerable text on Aboriginal health virtually without reference to cultural factors and still to be seen by many people as authoritative. It would take a much longer and more detailed analysis than we have space for here to establish that there has been a *generalised* decline in consideration of cultural factors, although the material presented below from Morrissey (2003b) certainly indicates that such approaches still comprise a tiny proportion of the overall research output on Aboriginal health.

There is a very long history in Australia of health researchers simultaneously stressing the importance of cultural factors in interpreting the health of whatever minority group they happened to be studying while totally neglecting any attempt at systematic investigation of the social processes involved. This has been a constant in relation to both Aboriginal and migrant health.

As long ago as 1978, Martin (1978) attempted to assess the way in which the Australian medical system approached the health needs of immigrants by reviewing all the available and relevant literature published since 1945. Of the 118 items reviewed by Martin, the vast majority portrayed immigrants as in some sense importing their problems. Only ten of the articles nominated the inadequacy of Australian healthcare provisions as a problem, and the overwhelming tendency was to stress the pre-migration experience of the immigrant, the migration process or the immigrant's 'culture' generally as being in some sense pathogenic (Martin 1978).

This example has considerable relevance to the subject of this chapter in two ways. First, Martin's description of the migrant health literature in 1978 could well apply to a very large proportion of what has been written about the social determinants of Aboriginal health up to 2004. Second, Martin's review illustrates the argument made above, that in an unequal cultural negotiation it is the relatively powerful participant who interprets the engagement. In the case of material reviewed by Martin, what she called the medical 'definers' of various migrant cultures were able not only to interpret these encounters in ways congenial to themselves, but, by consigning their patients' problems to the realm of 'culture' (as they defined it), were able to place them securely outside the sphere of feasible social or medical action.

The continuities between the 1970s literature on migrant health and contemporary discourses on Aboriginal health are illustrated by Morrissey (2003b), who searched health databases over the years 1990 to 2002 for publications that dealt to any degree with the social aspects of Aboriginal

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[1] Gray, A., Trompf, P. & Houston, S., *The Decline and Rise of Aboriginal Families* (pp. 80–123); Brady, M., Drug and Alcohol Use among Aboriginal People (pp. 173–218); Reser, J., *Aboriginal Mental Health: Conflicting cultural perspectives* (pp. 218–92); and Mobbs, R., *In Sickness and in Health: The sociocultural context of Aboriginal well-being, illness and healing* (pp. 326–8).

health. From the Health & Society Database he retrieved 433 citations and abstracts, which were searched for:

- use of appropriate social theory as an organising framework for research design;
- discussion of results in terms of social theory; or
- other theoretical discussion beyond the level of assertion (such as 'it is obvious that the health problems of Aboriginal people cannot be understood in isolation from their experience of 200 years of oppression').

This analysis resulted in a mere twenty-eight publications that met the criteria and many others that made theoretical *statements* linking poor Aboriginal health status to various socio-cultural and political factors (Morrissey 2003b).

Whose culture?

In 1991 the report of the National Inquiry into Racist Violence (NIIRV) stated:

> *Strategies to address the problem of racist violence against Aboriginal people must be linked with policies aimed at improving the status and the standard of living of Aborigines in Australian society… Structural changes are necessary to eliminate institutional racism and to provide appropriate services for the victims of racist violence (HREOC 1991:260, 269).*

The report was notable for its insistence that racism was not just a product of individual racist 'rednecks', but that it was deeply structured into 'mainstream' institutions and 'mainstream' culture, a view that historians and social scientists have argued for many years (e.g., Kidd 1997; Hollingsworth 1998; Cowlishaw & Morris 1997; Macdonald 2001).

This emphasis on racism has scarcely penetrated the literature on Aboriginal health. For example, in 2004 an article was published in *Social Science and Medicine*, which advocated a 'life course' approach to the treatment of end stage renal disease (Cass *et al*. 2004). This article was both notable and typical in three main ways. First, the authors, after a fairly extensive bibliographical review of the literature demonstrating the links between what they call socio-economic 'disadvantage' and health, produce a list of recommendations, which is virtually barren of any suggestion as to how these structural inequalities could be addressed.[2] Second, the *cultural underpinning* of social and economic marginalisation—institutionalised racism—is not mentioned, the clear implication (by default) being that it forms no part of the 'life course' of Aboriginal people. Third, the extent of the authors' engagement with the question of culture is confined to a single paragraph that analyses the cultural aspects of Aboriginal people's interaction with non-Aboriginal Australia entirely in terms of cognitive and linguistic dissonance at a micro, individual level, ignoring the structural and institutional factors stressed by the NIIRV.

In all of this they are not alone. The vast bulk of the (scarce) Australian literature on social gradients in health effectively treats social inequality as in some sense the product of forces beyond the scope of feasible social action. The absences of any attempt to address the issue of racism and the extremely restricted application of the concept of culture, however, are much more immediately germane because they typify important absences in the debate on social determinants in Australia and also because they are heavily intermeshed with each other.

The typicality of this approach cannot be doubted. The Thomson (2003) volume to which we have previously referred contains only one index entry for racism (and even then, the word is not actually used on the page for which it is indexed). More generally a search of the ATSIHealth database under the keyword 'racism' turned up twenty citations only for the past ten years relating to Aboriginal health, in most of which the topic was addressed peripherally only.

Krieger (2003), in reviewing American literature, admits at the outset that 'research on racism as a harmful determinant of population health is in its infancy'. In order to advance the field Krieger (2003:194) sets out to:

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[2] One recommendation, for improved educational participation, may be an exception to this but the authors do not ask how this might be achieved, nor why this need exists in the first place.

> *address three interrelated issues from the vantage of an epidemiologist guided by an ecosocial perspective (Krieger 1994, 2001[a], 2001[b]): (1) links between racism, biology, and health, including recognition of biological expressions of race relations and racialized expressions of biology; (2) methodological controversies over how to study the impact of racism on health; and (3) debates over whether racism or class underlies racial/ethnic disparities in health.*

The really important point of this quotation is that restricting the cultural negotiation between Aboriginal and non-Aboriginal people to considerations of cognitive and linguistic dissonance is a frame that cannot possibly accommodate the sort of questions Krieger is posing. It is also necessary to stress that this is the way in which cultural interaction has almost exclusively been portrayed in Australian cross-cultural health research, both in the Aboriginal and migrant contexts (e.g., Sinnott & Wittman 2001; Vicary & Andrews 2001; Maher 1999, to cite some recent contributions).

An additional dimension is described by Brady (1995) and Muecke (1992) who, among others, have drawn attention to the ways in which 'simplistic and static' notions of culture may form a mental 'prison' for Aboriginal people by being transformed from the 'dynamic present and future of peoples (and not just their past)' to 'a "thing" that you either have or have lost' (Brady 1995:1490).

What do whitefellas 'know' about Aboriginal culture?

We said at the beginning of this chapter that we would make no attempt at *describing* Aboriginal culture(s), but it is necessary to make three broad points. First, the bulk of the existing canon of anthropological/ethnographic work relating to Aboriginal people was produced well over twenty years ago. Second, most of it related, in any case, to social groupings unrepresentative of the way of life of the majority of Aboriginal people even at the time the research was done. Third, Aboriginal societies have changed very rapidly in the past twenty-five years in directions about which the existing canon tells us very little, driven by social forces about which it tells us even less.

The only one of these assertions needing argument is the third, since the other two can be verified easily enough through database searches. If the third needs any argument, let us point to three indicators of rapid social (and hence *cultural*) change since the early 1970s.

The first is the massive alteration in the pattern of age-specific death rates. This, in itself, is likely to have had massive effects on cultural production and reproduction, although the existing literature tells us very little about the nature and extent of these effects.

Second, the legal and social space within which Aboriginal culture can function has altered radically.

> *In practical, physical and legal terms major changes have occurred since the 1960s: the repressive legislation has all but gone, albeit leaving scars which will take a generation to fade: the system by which Aborigines were minors in law… has ended (Tatz 2001:5).*

Third, a massive indicator of social and cultural change is the very subject of the book from which the last quotation was taken. There is widespread agreement that suicide was virtually unknown in pre-invasion Aboriginal cultures. There is also plenty of evidence from contemporary studies to show that Aboriginal suicide was a rarity as late as the mid-1970s (Tatz 2001:24–5).

The point of all this is that before even thinking about some of the paths indicated by Kleinman and Leininger there must be some clarity about what is being responded to at a cultural level. Aboriginal culture, like any other, is not static and Aboriginal people neither become bereft of culture when they 'lose' the traditional, nor are they suddenly transformed into non-Aborigines. Any real attempt to respond to Aboriginal culture must be based on creating a social space in which the lived reality of Aboriginal culture can assert itself over and against the social construction of that reality by non-Aborigines.

In part, as we argue in the next section, creation of this social space necessitates changes in the emphasis and methodology of research, since research has been an important process in the reproduction of relations of inequality. Much more is involved, however, and not the least of this is the self-reflexive admission by researchers that medical research, like any other sort, is a cultural product that often derives from relations of extreme inequality between the researcher and the researched. Unless these inequalities are confronted at the level of research *process*, it is in evitable that they will be embodied in the research *findings* and, to the extent that research findings are embodied in health service practice, in that practice also.

Culture and methodology

General considerations: Biomedicine and Indigenous research methods

Research methodology is often a contentious subject but controversy is not confined to the apparent belief of some medical researchers that the words ‘quantitative’ and ‘objective’ are synonyms. The question of methodology has been a major area of concern among Aboriginal scholars and throughout the fourth world for many years. As the Maori scholar Linda Tuhiwai Smith states:

> *Research is one of the ways in which the underlying code of imperialism and colonialism is both regulated and realized. It is regulated through the formal rules of individual scholarly disciplines and scientific paradigms, and the institutions that support them (including the state) (Smith 1999:8).*

For this reason, she asserts, the word itself, ‘research’, is probably one of the ‘dirtiest words in the Indigenous world’s vocabulary’ and that there is an urgent need for Indigenous people to ‘research back’ (Smith 1999: 8).

This is a call that is being made by a number of researchers, and to some effect in a number of areas (Brady 1999; Humphery 2001). Currently writers such as Rigney (1999) and Lui and Sherwood (2000) advocate the necessity for theoretical frameworks and epistemologies that reflect and privilege an Indigenous Australian worldview. They also strongly identify the need for respect for alternative ways of knowing or knowledge and, in doing so, continue an argument going back thirty years (see Humphery 2001; WPAHBH 1981; Langton 1981a, 1981b; Langford 1983).

In spite of this advocacy, it cannot be said that this long-running debate regarding Indigenous control of, and benefit from, the research process has had much effect on the conduct of research into the health of Indigenous people. The vast bulk of this research remains fixed in the mode of what McMichael (1999) labels ‘black box’ epidemiology and biomedical science (Morrissey 2003b).

In other words, elucidating the effects of something as pervasive, complex, ambiguous and changing as culture is a task of a radically different sort from, say, establishing quantitatively the incidence of tuberculosis—and one that makes its own methodological and epistemological demands. For Indigenous peoples, for example, segregating the biomedical from the broader context of the ‘lived experience’, constructed within the realm of the cultural world, has the effect of abstracting from the totality of causation, and subsequently limits the potential outcomes of interventions that fail to incorporate and accept different ways of knowing.

Adopting a research approach that is appropriate to Aboriginal culture and conditions is essential in elucidating the centrality of culture in health, healing and (particularly) chronic disease and injury. To this end, there are lessons from the field that can be drawn from the experience of Philippine and New Zealand scholars who have ‘indigenised’ their research methodology to suit Indigenous research.

The Philippine experience with indigenisation

The Philippines has a long history of adopting an Indigenous research approach in the social sciences, spearheaded by an indigenisation (or decolonisation) movement in Philippine psychology that started in the early 1970s (Pe-Pua & Protacio-Marcelino 2000). The Indigenous approach can be described in terms of its informal cultural, formal structure, and technological procedures.

In terms of values and ideologies, Indigenous research recognises knowledge as inseparable from praxis, consciousness, identity and involvement. In terms of beliefs and theories, a multi-method, appropriate and total approach is the way to obtain valid information. In terms of norms and assumptions, the researcher seeks to be one with the group being studied, by way of his/her actions (Enriquez 1992).

In terms of division of labor, the Indigenous researcher and participants work at the level of unity. The researcher uses his/her ability to systematise things, with the participants reconfirming such efforts. In terms of distribution of power, power rests not on the Indigenous researcher but on the culture-bearer participants who provide and determine the scope and limits of research (Enriquez 1992).

In terms of problem definition, Indigenous researchers let the community of culture-bearers define the problems and issues (Enriquez 1992). Data collection follows what is described as a mutual-orientation model, where ‘both data collector and contributor give something to, and gain something from, the data collection' (Viney 1988, cited in Enriquez 1992:61). We can see from the above discussion that Indigenous research challenges the traditional role of researcher and participant. Enriquez (1992) argued that experimental and survey researchers wield a monopoly of power, making them 'research emperors', perpetuating their own interests and preserving the status quo, sometimes at the expense of the powerless Indigenous people. This power relation is modified in participatory research, where researcher and participants begin to share power and status and become co-equal. Indigenous research went a step further—reversing the power role relation (Enriquez 1992).

In unpacking the relationship between researchers and participants in Indigenous research, one guiding principle that emerged is that the level of interaction or relationship between the two parties (whether the researcher is treated as an insider or an outsider, for example) significantly determines the quality of the data obtained. Another principle is that researchers should treat research participants as equal, if not superior—as a fellow human being and not as a 'guinea pig' whose sole function is to provide data. Consistent with this, more importance should be attached to the welfare of the participants than to obtaining data from them. The goal of research is understanding, but not at the expense of the very people from whom this understanding will spring.

It will follow that research methods should be chosen on the basis of appropriateness to the population (and not sophistication of the method) and it should be made to adapt to existing cultural norms. Also, the language of the people should be the language of research at all times.

Decolonising methodologies in New Zealand and elsewhere

Linda Tuhiwai Smith, a Maori researcher, wrote her book *Decolonizing Methodologies: Research and Indigenous peoples* (1999) from a historical background that bears similarity to the Philippine experience of being colonised by foreign powers. The similarity with Australian Aboriginal experience, however, is more pronounced:

> *… research of Maori is marked by a history that has shaped the attitudes and feelings Maori people have held towards research. Research is implicated in the production of Western knowledge, in the nature of academic work, in the production of theories which have dehumanized Maori and in practices which have continued to privilege Western ways of knowing, while denying the validity for Maori of Maori knowledge, language and culture (Smith 1999:183).*

Smith poses the question, 'What happens when the researched becomes the researcher?': she answers this by describing the ways in which the Kaupapa Maori (Maori-centred) research approach 'has become a way of structuring assumptions, values, concepts, orientations and priorities in research' (1999:183). Kaupapa Maori research –

> *is related to 'being Maori'; is connected to Maori philosophy and principles; takes for granted the validity and legitimacy of Maori, the importance of Maori language and culture; and is concerned with 'the struggle for autonomy over our own cultural well being' (summarised by Graham Smith 1990, cited in Smith 1999:185).*

The Maori experience shares a strong resemblance with Philippine Indigenous psychology experiences in terms of identity politics. The question of 'who has/have the right to determine the Indigenous research agenda and conduct research—the Indigenous or the non-Indigenous?' is always a sensitive one. In both the Maori and the Philippine contexts, the answer leans towards participation of both, for as long as the Indigenous orientation is upheld.

Both approaches also promote rigour and ethics in research, accountability to the people, 'giving voice' to the Indigenous, and bringing that voice back to them through reporting back and acting on the voiced concerns and issues.

In concluding the discussion about methodology, we need to clarify that we are not arguing that these are the only approaches that have value. Biomedical science has many indisputable achievements; and, in any case, we maintain our position that the field of culture in Indigenous health has more than one occupant. Understanding the role of culture in Indigenous health is as much a matter of critical understanding of 'white' cultures as it is of understanding Aboriginal culture. In this task we argue for *an end to the privileging* of quantitative and experimental approaches, but not for their *discontinuation*.

Paths forward

In this last section we indicate some areas where we feel research and action is needed. We have restricted ourselves to a few areas where we feel that cultural factors are centrally important, areas in which we are particularly engaged. In other words our objective is illustration rather than exhaustive listing. There are plenty of other fields needing systematic research, which could be added to what follows.

It will be observed that throughout this chapter we have stressed the absence from Aboriginal health research of disciplined, theoretically informed study of the culture–health nexus and the attendant questions of racism, power, subordination and exclusion that this would entail. Research alone will not resolve these issues, nor will research alone even show how they *might* be resolved. This will only be achieved through political and social processes, which research may assist with or impede, as a great deal of it already does at present. The main thrust of this chapter has been how it might do the former rather than the latter.

At the level of service provision, the challenge is to design structures that would permit the expression of cultural diversity and an aware incorporation of this into the services offered. The philosophical basis of this would be that mechanisms are provided to empower the Aboriginal people and the communities they come from in the sense that they should have the means to make healthcare professionals aware of the *actual content* of their lived reality. Thus, instead of the service provider relating to Aboriginal people on the basis of some real or imagined prior knowledge of their culture, the service itself should be structured so as to build-in sensitivity to culture in process, and also sensitivity to the complex interrelation between ethnicity, gender, social class and factors unique to or associated with particular localities. This *cannot* be achieved without confronting the realities of power and control; without which a mountain of good (whitefella) intentions and an ocean of cultural-awareness training will remain ineffectual.

Comparative health service research

In most developing countries with diverse, multi-ethnic population structures, health systems have developed that reflect the social and cultural characteristics of the different population sub-groups. In the developed world, health systems in countries with a multi-ethnic population mix have not reflected sub-group cultural sensitivities. This is apparent in Australia, the United States of America, many European countries and, until recently, in the United Kingdom, as well, and was also true in many African countries prior to independence. While the technically advanced countries have provided very high quality of care in the private and public sectors and have implemented all the latest advances in medical technology and knowledge, the developing countries and the newly independent countries, all struggling with weak economies and low levels of industrialisation, have strived to provide health services that have addressed cultural sensitivities for the main ethnic groups in their countries. In so doing, developing countries have led the way in health delivery systems and have also guided global policy. In Australia, however, the most disadvantaged sector of the population, Aboriginal people, has been affected by the indifference displayed in health service provision (Lush, Walt & Ogden 2003; Ogden, Walt & Lush 2003).

There are many examples of successful implementation of healthcare delivery programs that have incorporated cultural norms and sensitivities. Such examples come from countries in Sub-Saharan Africa, India, Latin America and the Middle East, where there are instances of high-quality and culturally appropriate healthcare, in spite of prevailing and acute resource shortage. From many possible examples we refer to studies of HIV/AIDS prevention in East Africa (Willms, Chingono & Wellington 1996; Sewankambo, Spittal & Willms 2001), public health practice in Kerala (Kutty 2000) and primary healthcare in Cuba (Waitzkin, Wald, Kee & Danielson 1997).

Mental health research

In mental health research, culture has been accepted as an essential element of an individual's lived experience, is a critical consideration when assessing mental state and emotional wellbeing, and has been integrated within health service development and delivery in some countries (Durie 2001).

Understanding the expression, determinants and consequences of mental ill health is of the utmost importance to understanding the experience of disadvantage for Indigenous peoples. Aboriginal people throughout Australia suffer a disproportionate burden of mental illnesses and social and emotional wellbeing problems (SHRG 2003). Racism, stigma, environmental adversity and social disadvantage constitute chronic, perpetual causes of stress among Aboriginal communities, and, as such, have ongoing effects on the mental health and wellbeing of individuals. Factors contributing to the higher risk of mental illness and higher rates of grief, loss and trauma are complex and wide ranging. Erosion of family and community social structures through past policies leading to forced separations and undermining of traditional roles within families are likely contributors. The costs of ongoing social disadvantage, frequent premature deaths, high rates of suicide, injury and violence, and high rates of imprisonment, family violence and social dysfunction are important issues that must be considered as potential causes and consequences of a range of mental illnesses and social and emotional wellbeing problems faced by Indigenous peoples.

In comparison to the lack of representative mental health data in Australia, there is a wealth of data available from New Zealand and other parts of the world that shows that the mental health disparities experienced among minority groups defined by ethnicity are growing (Durie 2001).

Since at least 1974, the rates of first admissions for mental illness have been higher among Maori than non-Maori, and have continued to increase. Maori patients also exhibit different needs, receive different diagnoses, enter hospital through different referral mechanisms, and are more likely to re-admit (Durie 2001). Maori patients have also demonstrated poor treatment responses, are more likely to receive a misdiagnosis, and lack access to appropriate community care (Kokiri 1996).

One potential explanation offered by Durie is that the higher rates of mental illness among Maori are a result of 'cultural bias, if not frank discrimination' (Durie 2001:22). The misapplication of diagnostic criteria because of cultural barriers is one element of cultural bias. Professionals tend to interpret patient presentations according to their own values and beliefs and, as such, are open to misinterpretation, misdiagnoses and, as a consequence, mismanagement. Culture can similarly impact on the way in which an individual experiences, processes and manifests symptoms, and, as a result, the manner and stage at which the individual presents for assessment and care.

In essence, to ascribe diagnostic relevance to predominantly Western 'voices' of the manifestations of various illnesses does so at the risk of excluding the important role of culture in illness expression and, subsequently, places groups of cultural minorities at risk of substandard and even harmful treatment or non-treatment on the basis of culturally dominant perceptions. Theories, explanations, assessment and treatment that deny the importance of culture, cultural norms and expressions of illness and wellness deny the centrality of culture to Indigenous people's everyday lived experience. They undermine and reject Indigenous worldviews of health as the outward manifestation of spiritual, social, emotional, physical and cultural realms. And they place an already disadvantaged population at risk of further adversity and poor outcomes in interactions with modern institutions of health and social services.

Racism and identity

We have already alluded to the importance of instating racism as an urgent field of research in relation to Aboriginal health, but a holistic approach to this topic would involve the relationship between racism and identity (see Karlsen & Nazroo 2002).

Durie argues, 'Identity is a pre-requisite for mental health, and cultural identity depends not only on access to culture and heritage but also on opportunity for cultural expression and cultural endorsement within society's institutions' (Durie 2001:54).

Understanding what constitutes an 'Indigenous identity', how this is constructed through cultural practice and meanings, its self-construction and structural or societal construction, and the effects this can have on health and interactions with social institutions remains under-explored in the Australian setting. The development, transformation and maintenance of 'Indigenous identity' is complicated by rapid changes in perceived and acted roles within community life and the broader society, and by the contribution of identity from both within the individual and from external forces. As outlined by Wenitong (2001), in relation to Indigenous male health:

> *The effects of colonisation have brought about stress, a sense of worthlessness and burden on the lives of Aboriginal people through introduced policies, destruction of societies and the restriction of identified traditional roles. It is essential to include these issues when attempting to address the health of Indigenous men (Wenitong 2001).*

Despite an awareness of these issues in relation to the health of Indigenous males, little data exists on Indigenous constructs of masculinity, contemporary and traditional views of male identity, and their impact on health (Wenitong 2001).

The issue of identity as a determinant of health also covers the potential implications of conflict that can be created when individuals are placed in a process of transition between traditional and contemporary life.

> *People increase their sense of control over what is happening in their lives, when they define their own experience and situations in their own terms… Empowerment grows out of self-definition… It is harmful for outsiders to define the issues Anangu face today: whether it be called policy or planning. Sadly, many who undertake such responsibilities, do so because they want to help. They do not understand what they also take away (HALT 1991:1).*

Incarceration

Overall, Indigenous people (predominantly males) are about sixteen times more likely to be incarcerated than their non-Indigenous counterparts (ABS 2002). A cluster of issues surrounds the issue of incarceration, all of them poorly researched and most of them having strong linkages to questions of culture. To name only a few:

- the health status of incarcerated people, including mental health;
- the effects of imprisonment on family formation and maintenance;
- the effects of imprisonment on cultural maintenance and transmission, including gender role models (particularly male); and
- the effects of imprisonment in perpetuating the cycle of poverty and exclusion from the labour market.

Poverty, unemployment, psychological ill health, poor education and lack of opportunity are important contributors to the high levels of dysfunction within Indigenous communities. The manifestations of dysfunction (such as anti-social behaviour, crime, violence, self-harm, substance misuse) are important causes of separation between generations of males. It follows that separation itself can serve to further break these important links, and perpetuate the high levels of ill health experienced by successive generations of Indigenous males. Thus separation can be seen as not only a result of dysfunction and ill health within communities, but as a direct cause of dysfunction itself.

Employment

Unemployment is certainly not something that is essentially Aboriginal at a cultural level. In the broadest and most profound sense, however, it is deeply cultural in nature, one of the most salient features of the cultural negotiation between Aboriginal and 'white' Australia.

Unemployment has consistently been shown to be associated with an increased risk of death (Kaplan & Keil 1993) and has been noted to be associated with higher rates of behaviours that increase risk for a number of physical illnesses, such as smoking, harmful alcohol use, poor diet and physical inactivity (Gerdtham & Johannesson 2003).

Unemployment is often quoted as a key determinant of the health disadvantage faced by Indigenous people, but it has rarely been explored in detail. Unemployment can impact on self-esteem, self-worth, and identity and, thus, on health and wellbeing. The valuable contribution of employment, as a process by which a person's identity and self-worth are often determined, has been undermined by the lack of any real opportunity for meaningful employment in remote communities. These impacts are compounded by the effects of loss of income and by poverty.

Employment itself is additionally problematic for Indigenous people, however, even (or particularly) when earning a good income. There is no convincing evidence of an income-related health gradient *within* the Indigenous population, although there is admittedly a paucity of convincing research in this area. In the absence of such research, however, there are reasons to suspect that there may be factors at work that inhibit the emergence of an income-related health gradient, such as a functional relationship between the size of the income unit and the income level of the main earner, and this may be a product of obligations (in particular income unit size) increasing with income (Hunter 1999: Morrissey 2003a). Also, the pressures on Aboriginal employees in 'white' organisations to speak for all Aboriginal people and to be instant experts on all Aboriginal issues is (anecdotally) the source of a great deal of unhealthy stress, although there is no systematic research on this topic.

The nature of work is also an issue requiring structured and careful thought. The number of Indigenous people employed within sectors of the labour market responsible for the delivery of services to countrymen and women—health, social services, welfare, non-government organisations, charitable institutions, prison settings, drug and alcohol services, and community controlled services—is not an insignificant number. This, then, exposes Indigenous employees to repetitive psychological stress and strain, dissatisfaction with institutional policy, practice and outcomes, frustration with inflexible rules and, above all, continual lack of headway in terms of alleviating the disadvantage of other Indigenous peoples. These are often frustrations felt, lived and repeated at a very personal and profound level for Indigenous peoples within the construct of their family and community, social and cultural worlds.

Concluding remarks

This chapter probably only ripples a section of the surface of a very large and very deep pond. Nevertheless, we hope it provides the basis for discussion about the way forward on a very important set of issues. There is no clear map in relation to this way forward, even in theory. This is because the social processes to which we draw attention are dynamic, shifting and interrelated—also, because the methodological innovations we propose involve a great deal of 'learning by doing'. This chapter, in short, is a series of questions rather than a set of answers.

Nevertheless, we *do* make one firm proposition: that until Aboriginal health research engages with social and cultural process in appropriate ways at both the theoretical and methodological levels, we have no prospect of understanding (and less still of *altering*) the social determinants of chronic disease and injury among Aboriginal people. The big question is how we learn collectively to integrate the social with the biomedical.

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Chapter 16:

Culture in Health Research and Practice

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Introduction

People's concepts of health and illness relate to their ways of being in the world. The Western mind reifies ways of being and knowing as 'culture'. However, cultures are not *sui generis* and independent of socio-political and economic practices. Ways of being and knowing are continually subject to innovation and change. The term 'culture', like that of politics or economics, is a product of a peculiarly Western compartmentalisation of life. Because 'culture' is not separate from socio-political practices and trends, it would perhaps be better to talk of socio-cultural determinants of health and illness. Traditionally, Aboriginal views of health and illness derived from hunter–gatherer ways of being, and Western views derived from industrialised and post-industrialised city-state and nation-state cultures. Although Aboriginal and Western people today inhabit common space and time, in northern Australia there are major differences between Aboriginal concepts of health and illness and Western health professionals' views (Cass *et al*. 2002; Devitt & McMasters 1998; McDonald 2006b; Trudgeon 2000).

Within public health practice, the role of culture has largely been confined to the production of negative stereotypes and lists of health risks and behaviours (Brough 2000). These limited understandings support racist assumptions, which fail to acknowledge the reality of 'culture' as lived experience (Bhopal 1997). The literature around social determinants of health, including cultural identity, social status, social exclusion, support, isolation and autonomy, suggests the need within public health to understand the concept of culture more dynamically. In urban settings, supporting and strengthening cultural identity has been identified as an important factor in improving Aboriginal health (Bond 2003). This chapter examines the relationship between culture and health in Western and Indigenous health research and practice.

The concept of culture

In the mid-nineteenth century research into contemporary human societies diverged from social philosophy and natural history. Economics, political science, sociology and anthropology emerged as highly specialised and narrowly defined academic disciplines with claims to scientific status. They carved out distinct academic domains for themselves, with separate modes of inquiry, methods and goals (Acker 2005). American anthropologists adopted the notion of ‘culture’ from the German Romantic tradition and developed it into a theoretical concept, displacing more fluid concepts such as ‘customs’ and ‘practices’. Boaz, reacting against evolutionary theories of human societies, promoted ahistorical studies of small-scale societies that were believed to live within bounded cultures (Stocking 1996).

Geertz (1973) shifted the theoretical focus from ahistorical cultures to human agency and creativity. Humans do not simply transmit culture but create meanings and generate new cultural practices through social interaction. Sahlins’ historical anthropology and Wolf’s (1982) Marxist historiography swept away the notion of self-contained, integrated cultures uncontaminated by world history (Whitehead 2004). Gramsci and Foucault brought the issues of power and hegemony into theoretical focus (Woost 2005). For Clifford and Marcus (1986) culture is composed of dynamic and contested codes. Cultural practice, and ethnography, are political and ethical, and are as much processes of invention as of description (Szczelkun 2002).

‘Culture’ remains a core concept in some fields of anthropology, but it has lost its foundational power. As a theoretical concept, it has become as slippery as ‘identity’, which shifts and changes according to context (Szczelkun 2002). However, the concept of culture has spilled over into other disciplines including history, sociology and social work. It has emerged within diverse discourses including Indigenous discourses (see Committee on Indigenous Health 2002). Some theorists would do away with the concept altogether, as it has become more of a liability than an asset (Park 2005). For others, it is now such a ubiquitous term that they must continue to engage with it.

Health systems as cultural domains

Western medicine claims to be neutral, disinterested, abstract and objective. However, Australian health services and programs derive from Eurocentric forms and practices. The majority of health administrators and medical practitioners are white. The biomedical model appears monolithic and objective; its historically and culturally contingent nature is concealed (Coulehan *et al*. 2005). Western healthcare providers are seen to be the norm and the recipients of services are believed to be deficient in knowledge and practice. Target groups are seen as needing help from the mainstream. Indigenous people in particular become objects of power and the objects of services, while the cultural norm of whiteness is ignored (Shore 2000). Eurocentric structures and programs marginalise Indigenous cultural practices. By providing only a Western understanding of health, illness and treatment, Indigenous people are made strangers to their experiences of sickness and health (Heil 2003; Paul 2000).

Airhihenbuwa (1995) argues that health practitioners and researchers should be educated to recognise the cultural dimension in health for all people regardless of ethnicity. Health professionals can become aware of the cultural paradigms that underlie health programs, and understand that their cultural values influence their own attitudes and actions. Australia’s Eurocentric heritage imposes barriers to information-exchange with people of other cultures. Health education does not have to be equated with Westernisation or whiteness (Loustanau & Sobo 1997; Lupton 1995; Taylor J. S. 2003; Wright & Treacher 1982).

In some Aboriginal Medical Services (AMSs) community control is well developed and there is commitment to Indigenous cultural values at all levels of service delivery. Poliness (2004) says that at Wurli Wurlinjang, the Aboriginal health service in Katherine, unlike most general practice, clinics do not run to timed appointments. Rather, the doctors, patients and health workers work together to build relationships and help solve underlying problems. Aboriginal health workers see patients first, before inviting the doctor to come and join them as part of the treatment team. Aboriginal health workers focus on the spiritual and cultural wellbeing of patients, not just their physical problems. Their unique insight into community life plays a critical role in helping doctors understand patients’ illnesses. However, this service did not use Aboriginal health interpreters.

The Aboriginal Medical Services Alliance, Northern Territory (AMSANT), the peak body of the Aboriginal community-controlled health services in the Northern Territory, believes that the community-controlled model delivers a critique of Western medicine and the relations of power and authority between the patient and healthcare provider. In the AMSANT services the role of non-Aboriginal health staff is consultative rather than directive (AMSANT 2001:6). However, in some AMSs, community control, Indigenous involvement in management processes, commitment to Aboriginal cultural values, and development of shared understandings of health and illness are not well developed:

> *When I first came here I got told by the management that we were to hover in the background. I was told to let the Aboriginal health workers do all the basic care and they would come and see and consult with me if they feel they need to. Alright I was doing that. Then at the last meeting the health workers said, 'Oh, we want the Sister right next to us all the time'. But I have found that when I am in that clinic, nine times out of ten the health workers disappear. You can't find them (Nurse practitioner, in Cramer 2005:185).*

Recommendation: Aboriginal health workers and nurses from AMSs, such as the above, should spend some time in AMSs such as Wurli Wurlinjang, perhaps in the context of an exchange program, to observe and participate in the community-controlled model of health services management.

Culture in architectural design

Western architectural values are encoded in Australian hospitals, medical centres and health clinics. Australian health institutions are white intellectual spaces. The organisation of space in buildings sends crucial messages to clients regarding power relationships. As yet, few Aboriginal community-controlled health organisations have managed to influence architects to design AMS facilities in ways that reflect Aboriginal cultural values. Nunkuwarrin Yunti AMS in Adelaide is a custom-built Aboriginal health centre. A number of community-based clinics that were built after consultation with local people provide culturally appropriate features such as separate men's and women's entrances and areas. Some mainstream health clinics provide an outdoor circular sitting area around a fireplace in order to make Aboriginal clients feel comfortable. However, the majority of AMS buildings in Australia reflect hierarchical Western values. Space is sharply demarcated to protect medical specialists from the masses and to allow for privacy in the health provider–client relationship. A reception desk is normally positioned between sick people and the doctors' rooms. Receptionists face the crowds and organise them into controllable units to present to the doctor. However, in remote areas, an important cultural factor in the healing process is not privacy in the doctor–patient relationship, or patient confidentiality, but community witnessing.

Witnessing is more than attesting to events. Witnesses consent to, and participate in, a performance (Sansom 1980:96–102). Healing events require witnesses to ensure that the healer performs his or her task correctly and does not harm the patient. If things go wrong, and the patient is harmed, the witnesses will be implicated in the blame because they did not intervene to save the patient. Both healer and witnesses are required to constitute the healing performance (McDonald 2006a). For Minyintiri, an Anangu traditional healer, '[Nurses and doctors] work inside the clinic buildings inside private rooms, so I can't say what they do. Their work is hidden' (Minyintiri, in NPY Women's Council 2003:25). In some remote community clinics, Aboriginal people are able to be witnesses to healing practices despite the architectural construction of the healthcare facility:

> *People all come in at once and crowd into the clinic. I thought, 'Hang on a minute, there is a waiting room'. No-one wanted to leave and wait in the waiting room. So I saw them one by one while they all sat together (Nurse practitioner, in Cramer 2005:99).*

In matters of sexual health, however, Western codes of privacy and patient confidentiality are valued.

Memmott and colleagues (Memmott & Reser 1998; Memmott & Eckermann 1999) suggest that designers of Aboriginal public buildings work with culturally specific design knowledge based on Indigenous socio-spatial principles, preference for external orientation, concepts of respect and privacy, and values and attitudes about shared space. Aboriginalising of healthcare facilities can be directed and monitored by Indigenous community members. Indigenous involvement in architectural brief preparation can be drawn from Indigenous organisational representatives, local leaders, health staff and client representatives. In remote areas special care needs to be taken with the location of mortuary facilities. In Alice Springs many old people are reluctant to enter the hospital because of the collective presence of spirits of the many people who have died there.

Whiteness studies

Whiteness studies can contribute to an analysis of health systems as cultural domains. Whiteness operates as a social norm in Australia. This is the basis of its power (Shore 2000). White professional discourses, including discourses about Indigenous health, conceal white privilege and are complicit in perpetuating racial inequality. One of the insidious properties of the dominance of whiteness, and of white racial privilege in Australia, is its structured invisibility (Stephenson 1997). Whiteness studies investigate the economic and political histories behind the invention of whiteness. The purpose is to expose this fiction, to deconstruct the notion of a 'white race', and to make visible the history and practices of white superiority found in social life and institutions.

Whiteness studies (Moreton-Robinson 1999, 2000, 2001; Nakayama & Krizek 1995; Shore 1998, 2000) have been readily taken up by education and feminist researchers as a way to critique their disciplines and practices but not, thus far, by health researchers. This is a potentially fruitful area of research and one that could increase our understanding of Western institutions as cultural domains.

The biomedical model

The biomedical model of illness and healing is assumed to be cultureless (Taylor, J. S. 2003). However, Heil's (2003) research shows that the biomedical ideology is based on Western concepts of the self, that is, on the self-contained individual who is defined independently of family or community. This notion of the self influences the planning and delivery of Western healthcare. Treatment regimes are designed for patients who prioritise individualised bodily health over social health. In central western New South Wales, Aboriginal people have difficulty adhering to individualised treatment and preventative health programs. Health practitioners complain that Aboriginal patients do not look after their bodies and do not comply with healthcare recommendations. Disjunctures between biomedical requirements and Aboriginal compliance are grounded in the relational nature of Aboriginal cultures (Heil 2003).

Aboriginal people in many parts of Australia espouse a relational–moral aetiology of illness (McDonald 2006a). But the biomedical model of illness strips away social contexts of meaning and diminishes awareness of the socio-political causes of disease. Complex social and moral processes are reduced to narrow cause-and-effect relationships (Mishler 1981; Riessman 1989:193). Diseases are interpreted in terms of a mechanical aetiology. The biomedical model privileges the health professional as expert on the patient's health and teaches diagnosis and treatment in isolation from wider social, historical and politico-economic considerations (AMSANT 2001:6) Health professionals, who work within a biomedical framework, tend to ignore global relational–moral causality, for example, the effects of economic globalism, world trade agreements and neoliberal politics on Indigenous people's health.

Racist attitudes within health services

Contemporary Australia was formed by colonisation, and racist ideologies were used to rationalise Indigenous dispossession and displacement. Racism involves the practices of exclusion, oppression and marginalisation, as well as the stereotypes and symbols required by these processes (Stephenson 1997). Institutional and structural racism manifests itself in the laws, policies and practices of governments, institutions, public service sectors and transnational organisations. In Western countries political elites lead the way in articulating racist discourses against otherness (Wodak & van Dijk 2000). The Australian Government and dominant political forces are currently in breach of the International Convention on the Elimination of All Forms of Racial Discrimination (Malezer 2004:9).

Institutional racism

Institutional racism consists of the organisational policies and practices that reflect the cultural assumptions of the dominant group. These policies and practices serve to advantage the dominant group while disadvantaging and marginalising others. The practices of the dominant group, which are sanctioned by political elites, are seen as the norm to which other cultural practices should conform. In Australia, Western culture is taken to be the norm against which other cultures and practices are measured. Institutional racism in this way becomes hidden and subconscious even to those who practise it. Anti-racist education is needed to expose hidden and subconscious racist practices and to provide professionals with the intellectual tools to develop a critical understanding of their own cultural practices and values (RacismNoWay 2002).

Institutionalised racism in healthcare systems is characterised by inadequate funding for community health services, stereotypical views held by health professionals, language barriers, lack of cultural sensitivity and absence of cultural competences (Galabuzi 2002; King 1996). Institutional racism within Australian health services includes lack of interpreting services in regions where English is spoken as a second language, failure to fund cultural awareness programs for Western health professionals working in Indigenous communities, failure to give priority to preventative health programs in Indigenous Australia (that is, allocating the majority of funds to secondary and tertiary care programs), and failure of policy makers to incorporate health programs into community development and self-determination frameworks. Saggers and Gray (1991) argue that the emphasis on curative medicine is not only ineffective in combating Aboriginal ill health, but actually promotes it by diverting funds away from Aboriginal capacity-building and community development.

AMSANT (2001) found that some sections of the nursing workforce, including nurses' professional and representative bodies and individual nurses in remote communities, have been reluctant to acknowledge the greater authority of Aboriginal leadership to address Aboriginal health issues. Some nurses bring a paternalistic approach to their work with Aboriginal clients and attempt to undermine or obstruct the community's steps to take greater control. However, at the Council of Remote Area Nurses of Australia (CRANA) Conference 2000, CRANA responded positively to AMSANT's challenge to support the Aboriginal model of healthcare with a request to discuss opportunities for collaboration with AMSANT.

Intersectionality

Intersectionality has emerged as a research agenda mainly within Black Women's Studies (Corbie-Smith *et al*. 2000; Crenshaw 1996; Hine 1993; Zambrana 2001). Marginalised groups do not only inhabit racialised identities. They live at the intersection of multiple identifying factors, which serve to disempower them. These include race or ethnicity, language, gender, sexual orientation, educational achievement, socio-economic status, age or disability. Intersectional analysis is a way of understanding people's multiple identities, and the multiple forms of oppression that marginalised people attract. It is also a way of analysing the complexities of power relations. People can be both the oppressor and the oppressed. Intersectional analysis has yet to be taken up by education researchers or health researchers.

Colonised identities

Cultural identities are historical, fluid and dependent on context. As subjects we occupy different identities at different points of time (Hall, Held & McGrew 1992; Gergen 1991). We construct narratives of the self in order to produce coherent and continuous identities (Hall, Held & McGrew 1992:277). But colonisation and colonial attitudes freeze cultures. Cultures once fluid, alive and open to the future are classified, systematised and fixed through colonial interpretations. Colonisers, who by definition wield power, claim the central subject position in relation to Indigenous peoples and other minority groups. They take on themselves the task of defining the otherness of marginalised people.

Although Aboriginal people in Australia have successfully claimed the right to self-determine who is Aboriginal and to determine the basis upon which their claims are legitimised, descendants of colonisers who appear to be unaware of this legal change continue the task of defining who is and isn't an Aboriginal person. In the media and in some academic discourses, Indigenous people are classified according to an 'either/or' traditional versus contemporary dichotomy. In rural towns it is frequently stated that if Aboriginal people want the same material benefits as whites, they cannot make a claim for cultural distinctiveness and different cultural needs: Aboriginal people who use modern facilities cannot be traditional and cannot claim 'traditional rights' such as subsistence hunting of native animals. Aboriginal people find themselves to be too contemporary to be traditional, and too Indigenous to be modern (Stewart 2003). Stewart sees this project of defining and excluding as unfinished colonialism. An understanding of alternative modernities can help to break down the psychologically damaging traditional/modern dichotomy.

Indigenous modernities are not the same as Western modernity (Gaonkar 2001; Muecke 2004). Western modernity developed in the context of Enlightenment assumptions about autonomous personhood based on self-interest, private property and the social contract (Chakrabarty 2000:217–8). Indigenous modernities developed within the context of

European colonial domination, which negated Indigenous people's concepts of land tenure, relational personhood and forms of reciprocity. However, Indigenous modernities, both urban and rural, maintain distinctive meanings of 'family', childrearing practices, work practices, concepts of time, processes of decision-making and forms of sociality.

Marcus and Fischer (1986:78) encourage theorists to move away from:

> *measuring change against some self-contained, homogeneous, and largely ahistoric framing of cultural unit toward a view of cultural situations as always in flux, in a perpetual historically sensitive state of resistance and accommodation to broader processes of influence that are as much inside as outside the local context.*

Eckermann *et al.* (1992:109) believe that colonised Indigenous peoples need to develop a positive self-image to be able to function psychologically and socially. They need, above all, the power to define and organise their own cultural identities against white colonial and neo-colonial powers.

Social exclusion and inclusion

Galabuzi and Labonte (2002) describe social exclusion as the inability of certain groups to participate fully in civil society, to utilise public or social goods, and to participate in meaningful and economically viable employment. This inability relates to intersectional disempowerment. Social exclusion contributes to high health risks. Eckermann's (1977) study of a small Aboriginal population in rural southwest Queensland in the early 1970s found that about half of the adults drank to excess. She traced this to cultural exclusion and a socio-economic environment distinguished by few resources and unskilled or semi-skilled employment within an ever-growing atmosphere of chronic poverty. This was partially the result of restructuring of primary industries, which further restricted economic possibilities (Eckermann 1977, in Kunitz 1994:95). The social determinants of health approach needs to go beyond socio-economic measures to account for the health impacts of being excluded from the socio-cultural systems that facilitate access to economic and political resources.

Social exclusion of marginalised peoples has been intensified by the restructuring of global and national economies, the deregulation of markets, commoditisation of public goods, increased global migration, changes in workplaces towards flexible deployment, longer hours, work fragmentation, multiple jobs and non-standardised work, and the decline of the welfare state (Galabuzi & Labonte 2002). There are clear challenges here to health and education sectors in Australia, for example, the challenge to develop inclusive education and explore two-way (or intercultural) learning (Hooley 2002). Within the health sector, the development of Indigenous-specific health services and programs needs to continue and not be curtailed. Aboriginal community-controlled medical services today can learn from their thirty-year history. Organisations can develop more effective governance structures and community capacity-building within the broader struggle for Aboriginal self-determination (Martin 2004; Taylor R. C. 2003, 2004; CAEPR & Reconciliation Australia 2004).

Socialisation of health staff

Eckermann *et al.* (1992) attempt to make health professionals aware of their socialisation into professional roles by questioning the 'egalitarian principles' underlying the International Pledge and Hippocratic Oath; that is, the promotion of 'service irrespective of nationality, culture, creed, colour, age, sex, political or religious belief or social status'. Maori nurses in Aotearoa, New Zealand, suggest that this 'egalitarian' approach may 'harm the culturally different because they are different and they do have different needs' (Paige & Martin 1983, in Eckermann *et al.* 1992:163). When health staff members are encouraged to 'treat everyone the same', 'health' is defined by the dominant culture and it is the symptoms of the disease that are treated, rather than people. This contrasts with professionals who have developed the capacity to engage in intercultural dialogue and to switch between Western and Indigenous modes of knowledge and practice.

Winsor (2001:7) sees lack of respect as the basis of 'horizontal violence' towards Aboriginal health workers in mainstream health services. She talks of control, humiliation and denigration of dignity that routinely occur within the workplace, where other health professionals act as 'professional opponents and oppressors' (Winsor 2001:7). Winsor sees behavioural change as a requirement for equality in the workplace—the behaviours of co-workers must change to respect, and the behaviours of Aboriginal health workers must change to self-respect. Flick (1997) asks why the development of Aboriginal health worker training within Western individualistic career structures should be viewed as 'empowerment', and argues that non-Indigenous health professionals need to be educated about Indigenous relational values and paths to self-esteem.

Racism within Aboriginal community-controlled health services

Racism directed towards Aboriginal people is not only evident in mainstream health services—it is also expressed by Western professionals who work within Indigenous organisations. Racism within Aboriginal community-controlled health services tends not to be based on external appearances but on how far people's beliefs and values deviate from the Western norm. Western culture is taken to be the norm against which other cultures and practices are measured. In community-controlled health services, it is said that Aboriginal people do not have a work ethic, cannot keep appointments, cannot distinguish between work and leisure time, have no knowledge of bodily processes, and are hopelessly non-compliant with treatment regimes (Barker 2005; Cramer 2005).

> *People are shocking in their compliance with treatment regimes. They are just not willing to comply for whatever reason… There is still the expectation that the clinic will fix it… We are still here to pick up the pieces (Nurse practitioner, in Cramer 2005:123).*

Steffensen and Colker's (1982) study of Aboriginal women's compliance with treatment regimes shows that the absence of shared concepts between practitioners and patients may impede even willing compliance. When patients do not possess the background knowledge, or schemata, undergirding the Western practitioners' conclusions and proposed treatment, they are unable to fully understand what is communicated because they lack the conceptual framework for integrating and holding the information presented. Coulehan *et al.* (2005) state that a basic premise of successful health service delivery is effective communication between health staff and patients to achieve shared understandings about health, illness and treatment goals. This will enable patients to make informed decisions about treatment options and compliance with therapies. Devitt and McMasters (1998:165) suggest that the less patients understand what it is they must do and why, the more compliance itself becomes simply an issue of obedience.

High turnover of health staff

Borland (2000), Hegney, McCarthy and Rogers-Clark (2002), Carruthers and Warr (2004) and Cramer (2005:67–70) discuss the high turnover of staff in health services in rural and remote Indigenous communities. The current system of selection, medical education and remuneration does not encourage medical practice in rural and remote Australia (Mara 1999). Remote area practice, in particular, reveals inadequate preparation of healthcare staff, poor staff coping strategies, burn-out and rapid staff turnover, and poor continuity of health programs (Wakerman 1999). The research of Hegney (1998), Cramer (2005) and Drury (2005) indicates that healthcare staff frequently lack awareness of the debilitating effects of colonisation, do not have skills in intercultural communication, and are inadequately trained in health services management, chronic diseases management and preventative health programs. High turnover of health staff in Indigenous health services has been identified as a form of racism (Kaul 2003). Staff members are continually in a learning phase, the wheel is continually re-invented, and health programs are continually disrupted (Bookallil, Chalmers & Bell 2005; Mak & Marshall 2003; Smith 1997).

Reducing high staff turnover is a challenging task, given the working and living conditions of community life (Bell, Daly & Chang 1997; Alcorn & Hegney 2000; Bradley & McLean 2000; van Haaren & Williams 2000; Hegney, McCarthy & Rogers-Clark 2002). Borland (2000) described the challenges that rural nurses face in the delivery of services—dispersed populations, diverse cultures, geographic isolation, harsh extremes of climate, poor infrastructure, problematic transport, small economic base and limited political clout. Five themes emerged from Drury's 2005 study of the experiences of rural mental health nurses: provision of community healthcare; isolation, autonomy and advanced practice; professional development and status recognition; educational support; and caseload numbers and composition. Studies by Borland (2000) and Drury (2005) validate the perception that rural and remote nursing offers few incentives and few rewards in spite of increased responsibility and accountability.

AMSANT (2001) believes that the high levels of disease and disability in Aboriginal populations need to be addressed through the provision of well-resourced primary healthcare services based in communities. However, Deeble (2003) found that most of the 1999 federal government funding for Aboriginal health was directed to secondary and tertiary programs, highly technological solutions and high-level aged care. Deeble calculated that funding provided to

Aboriginal health services should increase by $245 million. The Australian Medical Association (2004) estimates that an extra $400 million per year is necessary to improve primary healthcare for Aboriginal people. The extra funds are needed to employ and educate additional health staff to meet the critical shortage of health professionals working in Aboriginal health. Kunitz (1994) believes that the basic inefficiency at the heart of health service delivery to Aboriginal people is grounded in politics, and that conflicts between Commonwealth and state governments are primarily responsible for ineffective implementation of programs.

Cramer's (2005:226–7) research reveals that nurses represent the largest proportion of health professionals and provide the largest proportion of health services in rural and remote areas. On the Ngaanyatjarra Lands in 1999 nurses and Aboriginal health workers provided between 89 per cent and 98 per cent of all health services rendered. But nurses' perceptions of healthcare delivery are largely unrecorded and are overshadowed by medical views of 'Aboriginal health'. Nurses also do not feature as an expenditure on Aboriginal and Torres Strait Islander health services. Ignoring the services nurses provide independently of doctors, the report merely noted that 'without information on the full set of services available in every region it was difficult to draw conclusions' about their accessibility. Cramer asserts that this missing information needs to be collected in order to expose the failings of health services records.

Hanna (2001) reports that difficulties facing rural and remote nurses first emerged decades ago, and recent federal government rural health strategies promised improvements in health outcomes. However, close scrutiny of funding allocations reveals that although nurses provide the majority of healthcare in rural and remote regions, they receive only a small fraction of funding support. For Cramer (2005:227), elision of nurse practice in remote and rural health records is nowhere more apparent than in the disproportionate 'mismatch' between federal budget allocations for doctors in comparison with nurses. In the 2000–01 rural health budget, over 76 per cent of workforce funds was allocated to doctors for education and other incentive programs. Nurses were subsumed under 'Allied Health Services' and no funding 'specifically targets' nurse practice issues.

Recommendation: More research should be conducted into strategic approaches to recruitment and retention of rural and remote area health staff. Research should be conducted into recording procedures of health services and into funding allocations.

Anti-racist strategies

Decolonisation is not just for the colonised; the process must also include the coloniser (Kortright 2003). Health research can include analysis of politico-economic policies and practices that create excluded groups and conditions (Galabuzi & Labonte 2002). National and regional health offices can establish official policies on racism within health services and develop strategic plans to combat racism. Anti-racist strategies can be taught in cultural education programs for new health staff and focus on the dominant culture, on whiteness, institutional racism, intersectionality and social exclusion (Hollinsworth 1992; Razack 2002). Health policies need to be developed within a social inclusion framework and should focus on empowering marginalised people. CRANA's commitment to collaborate with AMSANT to support Aboriginal models of health in remote area nursing practice is an example of what can be achieved (AMSANT 2001).

Socio-cultural factors that inhibit the development of healthy behaviours and successful participation in healthcare delivery

Many health researchers locate the solutions to Aboriginal ill health in well-funded healthcare services. However, others such as Kunitz (1994), Robinson (1996), Sutton (2001, 2005) and Thomson (2003) argue that Aboriginal health issues are too complex to be tackled solely by the available range of healthcare services. Historical, socio-cultural and environmental factors, which are outside the scope of medicine, contribute to the development of Aboriginal ill health (Thomson 2003:493).

Much contemporary literature on the social determinants of health omits culture as a factor that may work synergistically with other social determinants to perpetuate ill health. In his discussions on the social determinants of health, Marmot (2001, 2004) focuses on socio-economic factors, particularly social position and household income. People with low control over their life circumstances at work and in daily life have a higher incidence of metabolic diseases such as diabetes and cardiovascular illness. Marmot sees Indigenous peoples primarily as a socio-economically disadvantaged group. Policy makers, likewise, tend to treat Australian Aboriginal people as blank slates and do not take into account cultural difference or cultural dissonance with Western institutions.

Kunitz (1994:187) argues that Aboriginal people are not just an oppressed people who are victims of poverty and prejudice: they are a people with distinctive cultural practices that were developed in hunter–gatherer environments, but which in different environments can contribute to ill health. Sutton (2001, 2005) believes that the serious health problems faced by Aboriginal people arise from a complex conjunction of pre-colonial socio-cultural factors, including a kin-based economy, gender relationships and childrearing practices, with colonial and neo-colonial factors such as population density and the easy availability of alcohol, tobacco and other drugs. 'Culturally embedded behaviours' that directly impact on Aboriginal people's health include domestic sanitation and personal hygiene, housing density, diet, care of children and old people, conflict resolution, social acceptability of violence, cultural expression of emotions, the value placed on physical wellbeing, attitudes to new knowledge, and attitudes to behavioural change (Sutton 2005:2). The *Report of Uwankara Palyanyku Kanyintjaku* identified nine healthy living practices that need to be implemented to improve Aboriginal health in desert regions: washing people, washing clothes/bedding, removing waste, improving nutrition, reducing crowding, separating dogs and children, controlling dust, temperature control and reducing trauma (Nganampa Health Council, South Australian Health Commission & Aboriginal Health Organisation of South Australia 1987; Pholeros, Rainow & Torzillo 1993).

Marmot (2001, 2004) and other health researchers state that the social conditions associated with the best health are those of white, middle-class people. Sutton (2001:137) appears to believe that Western practices and values are better (or more healthful) than Indigenous ones, and that Indigenous people need to make 'deep cultural changes' in order to catch up. Sutton (2005:9) endorses Pearson's (2004) suggestion of sending children away from their home communities to urban regions, in this case to learn a different 'health culture'. What these statements ignore, and even conceal, is that the health problems endured by Aboriginal people are the direct outcome of agricultural, industrial and post-industrial practices. A nutrient-dense hunter–gatherer diet fits all the requirements for the prevention of diet-related chronic diseases (O'Dea 1994). Hunter–gatherer diets are advocated today as therapeutic diets for people at risk of diabetes and vascular disease (Eaton, Shostak & Konner 1988; Washington 1994; Cordain *et al*. 2002).

The health of Aboriginal people has been undermined by the nutrient deficiencies and infectious diseases of land-clearing agricultural societies and by the diet-related chronic diseases of industrial and post-industrial societies. Agricultural development is everywhere linked to decreasing average height, increasing obesity and a decline in overall health. The agricultural industry, developed to increase food production for increasing human populations, has had an adverse effect on human health and vitality (Cassidy 1980; Boustany 1999; Wadley & Martin 2000). The raison d'etre of the global food industry is no longer feeding the masses, but making large profits for the few (Paul & Steinbrecher 2003). Harris and Seid (2004:248) found that neoliberal politics, trade liberalisation and deregulated markets have led to unemployment, environmental degradation and health decline in economically deprived regions. Research by Hawkes (2002) and Morelli (2003) shows that healthy eating programs are undermined by the global food industry, which directs marketing particularly to children and teenagers. The global marketing of unhealthy food, tobacco and alcohol penetrates Third and Fourth World communities, and there is pressure on young Aboriginal people today to conform to a global fast-food culture (Kouris-Blazos & Wahlqvist 2000; McMurray & Smith 2001).

White middle-class people with high educational levels and high incomes are able to take advantage of health promotion messages about immunisation, quitting smoking, taking daily exercise and eating healthy diets. People who hold liberal atomistic models of human agency (that is, the perception that moral agents can act in isolation from others and are limited only by their own values and capacities) are able to prioritise individual bodily health over social wellbeing (Donchin 1995; Heil 2003). They avoid the diseases created by agricultural, industrial and post-industrial technologies by practising excessive personal hygiene, personal diet and exercise regimes, by not smoking and by drinking in moderation. Middle-class people keep their minds and bodies healthy by adopting the city-state virtues of reason, efficiency and moderation (Prior 1991:195).

Biomedical treatments are also tailored to the requirements of atomistic, self-motivating individuals. Chronic disease self-management programs are articulated in terms of future-oriented, goal-directed individuals who adhere to an ethic of delayed gratification (McDonald 2006b). However, rather than trying to turn Aborigines into white people, Western health professionals can learn to value and work with relational cultures. This valuing has already begun in some theoretical disciplines. Recent feminist work has moved away from a focus on individual autonomy towards a view of human action made meaningful through social engagement. An understanding of relational autonomy requires a focus on the importance of supportive social conditions for fostering human action (Sherwin 1998). Aboriginal families can follow the *Report of Uwankara Palyanyku Kanyintjaku* recommendations through community-based rather than individualised healthy living practices. Rather than expecting household heads to buy and maintain technologically complex equipment, Aboriginal cooperatives can run not-for-profit community facilities such as laundromats that include disinfecting facilities. Aboriginal cooperatives can also run not-for-profit cafes to sell healthy stews and soups at lower prices than commercial take-away food outlets.

Recommendation: Research should be conducted into the feasibility of developing or extending not-for-profit community facilities in order to implement the healthy living practices recommended by the *Report of Uwankara Palyanyku Kanyintjaku*.

In New South Wales the Aboriginal Employment Strategy, which began in Moree and has spread to other regional and urban centres, has the explicit goal of creating an Aboriginal middle class in regional and urban Australia (Dusevic 2005). The ability to generate a good income and standard of living, along with a sense of pride in one's talents and creative energies, does not have to equate with atomistic individualism. Collectivist cultures manage hygienic regimes and nutritional practices as well as individualistic cultures. Kim and Park's 2005 research shows that relational efficacy and social support received from significant others have a strong influence on human motivation, wellbeing and personal accomplishment in relational cultures. Whiteness studies can help people to make a critical distinction between middle-class attainment and whiteness (Moreton-Robinson 2001).

Time and sociality

In many parts of Australia Aboriginal people's cultural imperatives relate to particular concepts of time and forms of sociality. A Northern Territory man told Jordan (2005:99), 'We're not like you Balanda [white people]. You drink a little bit everyday, but we Aboriginal people don't do that. We drink it all at once and get full drunk. We're different.' Phillips (2003:20) stated that in a north Queensland community, Aboriginal people who drink alcohol tend to be binge-drinkers. They join grog parties and frequently drink for up to four to seven days at a time (Phillips 2003:45). Turner and Graham's (2005) survey of Aboriginal people living in Kakadu National Park found that food and drink coming into households was consumed relatively quickly, and a large proportion of the population went without food for a twenty-four hour period in the preceding week. Aboriginal people's use of food, alcohol, tobacco and other drugs reflects a temporal system in which the rewards of immediate consumption outweigh future adverse health outcomes.

At Murrin Bridge in central New South Wales, binge-drinking has been incorporated into notions of sociality and conviviality. 'Being on the grog' is 'good fun' and 'enjoyment'. People who decide to stop drinking, and move to another town to facilitate this, are considered to be 'not one of us' (Heil 2003:166, 206). As a result of shared identity and feelings of empathy between kin, family members often provide excessive drinkers with protection and support, and do not show disapproval towards their behaviour (Brady 2004). Parents supply teenage children with money for marijuana, saying, 'They are my blood. I have to help them out.' Help is seen in terms of short-term relief of stress, rather than in terms of the long-term adverse effects on health. O'Connor (1984), writing about alcohol use in Central Australia, argued that the priority of relationship is evident in decisions to keep drinking even when it causes ill health. If a choice between biological death and social death must be made, many people will choose biological death.

In some communities Aboriginal people do stop drinking by joining an honorary kin group such as the 'Church mob'. The decision to stop drinking may relate to a doctor's advice (Brady 2002) or it may relate to the person's family circumstances, for example, the desire to nurture young grandchildren. The person's individual decision to stop drinking needs to be nurtured and legitimised by a wider group. Kinspeople say of non-drinkers, 'The Church can't let them drink'. This is an acceptable explanation because it does not violate notions of kinship and social obligations.

The kinsperson is not saying, 'I won't drink with you'. Rather, the Church is saying, 'You can't drink with them'. Solutions to harmful drinking practices may be found in creating other kinds of honorary kin groups to support people who choose to stop drinking (McDonald & Wombo 2006).

Recommendation: Research projects should be developed to look for ways to 'work with' Aboriginal cultural practices and values, for example, working with kinship networks to discourage alcohol and substance use.

Childrearing practices

Aboriginal people in many parts of Australia adhere to permissive childrearing practices that worked well in hunter–gatherer times and that are humane in comparison with Western disciplinary practices. Traditionally, there were 'no recriminations for disobedience; in fact, there is no idea that a child should obey, for in the normal course of life, the child will do what he wants' (Hamilton 1981:78). Parents trusted the country (and the ancestors) to look after children and trusted their children to learn from their experiences. The land itself nurtured children by providing food and shelter. Aboriginal children were taught to be self-reliant and physically autonomous from a young age. Children learned by observation and imitation, and by trial and error. They learned many things about the world from peers rather than from their parents (Hamilton 1981; Tonkinson 1991:82–6; McDonald & Wombo 2006).

Boustany (2000:5), writing of Koori childhood in the Northern Rivers region of New South Wales, says that a 'sense of independence is strongly encouraged from childhood and Koori women will not molly-coddle their children as in western culture'. Urban Aboriginal and non-Aboriginal people stereotype each other's childrearing practices rather than trying to understand cultural differences. Urban Aboriginal people say that white children are babied by their parents and carers. Westernised people say that Aboriginal parents do not discipline their children. Western childrearing practices, which can be traced back to militarised city-state and nation-state cultures, would not prepare children for a self-reliant hunter–gatherer life. Likewise, permissive childrearing practices do not work well in a Western environment with institutions that are highly regulated and disciplinary, which promote an industrial work ethic, adhere strictly to the notion of working days and working hours, and run on clock time (McDonald & Wombo 2006).

Today in many parts of Australia, Aboriginal parents still trust the environment to provide for their children and trust their children to learn from their experiences, but the environment is no longer benign. Many parents are unable to provide parental guidance to their children because they have been unable to achieve a good life for themselves. Some parents are unavailable to their children because of their dependence on alcohol and other drugs (McDonald & Wombo 2006). The Kimberley Aboriginal Medical Services Council Health Promotion Unit and Social and Emotional Wellbeing Unit have made parental guidance and encouragement of children a high priority. The central theme, 'Children—Praise Them Up to Raise Them Up', is being promoted to Kimberley communities, parents and children (KAMSC 2005).

Recommendation: Collaborative research with Aboriginal psychiatrists, psychologists, doctors, nurses and health workers should be carried out to develop Indigenous parenting and family wellbeing programs that 'work with' Aboriginal childrearing practices to foster a strong sense of Aboriginal identity in young people and develop their ability to thrive (and to avoid the pitfalls of substance misuse, violence and legal-system entanglement) in the contemporary world. Mentoring programs for young people should be developed to help broaden young people's horizons and empower them to make life choices that will benefit themselves, their families and communities.

Colonial legacy

Phillips (2003), an Indigenous health researcher, has found that poor healthcare delivery in a north Queensland community reflects the legacy of colonisation—the community's relationship with the Church; factionalism between different landowning groups living in the community; factionalism between Community Council and health staff, which inhibits the development of creative solutions to community problems; and the failure to decolonise Western theoretical frameworks (Phillips 2003:115–17; 126–9). Other factors mentioned by Phillips include the role of kinship in taking up and continuing alcohol, tobacco and other substance use (64–6), and children's normalising of dysfunctional behaviours, for example, children imitating adult card playing and fighting (55, 77) and children playing with ropes around their necks following a community suicide (160).

Recommendation: Community-based collaborative research should be carried out to explore solutions to the problems identified by Phillips.

Pentecostal churches and provider–client relationships

Some Pentecostal churches in northern Australia inhibit successful Indigenous participation in health service delivery and contribute to Indigenous people's high mortality rates because pastors insist that God does not want people travelling to large metropolitan hospitals to undergo major operations such as kidney transplants. God wants to heal them in their own environment and without human intervention to demonstrate to Aboriginal people his supernatural power. Pastors make extravagant claims during healing sessions that the sick person will never again need a wheelchair, dialysis tubes or insulin. They claim that, 'God is at this very moment fashioning new kidneys for [the sick person] with his own hands' (McDonald 2001:143).

In many parts of Australia, Aboriginal people's cultural values are strongly egalitarian. Aboriginal people do not accept a hierarchical, authoritarian relationship between health practitioner and patient. Doctors are considered to be authoritative but fallible, and sometimes not to have the interests of their patients at heart. Many people do not feel any compulsion to give the doctor an accurate account of their diet and lifestyle and do not feel they must pay attention to the doctor's advice. In the provider–patient relationship, Aboriginal people see themselves as having a choice (McDonald 2006b). For Humphery *et al*. (2001), medical debates about patient compliance are inappropriate in a post-colonial era. The *Sharing the True Stories* project emphasises the need for health professionals and Indigenous clients to develop shared understandings of health and illness, thereby enabling Aboriginal people to exercise more control in their healthcare (Coulehan *et al*. 2005).

In northern Australian Indigenous communities, Aboriginal assimilation of Pentecostal messages about healing, resistance to hierarchical provider–patient relationships and a one-way flow of health information and health professionals' cultural knowledge deficits have contributed to many unnecessary deaths.

Ways to work with 'culture' to contribute to improved Indigenous health outcomes

Health promotion

Much mainstream health research has viewed cultural difference as an impediment to good health (Bond 2003). However, the Geneva declaration of the health and survival of Indigenous peoples affirms that cultural identity and expression is essential to a people's wellbeing (Committee on Indigenous Health 2002). In health promotion programs, a one-way flow of information from Western health professional to Indigenous patient is a form of institutional racism. If we do not explicitly take into account Indigenous beliefs and values, we are in fact excluding them and diminishing their value (Garcia 2001:15). Using Indigenous concepts and practices in health promotion programs can contribute to the decolonisation of Western medicine in Indigenous communities (Garcia 2002).

For Aboriginal people in many parts of Australia, sickness is perceived as coming from malignant outside forces or antisocial actions. In health programs it is helpful to view chronic diseases as coming from outside forces, for example, the effects of colonisation, and to speak in terms of tools to overcome these effects (Heffernan 1995:284). Cultural understandings, such as Aboriginal concepts of strength and weakness, heat and coolness, and flow and blockage, and cultural images of good lives and strong bodies can be developed to promote a sense of control over the disease. Aboriginal notions of strength (versus weakness), movement (versus stasis), coolness (versus heat) and flow (versus blockage) can be used to humanise Western physiology and produce health programs that are meaningful to Aboriginal people (McDonald 2006b).

HEATworks (Health Education and Theatre Works) is a Kimberley Aboriginal-controlled health promotion performance group. It uses writers, actors, musicians, singers and Aboriginal advisers who work within an Indigenous culture of oral transmission of knowledge. The group writes dramatic stories to help people identify with the characters and their problems. Health information is presented within 'real life' contexts. HEATworks has worked on Aboriginal youth anti-smoking campaigns, condom promotions, HIV/AIDS workshops, pap smear awareness programs, environmental health projects, NAIDOC Week programs, self-esteem workshops and health music concerts. The group has performed *No Prejudice, A Change of Heart, It's a Crab's Life, The Good Feeling* and *Moving Stories* (KAMSC 2004).

Health practitioners frequently find that Aboriginal people can repeat information about good nutrition and appropriate diets without feeling any compulsion to change their food choices (Harrison 1991:163; Cramer 2005:120–21; Saethre 2005). Health educators can engage with Aboriginal concepts of desirable food in order to counteract the aggressive marketing of the global food industry. Aboriginal people's love of sweet plants and fat grubs and animals is well known (Green 2003). When these food preferences coincided with energy-dense but nutrient-poor rations on pastoral and mission stations, metabolic disturbances occurred, leading to the current epidemic of diabetes and vascular disease. Health promotion messages can 'work with' Aboriginal people's food preferences by making a distinction between naturally sweet foods and artificially sweetened foods, or between sweet plants from the ground and sweet food made in factories.

If health education is taken out of a narrow biomedical framework, which focuses on micro-level bodily functions, it will become more accessible to Aboriginal people. Chronic diseases can be discussed within a larger socio-political framework, for example, their origins in agricultural practices and their intensification in industrial and post-industrial practices. Health programs can be developed within a framework of community empowerment to explore the relationship between globalisation and the increasing incidence of chronic diseases in economically deprived regions (Braithwaite & Lythcott 1989; McDonald 2006a). Community empowerment programs can explore ways to offset the negative impacts of globalisation on community life (McDonald & Henderson 2005).

Provider–client relationships

In Western countries over the last three decades the doctor–patient relationship has become an important focus of research attention. This relationship has evolved from a paternalistic model, where patients' preferences were generally ignored, to a current model of relative patient autonomy. The medical interview, the means by which the doctor elicits a patient's medical history, has been subject to scrutiny by social scientists (Haidet & Paterniti 2003; Roter 2000). In medical schools doctors are taught to create good interpersonal relationships, and learn to develop empathy, respect, unconditional acceptance and mutual trust (Ong *et al*. 1995:904).

Research papers have been written on patient-centred interviews (Nagy 2001), narrative-based interviews (Haidet & Paterniti 2003), participatory communication (Khadka 2000), 'truth telling', 'enhanced autonomy' models, 'relationship-centred' models (Quill & Brody 1996) and shared decision-making (Dominick, Frosch & Kaplan 1999). Doctor–patient communication influences the patient's satisfaction with care, adherence to treatment, understanding of medical information, coping with disease processes and quality of life (Ong *et al*. 1995).

Provider–client relationships in Indigenous communities

A number of studies have shown that Aboriginal patients in northern Australia frequently express dissatisfaction with their medical treatment and with the behaviour of doctors and nurses. They complain that health practitioners ask too many questions during the medical consultation. Health experts should know the patient's condition (Watson, Hodson & Johnson 2002; Phillips 2003; Cramer 2005:60–5, 120). The fact that Western doctors must question their patients to diagnose an illness, while traditional healers can see what is wrong, reveals the superiority of traditional healers (Peile 1997:167). Aboriginal people are often dissatisfied with the explanations provided by health professionals, and do not believe they are being told the 'full story' or 'true story' (Reid 1983; Watson *et al*. 2002; Weeramanthri 1996). People complain that doctors send some patients but not others to large metropolitan hospitals for treatment. Family members fear that disclosure of a relative's poor prognosis will contribute to that person's premature death (Trudgeon 2000).

A study by Cass *et al*. (2002) of communication between health professionals and Aboriginal patients with end-stage renal disease in Darwin revealed serious miscommunication, often unrecognised by participants, regarding fundamental issues in diagnosis, treatment and prevention. Factors impeding communication included dominance of the biomedical model, marginalisation of Indigenous knowledge, lack of control by the patient, lack of shared knowledge and understanding, differing modes of discourse, cultural and linguistic distance, lack of staff training in intercultural communication, and failure to call on trained interpreters. There was an absence of educational resources and opportunities to construct a body of shared understanding, not only of body organ physiology and disease, but of the cultural, social and economic dimensions of the illness experience of Aboriginal patients.

Fenwick and Stevens's (2004) report on Aboriginal women's experiences of post-operative pain in a Central Australian hospital reveals that Western-trained nurses have a profound knowledge deficit regarding Aboriginal interpretations and management of pain. Central Australian Aboriginal women believe that nurses should know when patients experience post-operative pain. Nurses know when to give patients medication, when to give patients food after an operation and when to get patients up to walk. They should also know when patients are in pain. Because Aboriginal women did not communicate their experiences of pain to nurses, nurses fell back on the old misconception that Aboriginal people have a high pain tolerance requiring less pain relief.

Eades's (1985, 1991, 1994) research into information-seeking reveals that in Western contexts information is frequently elicited by asking one-sided questions. People who are seeking information do not need to provide information about themselves or their motivations. However, in Aboriginal communities, information-seeking is a two-way process, with the questioned and the questioner both contributing information. In many situations in Australia, white people in positions of power ask direct questions of Indigenous people in ways that are highly inappropriate to Indigenous ways of interacting (Eades 1994). During medical interviews, doctors frequently ask narrowly constructed closed-ended questions that require yes/no answers. Haidet and Paterniti (2003) suggest that doctors should use conversational devices such as orientation statements, paraphrasing statements, reflections and empathic statements to de-emphasise the interrogational nature of the medical interview.

Boustany (2000) advises general practitioners in the Northern Rivers region of New South Wales to encourage patients to tell their own stories, to allow time for responses and to allow time for silent contemplation. She has found that Aboriginal people prefer to deliberate rather than make immediate decisions. The process of information-seeking can be helped by explaining why health practitioners need the information. If health practitioners are unable to obtain the information they need, the patient may be happy for them to ask family members or involve Aboriginal health workers. There is a conception that illness takes over a person, and that sick people are not responsible for their utterances while ill, so some Aboriginal people would prefer a close relative to speak for them.

Health services directed at the level of family and significant others are more likely to be successful than initiatives focused solely at the individual level. Sansom's (1982) study of life-threatening illness in a town camp focuses on the community of suffering (those who mobilise around the sick person). Sick people are believed to be temporarily deprived of volitional control, that is, they are rendered passive and unable to speak for themselves. The healing process is seen as the community's responsibility, and caring and supportive relationships are crucial to recovery (Sansom 1982). Observation and feeling are important forms of communication, and empathy and sociality are valued aspects of the therapeutic relationship (Mitchell 1996:269–70). In contrast, people who suffer from minor illnesses, which are not life-threatening, are required to exhibit personal stoicism.

The *Sharing the True Stories* project, conducted with Aboriginal client groups and health staff in renal and hospital services in the Northern Territory, identified three key strategies for improving communication between health professionals and Aboriginal patients: increasing Indigenous involvement in overall management processes and in provider–patient encounters; constructing shared understandings of key processes and concepts in healthcare through a sustainable collaborative process involving health practitioners, researchers and clients; and improving communication practices through institutional support and strengthening individual expertise (Smith 2003:5; Coulehan *et al*. 2005).

Ariotti (1999) discusses the reconstruction and re-empowerment of Anangu people's understanding of disability through the work of the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council. Service providers work within a framework that sees 'disability' in relational terms and does not confine itself to the limitations and sense of loss experienced by individuals separated from community. Service providers accept the directions of, and priorities established by, the community, as it is the perceptions of individuals within community that determine how the services are provided.

Cultural education programs

Cultural education programs for Western health staff are carried out by a number of organisations Australia-wide (see the appendix for a list of programs). However, despite the number of cultural awareness programs that are available, many health services in rural and remote areas, including Aboriginal community-controlled health services, do not provide cultural education programs for new health staff. Puntukurnu AMS in the Western Desert provides no cultural education programs for health staff working with the 2000–2500 Mardu people who live at Jigalong, Parnngurr, Punmu, Kiwirrkurra and Kunawarritji communities (personal communication, Camplin, Puntukurnu AMS). Many small health services do not have the funding to send health staff to cultural education programs. Many health administrators see cultural awareness programs as an unnecessary indulgence. Many Indigenous communities are so desperate for health staff that new staff are put to work immediately without any kind of orientation (personal communication, McKay, CRANA).

Recommendation: The Office for Aboriginal and Torres Strait Islander Health should fund cultural education programs Australia-wide for new health staff working in Indigenous communities and in health centres that have a majority of Indigenous patients/clients.

Cultural competence

In Western countries, cultural competence training is promoted as a key tool in reducing health disparities between whites and minority groups. Training in cultural competency has been incorporated into undergraduate medical education in America and Britain. Culturally competent doctors learn to adjust their attitudes and behaviours to the needs of patients from different cultural backgrounds. However, a criticism of cultural competence education is that it tends to become a decontextualised list of traits about ‘exotic others’. This can promote stereotyping and essentialising. In many cultural competence models what is missing is an analysis of the power relations between health providers and clients, particularly clients who come from different cultural backgrounds (Fuller 2002:198–200; Hunt 2001:2). March’s (2005) study did not show any direct link between cultural competency training and improvements in the health of cultural minorities. Despite widespread popularity amongst Western health professionals, cultural competency remains a vaguely defined goal, with no explicit criteria established for its accomplishment or assessment (Hunt 2001). Far more rigorous testing is needed to show that the training does more than just facilitate better interactions between caregivers and patients (March 2005).

Cultural awareness

Cultural awareness programs should not just be about other people’s cultures. Cultural competence ideally includes self-reflection and self-evaluation. Western health professionals who work in Aboriginal communities can be given the intellectual tools to develop a critical understanding of their own cultural practices and values. Western concepts of the self, concepts of time and the work ethic are not natural, but are social constructs that have their own particular histories. Historical research reveals that in Western countries before the Industrial Revolution, agricultural workers controlled their own production, and set their own working hours according to seasonal requirements (Bader 2002). The industrial work ethic was developed to support unnaturally long working hours for small rewards. Key elements of the work ethic were diligence, frugality and deferment of gratification. Factory schooling emphasised punctuality, obedience and order (Mokyr 2003; Rose 1985). In the transitional period, women and children were chosen as docile and malleable labour because adult males were often unruly and intoxicated (Mokyr 2003).

Benjamin (1988) sees time, in Western modernity, as continuous, empty and homogeneous. Any number of people, places and events can be slotted into this infinitely stretched-out flow of time. However, in non-industrial societies, time is embedded in human labour practices and seasonal events (Chakrabarty 2000). With industrialisation, working time was separated from the time of everyday life. Industrial time could be quantified, regulated and managed (Gasparini 1993). The introduction of industrial time-discipline was not spontaneously accepted by the new industrial workers (Bader 2002). Transgressions were frequent in the transitional period and were harshly penalised by industrial managers (Hobsbawm 1999; Thompson 1967).

Intercultural health services

The Mexican National Campaign to enhance the quality of health services has in the last decade been developing intercultural health services. Interculturality is based on dialogue, where both sides listen to each other, where both sides exchange cultural information or simply respect each other’s peculiarities. An intercultural approach develops same-level (horizontal) relationships and promotes empathy, equal opportunity, empowerment, win–win relationships and synergy (attaining results that could not be achieved independently). Acknowledging and incorporating cultural beliefs about health and illness into the assessment, diagnosis, treatment plan and prevention strategies contributes to successful healthcare (Garcia 2002).

After twenty-eight years of linguistic, ethnobotanical and health-related research with the Kukatja people of the Great Sandy Desert, Peile (1997) found that abstract biomedical knowledge and contextualised Indigenous knowledges need not be incommensurable, and called for an integration of Indigenous and biomedical practices in health services. Sheldon, a psychiatrist working in Central Australia, found Western models of clinical examination and assessment to be deficient in relation to Aboriginal patients. In his practice he consciously blended Indigenous and Western therapeutic practices. He worked with traditional healers and adopted Aboriginal language concepts for mood and behaviour disorders. His work is being continued by the Sheldon Foundation (Sheldon 1997).

In the 1980s Devanesen and Soong encouraged the practice of 'two-way medicine' in Central Australian health services by combining the best of Western and traditional medicine. In practice, this included recognising the skills of traditional healers and traditional midwives. Traditional paintings and stories were used in health education, and bush medicines were documented (Devanesen & Briscoe 1980). The Northern Territory Department of Health supported a 'bicultural approach' to primary healthcare by employing a number of traditional healers who worked alongside Aboriginal health workers, nurses and doctors in Central Australian health services. Healers worked with traditional understandings of bodily processes and worked to redress moral imbalances, relieve stress and balance-up sick people (Soong 1983).

Intercultural health service is not just about facilitating the parallel use of two discrete medical systems, or about adopting best practices from two medical paradigms. It is about facilitating a creative dialogue between the proponents of two medical systems, which in most Aboriginal communities are no longer discrete. It is about engaging Aboriginal and non-Aboriginal health professionals, researchers and community members to work together to develop common conceptual frameworks around health and illness within which health practitioners and patients can negotiate comprehensible treatment regimes, chronic disease management programs and prevention strategies. Notions of social, relational and family efficacies can be developed to facilitate behavioural change. Family-based programs, which mobilise family support and encourage family-generated health strategies, are likely to be more successful than individualistic treatment regimes, chronic disease management programs and preventive health programs (McDonald 2006b).

Western health professionals who work in intercultural health services can be educated about the colonial history of Indigenous people in Australia. They can develop respect for Indigenous cultural values, different meanings of 'family', different childrearing practices, and different ways of expressing social and emotional needs. They can learn to work with Indigenous kinship networks, forms of sociality, concepts of time and decision-making processes (Hooley 2000, 2002; Maddocks & Rayner 2003). The provider–patient relationship can become a process of information sharing and negotiation. Western and Aboriginal health practitioners and researchers can develop collaborative approaches to treating and preventing illness that satisfy both Western and Aboriginal understandings of good health.

> *And when we get together, for this story called* Sharing the True Stories*—we talk together, and present mobs of our own ideas, we bounce them backwards and forwards, backwards and forwards, those Balanda [non-Aboriginal people] and we Yolngu. What they are thinking, and what we are thinking, then we reach agreement for that point. Then we are joined together. Our story becomes one (Yolngu health researcher, in Coulehan* et al. *2005:2).*

Appendix

Cultural education programs

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Conclusion

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Beyond Bandaids: Exploring the Underlying Social Determinants of Aboriginal Health draws together work commissioned by the Cooperative Research for Aboriginal Health (CRCAH) to support the development of a research agenda on the social determinants of Aboriginal health. In this conclusion, our aim is to give a brief description of the evolving policy and research context with which this research agenda articulates. The interest in research in this field has occurred within an environment of increasing focus on the development of capacity in the health system, and in governments more broadly, to respond to the significant disparities in Indigenous outcomes. In this conclusion, we describe how the social determinants of health are contextualised within Aboriginal and Torres Strait Islander health and research policy. We finish by placing these developments in a global context by reference to the work of the World Health Organization's Commission on the Social Determinants of Health (CSDH).

Social determinants within the National Strategic Framework for Aboriginal and Torres Strait Islander Health

The broad framework for strategy in Aboriginal and Torres Strait Islander health was first established in the National Aboriginal Health Strategy in 1989 (NAHS Working Party 1989). Since then, there has been considerable policy elaboration on various elements of this strategy, including a focus on developing the institutional framework to support the planning, coordination and delivery of strategies. In the decade following the transfer of responsibility from the Aboriginal Affairs portfolio (then the Aboriginal and Torres Strait Islander Commission) to the Commonwealth Health portfolio (now the Department of Health and Ageing), much of the focus in the development of institutional structures has been within the health system (Anderson 2002, 2004b; Anderson & Wakerman 2005). This has resulted in the development of high-level multi-jurisdictional agreements, the Framework Agreements for Aboriginal and Torres Strait Islander health, regional planning forums, a national Indigenous health performance measurement framework, and strategies to improve health data and the contribution of research (Anderson 2004a). New programs that aim to increase the capacity of Indigenous primary health care services have been implemented in parallel with these broader system reforms.

Strategies to address the social determinants of Aboriginal health have continued to evolve but they have been framed by a health system-centred approach. In the main, they have also been driven by knowledge, from other population contexts, about the relationship between social factors and processes in health. Institutional reform strategies have been based on policy constructs such as ‘whole of government’ or ‘seamless government’. Since the abolition of the Aboriginal and Torres Strait Islander Commission in 2004, a number of reforms have been initiated which, in part, aim to improve the policy and administrative coordination across Australian government Aboriginal programs. (Anderson 2006, 2007; Cunningham & Baeza 2005). The Council of Australian Governments has also initiated trials to investigate the development of integrated and flexible delivery of services for Aboriginal people in eight sites across the country. Each of these was led by a state and Australian government agency and the evaluation reports finalised in 2007 (Australian Government 2005).

However, these developments have, in the main, focused on broad-level policy connections. They have not been driven by analysis that problematises the possible conflicts between programs across different sectors. The assumption underpinning these reforms is that improved administrative and policy coordination will enhance the access and uptake of government services, which would in turn drive improved outcomes. The extent to which the design of programs in other sectors may impact negatively on Indigenous health (or fail to maximise health outcomes) is not central to these reforms.

National strategy has, however, consistently had some focus on the determinants of Aboriginal health. The *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (NSFATSIH) was signed off by all Australian governments for the decade 2003–2013 (National Aboriginal and Torres Strait Islander Health Council 2003a, 2003b). It has nine key result areas, which in summary are (Anderson 2004b):

- Building the capacity of community-controlled health services so that individuals and communities can better address and manage their own health needs.
- Improving the responsiveness of the mainstream health system to Indigenous Australians, and developing stronger partnerships between mainstream and Indigenous-specific services.
- Improving the training, supply, recruitment and retention of appropriately skilled health professionals, health service managers and policy officers in both mainstream and Indigenous-specific health services.
- Improving outcomes with respect to mental health, suicide, family violence, substance misuse and male health (through non-health sectors strategies).
- Improving the delivery of safe housing, water, sewerage and waste disposal.
- Undertaking action in portfolios outside the health sector and implementing health gain strategies in the areas of education, employment, transport, food and nutrition, custodial health, aged and disability services, recreation and exercise.
- Improving the quality of information about how well the health sector is meeting the needs of Indigenous Australians.
- Aiming to provide an optimal level of resources for Aboriginal health commensurate with levels of need, costs of delivering services and community capacity to deliver health outcomes.
- Strengthening accountability, both to communities and to governments, for the delivery and effectiveness of health services.

The NSFATSIH, details of which can be found in Box 1, has a focus on health system reform and improved access to health care. This is in it own right addressing a significant determinant of Indigenous health as we outlined in our introduction. In this strategy, it is environmental health (Key Result Area 5) and ‘wider strategies that impact on health’ (Key Result Area 6) that most clearly articulate how the other social determinants have been drawn into the national policy framework. There is a clear intersection of this policy agenda with a number of the papers in this volume. This is perhaps most evident in the paper by Wayte *et al*. (Chapter 7), which presents a ‘Framework for Research on Aboriginal Health in the Physical Environment’.

There are a number of papers that address those determinants of health that are influenced by other sectors of government. For example: Bell *et al*. (Chapter 3) and Askell-Williams *et al*. (Chapter 4) with education; Walter's paper on poverty (Chapter 5); Lowry and Moskos on the labour force (Chapter 6); and Reynolds *et al*. (Chapter 12) and Smith (Chapter 13) with respect to legal systems and process.

Two papers, in particular, address issues fundamental to broad strategy: Campbell *et al*. on 'Community Development and Empowerment' (Chapter 9), and Sullivan *et al*. on 'Governance, Indigenous and Non-Indigenous, as a Social Determinant of Aboriginal Health' (Chapter 10). Henderson *et al*. (Chapter 8) tackle another key result area in national strategy, social and emotional wellbeing, and reframe it as a social determinant of health. There are also a number of papers that extend the scope of the social determinants of health to areas beyond current strategy. Those that raise the issues of culture and racism, such as Morrissey *et al*. (Chapter 15) and McDonald (Chapter 16), are good examples of this. Brough *et al.* (Chapter 11) examine the relevance of social capital to this field. Finally, there are those that critically interrogate key constructs relevant to the field. Vickery *et al*. (Chapter 2) and Tynan *et al*. (Chapter 1) have undertaken work that points to a different way of conceptualising the social determinants that takes into account Indigenous cultural and intellectual frameworks. Bond and Brough (Chapter 14) critique the way in which culture is constructed in public health discourse.

Box 1

National Strategic Framework for Aboriginal and Torres Strait Islander Health and the social determinants

Environmental Health

… [The NSFATSIH] aims to improve standards of environmental health, including housing and essential services, in Aboriginal and Torres Strait Islander communities. This key result area emphasises the collaboration needed between ATSIC and a range of other Commonwealth, State, Territory and local government agencies and authorities in improving environmental health services to Aboriginal and Torres Strait Islander communities. It supports closer links between health services and environmental health services and emphasises that Aboriginal and Torres Strait Islander peoples are entitled to the standards of service and legislative protection enjoyed by the broader Australian community. To achieve this, more culturally appropriate models of service delivery may be required.

Objective

- Levels and standards of environmental health in Aboriginal and Torres Strait Islander communities commensurate with the standards of the wider Australian community including equitable access to an environmental health workforce.
- Reduced rates of environmental health-related conditions (such as respiratory diseases).

Wider strategies that impact on health

… [The NSFATSIH] aims to develop partnerships with, and obtain commitment from, other sectors whose activities impact on health. Some strategies for developing joint action are nominated. Priority is given to collaborative approaches in areas such as food and nutrition, child and maternal health, recreation and exercise, aged and disability services, education, employment, transport and prison health.

Objectives

- Effective strategies for improving health in Aboriginal and Torres Strait Islander communities in partnership with other sectors.
- Policy and program initiatives in primary and secondary education that contribute to improved outcomes for both educational and health goals.
- Partnerships that address key issues that impact on health, such as nutrition, recreation and transport.
- Policy and program initiatives and effective partnerships that address the needs of Aboriginal and Torres Strait Islander peoples in custodial settings, including health care delivery, health education and post-release programs.

Source: National and Torres Strait Islander Health Council 2003b

Research and Indigenous health

Since the mid-1990s, Indigenous health research policy has increasingly focused on the development of capacity in health research systems to address questions that will improve policy and service development effectiveness, ultimately contributing to improved health and social outcomes for Aboriginal Australians. Some of this effort has addressed the development of methods and processes to assist with priority setting in Indigenous health. An example of this is the development, by the National Health and Medical Research Council (NHMRC), of *The NHMRC Road Map: A Strategic Framework for Improving Aboriginal and Torres Strait Islander Health through Research* (Aboriginal and Torres Strait Islander Research Agenda Working Group 2002). Other strategies have focused on the development of capacity in Indigenous health research, both with respect to individuals and in relation to research policy and institutional structures. Critically underpinning these strategies has been some investment in developing the skills and experience of Aboriginal Australians in all aspects of the research process. The aim here has been to bolster the development of Indigenous-led or Indigenous-partnered research practice.

These approaches provide an opportunity, and an imperative, for the future development of a research agenda in the social determinants of Indigenous health that is relevant both to service delivery and policy development. The framework and priorities articulated in the NHMRC Road Map for Aboriginal and Torres Strait Islander health research are illustrative of key aspects of what has been called the Indigenous health research reform agenda. The Road Map is drawn together by a number of key principles that include a commitment to a construction of health in which health is conceived of as '… not just the physical wellbeing of the body but a whole of life view, which embraces the life, death, life concept' (Aboriginal and Torres Strait Islander Research Agenda Working Group 2002). The importance of the involvement of Indigenous Australians and their communities in the development, conduct and communication of the research is emphasised along with the effective communication of research plans, progress and results. The Road Map document also signals the importance of research support strategies that aim to enhance the skills, knowledge and capacity in the Aboriginal and Torres Strait Islander research workforce. Further, it articulates principles that commit researchers to 'ethical research aiming to be of practical value to Aboriginal and Torres Strait Islander peoples and their service providers', as well as 'a focus on identifying "positive models" or examples of success' (Aboriginal and Torres Strait Islander Research Agenda Working Group 2002).

The Road Map sought to outline some key, high-level priorities for the national research agenda (see Box 2). The social determinants research agenda intersects most clearly with Priority No. 4 which directs the focus of the research community to the 'association between health status and health gain and policy and programs that lie outside the direct influence of the health sector' (Aboriginal and Torres Strait Islander Research Agenda Working Group 2002). However, the social determinants research agenda intersects with a number of the Road Map priorities. Research that clarifies the relationship between social processes and health outcomes within the Indigenous context could make a significant contribution to the development of improved prevention strategies. In this volume, the work on culture, racism and health provides an important contribution to the development of this research agenda by bringing to the foreground aspects of the social determinants agenda that have particular importance to Indigenous Australia. Health services research also has a critical role in the advancement of this agenda as it addresses one of the social determinants of health that does not get much direct attention in this volume—the need for strategies to improve access to health services, particularly primary health care. In order to build resilience and to promote children's health (Priority No. 2 below), the social factors that support healthy children and their social development need to be strengthened. Finally, as has been reiterated a number of times already, the social determinants research agenda needs to be supported by strategies that improve the overall capacity and performance of the research in the field of Indigenous health.

Box 2

Research Themes

NHMRC Road Map: A Strategic Framework for Improving Aboriginal and Torres Strait Islander Health through Research

1. Descriptive research that outlines patterns of health risk, disease and death. This information should be utilised to inform the development of sound preventive, early diagnosis and treatment-based interventions that are likely to result in meaningful health gain for Aboriginal and Torres Strait Islander peoples.
2. A research focus on the factors and process that promote resilience and wellbeing; in particular but not exclusively, during the periods of pregnancy, infancy, childhood and adolescence and form the basis for good health throughout the lifespan.
3. A focus on health services research that describes the optimum means of delivering preventive, diagnostic and treatment-based health services and interventions to Aboriginal and Torres Strait Islander peoples.
4. A focus on the association between health status and health gain, and policy and programs that lie outside the direct influence of the health sector.
5. A focus on engaging with research and action in previously under-researched Aboriginal and Torres Strait Islander populations and communities.
6. Development of the nation's Aboriginal and Torres Strait Islander health research capacity (including training Aboriginal and Torres Strait Islander researchers) and health research practice in relation to Aboriginal and Torres Strait Islander communities.

Source: Aboriginal and Torres Strait Islander Research Agenda Working Group 2002

The social determinants of Indigenous health in a global context

At its meeting in Nairobi in June 2006, the Commission on the Social Determinants of Health identified Indigenous peoples' health as a specific component of its work program. An International Review of Social Determinants of Indigenous Health was subsequently established to build on existing knowledge in the field of Indigenous health. In this conclusion we provide a summary of the findings of this review drawing from a report prepared for the CSDH by Mowbray (2007). The work undertaken for the Commission aimed to address three questions:

- What actions on the social determinants of Indigenous health would mitigate risk conditions and improve health outcomes for Indigenous peoples globally?
- What examples are there of successful action on the social determinants of health that have resulted in positive outcomes for the health and wellbeing of Indigenous peoples?
- What policies concerning the social determinants of health are most likely to be effective in improving the health of Indigenous peoples?

In order to address these questions, the CSDH convened an International Symposium on the Social Determinants of Indigenous Health in April 2007, which was hosted by the CRCAH and organised by Flinders University. A number of institutional partners provided funding and support for this two-day program, including the Australian Government (Department of Health and Ageing); the Canadian International Development Agency; the Canadian National Collaborating Centre for Aboriginal Health; the First Nations and Inuit Health Branch, Health Canada; and the Government of South Australia (Department of Health). The CRCAH's support and funding of the symposium was another step in the development of its social determinants research agenda.

It was intended that the symposium would provide a forum for international exchange between Indigenous peoples on the social determinants of health and lead to recommendations for tabling at the eighth meeting of the CSDH in June 2007. A situational analysis background paper was commissioned to 'summarise existing information on the social determinants of Indigenous health globally, including basic demography and epidemiology' (Mowbray 2007). This task was undertaken by facilitating authors from the London School of Hygiene and Tropical Medicine and drew upon a number of authors and reviewers from different regions across the globe. In January 2007, a call was made for contributed case studies to address the Commission's questions about actions and policies 'most likely to be effective in improving the health of Indigenous peoples' (Mowbray 2007:5). Operational problems that resulted from the timing of the call—which was tight in order to meet the CSDH's eighth meeting in Vancouver in June—and the time needed for translation, impacted upon the readiness of case study material. In general, however, the content of these case studies complemented the work undertaken in the international review. The symposia was attended by seventy-four participants from Australia, Belize, Cambodia, Canada, Chile, China, Ecuador, Guatemala, New Zealand, Peru, The Philippines and the United Kingdom. A number of the authors of papers in this monograph were among the Australian delegates who attended this workshop. Final draft versions of papers presented in this monograph were also made available to a review team who were undertaking the literature review and situational analysis.

The final themes that emerged from the workshop included: self-determination; ecology and environment; economic prosperity, fairness and equity; leadership and capacity strengthening; racism / dominance / imperialism; healing, services, systems, structures; cultural sustainability, protection, stewardship; land; human rights. These ideas and themes had remained remarkably consistent through the entire process, in both the written material and workshop process (Box 3 provides another window into these discussions with a summary of emerging ideas at the midpoint of the workshop). The themes identified in this process add to, elaborate and extend the ideas that have been highlighted in this monograph.

Despite the differences in the social and political context of Indigenous peoples worldwide, there was a remarkable degree of concordance at the workshop in the collective understanding that emerged regarding the role played by social processes in the development of disparities in Indigenous health. However, it was also clear, in particular through the case studies presented, that these broad ideas need to be critically interpreted within particular historical and social environments. In this sense, local research is required to identify how these more broadly defined processes might impact on local lives and realities.

Another significant finding was the understanding that, while the influence of social determinants on health can be identified in all populations, there is a specific cluster of factors and relationships that can be found in the Indigenous context. New descriptive and analytical work could be of considerable value in enhancing our understanding of these differences.

The role of work and other economic relationships is likely to be different within the context of Aboriginal Australia, where the realm of social life is distinctly organised relative to other Australians. The historical processes of colonialism, and the ongoing processes of social marginalisation, have effects on the health of Indigenous Australians that require the development of a particular approach to the analysis of social relationships critical to health outcomes. These challenges are pivotal to the future development of research in this field.

Box 3

Commission on Social Determinants of Health: Symposium on Indigenous Health

Emerging Themes

Ecological renewal and sustainability—issues and strategies
Including ecological damage (including global warming) and its impact on Indigenous people who are sustained by fragile ecologies; deforestation; the impact of mining and other resource based industries on Indigenous communities. The CSDH can highlight the significance of global processes to address these issues.

Political empowerment, legal and institutional reform—issues and strategies
Stop the violation of the human rights of Indigenous people; recognise the collective rights of Indigenous peoples (e.g. political representation; treaties, rights to self-determination; participation in institutional processes, land rights); reconciliation and negotiated settlements; ameliorate the harms caused by omission and commission by the criminal justice and legal system; address the problems of Indigenous peoples who straddle state and jurisdictional borders; UN Declaration on the Rights of Indigenous Peoples, global governance in health. Ensure equitable, effective access to the resources and services of a nation state or jurisdiction. The CSDH should do or recommend: support for global for a for Indigenous health and human rights (Draft UN Declaration on the Rights of Indigenous Peoples); draft UN General Comment on Children's Rights; Indigenous equivalent to the Kyoto Accord; affirm fundamental significance of collective rights of Indigenous peoples to self-determination; affirm and promote reconciliation and negotiated settlements; promote an agenda of better practice development across sectors such as housing, education, etc.; promote an agenda of legal reform; borders and health program.

Affirmation and respect for Indigenous cultures—issues and strategies
Address racism; support for Indigenous determination over the rate and direction of social change; affirm Indigenous spirituality; promote constructive dialogues on the values and behaviours that enhance well-being; facilitate the development of trust between Indigenous peoples and the institutions of the dominant state; promote social inclusion but not to the detriment of Indigenous cultural development. (The rapporteur asked whether 'spiritual fulfilment' should be a part of this set of issues.) The CSDH should support the UN Draft Declaration on the Rights of Indigenous Peoples, etc; and promote anti-racism strategies.

Economic prosperity—issues and strategies
Support and protect subsistence economies; minimise the misdistribution of wealth; enable Indigenous peoples to benefit from economic growth, in particular for those aspects of the economy that relate to Indigenous lands; address poverty; education and the development of other forms of intellectual capital. The CSDH should promote constructive dialogue on wealth distribution within states; promote ethical governance and practice in the transnational corporations responsible for the extraction of wealth.

Healing systems and services—issues and strategies
Invest and build the capacity of primary health care services; promote Indigenous governance, priority setting and development in health systems; support kin-based and traditional healing practices; primary health care; promote access to health services on the basis of need; link and coordinate disparate services; quality data. The CSDH should reinforce existing strategies for primary health care; promote development of mechanisms to improve data quality; and link into health services.

Nurturing families and individuals—issues and strategies
Promote, support nurturing relations within Indigenous families with respect to gender and generations; develop the capacity of Indigenous families and kin networks to respond to change in social roles; support the healthy development of Indigenous children and youth; promote resilience and 'mastery' in individuals; create a social climate in which Indigenous families and individuals take action to enhance their wellbeing; strategies to address addictions and other harmful behaviour; social and emotional wellbeing. The CSDH should reinforce significance of Indigenous self-determination in facilitating dialogue within Indigenous communities on addictions, harmful relationships, positive gender relationships, health-enhancing values and behaviours; promote programs and resources to support Indigenous families.

Source: Mowbray 2007

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