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Australia's National Institute for Aboriginal and  
Torres Strait Islander Health Research



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National  
University

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# Contents

Acronyms	iv
Foreword	v
Acknowledgments	vi
Executive summary	vii
Introduction	1
Research scope and methods	2
What is deficit discourse and why is it important?	2
Health policy and deficit narratives	6
<i>Case study 1: Overcoming Indigenous Disadvantage</i>	11
<i>Case study 2: Closing the Gap</i>	17
<i>Case study 3: The Northern Territory Emergency Response</i>	22
<i>Case study 4: National Aboriginal and Torres Strait Islander Health Policy and     Aboriginal and Torres Strait Islander Health Performance Framework</i>	26
Conclusion	30
References	31



# Acronyms

ABS	Australian Bureau of Statistics
ACER	Australian Council for Educational Research
AHMAC	Australian Health Ministers' Advisory Council
AIDA	Aboriginal and Islander Doctors' Association
AIHW	Australian Institute of Health and Welfare
AMSANT	Aboriginal Medical Services Alliance of the Northern Territory
ANU	Australian National University
APC	Australian Productivity Commission
ATSIC	Aboriginal and Torres Strait Islander Commission
ATSIHPF	Aboriginal and Torres Strait Islander Health Performance Framework
COAG	Council of Australian Governments
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
HoRSCFCA	House of Representatives Standing Committee on Family and Community Affairs
NACCHO	National Aboriginal Community Controlled Health Organisation
NAHS	National Aboriginal Health Strategy
NATSIHC	National Aboriginal and Torres Strait Islander Health Council
NATSIHP	National Aboriginal and Torres Strait Islander Health Plan
NCIS	National Centre for Indigenous Studies
NHMRC	National Health and Medical Research Council
NTER	Northern Territory Emergency Response
OID	Overcoming Indigenous Disadvantage
SCRGSP	Steering Committee for the Review of Government Service Provision



# Foreword

The way we think, speak, hear and understand the world coalesce to construct our realities. In this report, researchers from the National Centre for Indigenous Studies (NCIS) at the Australian National University tackle the difficult intellectual task of looking at how ‘discourse’ shapes the narrative of Aboriginal and Torres Strait Islander health and wellbeing. I was lucky enough to be part of the broader research team and thus privy to the complexity of this field of research.

You will see from the work herein, that discourses of Aboriginal and Torres Strait Islander health are far from simple, nor are they omni-directional. You will also see that the way policy is constructed, and the assumptions that underpin it, can be just as important as how policy is enacted.

The report also has a specific focus on the way that discourses of deficit are produced and reproduced. In our efforts to promote equality, too often policy has defaulted to a non-Indigenous norm as the benchmark. As a consequence, sometimes the act of measuring complexity is reductive. It squeezes out the wonderful diversity of Aboriginal and Torres Strait Islander Australia and reduces us, as the First Australians, to homogenised statistics devoid of difference. Similarly, complex understandings of the intergenerational variables that cause ‘disadvantage’ are conflated.

Our health and wellbeing is crucial and we must continue to elucidate and acknowledge our challenges and issues in this space, but we must also continue to ensure that we, as Aboriginal and Torres Strait Islander people with a wealth of strength and resilience, are not reduced to being a ‘problem to be fixed’. Making visible, understanding and challenging discourses of deficit in the way that Aboriginal and Torres Strait Islander health and wellbeing is constructed is, therefore, imperative work for us all.

I take this opportunity to recommend the report to you as the reader and to congratulate the research team on what is an important and well-researched intellectual contribution.

**Professor Michael Dodson**

August 2017



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# Executive summary

This report explores ‘deficit discourse’ in Aboriginal and Torres Strait Islander health policy. ‘Discourse’, in this context, encompasses thought represented in written and spoken communication and/or expressed through practices. The term draws attention to the circulation of ideas, the processes by which these ideas shape conceptual and material realities, and the power inequalities that contribute to and result from these processes. ‘Deficit discourse’ refers to discourse that represents people or groups in terms of deficiency – absence, lack or failure. It particularly denotes discourse that narrowly situates responsibility for problems with the affected individuals or communities, overlooking the larger socio-economic structures in which they are embedded. It is implicated with race-based stereotypes and there is evidence that it is a barrier to improving health outcomes.

Understanding how deficit discourses are produced and reproduced is essential to challenging them. Thus, this report examines various aspects of deficit discourse in policy, but in particular considers deficit metrics: the ways in which Aboriginal and Torres Strait Islander Australians are homogenised and statistically compared to non-Indigenous Australians. We consider the complex political roles such statistics play and how they can contribute to a narrative of deficiency. We also detail the active efforts (including in government policy) that are being undertaken to counter negative constructions.

This report is the first in a two-part series examining deficit discourse, and responses to it, in the field of Aboriginal and Torres Strait Islander health. A second report, *Deficit Discourse and Strengths-based Approaches*, reviews and analyses a growing body of work from Australia

and internationally that proposes ways to displace deficit discourse in health by using ‘strengths-based’ approaches. Such approaches seek to move away from the traditional problem-based paradigm and offer a different language and set of solutions to overcoming an issue.

It is crucial to note that in analysing and mapping discourses of deficit, our goal is not to ‘problem deflate’. Aboriginal and Torres Strait Islander Australians face well-documented realities of socio-economic ‘disadvantage’. However, a discussion of problems, facts and issues of socio-economic disadvantage is not in itself deficit discourse. Discourses of deficit occur when discussions and policy aimed at alleviating disadvantage become so mired in reductionist narratives of failure and dysfunction that Aboriginal and Torres Strait Islander people themselves are seen as the problem.

Our aim with this report is to provide the groundwork both for further analysis in this area, and for challenging and ‘changing the conversation’ about the health and wellbeing of Australia’s First Peoples.

## Research approach

The research for this report was guided by two key aims:

- to identify the narrative or discourse that frames Aboriginal and Torres Strait Islander health and wellbeing; and
- to examine the attributes of this narrative or discourse, including the attribution of causes of advantage or disadvantage.

Research was carried out over six months and included:

- reviewing scholarly literature on deficit discourse as it relates to the health of Indigenous peoples
- meta-analysing more than 70 health and wellbeing texts from the 1980s to today, and
- conducting a more detailed analysis on a subset of significant policy documents that address Aboriginal and Torres Strait Islander disadvantage and demonstrate shifts in national priorities.

The main analytical method used was critical discourse analysis – a form of linguistic deconstruction that aims to reveal the interconnections between language, power and ideology. This method highlights the role of language and associated thought in producing and challenging social inequality. The discussion in this report draws attention to the role of discourse in shaping how we imagine ourselves and others, and the relations between us, and in defining what can be thought, said and acted upon.

## Scholarship on deficit discourse

Scholarship in this area builds on earlier work that looks at constructions of Aboriginal and Torres Strait Islander people through essentialist tropes, such as primitivism and modernisation. Assumptions of Indigenous deficit have characterised relations between Aboriginal and Torres Strait Islander and non-Indigenous people since colonisation. Contemporary discourses of deficit have their origins in the race paradigm and subsequent colonial ideology.

Related work has shown the detrimental effects of colonisation on the health of Aboriginal and Torres Strait Islander people, and how discrimination continues to impact on their health and wellbeing.

Deficit discourse operates across a range of intersecting fields including education and health; it circulates in policy, media, everyday conversations and beyond. Media and political discourses often operate in tandem, reproducing negative discourses about Aboriginal and Torres Strait Islander people. McCallum and Waller (2012), for example, found that between 1988 and 2008, Australia's news media paid little attention to Aboriginal and Torres Strait Islander policy issues generally, unless they were controversial. Furthermore, the National Aboriginal Controlled Community Health Organisation (NACCHO) has argued that health providers often 'pathologise' Aboriginal and Torres Strait Islander communities by suggesting that they are either ignorant of services available or 'unaware of fundamental health concepts such as sanitation, nutrition and hygiene' (NACCHO 1997). Fforde et al. (2013:162) suggest that 'the prevalence and social impact of deficit discourse indicates a significant link between discourse surrounding indigeneity and outcomes for Indigenous peoples'. These links need to be better understood.

## Health policy and deficit narratives

Through four case studies of interlinked government report series and policy 'moments', we explore patterns of deficit discourse in the health and wellbeing policy field, and also show the diversity that exists within and between these. Indeed, far from being uniform, they demonstrate competing philosophies and values.

### ***Case study 1: Overcoming Indigenous Disadvantage***

The Overcoming Indigenous Disadvantage (OID) series reports on a range of indicators relating to Aboriginal and Torres Strait Islander health and wellbeing. The first five editions, in particular, systematically compare Aboriginal and Torres Strait Islander Australians, in the aggregate, to non-Indigenous Australians. The reports reveal the politically diverse ways that emphasis on statistical disparities can be interpreted and deployed: deficit statistics can help to politicise issues of inequality by drawing attention to government failure in providing effective and culturally relevant services to citizens. However, they can also reduce rich and diverse populations to a singular entity that then becomes defined by a ‘failure’ to achieve ‘normality’ (benchmarked by a similarly singularised entity made up of everyone else.)

A 2012 review of OID highlighted a desire among many stakeholders for a report that focuses less on ‘gaps, absences, lack’ (ACER 2012:14), and that instead recognises the ‘achievements, strengths, and the positive dimensions of Indigenous experience’ (ACER 2012:5). In response, subsequent OID reports adopted a more ‘strengths-based’ approach (SCRGSP 2014). Such approaches are further examined in the companion report to this one, *Deficit Discourse and Strengths-based Approaches*.

### ***Case study 2: Closing the Gap***

The Council of Australian Governments’ (COAG) Closing the Gap strategies and targets emerged in response to a call in 2005 from the then Aboriginal and Torres Strait Islander Social Justice Commissioner, Tom Calma, for the Commonwealth Government to commit to achieving health equality for Aboriginal and Torres Strait Islander Australians within 25 years, and to a related social justice campaign called ‘Close the Gap’. Since 2008, government policy formation and monitoring in the field of Aboriginal and Torres Strait Islander health has been strongly influenced by the COAG Closing the Gap agenda.

Like OID, Closing the Gap is dominated by deficit metrics and statistical equality targets, and reflects the complex politics underlying these. As noted, such statistics can be deployed to make demands on governments in cases where they are seen to be failing in their responsibilities to citizens, but they can also form a reductionist deficit narrative that homogenises and essentialises Aboriginal and Torres Strait Islander people. A focus on a limited range of indicators and targets can, at times, eclipse the reasons underlying the statistical differences. This includes lack of access to appropriate health services, structural inequalities and racism in the provision of health care, as well as the different values and life choices made by Aboriginal and Torres Strait Islander people that at times fall outside mainstream norms.

### ***Case study 3: Northern Territory Emergency Response***

Although the Northern Territory Emergency Response (NTER or Intervention) can, in certain respects, be viewed as a divergence from the broader health policy and practice trends of the time (2007), we use it here to highlight the connections between policy and media in deficit discourse and to highlight how the framing of ‘difference’ relative to a stipulated norm can become a discourse of deficit. This case study focuses on the policy, media and political discourse surrounding the Intervention, in which cultural ‘difference’ was repeatedly framed as dysfunctionality and polemically used to legitimate government action. Political discourse of deficit surrounding the Intervention in the Northern Territory directly influenced the development of health policy for Aboriginal and Torres Strait Islander Australians in ways that contradicted both ethical and best practice guidelines in the delivery of child health checks.

### ***Case study 4: National Aboriginal and Torres Strait Islander Health Plan and Aboriginal and Torres Strait Islander Health Performance Framework***

The final case study focuses on two contemporary health policy documents: the National Aboriginal and Torres Strait Islander Health Plan 2013–2023 or NATSIHP (Commonwealth of Australia 2013) and the Aboriginal and Torres Strait Islander Health Performance Framework 2017 or ATSIHPF (AHMAC 2017). Both of documents demonstrate increasing nuance in the discourse, as well as an ongoing tension. They actively incorporate Aboriginal and Torres Strait Islander perspectives on health, and acknowledge the limits of reductionist, technical understandings of health and wellbeing. NATSIHP for example – an overarching document that plays a critical role in setting policy direction – takes a strengths-based approach that emphasises human rights, partnership, holism and wellbeing as foundational to Aboriginal and Torres Strait Islander health care and delivery. The plan positions ‘culture’ as central to all other components of its approach, stressing that ‘Aboriginal and Torres Strait Islander peoples have the right to live a healthy, safe and empowered life with a healthy strong connection to culture and country’.

Predominantly, NATSIHP steps outside a deficit narrative. At the same time, it is still explicitly underpinned by the Closing the Gap framework and the notion of statistically measuring Aboriginal and Torres Strait Islander disadvantage. This prevalence of deficit statistics is likely a consequence of at least three factors. The first, as has been pointed out, is that statistics can do important work in highlighting relations of inequality or changes over time; their seeming simplicity affords them impact in making plain that many state systems are, at present, failing people. Secondly, on the surface their specificity also (problematically) appears to render complex issues knowable in some way and, therefore, amendable to ‘technical’ intervention. Lastly, policy makers are obliged to work within certain overarching frames set out by the government of the day, in this case Closing the Gap. As such, in policy and practice different narratives and priorities come together in complex ways – coexisting and sometimes sitting in tension with one another.

## Conclusion

- ‘Deficit discourse’ is a mode of thinking that frames and represents Aboriginal and Torres Strait Islander people in a narrative of negativity, deficiency and failure (Fforde et al. 2013). It particularly occurs when discussions about disadvantage become so mired in reductionist narratives of failure that Aboriginal and Torres Strait Islander people themselves are seen as the problem.
- These discussions thus become a continuation of the pejorative and patronising race-based discourses that have long been used to represent Aboriginal and Torres Strait Islander people. Deficit discourse is both a product of, and reinforces, the marginalisation of Aboriginal and Torres Strait Islander people’s voices, perspectives and world-views.
- It appears likely that deficit discourse impacts on the health and wellbeing of Aboriginal and Torres Strait Islander people in multiple ways. It contributes to forms of external and internalised racism, and shades out solutions that recognise strengths, capabilities and rights.
- In this report we have paid particular attention to deficit statistics, such as in the Closing the Gap agenda. We argue that deficit data has been used for politically diverse purposes, including by Aboriginal and Torres Strait Islander advocates to highlight injustice and hold governments to account.
- However, divorced from context and frequently reiterated, such statistics can also form a narrative that homogenises and dehumanises Aboriginal and Torres Strait Islander people into an intractable ‘problem’ to be ‘dealt’ with. Worse, they can form part of a narrative that situates responsibility for inequalities wholly with Aboriginal and Torres Strait Islander people themselves, obscuring the ways entrenched structural inequalities are affecting health.
- At the same time, policy itself is far from monolithic: it incorporates a range of views, is often ‘discursively aware’, and exists in a state of flux and contestation. It demonstrates a tension between a desire to ‘fix’ the ‘Indigenous other’ according to a normative non-Indigenous ideal, and more sophisticated understandings of the roles that factors such as language, country and community control play in health outcomes.
- In certain circles there is an increasing awareness of deficit discourse and we are hopeful that such discourse will continue to be critically explored, challenged and disrupted, and that recognising the rights, culture, diversity and strengths of Aboriginal and Torres Strait Islander people will become the norm.





# Introduction

Unfortunately, governments continue to see Aboriginal and Torres Strait Islander disadvantage from a deficit-based approach – addressing the ‘Indigenous problem’. Governments need to move to seeing us as capable and resilient... (Gooda 2011:9)

In his 2011 Social Justice Report, former Aboriginal and Torres Strait Islander Social Justice Commissioner Mick Gooda, quoted above, drew attention to an ongoing discourse of deficit by governments, and the need to shift to a more emancipatory narrative to tackle Aboriginal and Torres Strait Islander disadvantage. Indeed, since the enacting of the ‘doctrine of discovery’<sup>1</sup> (Miller et al. 2010), in policy settings Aboriginal and Torres Strait Islander people have frequently been defined by what they ‘lack’ in comparison to a utopian non-Indigenous ideal. One of the greatest challenges for the nation is to articulate a vision for Aboriginal and Torres Strait Islander health, and to build policy that does not deny the current entrenched inequalities in health outcomes, but that recognises the successes, resilience and strengths of Aboriginal and Torres Strait Islander people, communities and the organisations that work with and for them.

One of the ways in which research can contribute to this vision is by providing evidence and ideas to help map contemporary discourse and challenge the dominant deficit narrative attached to Aboriginal and Torres Strait Islander health and wellbeing. This report represents part of a larger research effort being undertaken at

ANU’s National Centre for Indigenous Studies, concerning discourses of deficit in Aboriginal and Torres Strait Islander affairs.<sup>2</sup> It is ‘paired’ with another entitled *Deficit Discourse and Strengths-based Approaches: Changing the Narrative of Aboriginal and Torres Strait Islander Health and Wellbeing* (Fogarty et al. 2018), also produced at the NCIS and funded by the Lowitja Institute. *Deficit Discourse and Strengths-based Approaches* documents and critically analyses ways to reframe Aboriginal and Torres Strait Islander health in terms of strengths-based approaches. It thereby contributes to an understanding of how we can challenge deficit discourse in the health and wellbeing setting, and we encourage people to read the reports in conjunction with one another.

This report maps key elements of deficit discourse as it operates in the health and wellbeing sector. We hope it proves useful in providing the groundwork for further analysis, and for challenging and ‘changing the conversation’ about the health of Aboriginal and Torres Strait Islander Australians. In what follows we first describe our research approach, then review the scholarship on deficit discourse. We go on to analyse a cross-section of health literature with particular attention to policy documents, providing four case studies to illustrate key points. We conclude by finding that although deficit discourse is prevalent, there are diverse political objectives underlying it as well as active efforts to counter it.

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1 The doctrine of discovery is a legal principle which states that while Indigenous peoples continue to ‘own’ the land of their ancestors, colonists from the invading nation are granted exclusive property rights to the same land. It is the principle on which the legal fiction of Terra Nullius is based.

2 This includes a 2015–2018 Australian Research Council Discovery Indigenous project (IN150100007) entitled ‘Deficit Discourse and Indigenous Education’. This project explores the nature and prevalence of deficit in the discursive space around ‘Aboriginality’ and the relationship between deficit discourse and outcomes for Aboriginal and Torres Strait Islander people, with a focus on education policy.



# Research scope and methods

The research for this report was guided by two key aims:

- to identify the narrative or discourse that frames Aboriginal and Torres Strait Islander health and wellbeing; and
- to examine the attributes of this narrative or discourse, including the attribution of causes of advantage or disadvantage.

The project was carried out over six months, with the team first reviewing the scholarly literature on deficit discourse in Indigenous health more generally. This informed all parts of this report, but particularly the following section, which summarises scholarly work on deficit discourse. We then identified more than 70 texts for meta-analysis, from the 1980s to today, across the multi-disciplinary field of Indigenous health and wellbeing. This included peer-reviewed academic materials, policy documents and grey literature (such as websites, speeches and submissions). As the initial sample encompassed a large number of documents, for practical purposes we then focused on a subset of materials for more detailed analysis: namely, significant policy documents that address Aboriginal and Torres Strait Islander disadvantage and demonstrate

shifts in national priorities. This report uses a number of these policy approaches, frameworks and report series as case studies (see ‘Health policy and deficit narratives’, p. 6).

The main analytical method used was critical discourse analysis — a form of linguistic deconstruction that aims to reveal the interconnections between language, ideology and power (Blomeart & Bulcaen 2000:447; Liu & Guo 2016:1076). This method highlights the role of language and associated thought in producing and challenging social inequality (Van Dijk 1993:249). In particular, it draws attention to the role of discourse in shaping how we imagine ourselves, others and the relations between us, and to the role of discourse in defining what can be thought, said and acted upon. The team drew on discourse analysis to identify key tropes, narratives and counter-narratives of Indigenous deficit; how responsibility for disadvantage is attributed; how the ideas embedded in specific communicative contexts function as part of broader shared discourses about the health of Indigenous peoples; and how such ideas may shape, limit or enable opportunities for action and reform in the health context.



## What is deficit discourse and why is it important?

Discourse is more than simply how perceptions are expressed through language. It is ‘systems of thoughts composed of ideas, attitudes, courses of actions, beliefs and practices that shape reality by systemically constructing the subjects and the worlds of which they speak’ (Kerins 2012:26).

As such, discourse shapes what can and cannot be considered ‘truth’, and influences group and individual relationships accordingly.

This report focuses on the ‘discursive formation’ of ‘Indigenous health and wellbeing’, with



specific reference to patterns of deficit discourse. According to Foucault (1972:131), a 'discursive formation' is a body of knowledge characterised by a 'general enunciative principle' that governs a group of statements or verbal performances. It encompasses large disciplines of inquiry such as 'medicine' or 'economics' that, Foucault argued, could be identified on the basis of some perceived unity or regularity (Foucault 1972:38). In essence, a discursive formation is one in which ideas and statements (in this case, texts) operate together to constitute a 'regime of truth'.

'Deficit discourse', as it is known in the scholarly literature, is a mode of thinking that frames and represents Aboriginal and Torres Strait Islander people in a narrative of negativity, deficiency and failure (Fforde et al. 2013). Previous research has illuminated that racism and discrimination have a demonstrable impact on the health of Aboriginal and Torres Strait Islander Australians (Paradies, Harris & Anderson 2008; Anderson 2013). Similarly, the impacts of colonisation have also been extensively explored (Dudgeon, Milroy & Walker 2014; Sherwood 2013; Sweet et al. 2014). Yet there has been far less work in the Australian context on the nuances of deficit discourse, the elements of its construction and reproduction, or its potential impacts on health.

The National Aboriginal Controlled Community Health Organisation (NAACHO) has argued that health providers often 'pathologise' Aboriginal communities by suggesting that Aboriginal people are either ignorant of services available or are 'unaware of fundamental health concepts such as sanitation, nutrition and hygiene' (NACCHO 1997). Similarly, Arabena (2013) has drawn attention to the pervasiveness of deficit discourse in the Indigenous health sector, suggesting that language used in the policy environment represents Aboriginal and Torres Strait Islander people as incompetent, irresponsible and the source of the 'problem'. Thus framed, responsibility for poor health indicators is implicitly or explicitly attributed to Aboriginal and Torres Strait Islander people themselves, rather than to the failure by health providers to supply adequate, culturally appropriate services.

Deficit discourse is not exclusive to health contexts: assumptions of deficit have characterised relations between Aboriginal and Torres Strait Islander and non-Indigenous people since colonisation. Historically, colonial ideology based in the race paradigm adhered to constructed 'truths' about Aboriginal and Torres Strait Islander people that were underpinned by notions of deficiency but had very little to do with how they saw themselves (Dodson 1994; Langton 1993; Russell 2001). By identifying Aboriginal and Torres Strait Islander people in terms of what they lack in relation to a utopian non-Indigenous ideal, such discourses have seen 'Aboriginality' change from being a daily socio-cultural practice to a 'problem to be solved' (Dodson 1994:3).

There is a large and growing body of writing about constructions of Aboriginal and Torres Strait Islander people through discourses of race, and persisting notions of savagery (Nakata 2007), primitivism (Russell 2001), and race and essentialism (Paradies 2006; de Lepervanche & Bottomley 1988; Lattas 1993; Muecke 1982). In the Australian context, Paradies (2005; 2006) and others (Berman & Paradies 2010) have written extensively on racism, anti-racism and disadvantage, considering various manifestations such as covert and overt racism. These studies include an exploration of the relationship between racism and Aboriginal and Torres Strait Islander health. For example, Paradies, Harris & Anderson (2008) studied the impact of racism on the health of Indigenous peoples in Australia and New Zealand/Aotearoa, finding that the nature and ubiquity of racism at systemic levels require improvements in health system performance and a need to estimate systematically the cost of racism to society in both countries (2008:16).

Similarly, Tang and Browne (2008) consider the influence of race on health care access for Aboriginal people in a Canadian urban centre. One of their major findings is that 'egalitarian premises operating in health care continue to de-historicize... or divert attention away from the structural inequalities that organize "differences" in people's experiences of health and health care'

(Tang & Browne 2008:123). In conjunction with critiques of racialisation, there is also work that explores negative and discriminatory patterns of thought that come from race-based bias (Aldrich, Zwi & Short 2007; Fforde et al. 2013; Gorringe, Ross & Fforde 2011; Bourke et al. 2010). For example, Aldrich, Zwi & Short (2007:135) suggest that decades of political discourses ‘othering’ Aboriginal and Torres Strait Islander people have ‘permeated health policy and therefore may have contributed to (poor) health outcomes’.

Closely related to this literature is work that outlines the influence of racial stereotypes on identity formation. Gorringe, Ross and Fforde (2011), for example, examine how pervasive discourses of deficit, based in the race paradigm, affect Aboriginal and Torres Strait Islander people’s concepts of their identity. Furthermore, they examine how racial constructs impact on notions of authenticity, both in and beyond Aboriginal and Torres Strait Islander communities (also see, Beckett 1988; Hollinsworth 1992). The complex intersections between Aboriginal ill health, notions of culture and Aboriginality are also the subject of a personal essay by Aboriginal and South Sea Islander academic Chelsea Bond (2005). Focusing on health practice, Bond explores the characterisation of Aboriginal people in terms of illness rather than in relation to positive notions of culture and identity. Kowal and Paradies (2005) also consider the role of race and culture in their study of health practitioners’ narratives.

In this body of literature, particular emphasis is given to identifying those underlying racial and cultural factors that influence attitudes, behaviours, and discourses in Indigenous health and wellbeing (e.g., Farmer et al. 2012; Fforde et al. 2013). Fforde et al. (2013:162) suggest that ‘the prevalence and social impact of deficit discourse indicates a significant link between discourse surrounding indigeneity and outcomes for indigenous peoples’.

Central to much of this academic work is recognition of the lasting impacts of (neo) colonial, racist discourses (e.g., Bourke et al.

2010). Contemporary discourses of deficit, no matter how subtle, have their origins in the race paradigm and subsequent colonial ideology. For example, Thomas, Bainbridge and Tsey (2014) conducted a survey for the centenary year of the *Medical Journal of Australia*, examining how the health of Aboriginal and Torres Strait Islander Australians has been deeply influenced over the past century by colonial social ideologies.

In certain discursive spaces in Australia, the term ‘Aboriginal and Torres Strait Islander people’ has come to be associated with particular negative tropes, such as being unhealthy, undereducated, unemployed, violent and socially dysfunctional. Associated with each of these tropes are certain sub-tropes; for example, ‘unhealthy’ is linked in turn with overcrowding, neglect and substance abuse. Such tropes of deficiency reduce and homogenise people, and tell us nothing about their complex lives and socio-economic circumstances. As we go on to explain, however, it has at times been all too easy to assume (latently or blatantly) that such problems stem from the moral and cultural failings of Aboriginal and Torres Strait Islander people themselves.

Recent research has begun to highlight the influence that deficit discourse wields when setting the agenda in, and the terms of debate around, a variety of Aboriginal and Torres Strait Islander issues. A number of works explore deficit discourse in relation to arenas that impact on Aboriginal and Torres Strait Islander people’s wellbeing, including in education, sports, and the media (Vass 2013; Bamblett 2011; McCallum & Holland 2010). There is a growing understanding of the relationship between deficit discourse and Indigenous outcomes in the field of education (e.g., Gorringe & Spillman 2008; Sarra 2011), and of the social impact of related behaviours such as lateral violence (Gooda 2011; Dudgeon, Milroy & Walker 2014). However, its influence is significantly under-theorised and little understood in the Australian context, including within the health sector.

In the (re)production of deficit discourse the interconnections between policy and media

are important. Media and political discourses often work synchronously to create negative concepts of Aboriginal and Torres Strait Islander identity, with insidious outcomes for health policy. The circulation, distribution and reception of discourses on Aboriginal and Torres Strait Islander health and wellbeing through media occupy a particular political and ideological space. In a major study in this area, McCallum and Waller (2012) found that policymakers working within government departments were 'media experts who have adopted "media logic" in their practices' (McCallum 2012:vii), with the result that media is used to pre-empt, monitor and strategically influence policy debate. These media practices can be a major influence in deficit discourse and they vary in intensity over time. This is particularly true of the discourse around Aboriginal and Torres Strait Islander health and wellbeing, the media coverage of which is frequently 'intense'. However, McCallum and Waller (2012) found that between 1988 and 2008, Australia's news media paid little attention to Aboriginal and Torres Strait Islander policy issues generally, unless they were controversial (McCallum 2012:vii). Their study also makes clear the relationship between media, politics and issues of 'policy intractability', with a number of papers in the volume illuminating this through the media coverage of the Northern Territory Emergency Response (NTER, or Intervention) (see case study 3, p. 22).

The relationship between politicians and the media is also writ large in the deficit discourses reproduced in the media. The way the values and beliefs of politicians have contributed to shaping health policy, and have influenced health outcomes for Aboriginal and Torres Strait Islander people, are the subject of a paper by Aldrich, Zwi & Short (2007). Over three decades (from 1972 to 2001), they identified four types of political discourse:

- the competence of Aboriginal and Torres Strait Islander people to 'manage'
- the control of, and responsibility for, Aboriginal and Torres Strait Islander people's health

- Aboriginal and Torres Strait Islander people as 'other', and
- the 'problem' concerning Aboriginal and Torres Strait Islander health.

These discourses are then replicated in the media, creating a self-fulfilling cycle of news, media and political views. Conversely, Gray and Bailie (2006), in a study on the human right to health, consider the role of politicians, media, public policy and the way the media give inadequate attention to rights-based discourses.

It is crucial to note that in analysing and mapping discourses of deficit, the goal is not to 'problem deflate', as Aboriginal and Torres Strait Islander Australians face well-documented realities of socio-economic 'disadvantage'. However, a discussion of the problems, facts and issues associated with this socio-economic disadvantage is not in itself deficit discourse. Rather, deficit discourse arises when discussions and policy aimed at alleviating disadvantage become so mired in reductionist narratives of failure and dysfunction that Aboriginal and Torres Strait Islander people themselves are seen as the problem. For example, the Northern Territory Emergency Response, or 'Intervention', was premised on the complete failure of remote Aboriginal and Torres Strait Islander communities (see case study 3, p. 22). This in turn allowed for a proliferation of draconian policy approaches that were applied to all people in effected remote communities, regardless of their social, economic and cultural strengths and responsibilities (Lovell 2012, 2014; Kowal & Paradies 2005).

In the following section we take up many of these themes in more detail, exploring deficit discourse particularly in relation to a cross-section of Aboriginal and Torres Strait Islander health-related policy documents, and using case studies to illustrate our argument. However, our story is not one of despair: we also show that while deficit discourse is prevalent, there are powerful counter-narratives in play.



# Health policy and deficit narratives

The landscape of government health policy in Australia is naturally complex, encompassing different levels (from overarching long-term visions and principles, to detailed designs for specific health projects), different scopes (Australia-wide, Aboriginal and Torres Strait Islander-specific, multi-sectorial and so forth), different bodies (including Commonwealth and state governments and statutory bodies) and different goals. There are also documents, such as reports and evaluations, that do not constitute policy *per se*, but are designed to influence it. Each policy statement or report is shaped by the political circumstances that gave rise to it and the backgrounds of those who created it, and each text articulates with others (printed and spoken, in health and beyond) in a unique set of ways.

In this section we focus on government policy and related government texts. While it would be impossible in a report such as this to do justice to the full breadth of government health policy relating to Aboriginal and Torres Strait Islander Australians, we examine a number of interlinked report series and policy ‘moments’ both to highlight key themes and to show the diversity that exists within and between them. Indeed, far from being uniform, at times they show evidence of balancing competing philosophies and values that reflect the complexity of the health landscape, the variety of professions it incorporates, and both longstanding and short-lived political movements, conversations and agendas in Australian society and beyond.

In approaching the research, we conducted a broad discursive analysis of key policy texts from 1984, the year responsibility for Commonwealth Aboriginal and Torres Strait Islander health programs came under the remit of the Department of Aboriginal Affairs. Another watershed moment in the formulation of Aboriginal and Torres Strait Islander health policy came in 1989, when the Commonwealth Government introduced the *National Aboriginal Health Strategy* (NAHS) (NAHWP 1989), which has remained an important foundational piece of policy. The outcome of work carried out by the National Aboriginal Health

Strategy Working Party (NAHWP), it arose, in part, from a realisation that there was no national Aboriginal and Torres Strait Islander health strategy. The formation of the Working Party was the result of an agreement by Commonwealth, state and territory health ministers in December 1987 (Gardiner-Garden 1994). Essentially, the NAHS identified the need for a clear delineation of Commonwealth/state responsibility and ‘specific strategies in areas such as alcohol abuse, women’s health, infectious and chronic diseases, and violent anti-social behaviour’ (Gardiner-Garden 1994:2).

In the years following the release of the NAHS, significant developments in Aboriginal and Torres Strait Islander health policy can be tracked through key documents. For example, in 2000 the House of Representatives Standing Committee on Family and Community Affairs (HoRSCFA) released its final report, *Health Is Life*. In 2003 the Commonwealth Government released the *National Strategic Framework for Aboriginal and Torres Strait Islander Health, 2003–2013* (NATSIHC 2003), followed 10 years later by the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* (Commonwealth of Australia 2013). Similarly, we can track key documents released by statutory bodies such as reports by the Australian Bureau of Statistics (ABS) and the Australian Institute of Health and Welfare (AIHW). For example, between 1997 and 2017, a joint program between the ABS and the AIHW produced a series of reports entitled *The Health and Welfare of Australia’s Aboriginal and Torres Strait Islander Peoples*. Through analysis of these types of documents we begin to identify a changing set of policy narratives.

It is also important to note how policy documents relate to each other. For example, *The National Strategic Framework* of 2003 takes into account recommendations from the 1991 Royal Commission into Aboriginal Deaths in Custody (Johnston 1991) and the *Health Is Life* report (HoRSCFA 2000), and seeks to redress implementation failings of the 1989 NAHS. In this way we can see that while narratives emerge and are produced in key policy texts, they

are also interrelated and (re)produced as well as being refined or extended across time.

Similarly, policy texts relating specifically to Aboriginal and Torres Strait Islander health, should be seen as having a dialectic relationship with parallel developments in wider social policy, including in education, housing, and social justice. Major reporting in some of these areas includes the Australian Productivity Commission's biannual reports *Overcoming Indigenous Disadvantage* (starting in 2003), and the Human Rights Commission's *Social Justice Reports* (from 1993) prepared by the Aboriginal and Torres Strait Islander Social Justice Commissioner.

Intersecting with these reports, is the work of government bodies such as COAG, which in 2008 began monitoring and reporting on the Closing the Gap targets, with Aboriginal and Torres Strait Islander health as one of the key indicators. In terms of discourse analysis, therefore, we are mindful of the importance of 'intertextuality' in mapping and analysing the production of key narratives both inside and beyond the Indigenous health field.

The following timeline provides a sense of Australian health-related policy development over the past few decades and shows how our four case studies are situated in this broader trajectory.

**Table 1: Selected Australian government health policy documents and events**

<b>1984</b>	Responsibility for Australian Government Aboriginal health programs transferred to the Department of Aboriginal Affairs
<b>1985</b>	Australian Institute of Health and Welfare established
<b>1986</b>	Formation of a Joint Ministerial Forum (Commonwealth, states and territories) on Indigenous Health, which led to the development of the National Aboriginal Health Strategy Working Party
<b>1987</b>	Agreement by Commonwealth, state and territory ministers to form a National Aboriginal Health Strategy Working Group
<b>1988</b>	Royal Commission into Aboriginal Deaths in Custody begun
<b>1989</b>	First National Aboriginal Health Strategy Working Group report: <i>A National Aboriginal Health Strategy</i>
<b>1990</b>	Aboriginal and Torres Strait Islander Commission (ATSIC) established assuming national responsibility for health
<b>1991</b>	<i>Aboriginal and Torres Strait Islander Health Goals and Targets (interim)</i> published by ATSIC Report of the Royal Commission into Aboriginal Deaths in Custody First National Health and Medical Research Council (NHMRC) <i>Guidelines on Ethical Matters in Aboriginal and Torres Strait Islander Health Research</i>
<b>1992</b>	<i>National Commitment to Improved Outcomes for Aboriginal and Torres Strait Islander People</i> endorsed by Commonwealth, state and territory governments
<b>1993</b>	National Aboriginal Community Controlled Health Organisation established as the new umbrella organisation for Aboriginal medical services
<b>1994</b>	ATSIC established Health Infrastructure Priority Projects scheme ABS conducted National Aboriginal and Torres Strait Islander Survey
<b>1995</b>	Responsibility for Aboriginal and Torres Strait Islander health transferred from ATSIC to Commonwealth Department of Human Services and Health

1996	Commonwealth approval extended for all Aboriginal Medical Services to access bulk-billing for Medicare Commonwealth established National Aboriginal and Torres Strait Islander Health Council
1997	<i>The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples</i> first released <i>Bringing Them Home Report</i> published following the 1997 National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families National Aboriginal and Torres Strait Islander Health Performance Indicators endorsed by all health ministers <i>National Training and Employment Strategy for Aboriginal and Torres Strait Islander Health Workers</i> released NHMRC produced <i>Promoting the Health of Indigenous Australians: A Review of Infrastructure Support for Aboriginal and Torres Strait Islander Health Advancement</i>
1998	<i>National Indigenous Australians' Sexual Health Strategy, 1996–97 to 1998–99</i> launched AIHW released the review <i>Expenditures on Health Services for Aboriginal and Torres Strait Islander People</i>
1999	Australian National Audit Office released its report <i>National Aboriginal Health Strategy – Delivery of Housing and Infrastructure to Aboriginal and Torres Strait Islander Communities</i>
2000	The House of Representative Standing Committee Inquiry into Indigenous Health tabled its report: <i>Health Is Life</i> First data collected on Aboriginal and Torres Strait islander substance abuse
2001	The Australian Health Minister's Advisory Council developed <i>Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework</i>
2002	COAG agreed to produce regular reports on indicators of Indigenous disadvantage – the <i>Overcoming Indigenous Disadvantage: Key Indicators</i> report series (see case study 1)
2003	State and territory governments endorsed the National Framework for <i>Aboriginal and Torres Strait Islander Health: Framework for Action by Governments</i> ATSIC released <i>Family Violence Action Plan</i> First <i>Overcoming Indigenous Disadvantage: Key Indicators 2003</i> report released Release of consultation paper <i>The Development of a National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing 2004–2009</i>
2004	Australian Government announced that responsibility for delivery of Aboriginal and Torres Strait Islander-specific programs and services will follow a 'whole-of-government' approach ATSIC was abolished
2005	<i>Overcoming Indigenous Disadvantage: Key Indicators 2005</i> published <i>Aboriginal and Torres Strait Islander Sexual Health and Blood-Borne Viruses Strategy 2005–2008</i> released

- 2007** Australian Government announced Northern Territory Emergency Response (or Intervention) on 21 June 2007 (see case study 3)
- The Intervention results in Child Health Check Initiative (see case study 3)
- Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) submission on the NTER
- In April, Oxfam released its report, *Close the Gap: Solutions to the Indigenous Health Crisis Facing Australia*, which outlines disparities in life expectancy between Aboriginal and Torres Strait islander and non-Indigenous Australians. The Close The Gap campaign includes a coalition of 40 Australian health organisations
- In December 2007, COAG committed to ‘Closing the gap in Indigenous disadvantage’ by closing the gap in life expectancy between Aboriginal and Torres Strait Islander people, and halving the gap in mortality rates for Aboriginal and Torres Strait Islander children under 5 years of age by 2018 (*National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*)
- Overcoming Indigenous Disadvantage: Key Indicators 2007* published
- 2008** In February, Prime Minister Rudd’s Apology to the Stolen Generation includes reference to ‘closing the gap’
- Statement of Intent signed by the Australian Government and Aboriginal and Torres Strait Islander health leaders signalling working together to close the gap around health indicators
- In July, the report *Progress of the Northern Territory Emergency Response Child Health Check Initiative: Health Conditions and Referrals* is released. The National Aboriginal Torres Strait Islander Health Equality Council chaired by Professor Ian Anderson is put in place to advise on the development of health-related goals
- COAG announced \$4.6 billion for Aboriginal and Torres Strait Islander issues
- 2010** Second *Closing the Gap on Indigenous Disadvantage: The Challenge for Australia* report tabled in Parliament by Prime Minister Rudd; Closing the Gap Steering Committee released its own shadow report
- The National Aboriginal and Torres Strait Islander Women’s Health Strategy* released
- 2011** Evaluation of the Northern Territory Child Health Check Initiative
- Third *Closing the Gap on Indigenous Disadvantage* report tabled
- Overcoming Indigenous Disadvantage: Key Indicators 2011* published
- 2012** Fourth *Closing the Gap on Indigenous Disadvantage* report tabled
- 2013** *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* released (see case study 4)
- Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023* forms a central plank of the overarching COAG approach to ‘closing the gap in indigenous disadvantage’
- Fifth *Closing the Gap on Indigenous Disadvantage* report tabled

<b>2014</b>	<p><i>Australian Government Indigenous Australians' Health Program</i> commenced, consolidating four existing funding streams (primary health care base funding, child and maternal health programmes, <i>Stronger Futures in the Northern Territory and the Aboriginal and Torres Strait Islander Chronic Disease Fund</i>)</p> <p>Sixth <i>Closing the Gap on Indigenous Disadvantage</i> report tabled</p> <p><i>Overcoming Indigenous Disadvantage: Key Indicators 2014</i> published</p>
<b>2015</b>	<p>Seventh <i>Closing the Gap on Indigenous Disadvantage</i> report tabled</p>
<b>2016</b>	<p>Aboriginal and Islander Doctors' Association (AIDA) media release on the influence of racism in provision of health care to Aboriginal and Torres Strait Islander Australians</p> <p><i>Indigenous Advancement Strategy's Safety and Wellbeing Programme</i></p> <p><i>National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2023</i></p> <p>Eighth <i>Closing the Gap on Indigenous Disadvantage</i> report tabled</p> <p><i>Overcoming Indigenous Disadvantage: Key Indicators 2016</i> published</p>
<b>2017</b>	<p><i>Aboriginal and Torres Strait Islander Health Performance Framework 2017</i> (see case study 4)</p> <p>Prime Minister Turnbull presents ninth <i>Closing the Gap on Indigenous Disadvantage</i> report to Parliament. Closing the Gap Steering Committee presents its shadow report</p> <p><i>My Life My Lead - Opportunities for strengthening approaches to the social determinants and cultural determinants of Indigenous health: Report on the national consultations December 2017</i></p>

From our broader analysis of policy texts, our four case studies focus on selected health discourses in the following report series and policy strategies and plans:

- Case study 1: *Overcoming Indigenous Disadvantage: Key Indicators* (series of reports beginning in 2003 produced by the Steering Committee for the Review of Government Service Provision or SCRGSP, on behalf of COAG)
- Case study 2: *Closing the Gap targets, strategies and reports* (beginning in 2008, with annual reports since 2010 presented by the Prime Minister to the Australian Parliament)

- Case study 3: The Northern Territory Emergency Response or Intervention
- Case study 4: *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* (produced by the Commonwealth Department of Health); and *Aboriginal and Torres Strait Islander Health Performance Framework 2017* Report (produced by the Australian Health Ministers' Advisory Council (AHMAC) and AIHW).

These case studies have been chosen for their influence in, and on, the broader discursive formation of Aboriginal and Torres Strait Islander health policy, as well as being representative of key discursive movements within the field.



## Case study 1: Overcoming Indigenous Disadvantage

The *Overcoming Indigenous Disadvantage: Key Indicators* report series is an important government initiative that informs the health sector, as well as other areas relevant to Aboriginal and Torres Strait Islander people. An OID report has been released almost every two years since 2003, and have been growing ever larger – from 375 pages in 2003, to 3,558 pages in 2016. They are produced by the Steering Committee for the Review of Government Service Provision, at the request of COAG, and originate from a final recommendation by the Council for Aboriginal Reconciliation (SCRGSP 2016:1.11).

The OID reports are intended to help governments understand Aboriginal and Torres Strait Islander disadvantage, measure the impact of policies and programs, and develop more effective approaches. Their purpose is also increasingly framed as assisting Aboriginal and Torres Strait Islander Australians in understanding disadvantage and scrutinising government performance (see below). This is guided by a specific vision, as the 2003 report explains:

that Indigenous people will one day enjoy the same overall standard of living as other Australians. They will be as healthy, live as long, and participate as fully in the social and economic life of the nation. (SCRGSP 2003:1.1–1.2)

OID is now one among a suite of similar government reports based heavily on quantitative analysis, including AIHW's *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, the Prime Minister's *Closing the Gap* report and AHMAC's *Aboriginal and Torres Strait Islander Health Performance Framework*, to name a few. What makes OID distinctive is a focus on outcomes and a whole-of-government perspective. Interactions between sectors (such as health and education) are emphasised.

The OID reports are structured around the following hierarchy of outcomes, indicators and actions:

'Priority outcomes' are the highest-level descriptors of wellbeing. These have remained unchanged over the seven reports:

1. Safe, healthy and supportive family environments with strong communities and cultural identity.
2. Positive child development and prevention of violence, crime and self-harm.
3. Improved wealth creation and economic sustainability for individuals, families and communities.

'Headline indicators' comprise around a dozen selected and relatively specific indicators that are intended to sum up the state of Aboriginal and Torres Strait Islander disadvantage. These were reconfigured in the 2009 report to include six headline indicators and six (by 2016, seven) COAG Closing the Gap targets (for these targets, see p. 17). In the 2003 report, health-related headline indicators included:

- Life expectancy at birth
- Rates of disability and/or core activity restriction

- Suicide and self-harm
- Substantiated child protection notifications
- Deaths from homicide and hospitalisations for assault.

‘Strategic areas for action’ are broad themes for policy action, including ‘Early child development’, ‘Healthy lives’ and ‘Safe and supportive communities’. ‘Strategic change indicators’, meanwhile, are intended to signal the state of affairs and the extent of change within the strategic areas for action. These are the most specific units of focus in the reports. The table below highlights change indicators for three of the health-related strategic areas in the 2003 and 2009 reports.

<i>2003 Strategic change indicators</i>	<i>2009 Strategic change indicators</i>
<p><b>Early child development and growth:</b></p> <ul style="list-style-type: none"> <li>• Rates of hospital admission for infectious diseases</li> <li>• Infant mortality</li> <li>• Birthweight</li> <li>• Hearing impediments</li> </ul>	<p><b>Early child development:</b></p> <ul style="list-style-type: none"> <li>• Maternal health</li> <li>• Teenage birth rate</li> <li>• Birthweight</li> <li>• Early childhood hospitalisations</li> <li>• Injury and preventable disease</li> <li>• Basic skills for life and learning</li> <li>• Hearing impediments</li> </ul>
<p><b>Substance use and misuse:</b></p> <ul style="list-style-type: none"> <li>• Alcohol and tobacco consumption</li> <li>• Alcohol-related crime and hospital statistics</li> <li>• Drug and other substance use</li> </ul>	<p><b>Healthy lives:</b></p> <ul style="list-style-type: none"> <li>• Access to primary health</li> <li>• Potentially preventable hospitalisations</li> <li>• Avoidable mortality</li> <li>• Tobacco consumption and harm</li> <li>• Obesity and nutrition</li> <li>• Tooth decay</li> <li>• Mental health</li> <li>• Suicide and self-harm</li> </ul>
<p><b>Effective environmental health systems:</b></p> <ul style="list-style-type: none"> <li>• Rates of diseases associated with poor environmental health</li> <li>• Access to clean water and functional sewerage</li> <li>• Overcrowding in housing</li> </ul>	<p><b>Home environment:</b></p> <ul style="list-style-type: none"> <li>• Overcrowding in housing</li> <li>• Rates of disease associated with poor environmental health</li> <li>• Access to clean water and functional sewerage and electricity services</li> </ul>

Prior to the publication of the initial report in 2003, the SCRGSP sought feedback on possibly including indicators of 'culture and spirituality' (SCRGSP 2003:2.11). Although many of the Aboriginal and Torres Strait Islander people consulted affirmed the importance of cultural diversity and identity, they pointed out that these could not be reduced to narrow indicators, and that spiritual matters fall outside the remit of what a government performance report should seek to address. However, a small number of what the OID authors describe as 'indicators of culture' did make it into the report, including Aboriginal and Torres Strait Islander languages, Indigenous studies in school curricula, heritage management and access to land for cultural purposes.

In reporting on the aforementioned indicators the OID reports focus on statistics, especially statistical comparison. The first five editions, in particular, systematically compare Aboriginal and Torres Strait Islander Australians in the aggregate, against non-Indigenous Australians. This clearly relates to the overall OID vision 'that Indigenous people will one day enjoy the same overall standard of living as other Australians'. In the reports the 'gap' between the two 'groups' is reiterated over and over. In almost every case, the status of Aboriginal and Torres Strait Islander people, as rendered in the statistics, appears to fall short of national norms.

This is particularly evident in the 'key messages' boxes that appear throughout the reports, usually highlighting principal indicator-statistics for that section. A representative sample from the 2003–2011 reports include:

The life expectancy of Indigenous people is around 20 years lower than that for the total Australian population. (SCRGSP 2003:3.3)

Suicide death rates were much higher for Indigenous people (between 12 and 36 per 100,000 people) than other people (between 11 and 16 per 100,000 people) in 1999–2003, in most states and territories for which data are available. (SCRGSP 2005:3.55)

After adjusting for age differences, the homicide rate in the Indigenous population was 5 to 15 times the rate in the non-Indigenous population in Queensland, Western Australia, South Australia and the Northern Territory. (SCRGSP 2007:90)

Indigenous people were 4.8 times as likely as non-Indigenous people to live in overcrowded housing in 2006. (SCRGSP 2009:9.3)

There were 78.7 births per 1000 Indigenous teenage women compared with 13.9 births per 1000 non-Indigenous teenage women in 2009. (SCRGSP 2011:5.18)

Presenting a more positive outlook, meanwhile, are regular 'things that work' case studies, which are provided in the 2005 report onwards. These mostly draw on qualitative data from evaluation reports to describe initiatives that have had positive outcomes for Aboriginal and Torres Strait Islander people.

The 2003 to 2011 OID reports paint a depressing picture of Aboriginal and Torres Strait Islander disadvantage that extends seemingly across the board. The effects (both intended and unintended) of such a narrative are complex. The authors of the 2016 OID, describe the document as providing:

a public report card on progress in overcoming Indigenous disadvantage. It can help governments assess the effectiveness of policies and inform the development of new approaches. It can assist Aboriginal and Torres Strait Islander Australians to hold governments to account, and to develop their own responses. (SCRGSP 2016:iii)

This points to the important role deficit statistics can play in politicising issues of inequality. By drawing attention to areas in which governments are failing to provide effective and culturally relevant services to their citizens, they can help citizens *hold governments to account*.

Statistics, however, provide only pieces of evidence that do not tell a full story of their own. They are always deployed in particular contexts for particular purposes, and the narratives constructed around and through them can be more or less deliberately crafted. Just as statistics can be deployed to highlight government failure, they can also form a narrative that homogenises and dehumanises Aboriginal and Torres Strait Islander people into an intractable ‘problem’ to be ‘dealt’ with or, worse, that ‘blames the victim’ for inequalities. Furthermore, after being published, statistics can be redeployed by others in ways that differ from their original framing.

As Kukutai and Walter point out, ‘the ordinariness’ of the Indigenous/non-Indigenous dichotomy and comparisons – which discursively homogenises internally diverse groups, as well as establishing false distinctions – ‘masks its inherent potential to underpin pejorative discourses of Indigenous lived reality’ (Kukutai & Walter 2015:322). They explain that:

For Māori and Aboriginal and Torres Strait Islander people, the story being told [through statistical data] rarely comports to our own worldview but more likely reflects the limited and/or erroneous understanding of who we are by the non-Indigenous majorities who produce and engage with official statistics. In a circular process, the more the story of the data are told from a non-Indigenous standpoint, the more evidence there is [to] embed that worldview as ‘the truth’. The result goes beyond mere differences in terms of statistical stories and interpretations. Statistical categorisations play an important part in cementing a symbolic ethnic and racial order, and the ways in which indigenous identities are framed has particular consequences for how such hierarchies are maintained. (Kukutai & Walter 2015:322)

A focus on statistically measuring Aboriginal and Torres Strait Islander health did not start with OID – it is a continuation of a broader trend – and debates about ‘statistical equality versus cultural difference’ are long-standing (Jordan, Bulloch & Buchanan 2010). In the late 1980s and early 1990s there were efforts to quantify disadvantage across a host of policy areas and in academia. This was part of a broader policy push, dating at least from the Hawke government in 1987 (Altman 2009:4), to create statistical equality between Aboriginal and Torres Strait Islander and non-Indigenous Australians. In health, it manifest as sets of comparative statistics. The NAHS, for example, was a key document in providing Aboriginal and Torres Strait Islander health statistics, which were needed to illuminate what has since unfortunately become known as the ‘Aboriginal health problem’. In the NAHS we see the early stages of health relativity measurement in Australia, where the health of Aboriginal and Torres Strait Islander people is measured in comparison to non-Indigenous people. Unfortunately, the quantification of ‘ill health’ contributed to a discursive connection

between poor health status and Aboriginal and Torres Strait Islander identity. As Walter (2010:51) notes:

despite the frequently positive intentions of producers and users, the tendency to an automatic rating of the problematic Indigenous ‘other’ alongside that of the normal Australian by socio economic and demographic indicators pervades the analytical frame with a subtle depreciatory tone.

This is further discussed in case study 2 on Closing the Gap.

In its very title, *Overcoming Indigenous Disadvantage* takes a certain political stance, drawing attention to the structural (but surmountable) social, economic and political challenges which confront Aboriginal and Torres Strait Islander Australians. But by so closely associating ‘Indigenous’ with ‘disadvantage’, it also contributes to a broader discursive association between the two.

‘Indigenous disadvantage’ is a motif across several ‘suites’ of policy documents and, again, did not emerge with the OID reports. The pervasiveness of a discourse around Aboriginal and Torres Strait Islander disadvantage in health mostly stems from genuine policy efforts to improve people’s health. However, the recurrent theme that Aboriginal and Torres Strait Islander Australians (as a singular, disaggregated group) are ‘falling short’ of non-Indigenous norms, has led to critique that OID emphasises disadvantage rather than overcoming disadvantage.

In 2012, the Australian Council for Educational Research (ACER) reviewed the OID reports on behalf of the SCRGSP (ACER 2012:5). The review found that many people from all stakeholder groups – Aboriginal and Torres Strait Islander and non-Indigenous people across several sectors including health, education, employment and justice – felt the reports were too negative. With negative headline indicators, such as child abuse and family violence, the reports were perceived as telling a story of despair rather than of hope.

The OID report was generally seen to be meeting its objectives in terms of reporting on government performance but the objectives themselves were questioned. It was suggested that the origins of the report are to be found in a traditional deficit model rather than being grounded in a strengths-based model. (ACER 2012:14)

The review’s authors point out a disjuncture between the OID purpose in reporting on the COAG Closing the Gap agenda – ‘a perspective that focuses on gaps, absences, lack’ (ACER 2012:14) – and a desire among many stakeholders for a report ‘that recognises achievements, strengths, and the positive dimensions of Indigenous experience’ (ACER 2012:5). Such strengths included resilience, connectedness to Country, and cultural and linguistic diversity. Some of those surveyed suggested the case studies that appear in the reports better capture such positives than the statistical analysis. One reason for this may be that, as noted above, complex aspects of wellbeing such as cultural identity are not easily rendered in statistics (nor, perhaps, should they be) and qualitative material is better able to capture their complexity.

The review's authors made two key recommendations on this aspect of their findings – that the SCRGSP:

- 'consider changing the title of the *Overcoming Indigenous Disadvantage* report to one that is more suggestive of Indigenous strengths'; and
- 'examine ways in which information about Indigenous strengths (such as connectedness to land and country, resilience, Indigenous leadership, language) can be incorporated to help shift the balance of the report from a negative focus on disadvantage to a more positive focus on overcoming this disadvantage' (ACER 2012:17)

In response to the review, the 2014 OID report adopted more focus on 'strengths-based' reporting, as well as more fully engaging Aboriginal and Torres Strait Islander people in all phases of the reporting process (SCRGSP 2014). While the report's title did not change, efforts were made to reframe its objective from 'overcoming disadvantage' to 'improving wellbeing' (using conceptions of wellbeing informed by Aboriginal and Torres Strait Islander Australians' values).

Due to the emphasis placed on the cultural aspects of wellbeing in consultations with Aboriginal and Torres Strait Islander Australians, the SCRGSP decided to give greater prominence to cultural indicators. This included renaming the 'Governance and leadership' strategic area as 'Governance, leadership and culture', and placing it before the other areas to emphasise its fundamental role; grouping the 'cultural' indicators under this area to allow for discussion of the connections between culture and other outcomes; and introducing new indicators for outcomes that Aboriginal and Torres Strait Islander Australians identified as being important to them. They also shifted some indicators from negative to neutral or positive terms: 'tooth decay', for example, became 'oral health' and 'hearing impediments' became 'ear health'. And in the 2016 report, a chapter on 'measuring multiple disadvantage' was reframed to focus on interactions that improve outcomes for Aboriginal and Torres Strait Islander Australians (SCRGSP 2016:2.12).

In addition, both the 2014 and 2016 reports included a section on 'The historical context', which contained important information that situates the data in a much larger story. The 2016 report acknowledges that disadvantage derives from 'both immediate social, economic and cultural determinants, and deeper underlying causes', before pointing to the roles of colonialism, dispossession and racism in structuring present-day disadvantage. This section also makes it clear that government has been fundamentally implicated in the causes of disadvantage, for example, by noting that in many circumstances 'lack of services or poorer quality services for Aboriginal and Torres Strait Islander people appeared to be tolerated' (SCRGSP 2016:1.11).

There is still a considerable focus on 'the gap' in the reports, although efforts have been made to note positive outcomes before discussing outcome gaps between Aboriginal and Torres Strait Islander and non-Indigenous Australians. For example, in the 2016 OID, the Key messages box for the 'Access to primary health care' strategic change indicator begins:

In 2014–15, 39.7 per cent of Aboriginal and Torres Strait Islander Australians aged 15 years and over reported their health status as excellent or very good. This was a decrease from 43.7 per cent in 2008. (SCRGSP 2016:8.3)

Given the extent to which the OID series is still constrained by a focus on the gap, some people may view such changes as, at least partly, cosmetic.

This OID case study draws attention to the politically diverse ways in which a statistical emphasis on the gap can be interpreted and deployed. Deficit data can be seen as a tool to demand more effective and appropriate service provision from government, but can also reduce rich and diverse populations to a singular entity that then becomes defined by a 'failure' to achieve 'normality' (benchmarked by a similarly singularised entity made up of everyone else.)

Even where deficit data is initially deployed for emancipatory purposes, its dominance in the Australian context has at times seen it slip into the latter, forming a narrative that homogenises and dehumanises Aboriginal and Torres Strait Islander people. As we discuss in the context of the Intervention (see p. 22), such deficit discourse can also be redeployed in new frames that concentrate blame on Aboriginal and Torres Strait Islander communities by transforming disadvantage into moral failure, and suggesting that these communities do not so much confront constrained opportunity as lack a willingness to take up opportunities.

Strengths-based approaches provide one set of ways to counterbalance deficit discourse (Fogarty et al. 2018). This does not, however, mean abandoning all attention to deficit statistics, as these still do important political work. Rather, it means not letting them eclipse the positives, elide the larger context, reduce people to enumerated problems, or overlook the more complex aspects of Aboriginal and Torres Strait Islander wellbeing that are not amenable to quantification.

## *Case study 2: Closing the Gap*

Closing the Gap is a government commitment to achieving equality between Aboriginal and Torres Strait Islander and non-Indigenous Australians in a range of health and wellbeing measures. It focuses on six targets, agreed to by federal, state and territory governments through COAG:

1. close the life expectancy gap within a generation
2. halve the gap in mortality rates for Indigenous children under five within a decade
3. ensure access to early childhood education for all Indigenous four years olds in remote communities within five years
4. halve the gap in reading, writing and numeracy achievements for children within a decade
5. halve the gap for Indigenous students in year 12 attainment or equivalent attainment rates by 2020, and
6. halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade. (FaHCSIA 2009:5)

Each year, progress against these targets is measured in a Closing the Gap report that the Prime Minister releases to Parliament. Like the OID reports, these provide a combination of gap-focused statistics and case studies.

Closing the Gap emerged in response to pressure within and outside government. In his 2005 Social Justice Report, Aboriginal and Torres Strait Islander Social Justice Commissioner Tom Calma had urged the governments of Australia to commit to achieving health equality for Aboriginal and Torres Strait Islander Australians within 25 years. In 2006, a social justice campaign – that came to involve more than 40 health and human rights organisations, including NACCHO, Australians for Native Title and Reconciliation, and Oxfam Australia – formed around this target. The coalition, known as the National Indigenous Health Equality Campaign, headlined its public awareness initiative with the slogan ‘Close the Gap’.

The Commonwealth government took up the challenge in 2008, when it signed the *Indigenous Health Equality Summit Statement of Intent*, agreeing to work with Aboriginal and Torres Strait Islander people ‘to achieve equality in health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by the year 2030’.

As such, Closing the Gap policies in part reflect Aboriginal and Torres Strait Islander demands for governments to take a greater share of responsibility, and, as such, they show the complex politics underlying deficit statistics. As we point out above, deficit statistics can help to politicise issues of inequality, drawing attention to areas in which governments are failing to provide effective and culturally relevant services to their citizens, even while such statistics can contribute to a narrative of deficit (see below).

Over the past decade, Aboriginal and Torres Strait Islander health policy formation, performance and monitoring have been strongly influenced by the Closing the Gap agenda. At the 2008 Indigenous Health Equality Summit, the government committed to several broad-ranging strategies: to develop health infrastructure; to ensure the participation of Aboriginal and Torres Strait Islander people and organisations in health planning; to support Aboriginal community controlled health centres; to improve access to mainstream services; and to create culturally appropriate and affordable health services. The six measurable targets (listed above) to monitor improvements in the health and wellbeing of Aboriginal and Torres Strait Islander Australians were developed to achieve these strategies.

Unfortunately, a focus on the indicators has, at times, eclipsed the original broad-based health commitments. Rather than providing measures of government policy success, the Closing the Gap indicators create, in the minds of many Australians, the idea of Aboriginal and Torres Strait Islander failure (Paradies 2006).

The health measures included in the Closing the Gap report point to statistical categories of deficit, including the often-recounted measure of Aboriginal and Torres Strait Islander life expectancy being significantly lower than that of the non-Indigenous population; the extremely high rates of suicide; child mortality being significantly higher than the non-Indigenous population; and the much higher rates of smoking in Aboriginal and Torres Strait Islander communities. We do not seek to discount these health problems, rather, we focus



on how politicians and government agencies at times perpetuate this discourse in ways that obfuscate the reasons behind these differences: namely, the lack of access to appropriate health services, structural inequalities, racism in the provision of health care, as well as the different values and life choices made by Aboriginal and Torres Strait Islander people that move them away from measurements of the 'norm' in health outcomes.

The Closing the Gap Campaign Steering Committee response to the 2017 Australian Government Closing the Gap report highlights the lack of access to appropriate health care services and structural inequalities as major contributing factors to poor health outcomes for Aboriginal and Torres Strait Islander Australians (Wright & Lewis 2017:11). Quoting Alford (2015:403), the report's authors describe those factors that are 'potentially lethal for many Indigenous people' as:

- limited Aboriginal and Torres Strait Islander-specific primary health care providers
- underutilisation of mainstream services and limited access to government health subsidies
- problems caused by using price signals in the public health system
- a lack of access to private health care insurance; and
- the failure to maintain government expenditure on health services over time.

In addition to the lack of access to appropriate health services, racism in the provision of services has also been identified as a major problem with the health system. A recent statement released by AIDA quotes Paradies (2014), who claims that:

healthcare provider racism can lead to poorer self-reported health status, lower perceived quality of care, underutilisation of health services, delays in seeking care, failure to follow up recommendations, societal distrust, interruptions in care, mistrust of providers and avoidance of health care systems (AIDA n.d.:2).

This statement suggests that while issues of racism are central to the provision of health care to Aboriginal and Torres Strait Islander Australians, the political discourse which focuses on indicators and 'closing the gap' often elides consideration of the way that structural discrimination and racism affect health outcomes. Pholi, Black & Richards (2009:5) suggest that this failure to measure racism is political, as it means that racism remains the individual problem of Aboriginal and Torres Strait Islander people because there is no statistical evidence of the systemic racism and inequality in the provision of health services.

Closing the Gap indicators are, by definition, based on comparison. Non-Indigenous Australia is established as the norm that Aboriginal and Torres Strait Islander Australia is failing to meet. In this way, the indicators are not only producing knowledge about Aboriginal and Torres Strait Islander Australians, they are also constructing the category of Indigeneity. Here the act of measuring also has the effect of producing what it is that is being measured. Pholi, Black & Richards describe the process by which the 'Indigenous' category is represented with a negative discourse around failing to meet the targets associated with health, education, employment and wellbeing:

Performance measurement in Closing the Gap requires a range of baseline data on what is *wrong* with Indigenous people. Deficit data then forms the basis of what is *known* about Indigenous people. This in turn sets the strategic goals for action to *fix* Indigenous people. Because the deficits are clearly situated within Indigenous Australians, progress is measured by the extent to which Indigenous Australians change for the better, thus insulating existing institutions, systems and power structures from an expectation to change also, or change instead. (Pholi, Black & Richards 2009:9–10)

The authors go on to explore how the defining feature of the Closing the Gap narrative is that of deficit: Aboriginal and Torres Strait Islander Australians are failing to meet a standard, which therefore suggests there is something wrong with them that in turn must be fixed. This narrative places the responsibility for failure to achieve equitable health outcomes on to Aboriginal and Torres Strait Islander people themselves, rather than government. For example, one of the first pages of the 2009 Closing the Gap report acknowledges that, ‘In remote areas, successive governments have failed to properly coordinate their efforts and to fund them adequately, resulting in acute and visible need’ (FaHCSIA 2009:4). But a few sentences later the report shifts responsibility, stating:

In more recent times, governments have taken strong action to intervene in Indigenous communities in order to protect children from violence and abuse. While such urgent action has been and may again be necessary in the future, too little focus has been given to the longer term task of building personal and community responsibility – a challenge that must be met if Indigenous life outcomes are to improve. (FaHCSIA 2009:4)

Health measures included in the Closing the Gap report have repeatedly signalled how governments, year after year, have failed to ensure that the ‘gap’ closes. Rather than this being seen as evidence of government policy failure, the Closing the Gap discourse of Aboriginal and Torres Strait Islander failure is increasingly being understood as representative of the ‘Indigenous’ condition, particularly among the non-Indigenous population who have little contact with Aboriginal and Torres Strait Islander people (Paradies 2006). These narratives increasingly skew popular conceptions of Aboriginal and Torres Strait Islander identity that require people either to conform to the established idea of Aboriginal and Torres Strait Islander communities as sick, poor and under-educated or risk being viewed as less ‘authentic’ (Paradies 2006).

Health indicators that measure ‘Indigenous’ failure relative to non-Indigenous norms fail to take into account the difference and diversity of Aboriginal and Torres Strait Islander people’s experiences. While the *2017 Closing the Gap* report speaks to a diversity of health outcomes, even between the various state and territory jurisdictions, the tables and narrative of the report essentialise this diversity into a single narrative of Aboriginal and Torres Strait Islander failure to meet non-Indigenous outcomes. What is lost from these statistical indicators is that changes in health outcomes occur among and between Aboriginal and Torres Strait Islander communities, as well as across jurisdictions. Health outcomes differ substantially based on the location of the Aboriginal and Torres Strait Islander population and the differing health policies pursued across different jurisdictions. For example, there is a substantial difference

between the Aboriginal and Torres Strait Islander child mortality rate in New South Wales (111 per 100,000) and the same measure in the Northern Territory (333 per 100,000), but the overall measure averages these figures across the entire population suggesting that there has been no statistically significant change in the child mortality rate between 2008 and 2015 (Department of PM&C 2017:23). By conflating this data into a single statistic, the discourse shifts from considering differential outcomes based on structural differences in access to health infrastructure or alternative policy frameworks, onto a defining narrative of Indigeneity.

The discourse of Closing the Gap assumes that success will be achieved when a specific set of outcomes are the same for Aboriginal and Torres Strait Islander Australians as for non-Indigenous Australians. This represents an ideology of normalisation. Pholi, Black & Richards (2009:10) write that in the Closing the Gap discourse, success is defined by the extent to which Indigenous Australians conform to a set of pre-determined, measurable characteristics of the non-Indigenous ideal, while 'failure' is any outcome that falls below, or manifests outside the scope of these ideal indicators.

This definition of success requires a convergence of outcomes between Aboriginal and Torres Strait Islander and non-Indigenous people, which, according to Altman (2009:4), for many indicators 'will take decades – even over a century' to achieve.

The embedded ideology of normalisation in the Closing the Gap policy framework fails to take into account that many Aboriginal and Torres Strait Islander Australians may have different aspirations and values around what they think of as a good life (Bulloch & Fogarty 2016). Altman argues that the Closing the Gap policy approach reflects the values and norms of the dominant society, but 'fails to value Indigenous difference and fails to accommodate Indigenous aspirations in all their diversity' (Altman 2009:1). For example, the creation of a statistical average creates a fictional Aboriginal and Torres Strait Islander person, removed from kinship or social settings who is defined by failing to meet the indicator being measured (Taylor 2008; Altman 2009).

The ideology of normalisation can create disconcerting dilemmas for health professionals working to close the gap. Kowal describes the efforts of these 'white' health workers engaged in improving health indicators based on mainstream social norms, who at the same time view this approach as a type of 'neocolonial project to make Indigenous people conform to Western lifeworlds' (Kowal 2015:7). Here the dilemma for some health workers appears to be that their health messages and approach can often conflict with the social and cultural practices of the Aboriginal and Torres Strait Islander people with whom they are working, particularly in remote Australia.

For example, to maintain a healthy and nutritious diet, Aboriginal and Torres Strait Islander people must refrain from sharing food with their kin, a practice that is informed by their social norms of sharing and reciprocity (Kowal 2015:7; Dussart 2009). Similarly, to avoid drinking or smoking they must not engage in the social practices of sharing tobacco and alcohol (Kowal 2015:7; Brady 1993). These examples suggest that for many Aboriginal and Torres Strait Islander people their life choices are influenced by ideas of relatedness and social values that create complex, contextual health outcomes far beyond the narrative captured by a fictional average 'Indigenous' person.

Finally, the discourse around Closing the Gap and health indicators can operate to exclude Aboriginal and Torres Strait Islander voices from the debate. In his keynote address to the Australian Institute of Health and Welfare Conference in 2009, Professor Mick Dodson pointed to challenges in the Aboriginal and Torres Strait Islander health sector caused by the use of indicators as measures of wellbeing:

We've got to be careful, in our pursuit of genuine equality in health and other important areas, that we don't repeat the same mistakes of the past in deciding for Aboriginal people what their welfare is.

In the close the gap framework, we need to avoid what one paper called 'reducing Indigenous Australians to a range of indicators of deficit, to be monitored and rectified towards government-set targets'. (Dodson 2009)

A similar point was also made by the CEO of the Lowitja Institute, Romlie Mokak, at the 2016 Medicine and Society oration:

Power in the policy world sits with others, not with Aboriginal and Torres Strait Islander peoples. It resides outside of the domain of Aboriginal and Torres Strait Islander people... we are outsiders to the intimate internal discussions about our very own health and wellbeing. (Mokak 2016)

These quotes suggest that the Closing the Gap indicators may work to embed power relations whereby Aboriginal and Torres Strait Islander Australians are measured and evaluated by a technical knowledge over which they have little control. At worst, the Closing the Gap policy creates a range of indicators that include an underlying set of values and assumptions designed with little reference to the lived experience of the Aboriginal and Torres Strait Islander people whose health and wellbeing they are intended to assess.

### ***Case study 3: Northern Territory Emergency Response***

The Northern Territory Emergency Response (NTER, or Intervention) was an Australian Government-led intervention that included substantial legislative changes to the provision of welfare, land tenure, law enforcement, employment schemes and funding for Aboriginal organisations, all of which were directed at the Aboriginal and Torres Strait Islander population of the Northern Territory. The NTER was announced by then Prime Minister John Howard and the Hon Mal Brough, Minister for Indigenous Affairs, in a joint media conference held on 21 June 2007. Political and media commentary at the time of the 'emergency response' announcement described all Aboriginal and Torres Strait Islander communities as places of dysfunction, with Aboriginal and Torres Strait Islander men in particular repeatedly labelled as child abusers and paedophiles. This discourse was perpetuated by the media, including the ABC's *Lateline* show, as well as political leaders. The full scope of the Intervention was subsequently detailed in more than 500 pages of hastily written legislation, in a series of measures supposedly designed to address the problems of child abuse in the Northern Territory.

Although the NTER can, in certain respects, be viewed as a divergence from broader health policy and practice trends of the time, we use it here to highlight the connections between policy and media in deficit discourse and to highlight how the framing of Aboriginal and Torres Strait Islander ‘difference’ relative to a stipulated norm can become a discourse of deficit. This case study will focus on the policy, media and political discourse surrounding the NTER where cultural ‘difference’ was repeatedly framed as dysfunctionality and polemically used to legitimate government action. It will demonstrate how the political discourse of deficit surrounding the Intervention in the Northern Territory directly influenced the development of health policy for Aboriginal and Torres Strait Islander Australians in ways that contradicted both ethical and best practice guidelines in the delivery of child health checks.

Across the research base we have analysed, it is clear that the dominant discourses propagated through media and politics work to marginalise or silence the voices, perspectives and world-views of Aboriginal and Torres Strait Islander people. In terms of the production of deficit discourse in Aboriginal and Torres Strait Islander health and wellbeing, this has two major effects. First, media provides a platform for political views and news within Aboriginal and Torres Strait Islander health affairs that accentuates the dramatic, controversial or the problematic. Simultaneously, discourses of crisis or dysfunction in the media squeeze out news focusing on success, strength or ‘good news’. This then leads to a distorted public perception that ‘ill health’ is a defining characteristic of Aboriginal and Torres Strait Islander communities.

Secondly, the near absence of Aboriginal and Torres Strait Islander voices in the political–media nexus, enables such perceptions to go unchallenged and be continuously reproduced, such that they develop their own internal authenticity. Where their voices are publicised, they are often strategically deployed to concur or support the hegemonic discourse that the Aboriginal and Torres Strait Islander population is unhealthy (McCallum 2012). It is clear that the media and its relationship to political power have both direct and indirect effects upon the production and reproduction of policy itself and, *ipso facto*, on Aboriginal and Torres Strait Islander health and wellbeing, as we will go on to demonstrate.

Political announcements made at the time of the Federal Government’s declaration of the ‘emergency response’ in the Northern Territory contain a pervasive discourse that Aboriginal and Torres Strait Islander communities are ‘uncivilised’ and ‘dysfunctional’ places in which children are regularly abused (Macoun 2011:524). Announcing the need for the emergency response, Prime Minister Howard made the following media statements:

What we have got to do is confront the fact that these communities have broken down. The basic element of a civilised society don’t exist. (Interview 22 June 2007) (PM Transcripts 2007)

We have been presented with the most compelling evidence of total failure in society. (Interview 21 June 2007) (ABC 2007)

I’m not saying it hasn’t happened in other communities and I’m not saying it’s only in Indigenous communities that this sort of thing’s happened... But these are the most egregious examples, the most squalored concentration that you can find in our community of these sorts of things. (Interview 21 June 2007) (ABC 2007)

In the Prime Minister's description, Aboriginal and Torres Strait Islander communities become places that are 'uncivilised', without order – failed societies with a 'squalored concentration' of child abuse. They are social dystopias.

These initial media statements by Prime Minister Howard also involved a series of racist descriptions around the failure of Aboriginal and Torres Strait Islander parents to care for their children:

We are dealing with children of the tenderest age who have been exposed to the most terrible abuse, from the time of their birth, virtually. And any semblance of maintaining the innocence of childhood is a myth in so many of these communities.

This social malaise cannot and should not be seen as just a failure of government. The primary responsibility for the care and upbringing of children must rest with parents and we should be honest and mature enough as a society to recognise this fact. (*The Age* 2007)

These quotes employ deeply racist essentialist descriptions of Aboriginal and Torres Strait Islander people and their failure to care for their children, portraying *all* Aboriginal and Torres Strait Islander children as vulnerable and *all* parents as negligent. Aboriginal and Torres Strait Islander men were regularly described as the source of violence and moral failure; the Prime Minister described how 'women and children are petrified of violence and sexual molestation' (Howard 2007). In this politically loaded discourse, Aboriginal and Torres Strait Islander communities are represented as sites of moral failure with parents held responsible for supposedly failing to care for their children. In the Prime Minister's discourse, 'communities' becomes a synonym for 'culture' with Aboriginal and Torres Strait Islander culture being held as morally depraved.

In the political discourse surrounding the Intervention the idea of the vulnerable child was used reflectively to justify government action in the context of the uncivilised savagery of Aboriginal and Torres Strait Islander communities and the supposed neglect of children by their parents. Amid this discourse of deficit and parental failure, Minister Brough announced that the Northern Territory Emergency Response would intervene to protect the 'little children'. This intervention was described as a type of 'new paternalism' by the then Health Minister, Tony Abbott, in which the Federal government assumed the role of protector of vulnerable Aboriginal and Torres Strait Islander children. This role initially included mandatory health checks for all children in the Northern Territory under the age of 16 (Brough 2007).

In initial political statements, child health checks were described as being 'forensic', which prompted widespread opposition from various medical experts on the grounds that mandatory health checks were unethical and had the potential to traumatise children (Anderson, Baum & Bentley 2007:138; Boffa et al. 2011). Such criticism from the medical profession eventually prompted a change in policy: health checks became voluntary, and forensic examinations for sexual abuse no longer part of the standard health check. The subsequent evaluation of the Child Health Check Initiative described the development process of the health strategy as unusually rapid and arising from intense political pressure (Allen & Clarke 2011). This is revealing in that it points to the flawed nature of policy development as dictated by the then Federal government, resulting in a reversal of the initially stated objective of mandatory health checks.

The Child Health Check Initiative evaluation also reveals how deficit discourse informed the development of health policy during the NTER. The evaluation report contains important findings about how the framing of the NTER as an ‘emergency’ designed to protect vulnerable children led directly to a hastily devised health policy with potentially unethical and damaging outcomes:

In the case of the NTER, we found no evidence of detailed consideration of policy options. The options that had been developed in consultation with communities involved (the recommendations in the *Little Children Are Sacred* Report) were ignored, or perhaps more accurately left behind in the stampede. The Australian Government did not discuss policy implementation issues with DoHA [Department of Health and Ageing], leading to an announcement of policy that was technically and ethically flawed and which created fear among the groups it was designed to protect. (Allen & Clarke 2011:44).

The failure even to discuss the roll-out of child health checks with the Department of Health and Ageing prior to the announcement being made suggests that politicians were motivated by political interests rather than by the development of appropriate policies to address child abuse.

The framing of the Intervention as an effort by the Federal Government to protect vulnerable children was repeatedly challenged in the initial stages of the emergency by the Aboriginal Medical Service Alliance of the Northern Territory. AMSANT wrote in 2007:

We are further dismayed that the estimated \$500 million cost (not including the health checks and follow up care) of largely inappropriate and counter-productive intervention measures represents a lost opportunity to direct those resources to areas of urgent need that would directly contribute to reducing the incidence of child sexual abuse in Aboriginal communities. (AMSANT 2007:2)

This statement points to the incongruity of Intervention measures that targeted Aboriginal and Torres Strait Islander land, permits and welfare payments rather than offering any sustained effort to protect vulnerable children.

In terms of deficit discourse, the report evaluating the Child Health Check Initiative describes the discourse around Aboriginal and Torres Strait Islander people that led to the initiative as viewing:

Aboriginal people (particularly men) as incompetent and/or perpetrators, Aboriginal culture as a negative influence on people’s development, and Aboriginal organisations as generally corrupt or inept. (Allen & Clarke 2011:44–45)

This description holds all of the pillars of deficit thinking: essentialist stereotyping that denigrates Aboriginal and Torres Strait Islander people (men in particular), culture and organisations. Following the logic of the new paternalism embraced by the then Minister for Health and articulated by Prime Minister Howard, Aboriginal and Torres Strait Islander people suffer from moral deficiencies for which the solution is government intervention and supervision to ensure that they adhere to mainstream behavioural norms (Bielefeld 2016:156).

In the deficit discourses that surrounded the Intervention, ‘Aboriginality’ became the marker for moral failing. Lovell points out that in introducing ‘income management’ as part of the Intervention package, Minister Brough repeatedly described how this would be useful in creating ‘responsible behaviour’ among welfare recipients (Lovell 2016:438). Intervention efforts were framed around the need to ‘normalise’ Aboriginal and Torres Strait Islander communities as well as changing their cultural behaviour ‘with the clear aim of altering people’s values in the longer term to embrace those of mainstream Australia’ (Altman 2007:10). This, in turn, provided the rationale for greater state intervention in Aboriginal and Torres Strait Islander affairs leading to the Northern Territory Emergency Response.

#### ***Case study 4: NATSIHP and ATSIHPF***

The Intervention can be seen as a low point in Aboriginal and Torres Strait Islander policy discourse generally, and in health policy specifically. However, the Aboriginal and Torres Strait Islander health policy field is not monolithic or omni-directional and has continued to evolve.

As a final case study, we interrogate two contemporary Aboriginal and Torres Strait Islander health policy documents:

- the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* (NATSIHP), and
- the *Aboriginal and Torres Strait Islander Health Performance Framework 2017* Report (ATSIHPF).

In each of these documents we see increasing nuance in the discourse, as well as an ongoing tension. The nuance can be found in the degree to which these policy documents actively incorporate Aboriginal and Torres Strait Islander perspectives on health, and acknowledge the limits of reductionist, technical understandings of health and wellbeing. The tension is that such shifts sit alongside pervasive discourses of deficit, sometimes within the same document.

The *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* was produced by the previous Australian Government led by Prime Minister Julia Gillard, with the Hon Warren Snowden as Minister for Indigenous Health, as a ‘policy framework designed to guide policies and programmes to improve Aboriginal and Torres Strait Islander health over the next decade’ (Commonwealth of Australia 2013:1). As an overarching document, it plays a critical role in setting policy direction, while also representing the state’s discursive position (at a particular point in time) in relation to Aboriginal and Torres Strait Islander health.

The NATSIHP takes a strengths-based approach that emphasises culture, human rights, partnership, holism and wellbeing as foundational to Aboriginal and Torres Strait Islander health care and delivery. It lays out its overarching vision for the health system as follows:

The Australian health system is free of racism and inequality and all Aboriginal and Torres Strait Islander people have access to health services that are effective, high quality, appropriate and affordable. Together with strategies to address social inequalities and determinants of health, this provides the necessary platform to realise health equality by 2031.



The four key principles informing the NATSIHP are:

- Health equality and a human rights approach
- Aboriginal and Torres Strait Islander community control and engagement
- Partnership between Aboriginal and Torres Strait Islander people, federal, state and territory governments and service providers
- Accountability.

The NATSIHP positions 'culture' as central to all other components of its approach, stressing that 'Aboriginal and Torres Strait Islander peoples have the right to live a healthy, safe and empowered life with a healthy strong connection to culture and country'. It points out that culture should not be conflated with 'excessive behaviours which can have a detrimental effect on the health and wellbeing of people, their families and communities' and which 'have no basis in Aboriginal and Torres Strait Islander cultures' (Commonwealth of Australia 2013:9). Following on from the recognition of culture, the NATSIHP prioritises a holistic view of health – one that recognises connections with education, employment, wellbeing, language, and traditional knowledge, as well as broader issues of social justice, equity and rights.

The principles above are reflected in the 'Priorities' section of the NATSIHP (Commonwealth of Australia 2013:14–28). For example, in discussing the context of 'social determinants' it states:

Improvements in Aboriginal and Torres Strait Islander people's health requires an integrated approach encompassing the strengthening of community functioning, reinforcing positive behaviours, and improving education participation, regional economic development, housing and environmental health, and spiritual healing. It is vital for communities and individuals to have the ability and freedom to be empowered and able to translate their capability (knowledge, skills, understanding) into action. (Commonwealth of Australia 2013:13)

It is notable that issues of racism are explicitly addressed, including an acknowledgment of evidence suggesting 'that racism experienced in the delivery of health services contributes to low levels of access to health services by Aboriginal and Torres Strait Islander people'. It also states that experiences of racism are

compounded by the traumatic legacy of colonisation, forced removals and other past government discriminatory policies. The consequences of these events have been profound, creating historical disadvantage that has been passed from one generation to the next. (Commonwealth of Australia 2013:14–15).

Predominantly, the NATSIHP steps outside a deficit narrative. However, at the same time it is still explicitly underpinned by the Closing the Gap framework and the notion of statistically measuring Aboriginal and Torres Strait Islander disadvantage. For example, the quote about empowerment above is immediately preceded by the statement:

... chronic ear disease negatively affects the education attainment of Aboriginal and Torres Strait Islander school children, and poor health explains 42.7 per cent of the known gap in labour force participation for Aboriginal and Torres Strait Islander males, and 13.9 per cent of the gap for Aboriginal and Torres Strait Islander females in non-remote locations. (Commonwealth of Australia 2013:13)

This prevalence of deficit statistics is likely a consequence of at least three factors. One is that, as pointed out above, statistics can do important work in highlighting relations of inequality or changes over time; their seeming simplicity affords them impact in making plain that many state systems are, at present, failing people. Secondly, their specificity also (problematically) appears to render complex issues knowable in some way, and therefore amendable to ‘technical’ intervention (Scott 1998). Lastly, policy makers are obliged to work within certain overarching frames set out by the government of the day – in this case, Closing the Gap. As such, in policy and practice different narratives and priorities come together in complex ways, coexisting and sometimes sitting in tension with one another. Thus, even when policy demonstrates overt narratives of Aboriginal and Torres Strait Islander strengths, the status quo may be only partially or superficially challenged.

The 2017 Aboriginal and Torres Strait Islander Health Performance Framework provides further evidence of the ways multiple narratives operate simultaneously in policy. The ATSIHPF ‘monitors progress in Aboriginal and Torres Strait Islander health outcomes, health system performance and the broader determinants of health’ (AHMAC 2017:4). The *2017 ATSIHPF Report* is the sixth such report and provides 268 pages of data and discussion across a range of health indicators and measures of health policy concerns. In a similar vein to the OID reports, the ATSIHPF can be seen both to continue the narrative of the Closing the Gap agenda, while also giving credence to discourses based in strength, cultural vitality and holistic understandings of Aboriginal and Torres Strait Islander health.

For example, the ATSIHPF provides evidence of a range of data and approaches that could be thought of as challenging deficit discourse about health performance, such as:

- Acknowledgment of racism and colonisation as impacting on Aboriginal and Torres Strait Islander health (p. 27)
- The importance of ‘community function’ in health outcomes (pp. 165–7)
- The role of cultural competency (p. 163)
- Acknowledgment of the difficulties of measuring certain aspects of Aboriginal and Torres Strait Islander health performance (p. 4)
- The complexity of social determinates (throughout the report)
- The role of access to Country in better health outcomes (including for urban Aboriginal and Torres Strait Islander populations) (pp. 126–8)
- Competent and self-determined forms of governance (p. 174)
- The primacy of social and emotional wellbeing and holistic forms of assessment in Aboriginal and Torres Strait Islander health (p. 76)
- The importance of strengths-based approaches in developing policy positions (p. 10).

The ATSIHPF also explicitly questions some of its own assumptions. For example, in its efforts to balance the dominance of statistics based in the medical paradigm, the ATSIHPF provides some strengths-based measures of social capability and capacity, such as ‘community functioning’ (AHMAC 2017:64). Putting aside the fact that any effort to measure sociality statistically may in itself be an act of rendering complexity technical, there is a genuine acknowledgment here that ‘different cultures give greater or lesser priority to different types

of functioning' (AHMAC 2017:64). Similarly, the ATSIHPF also explicitly acknowledges that ideals of functionality from a Western perspective 'do not necessarily align' (AHMAC 2017:64) with a diversity of cultural understanding in Aboriginal and Torres Strait Islander health.

Paradoxically, however, in the Overview section of the report (which functions as an executive summary) we see much of the nuance of such discourse emptied out in favour of that which can be easily measured and described numerically. While at one level this is perhaps a function of brevity and ease in making plain the information contained in the report, at another level it speaks to the way in which a technical rendering of Aboriginal and Torres Strait Islander health as statistics is so pervasive.

Using these two reports and our earlier discussions as evidence, it is tempting to see a simple dichotomy in the analysis. On the one hand, there is a long history of measurement and a desire to 'fix' the 'Indigenous other' according to a normative non-Indigenous ideal. On the other hand, there are counter-narratives advocating for the importance of culture, strength and diversity, while also calling for alternative understandings of the role of language and land in health outcomes. Our discursive analysis shows that these differing, and at times opposed, narratives co-exist in complex ways. This reflects the fact that there is no simple discursive position advanced by the state, nor is there a single position advocated by a diversity of Aboriginal and Torres Strait Islander views across the country. Rather, the production of policy discourse must be considered an amalgam of political, academic and 'grass-roots' views in a state of constant change and contestation.



# Conclusion

As the product of a relatively contained (six-month-long) study, this report is intended to progress an emerging conversation and research agenda – one that we hope will grow, evolve and ultimately become redundant.

As we have pointed out, meta-narratives and tropes operating in a discursive field such as health have important roles in reproducing certain understandings of the world and structuring what courses of action seem possible, practical and ethical. Language, concepts and practices together constitute self-perpetuating ‘regimes of truth’ in a context where some people are agents and others are made ‘objects’ of the discourse. Deconstructing discourse is, therefore, essential to bringing relations of inequality into sharper focus.

‘Deficit discourse’ is a mode of thinking that frames and represents Aboriginal and Torres Straits Islander people in a narrative of negativity, deficiency and failure (Fforde et al. 2013). In certain discursive spaces in Australia, the term ‘Aboriginal and Torres Strait Islander people’ has come to be associated with particular negative tropes, including unhealthy, undereducated, unemployed, violent, and socially dysfunctional. Associated with each of these are certain sub-tropes, for example, ‘unhealthy’ is linked in turn with overcrowding, neglect and substance abuse.

Our review of the literature indicates that such deficit discourse impacts on Aboriginal and Torres Strait Islander health in multiple ways. It appears likely that at times it contributes to subtle forms of external and internalised racism, but it also shades out solutions that recognise strengths, capabilities and rights. Deficit discourse is both a product of, and reinforces, the marginalisation of the voices, perspectives and world-views of Aboriginal and Torres Strait Islander people.

It is crucial to note that in analysing and mapping discourses of deficit, we do not seek to ‘problem deflate’. Aboriginal and Torres Strait Islander Australians face well-documented realities of socio-economic ‘disadvantage’. Discourses of deficit occur when discussions and policy aimed at alleviating disadvantage become so mired in reductionist

narratives of failure and inferiority that Aboriginal and Torres Strait Islander people themselves are seen as the problem. These discussions thus become a continuation of pejorative and patronising race-based discourses in terms of which Aboriginal and Torres Strait Islander people have long been represented.

In this report we have paid particular attention to deficit statistics, such as in the Closing the Gap agenda. We argue that deficit data has been used for politically diverse purposes, including by Aboriginal and Torres Strait Islander advocates, to highlight injustice and hold government to account. However, divorced from context and frequently reiterated, such statistics can also form a narrative that homogenises and dehumanises Aboriginal and Torres Strait Islander people into an intractable ‘problem’ to be ‘dealt’ with. Worse, they can form part of a narrative that situates responsibility for inequalities wholly with Aboriginal and Torres Strait Islander people themselves, obscuring the ways entrenched structural inequalities are affecting health.

At the same time, policy itself is far from monolithic: it incorporates a range of views, is often ‘discursively aware’, and exists in a state of flux and contestation. We particularly see a tension between a desire to ‘fix’ the ‘Indigenous other’ according to a normative non-Indigenous ideal, and counter narratives advocating for notions of culture, strength and diversity. These latter voices are calling for more sophisticated understandings of the roles that factors such as language, country and community control play in health outcomes. These views come together in complex ways. As Li notes, schemes to improve the human condition face a messy reality where ‘attempts to achieve the ‘right disposition of things’ encounter – and produce – a witches’ brew of processes, practices, and struggles that exceed their scope’ (Li 2007:28). This gives us hope: in the ‘messy’ reality of policy making and implementation change is constant, and if we are critically aware of discourses of deficit in Aboriginal and Torres Strait Islander health they will remain open to challenge and disruption.



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