

**Changing the Conversation:
Strengthening a rights-based holistic approach to
Aboriginal and Torres Strait Islander health and
wellbeing**

A report drafted for Indigenous Allied Health Australia

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Executive Summary

The Close the Gap Campaign beginning in 2007 is a response to the poor health outcomes many Aboriginal and Torres Strait Islander people experience compared to non-Indigenous Australians. The phrase ‘closing the gap’ – whether on health, education or employment – is a common expression within program and policy initiatives. This report aims firstly to identify some of the underlying causes of such disparities and to suggest some ways in which Aboriginal and Torres Strait Islander health inequalities can be better conceived of and approached. It attempts to change the conversation surrounding Indigenous health by adopting a strengths-based approach, as opposed to focussing on ‘problems’ surrounding it. This ensures a positive sense of cultural identity where community leadership can be embraced and advocated for, and further enables innovative and dynamic approaches and processes towards health programs and policies.

In attempting to change the conversation, this report outlines the importance of realising the underlying causes of ill health for Aboriginal and Torres Strait Islander people and adopts a human rights framework in order to develop recommendations. The Universal Declaration of Human Rights (1948) and the UN Declaration on the Rights of Indigenous Peoples (2007) is used as a basis for this framework and allows two significant findings to be made:

1. Aboriginal and Torres Strait Islander-led strategies and conceptualisation of health must be recognised as of fundamental importance.
2. Health determinants are broad, complex and interrelated.

Beyond merely recognising them as visionary goals, or institutional values, this report incorporates these key findings into real strategies for implementation in

communities, service centres and hospitals. These two findings inform the four major recommendations of this report:

1. Culturally responsive health care delivery needs to be the basis of any health service training and implementation. This encourages health professionals to effectively engage with Aboriginal and Torres Strait Islander patients, including responding to differing perceptions of health, wellbeing, illness and the body.
2. An Aboriginal and Torres Strait Islander health workforce is fundamental to improving health outcomes. The recruitment and retention of this workforce needs to be an essential element of health policy, programs and initiatives.
3. An interdisciplinary approach in the health sector must be adopted. This demands the integration of several disciplinary approaches into a single patient consultation, whereby the patient is not only involved in all aspects of decision making processes, but the structural separation of disciplines within the health system are broken down in order to treat the patient holistically.
4. The role of allied health in Australia's health system should be strengthened. Allied health is an important component of primary health care and allied health workers need to be recognised as key players in any attempt to provide a holistic health care service.

While adoption of these recommendations would likely see an improvement in the health outcomes of Aboriginal and Torres Strait Islander people, this report acknowledges that Aboriginal and Torres Strait Islander people are not a homogenous group and that perspectives on health and the issues discussed throughout this paper might not be in accordance with all peoples, and does not seek to speak on behalf of all Indigenous communities in Australia.

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List of Abbreviations

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
COAG	The Council of Australian Governments
IAHA	Indigenous Allied Health Australia
ICESCR	International Covenant of Economic, Social, and Cultural Rights
NACCHO	National Aboriginal Community Controlled Health Organisation
NAHS	National Aboriginal Health Strategy
NGO	Non-Governmental Organisation
UN	United Nations
WHO	World Health Organisation

INTRODUCTION

‘You cannot fix the health gap in the doctor’s surgery alone.’

- Mick Gooda (pers. comm., 11 April 2013)

In April 2007, the Close the Gap campaign was officially launched. Put forth by Australia’s peak Indigenous and non-Indigenous health bodies, NGOs and human rights organisations, the campaign emerged out of the 2005 Social Justice Report which argued for the basic right to health to be realised (Australian Human Rights Commission, 2013). The campaign’s goal is to raise the health and life expectancy of Aboriginal and Torres Strait Islander peoples to that of the non-Indigenous population by 2030 (NACCHO, 2013). Currently, Aboriginal and Torres Strait Islander people continue to have a lower life expectancy and are twice as likely as non-Indigenous people to report fair/poor health, a statistic that has remained unchanged since 2002 (ABS, 2012). They are three times more likely to be in hospital due to self-harm (Calma 2009: 28 cited in Smallwood, 2011). Furthermore, health problems such as poor maternal and child health, infectious diseases, injury, diabetes and heart diseases are of major concern, not to mention high rates of smoking, obesity, and other behavioural risk factors (Anderson et al., 2006; Cunningham et al., 2008).

Health outcomes for Indigenous Australians are not only poor by national standards but contrast poorly compared to the health of other Indigenous populations and to outcomes achieved in places such as Canada and New Zealand (Booth and Carroll, 2005a: 1). Indeed, ‘Australia is unique among comparable post-colonial societies in failing to make substantive reductions to the Indigenous/non-

Indigenous health differential' (Oxfam, 2007 cited in O'Sullivan, 2012). In response, the Council of Australian Governments (COAG) has pledged to develop and implement strategies to address health disadvantage, with 'closing the gap' now a well-known phrase associated with such goals. Critical inequalities persist however, and they will be addressed in this report. In doing so, it will not only contribute to the Close the Gap movement in encouraging a human rights approach when considering health outcomes, but will further add to the debate surrounding the meaning of health and its determinants.

While much has been said of the 'problems' in Aboriginal and Torres Strait Islander health, this report will take a strengths-based approach and attempt to change the conversation surrounding such issues. In doing so, it will focus on ways to improve health status by looking at its multiple and complex dimensions and suggest ways in which to improve on the current situation. Further, a strengths-based approach means advocating for a positive sense of cultural identity that acknowledges and builds upon strong community leadership. This report outlines how this approach can better enable programs and policies that are more innovative and dynamic than has been possible under previous health paradigms in Australia (Stronger Smarter, 2013). In this way, concepts of primary health care underlie discussions in this paper, as understood by the Alma Ata declaration of 1978 and as a core concept of the World Health Organisations (WHO) goal of 'health for all' (Couzos et al., 2003). Primary health care is:

'...a holistic approach which incorporates body, mind spirit, land, environment, custom and socio-economic status. [It] is an Aboriginal cultural construct that includes essential, integrated care... made accessible to communities (as close as possible to where they live) through their full

participation in the spirit of self-reliance and self-determination. The provision of this calibre of health care requires an intimate knowledge of the community and its health problems, with the community itself providing the most effective and appropriate way to address its main health problems...?’

(Couzos et al., 2003: xxxii)

This definition outlines a number of key elements that will form the basis of this paper’s exploration of Aboriginal and Torres Strait Islander health outcomes. These include: considerations of the broader determinants of health, the importance of community leadership and the intimate knowledge of patients required by health workers. These key factors are also central to a holistic outlook towards health, a crucial concept that can be seen in many Aboriginal and Torres Strait Islander approaches to health. A holistic approach to health is increasingly called upon from numerous quarters to close persistent health gaps, as it encourages health to be defined as a person’s ‘total wellbeing’, including the ‘social, emotional, and cultural wellbeing of the whole community’ (Shahid et al., 2009; Lutschini, 2005). A holistic approach acknowledges that ‘healing is not just physical; it’s mental, emotional and spiritual as well’ (Shahid et al., 2009). This approach then calls for the notion of health as currently conceived in Australia to be questioned and perhaps reworked in order to account for Aboriginal and Torres Strait Islander conceptions and solutions to health determinants and outcomes.

This paper will explore current health issues and their solution from a human rights framework before moving on to flesh out what this means for health in Aboriginal and Torres Strait Islander communities. Chapter One takes up this framework, gives it definition and explores the ways in which poor health outcomes for many Aboriginal and Torres Strait Islander people can be seen as both the result

and cause of human rights violations. While often labelled as merely symbolic, this chapter will argue for practical action regarding the health of Aboriginal and Torres Strait Islanders to be taken based on both the Universal Declaration of Human Rights (1948) and the UN Declaration on the Rights of Indigenous Peoples (2007). The link between human rights and health will be uncovered, and further used to recognise the underlying and broader social, historical and political determinants of health, and the importance of an Aboriginal and Torres Strait Islander health professional workforce.

By adopting the human rights framework as an overarching guide to problem framing, two significant findings are uncovered; first, Aboriginal and Torres Strait Islander-led strategies and conceptualisations of health must be recognised as of fundamental importance and, second, that health determinants are broad, complex and interrelated. These two arguments will form the basis for thinking about new approaches and solutions in Chapters Two and Three respectively. Both chapters analyse these complex arguments through detailed literature review and interviews with key thinkers and advocates. Chapters Two and Three suggest four recommendations for the improvement of Aboriginal and Torres Strait Islander people's health. These are: health care delivery must be made culturally responsive, an Aboriginal and Torres Strait health workforce should be recruited and retained, interdisciplinary approaches in the health sector need to be embraced, and the place of allied health in Australia's health system must be expanded.

Chapter Two will explore current diverging conceptions of health, wellbeing, illness, and the body. In doing so, Australia's mainstream health system - that of Western biomedicine - will be placed in its particularly cultural context, questioned and contrasted to the holistic view of health held by Aboriginal and Torres Strait Islander peoples. It is asserted here that cultural responsiveness and an Aboriginal and

Torres Strait Islander-led approach (including the support and retaining of Aboriginal and Torres Strait Islander health professionals), would not only benefit the current health gap between Indigenous and non-Indigenous Australians, but our society as a whole.

Chapter Three refers to earlier frameworks and discussions in order to look at the social, historical and political determinants of health, while also acknowledging racism as a determinant of health. It will be argued that such determinants are not causal or linear, rather they are interrelated, and can be seen as recurring ‘daily realities’ that too often challenge the health and wellbeing of Aboriginal and Torres Strait Islander individuals, families, and communities. In order to address these daily realities and in keeping with an Aboriginal and Torres Strait Islander holistic understanding of relatedness, it is argued that an interdisciplinary approach must be taken up in the health system. This includes allied health as one means of addressing the siloing of health disciplines.

CHAPTER 1: HEALTH AND HUMAN RIGHTS

‘Rights are only rights when they are exercised’

- Mick Gooda (2010)

This chapter outlines a human rights framework for interpreting health inequality. It builds this approach around the rights described by the Universal Declaration of Human Rights (1948) but also the UN Declaration on the Rights of Indigenous Peoples (2007), here referred to as the Declaration. These documents are significant for the Social Justice Reports, put out each year by the Aboriginal and Torres Strait Islander Social Justice Commissioner since 1993. The reports monitor the exercise and enjoyment of human rights by Australia’s Indigenous people, and use human rights as a basis upon which to advocate for change in not only the health system but the political, economic and legal arena. These reports formed the basis for the Close the Gap campaign, illustrating the growing literature and recognition of the human rights framework, particularly in the context of health and the health of Indigenous peoples worldwide.

While often considered a symbolic paradigm, it will be shown that practical action can come from the human rights framework in policy and procedure implementation on both an international and domestic front. In using this framework it is argued that not only are the links between rights and health explicitly named, but further asserted will be the notion that poor health is in fact both a consequence and contributor of human rights violations. Such inextricably linked concepts encourage further exploration of how the right to health can be seen as the right to the ‘opportunity to be healthy’. The government, for example, cannot make you healthy,

yet they have a duty to provide the opportunities to be healthy (Gooda, 2010). This gives way to instructive frameworks so as to enforce available, accessible, acceptable and quality health services.

In using the human rights framework, the following chapters will draw upon two major arguments recognised within this paradigm; that of the importance of an Aboriginal and Torres Strait Islander lens towards health and the importance of recognising the broader, complex and interrelated determinants of health (social, historical, political, racism) in determining health outcomes. In reflecting upon the human rights framework, these factors call for a holistic and interdisciplinary approach, and an Aboriginal and Torres Strait Islander and community-led approach towards health and Australia's health system.

Human rights and health: the Declaration and its practical uses

Human rights will refer here to the international norms that apply equally to all people worldwide, as outlined in the Universal Declaration of Human Rights that was put forth in 1948 in response to the violations of World War II. This document was the first expression of internationally agreed human rights principles. More and more, Articles from both the Universal Declaration of Human Rights (1948) and the UN Declaration on the Rights of Indigenous people (2007) are being drawn upon to argue for health equality for Indigenous peoples, in legal, political, economic and moral settings. This is the human rights paradigm. The Australian context is no exception.

Using human rights as a basis for setting political and legal agendas remains a contentious issue when considering Aboriginal and Torres Strait Islander wellbeing in

Australia. The UN Declaration of Human Rights does not create any new rights in international law. Indeed, it has been argued that within an Australian context the human rights framework is inoperable from both a legal and even moral framework. It is argued that this is due to the dismantling of structural forms of criticism by the Australian Government, with past governments reluctant to commit to a definition of human rights or international responsibilities (Gray and Bailie, 2006). Furthermore, it is often argued that such rights are abstract concepts, symbolic in their meaning but of no real use to practical action when addressing disadvantage at a ground level (Sutton, 2009). Their broad nature has been questioned, with Merlan (2009) arguing that ‘the applicability of a single, allegedly universal system of rights’ should be questioned, as it contrasts to the notion that particular social and historical contexts need to be considered in ‘any good theor[y] and practice’.

There are, however, many strong arguments for the use of such a paradigm. This paper will be written on the basis that the human rights framework has a practical place in Australian policy and law. Smallwood (2011: 2) argues that if policies based on human rights are under attack, so too is the ‘allied notion of social justice’. While perhaps symbolic, using the human rights framework can also be practical, with Gooda (2010) arguing that actions that do not have solid foundations based on rights will always fail. Here, human rights provides a framework to not only guide policy making and influence the design, delivery and monitoring of health care systems, but also allows for the recognition of the underlying causes of health to be seen in Australia, as well as the inter-connections with other issues (see Social Justice Commissioner, 2005: 37; Gooda, 2010; Social Justice Commissioner, 2013).

It can be argued that the universal nature of the Declaration provides the international community with ‘the minimum standards for the survival of Indigenous

people ... each provision provides a benchmark or baseline as to how the rights should manifest themselves in the lives of Indigenous individuals and groups' (Sambo Dorough, 2006: 226). In this regard, national, state, and local governments have a framework upon which to base policy development and implementation in regards to political, legal, social and economic action. Calma (Social Justice Commissioner, 2005) argues that by using a human rights-based approach to address current health inequalities, the government must not only respond and address issues of health, but do so within a set time frame. In this sense, the practical actions and outcomes needed to address social disadvantage are usefully seen in terms of 'the realisation of human rights', and are inextricably linked (Gooda, 2010).

Health as both a contributor and consequence of human rights violations

The Universal Declaration of Human Rights is Article 25.1 states that:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control (United Nations General Assembly, 1948).

The links between health and human rights are profound and numerous. At the most simple level, health, as outlined above, is recognised internationally as a basic human right. However the interrelations between the notions of health and human rights are far broader and deeper than this, and encompass issues surrounding equality, poverty and structures of power. Instead of viewing health as an isolated human right that

should be morally or legally enforced, this paper will argue for a human rights framework to be implemented when considering health on the basis that health and other human rights are interconnected and interdependent.

The promotion and protection of health rights can be viewed as being interdependent upon the promotion and protection of many, if not all, other human rights (Mann, 1997), with the stress on not only civil and political rights but economic and social rights as well (Farmer, 2005). This interrelation and its effects on the health status of marginalised groups can be seen as a cycle. Groups who suffer social inequity – often racial minorities such as Aboriginal and Torres Strait Islander people – have been shown also to be more vulnerable to abuses of not only civil and political rights, but social and economic rights (Farmer, 2005). The results of such violations are more often than not detrimental to health (Gray and Bailie, 2006: 450). Those people suffering from poor health are more likely to be socio-economically disadvantaged, and therefore less likely to be able to ‘mobilise the resources or power to protest against and rectify their social inequality’ (Farmer, 2005; Gray and Bailie, 2006: 450; Sen, 1999). Thus the cycle continues, with poor health arising from rights violations, but also compounding and fostering social, economic, civil and political rights abuses. In this sense, recognition of the interdependency of health and human rights requires identifying and overcoming the broader social, structural, economic, political and cultural obstacles that keep disadvantaged groups from accessing the full benefits of health initiatives (Braveman and Gruskin, 2003).

Since the development of the United Nations, ‘a “health and human rights” language [has developed]... which has allowed for the connections between health and human rights to be explicitly named, and therefore for conceptual, analytical, policy and programmatic work to begin to bridge these disparate disciplines and move

forward' (Gruskin and Tarantola, 2001: 311). Acknowledging the links between health and human rights allows for Indigenous conceptualisations of health to be acknowledged as fundamental (to be discussed in Chapter Two). It further allows for the recognition of deeper social determinants of health (Social Justice Commissioner, 2005: 37; Gray and Bailie, 2006) as will be discussed further in Chapter Three.

The right to the opportunity to be healthy

In Australia, the broader perspectives offered by the human rights framework has led to the right to health to be seen in terms of opportunity gaps. This is often understood as the right to opportunities to be healthy, which includes 'the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health' (Gooda, 2010). Such a right involves the recognition of those broader civil, social and economic rights and obstacles that are linked to health outcomes and causes. Gooda (pers. comm., 11 April 2013) further asserts that while the government cannot make you healthy, 'governments have a duty to provide *the opportunity* to be healthy'.

The right to health can therefore be understood as equal opportunities within the health care system. As outlined by the International Covenant of Economic, Social, and Cultural Rights (ICESCR, cited in Gooda, 2010), the right to health therefore contains the following 'interrelated and essential elements':

Availability - Functioning public health and health-care facilities, goods and services, as well as programs, have to be available in sufficient quantity within a country.

Acceptability - All health facilities, goods and services must be respectful of medical ethics as well as respectful of the cultures of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

Accessibility – Health facilities, goods and services have to be accessible to everyone without discrimination. Accessibility has four overlapping dimensions:

1. Non-discrimination: health facilities, goods and services must be accessible to all, in law and in fact, without discrimination.
2. Physical accessibility: health facilities, goods and services must be within safe reach for all sections of the population. This also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including rural areas.
3. Economic accessibility health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups.
4. Information accessibility: includes the right to seek, receive and impart information and ideas concerning health status.

Quality – As well as being culturally accessible, health facilities, goods and services must also be scientifically and medically appropriate and of good quality.

As outlined in this document, the right to health extends much further than the biomedical basics, and includes ‘underlying determinants’ and respect for culture. These are topics that will be discussed further below, however it is important to note them here when discussing their relationship to rights and health. O’Sullivan stated recently that ‘[e]qual opportunity for good health is a mark of equal moral worth, just as comparable access to the highest achievable level of health care distinguishes equal citizenship and protects access to political, economic and social liberties’ (O’Sullivan, 2012: 688).

Human rights: self-determination in the context of health

As we have seen, the Universal Declaration of Human Rights articulates the basic human right to health. This has further led to the questioning and exploration of the essential idea that rights and health are indeed linked, allowing for broader social, economic, political, historical and cultural factors to be recognised and included when considering health outcomes of marginalised groups. Aboriginal and Torres Strait Islander people are often considered as one such group, coming under the banner of Indigenous peoples. How then are the rights of Indigenous peoples embedded in the discussion surrounding rights and health, as opposed to simply universal human rights?

At an international level numerous major developments have been made concerning Indigenous rights protection, yet it can be argued that the most significant milestone was the passage of the UN Declaration on the Rights of Indigenous Peoples in September 2007 (the Declaration), recognising and articulating the particular entitlements of Indigenous peoples to the existing universal human rights standards outlined in the UN Declaration of Human Rights (1948). The right to health is defined throughout the Declaration, yet most evidently in Article 24.2 which states:

Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health.

Health is inherent and interrelated when articulating human rights, as outlined in the Declaration. Yet there is more than the stark recognition of simply ‘the right to health’ when it comes to Aboriginal and Torres Strait Islander people’s health outcomes. Many scholars have noted other specific Articles throughout the Declaration on the Rights of Indigenous Peoples that links rights and health (Gooda, 2010; Smallwood, 2011), and when violated, impact health outcomes of Indigenous peoples (see textbox 1). Among these are the right to social, civil, economic and political freedom, and self-determination. These Articles, while outlined here, will be referred to and discussed in more detail in the following chapters.

TEXTBOX 1

The right to health as outlined in the UN Declaration on the Rights of Indigenous Peoples (2007)

Article 21.1

Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security.

Article 23

Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

Article 24

1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.

2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realisation of this right.

Conclusion

This chapter, in exploring the human rights paradigm, has allowed the links between rights and health to be named and laid the foundation for a human rights framework to be further explored in an Australian context. This will be done by exploring the critical themes of Aboriginal and Torres Strait Islander conceptualisations and therefore realisations of health, and of the broader, underlying determinants of health. These two findings will make up Chapters Two and Three of this report. Further drawing from this framework, a holistic, interdisciplinary and culturally responsive approach, and Aboriginal and Torres Strait Islander and community-led health system and workforce will be proposed as ways to improve upon current health statistics.

Drawing from parts of the Declaration such as ‘the right to ... traditional medicines and [maintenance] of health practices’, the next chapter will explore the definition of health from an Aboriginal and Torres Strait Islander perspective (holistic perspective). It will assert that it is not only a human right to be able to determine a holistic take on health, but beneficial to individual, family and community health outcomes.

In considering the right to self-determination and the right to ‘maintain traditional health practices’, the next chapter will further make recommendations based on the practical need for an Aboriginal and Torres Strait Islander-led approach. Such an approach would recognise the importance of assuring the provision of culturally responsive services, and supporting and retaining Aboriginal and Torres Strait Islander health professionals. It will be seen that a human rights framework provides a basis to implement and stand by such practical actions and ideas.

CHAPTER 2: CONCEPTIONS OF HEALTH

What we can learn from an Aboriginal and Torres Strait Islander perspective

Much literature notes the considerable differences that exist in the perceptions and definitions of health, healthy living, wellbeing and illness, and the meaning of disease and death between Indigenous Australians and the dominant Anglo-Australian society (see Brady, 1992; Cunningham et al., 2008; Heil, n.d.; Maher, 1999; Morgan et al., 1997; Shahid, 2009). This chapter will explore such diverging perceptions of health and make the argument that these differences need to be built into the health system. Thus it will attempt not only to look at the Aboriginal and Torres Strait Islander culture and its relations to health, but also encourage biomedicine as Western culture to be explored and questioned.

While widely contested throughout academic circles, the notion of ‘culture’ can be understood for the purposes of this study as ‘a complex set of beliefs and behaviours we acquire as part of our relationships within particular families and other social groups’, that further ‘predisposes us to view and experience health and illness in particular ways’ (Saggers et al., 2011: 2). Conceived in this way, we can extend questioning of culture to not only Aboriginal and Torres Strait Islander cultures, but to Anglo-Australian society as well. What is critical for this study is not the characterising of cultures, but understanding the relationships that are manifested and expressed in cultural constructs. Importantly, these underlie many of the societal factors surrounding medicine, health and perceptions of the body and wellbeing. In this sense, the Western health system and biomedicine can be explored as a particular ‘culture’ itself, one that is commonly considered the ‘best’ or only means to address Aboriginal and Torres Strait Islander health. This paper interrogates this notion by

illustrating how approaches that emanate from Aboriginal and Torres Strait Islander perspectives are not only legitimate but promise new gains in closing the gap.

The questioning of the dominant health system in Australia in this chapter will allow for a deeper understanding of the differences in health perceptions. It is asserted that a holistic approach is the minimum that is needed for health workers to be aware of more than biomedical explanations of 'illness' and 'health'. In doing so, it will be recognised that a culturally responsive health service is essential within the health system. Moreover, the broader health system can learn much by looking through an Aboriginal and Torres Strait Islander lens when considering the notions of health, wellbeing, illness and the body, in turn calling for not only increased recruiting and retention of Aboriginal and Torres Strait Islander health professionals but consideration of some of the key broader determinants of health, and strategies to realise these (discussed further in Chapter Three).

PART I: DIVERGING CONCEPTIONS OF HEALTH

Australia's dominant health system: Biomedicine

In responding to ill health, human societies create medical systems of one sort or another, consisting of beliefs and practices aimed at promoting health and alleviating disease (Baer et al., 2003). The global dominance of the Western medical system (including Australia's medical system) is now referred to in academic circles as 'biomedicine' (Baer et al., 2003: 11), a system which focuses on the biological cause of disease (at its simplest, bacteria). While recognising the value of biomedicine, and the astonishing impact it has had on population health, this section will argue that it is part of a rarely explored culture that should be examined and questioned. This should be done particularly by considering the roles that political, economic, historical and social factors play in the production of disease as opposed to pathogenic causes

Anthropological literature concerning biomedicine acknowledges the degree to which ethnocentricity devalues to different extents the knowledge of other ethnomedicines ('traditional medicines'), including lay beliefs and practice (Hahn and Kleinman, 1983; Baer et al., 2003). It is often argued that the Western health system addresses the individual as a bounded entity and assumes that an individual's health and body care is of primary concern (Heil, n.d.). It is argued that guiding biomedicine is 'its commitment to a fundamental opposition between spirit and matter, mind and body, and (underlying this) real and unreal' (Scheper-Hughes and Lock, 1987: 8). Thus, a basic dualism characterises clinical medicine as it interprets the body as a machine and leaves little room for the consideration of 'mindful' causations of somatic (bodily) states (Scheper-Hughes and Lock, 1987).

It is often argued that the Anglo-Australian model prescribes to such a paradigm and that indeed ‘the essential problem with the mainstream health system is that it is biomedically focused and [therefore] imbalanced’ (G Phillips, pers. comm., 12 April 2013). Hahn (cited in Baer, 2003: 12), for example, notes that biomedicine ‘emphasises curing over preventions and spends much more money on hospitals, clinics, ambulance services, drugs, and “miracle cures” than it does on public health facilities, preventative education, cleaning the environment, and eliminating the stress associated with modern life’. Phillips, a noted expert, describes how historically medical students and doctors are very much acculturated to ‘solving the problem ... they want to know what the formula is, how do we fix this disease, how do we get them out of our clinic in fifteen minutes and how do we solve the problem’ (G Phillips, pers. comm., 12 April 2013).

The above examples illustrate the imbalance witnessed in Australia’s biomedical system, where government spending focuses on biomedical solutions to health, and doctors are acculturated to viewing patients as numbers that simply need ‘a problem solved’. To more deeply understand such problems, particularly when addressing Indigenous health, and to attempt to provide positive solutions to them, an Aboriginal and Torres Strait Islander perspective needs to be further explored.

Definitions of health: An Indigenous perspective

As illustrated in Chapter One, the right to health as put forth in both the Universal Declaration of Human Rights (1948) and the UN Declaration on the Rights of Indigenous people (2007) alludes to a deeper understanding of health, one that includes the meaning and conceptualisation of health from an Indigenous perspective.

In understanding these embedded and broader issues, Australia's mainstream biomedical health model described above does not entirely comply with what has been defined as the right to health. Nor does it comply with international and national definitions of health, particularly from an Aboriginal and Torres Strait Islander perspective, as will be explored here.

The World Health Organisation (WHO) defines health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity' (WHO, 1948). This key point here – 'not merely the absence of disease or infirmity' – is what many argue is missing from Australia's biomedical-dominated health system, particularly when it comes to the epidemiology of disease from an Aboriginal and Torres Strait Islander perspective.

The National Aboriginal Health Strategy's (NAHS) understanding of Aboriginal and Torres Strait Islander health is frequently endorsed by numerous groups and institutions in Australia. Health in this definition is:

...not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total well-being of their Community. It is a whole-of-life view and includes the cyclical concept of life-death-life. Health care services should strive to achieve the state where every individual is able to achieve their full potential as a human being and thus bring about the total well-being of their community (National Aboriginal Health Strategy, 1989).

Comparing this definition of health to the mainstream health care system approaches in Australia demonstrates obvious differences between the underlying values of

Western biomedicine and traditional Aboriginal and Torres Strait Islander health beliefs (Heil, n.d.; Maher, 1999). As the biomedical approach focuses on the recognition and treatment of disease, healthcare providers then ‘concentrate only on a sick individual, and not on the individual as part of a much wider social setting’ (Reznik et al., 2001: 26). It is that wider social setting, clarified in the definition above and compounded by ‘cultural’ differences that can often account for the underlying factors behind poor health outcomes in Indigenous communities.

Health perceptions and the relation to health outcomes

The difference in perceptions and conceptualisations of health between Aboriginal and Torres Strait Islander peoples and the current Western health care system in Australia can result in miscommunication and, in turn, poorer health outcomes for individuals, families and communities. It must be noted here that this is only one reason for poor health outcomes and, as reiterated throughout this paper, is related to and inextricably linked with many other factors.

Cases of disease increase in Aboriginal communities are often associated with ‘non-compliance’ from Aboriginal and Torres Strait Islander patients. Harrington et al. (2006) challenge the perceptions of ‘the problem of non-compliance’, in the past seen in terms of patient behaviour and characteristics and as a problem with doctor-patient relationships. Miscommunication can be one reason for ‘non-compliance’, for example, and is often overlooked by medical practitioners as an inhibitor to appropriate diagnosis, patient inclusion in decision making, and better health outcomes (Lowell, 2001; Cass et al., 2002). Factors impeding communication, as identified in Cass et al.’s study (2002), can include lack of control by the patient,

dominance of the biomedical model, lack of shared knowledge and understanding, cultural and linguistic distance, lack of staff training in inter-cultural communication and failure to call on trained interpreters. Labelling a patient as ‘non-compliant’ can have disastrous effects, as it can lead to exclusion or different treatment of the patient, resulting in only more personal and physical health problems (M Gooda, pers. comm., 11 April 2013).

The above factors can all be seen as diverging ‘cultural issues’. There are numerous factors surrounding ‘culture’ from an Aboriginal and Torres Strait Islander perspective (see textbox 2), one example being the importance of kinship and relations. As Morgan et al. (1997: 598) note, ‘the fulfilment of obligations to the group is more important to Aboriginal society than isolated individual behaviour’, a factor that complicates attempts to attribute problems to Indigenous persons’ agency when the mainstream medical discourse prioritises the individual body over society and relations. Textbox 2 briefly explores more ‘cultural’ implications impeding health outcomes. Something is therefore needed to take into account those determinants that may affect health which biomedicine dominates, or even ignores.

TEXTBOX 2

Cancer and Culture: an example of diverging perceptions in health

Although experiencing a lower overall incidence of cancer as compared to non-Indigenous Australians, Aboriginal and Torres Strait Islander peoples are more likely to experience poorer outcomes from cancer, including later diagnosis, lower participation in screening, poor continuity of care, and poorer compliance with treatment, meaning they are more likely to die from their cancers than other Australians (Cunningham et al., 2008; Shahid et al., 2009). Reasons for this lay partially behind the Aboriginal concepts of ‘shame’ – seen for example in the embarrassment and discomfort associated with pap smear procedures or mammograms - combined with spiritual and fatalistic attitudes surrounding death. Fatalism in this sense can be a reflection of experienced outcomes, with almost all people in Shahid et al.’s study (2009) having a connection to a family member or friend who has not survived cancer. It can also be an association with spiritual causes of illness that can be seen to provide answers to the questions of ‘why me?’ and ‘why now?’ that Western biomedicine cannot explain (Maher, 1999: 231). Differing perceptions surrounding health do influence health outcomes. Cultural differences demand a holistic approach towards health and healing, in order to account for miscommunication and to close the gap in poor health outcomes.

The example in Textbox 2 is merely a snapshot of the myriad of complex and numerous factors underlying differences in perceptions of health, wellbeing, illness and the body. To look further into differing perceptions within different Aboriginal and Torres Strait Islander communities and individuals is not within the scope of this paper; however, from the illustrations above it has been made clear that such

conceptualisations differ on many levels, and further hold numerous consequences for an individuals and community's health. The next section will explore, through a human rights framework, positive and successful ways in which to address the conflicts illustrated above.

PART II: THE IMPORTANCE OF CULTURAL RESPONSIVENESS AND AN ABORIGINAL AND TORRES STRAIT ISLANDER AND COMMUNITY-LED APPROACH

The right to self-determination

When considering issues of cross-cultural communication, or miscommunication, it is clear that Australia is in need of practical steps to address diverging perceptions of health, wellbeing, illness and the body. These can be informed by the human rights framework, particularly by consulting the Declaration of Indigenous Rights. Of particular importance here is Article 3 of the Declaration, which states that:

Indigenous peoples have the right to self-determination. By virtue of this right they freely determine their political status and freely pursue their economic, social and cultural development.

As a human right, self-determination can be understood by the essential idea that ‘human beings, individually and as groups, are equally entitled to be in control of their own destinies ... to live within governing institutional orders that are devised accordingly’ and where all peoples ‘... are to be full and equal participants at all levels in the construction and functioning of the governing institutions under which they live’ (Anaya, 2009: 187). It is, put simply, ‘a right of choice, participation and control’ (Social Justice Commissioner, 2011: 23).

Smallwood (2013) sees self-determination as the antithesis of what she terms ‘restoration’, a notion that implies the doing of things *to* Aboriginal and Torres Strait Islander peoples, as opposed to *with* them. She argues that key to better health

outcomes and a part of the human rights framework is the need to work against restoration – or towards self-determination – as the top-down approach of the government and their policies still impacts the health equalities of Australia's first peoples. A bottom-up approach to health and policies surrounding health, perhaps here identified as self-determination, would allow for a change in the mentality of the issues surrounding health, including providing more culturally responsive services that will be further discussed below (Smallwood, 2013).

Social, economic and political links between self-determination and improving health outcomes are recognised at a basic level in Chapter Three. Here, such links will be explored so as to improve health outcomes on the basis of the cultural factors and perspectives described above.

Cultural responsiveness

In response to the discrepancies in perceptions and ideas surrounding health, medicine and the body, the notions of cultural safety, cultural respect, cultural awareness, cultural competency, cultural sensitivity and, more recently, cultural responsiveness have been brought into focus by more and more health services, providers and educators. Each of these terms, often used interchangeably, refers to the knowledge a service-provider has on a client or patients' cultural background, and how they use this knowledge to respond to the clients' needs. This paper will use the term cultural responsiveness to refer to this knowledge in order to emphasise a patient-centred care model within the health system, as opposed to some of the other above terms that might 'conjure a false notion of finality with a construct that entails life-long self-reflection and new learning' (Ring, 2009: 121). This includes paying particular

attention to social and cultural factors in ‘managing therapeutic encounters with patients from different cultural and social backgrounds’ (Carteret, 2011). It can be seen as a cyclical and ongoing process, requiring health professionals to continuously self-reflect and proactively respond to the person, family or community with whom they interact (Indigenous Allied Health Australia, 2013c). Furthermore, this practice does not endorse the bounded categorisation of ‘culture’, but rather attempts to acknowledge the uniqueness of the individual, family or community, and the way in which cultural practices and social relations constantly change and develop.

The clinician-patient relationship is often pointed to when considering health outcomes, with O’Brian et al. (2007) arguing that it is indeed the process of care delivery (i.e. what clinicians do to, and for, patients) that is essential to not only the effectiveness of treatment, but also ‘the degree to which treatment either inhibits or promotes an improvement in mental health recovery’, for example. As will be discussed in more detail in Chapter Three, racist attitudes (intentional and unintentional) and the underlying and often unacknowledged social, historical, and political determinants of health can affect such a relationship. Furthermore, vastly different perceptions of health between clinician and patient can contribute to miscommunication, an uneasy clinical setting, and therefore ‘non-compliance’ and poor health outcomes. Harrington et al. (2006) found that compliance, for example, was associated more with good relationships and communication as opposed to the disease specific details and was far more valued by patients. In regards to clinician-patient relationship, teaching cultural responsiveness to students encourages a focus on that relationship, and an understanding of how clinician biases and assumptions may affect the delivery of care (Jarris et al., 2012).

Of further importance to patients and provided by teaching cultural responsiveness is the idea that physical care is equally as important as emotional and spiritual care (Harrington et al., 2006; G Phillips, pers. comm., 12 April 2013). This is evidently key when considering Aboriginal and Torres Strait Islander health perceptions, and takes into account the holistic view of health that they take. Phillips (pers. comm., 12 April 2013) argues this understanding needs to be brought into the view of western medicine so as to allow ‘outcome measures and processes [to] go hand in hand’ (O'Brien et al., 2007: 673). By adopting this responsiveness, we can move beyond merely recognising inequalities in health and towards acknowledging and addressing the broader issues surrounding delivery of health.

In this sense, cultural responsiveness can reach further than just the clinical setting. Drawing upon human rights and the underlying determinants of health, O'Sullivan (2012: 690) argues that ‘the continuing and pervasive influences of ... historical and contextual considerations explain the proposition that equitable Indigenous access to a culturally responsive policy process is preliminary to sustained improvements in Indigenous people’s health outcomes’ . Providing a culturally responsive service is therefore essential not only in improving health outcomes on a social and cultural level, but can be viewed as a basic right. Paired with equitable access to health facilities and services, a culturally responsive service is critical when considering health outcomes for Aboriginal and Torres Strait Islander people.

The importance of Aboriginal and Torres Strait Islander health professionals

One of the best ways to ensure a culturally responsive service to Aboriginal and Torres Strait Islander patients is to support and retain an Aboriginal and Torres Strait

Islander health workforce. Internationally, addressing the underrepresentation of Indigenous health professionals is recognised as integral to overcoming Indigenous health inequalities (Hetzl, 2000; Curtis et al., 2012). In the Australian context, in 2006 Indigenous Australians made up only one percent of the health workforce (AIHW, 2008 cited in Taylor and Guerin, 2010: 2). While the non-Indigenous majority of the workforce need to ‘accept significant share of the responsibility’ (Taylor and Guerin, 2010) through providing a culturally responsive service, the importance of recruiting and retaining Aboriginal and Torres Strait Islander health professionals cannot be understated.

Drawing upon the human rights framework outlined above - including arguments for both an interdisciplinary and holistic approach, and the importance of cultural responsiveness within clinician-patient relationships - Aboriginal and Torres Strait islander health professionals must surely be some of the best people to respond to the health needs of other Aboriginal and Torres Strait Islander people. Elsewhere, other countries such as Canada, have responded and initiated successful and positive health institutions to combat poor Indigenous health outcomes (see Textbox 3). Anderson (2001: 257) argues that ‘interventions in policy will only impact on population health outcomes if they impact on individuals or the relations between individuals’. In this sense, Australia’s health system – indeed all of Australia’s structures and policies – should encourage and foster such relationships. Supporting an Aboriginal and Torres Strait Islander health workforce is one way to tackle this.

An Aboriginal and Torres Strait Islander Community-led approach

As emphasised by examples of the ‘inability and/or unwillingness of mainstream services to effectively engage with the complexity of Aboriginal health’ (Tynan et al. 2007: 13), Aboriginal community-controlled health services are often called on to be at the centre of primary health care provision. In their research, Tynan et al. assert that:

Aboriginal communities are owners of their health and it is only through interventions built on understanding their perspectives of health determinants that changes in health are also owned, implemented and successful (Tynan et al., 2007: 2).

As exemplified in the case study in Textbox 3 and continuously asserted internationally and within the Australian context, a community-led approach is one of the best ways to combat Indigenous health issues. Gooda (pers. comm., 11 April 2013) points out that ‘...it’s always a constant balance. It’s at that balancing point [when considering rights and health] where the conflict occurs, [that] is where the conversation with the community has to happen’.

To account for difference in perceptions and values, particularly in the health arena, is one challenge identified by Gooda (pers. comm., 11 April 2013) that currently faces government policy and programs and the health care system in Australia. The development and implementing of policy and programs to *simultaneously* address the variety of factors discussed throughout this paper should be done ‘in a way that accounts for contemporary Indigenous social reality, recognising that improvement of individual indicators in themselves do not necessarily correlate with better health’ (Tynan et al., 2007: 13).

This identified challenge resonates with the current constrained way in which Australia's health system works. It can be argued that the Western health system treats each health profession as a silo, or in isolation from other professions, and thereby treats individuals and their health as separate from other issues. As discussed above, a holistic approach whereby issues within *and* surrounding health, even many that are seemingly non-related, are seen as linked and should be taken into account. This should be done not only for the benefit of Aboriginal and Torres Strait Islander people, but for society as a whole.

Many argue that we should use an Aboriginal and Torres Strait Islander perspective when approaching health to guide policy and procedure on broader and larger scales (M Gooda, pers. comm., 11 April 2013; G Phillips, pers. comm., 12 April 2013). Phillips argues;

...one of the great things again about Aboriginal health being its own paradigm is that all of these services must work together holistically to treat the whole person. And in fact non-Aboriginal people need that as well... Our people have been so innovative in creating systems and drawing on our culture that says that health is holistic and is related to the health of the land and the health of the community. Those cultural viewpoints actually help us create really innovative health models and those health models are about how health workers, nurses, doctors, physios and psychologists have to work together (G Phillips, pers. comm., 12 April 2013).

In order to do this, we can again draw from the human rights paradigm, and the links made between health, poverty and equality. Phillips (pers. comm., 12 April 2013) notes the importance of institutional and societal power relationships that impact on all players in any health interaction. In encouraging Aboriginal and Torres Strait

Islander health professionals and communities to grow and take charge of their health, such structural imbalances are in turn realised and challenged. While this is only one factor amongst many when attempting to close the gap in health outcomes, using a human rights framework to address and change those imbalanced power relations involved in Aboriginal and Torres Strait Islander health is essential (G Phillips, pers. comm., 12 April 2013).

TEXTBOX 3:

Canada: An Aboriginal-led initiative addressing addiction

Canada has long provided a case where Aboriginal-led initiatives to improve health outcomes have proved successful. The Nechi Training, Research and Health Promotions Institute was founded in 1974 in response to problems of addiction within Aboriginal communities. The Nechi model is abstinence-based, and uses psychotherapy taught and delivered by Native trainers in a culturally responsive manner (Phillips, 2003). It has been applauded for its indigenisation of the Alcoholic Anonymous model (Taylor et al., 2010: 38), and in its incorporation of culture and spirituality, such as sweatlodges and other healing ceremonies, as its foundation (Phillips, 2003). It is said to be ‘a decisive statement that native culture and spirituality is something to be reckoned with in addictions treatment’ (Brady, 1995). Hodgson (cited in Phillips, 2003: 141) notes that ‘the Nechi model is from a world view that the collective wellbeing is paramount’. By placing importance on incorporation of health and mind-body-spirit healing, Nechi is a model that has been successful. Often looked upon as an example to be taken up in Aboriginal and Torres Strait Islander Australia (Brady et al., 1998; Phillips, 2003; Taylor et al., 2010), the Nechi Institute is an example where the Western biomedical system and a holistic and Indigenous approach can be successful.

Conclusion

This chapter has encouraged the questioning of Australia’s dominant biomedical health model in regards to its ideological opposition of mind and body, and ignoring the role played by social, political, economic, environmental and economic factors in

determining health outcomes. When considering an Aboriginal and Torres Strait Islander definition of health (or rather, the multiple and complex definitions), broader issues are included in disease epidemiology. For example emotional, spiritual, relational and environmental factors can all influence an individual's health. This can certainly impact how the patient-clinician relationship is played out in the clinic, in turn affecting health outcomes for Aboriginal and Torres Strait Islander individuals, families and communities.

As suggested here, one way to approach discrepancies within our current health system is to provide a culturally responsive health service that will allow a proactive, rather than reactive, service that focuses on the needs of the individual, family or community. Furthermore, it must be recognised that to be culturally responsive is multi-layered, and while placing the onus on the clinician, the health service and training that's provided must also be engaged in cultural responsiveness so as to achieve positive outcomes. Providing a culturally responsive health service, however, is merely the first step in addressing these issues. A human rights framework demands the notion of self-determination be more central, and calls for action in the form of an Aboriginal and Torres Strait Islander community-led approach and the need for an Aboriginal and Torres Strait Islander health workforce to be recruited, supported, and retained. In order to address health as part of a wider social, economic, political, environmental and cultural setting, and to encourage strong and understanding of relationships between patients and clinicians, supporting this workforce is not only useful, but necessary.

The next chapter will discuss in more detail what those social, historical and political determinants of health are. It will also explore the role of racism in Australia as a determinant of health.

CHAPTER 3: DETERMINANTS OF HEALTH FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

Why an interdisciplinary and allied health approach is useful

The previous chapter explored how perceptions of health can diverge and how, in Australia, this has contributed to poor health outcomes. In this way, it has been argued that health can arise from far more than just biological interactions within the body. Further drawing from these notions and a human rights framework, this chapter asserts that social, historical and political determinants, and racism, are key to considering health outcomes for Aboriginal and Torres Strait Islander people. While social determinants of health are now widely recognised as important factors, political and historical factors, and racism as a determinant of health, are often overlooked. Recognising broader determinants of health also allows for a holistic view towards health to be taken, as commonly held by Aboriginal and Torres Strait Islander people, and allows disease epidemiology to be viewed in a much broader light than biomedical causes.

Determinants of health are numerous and varied. In order to provide a brief overview of what is meant by the determinants of health, the social, historical and political dimensions of experiences of health will be briefly explored. Education, housing, employment and socio-economic status all come under the umbrella of social determinants of health. The role of racism is also recognised as significant as it influences patient-clinician relationships and therefore health outcomes. In highlighting a range of determinants, this chapter does not aim to deeply analyse each but merely illustrate how complex and interrelated the issues and factors surrounding

the determinants of health are. In doing so, further consideration can also be given to geographical and economic circumstances, not covered in this paper.

In turn, it is argued that an interdisciplinary approach towards health would be one means of recognising and therefore overcoming broader social, historical and political disease epidemiology, as well as those that this paper cannot cover. An expanded role for allied health is proposed as an approach to recognising the underlying determinants of health, and crucial in addressing such issues so as to improve the health gap.

PART I: THE DETERMINANTS OF ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Social determinants of health

The social determinants of health are numerous and interconnected. Education (see Bell et al., 2007; Dunbar and Scrimgeour, 2007; Biddle, 2010), labour force participation or employment (see Walter and Mooney, 2007), social capital (see Baum, 2007), and housing (including problems of overcrowding) (see Booth and Carroll, 2005b) are just some of the factors that have been identified as some of the social determinants of health. Socio-economic factors surrounding Indigenous disadvantage account for between one-third and one-half of the gap in health status between Indigenous and non-Indigenous Australians, as opposed to health behaviour (such as smoking), or factors surrounding health service delivery (Booth and Carroll, 2005a).

Recognising social determinants of health is not a new phenomenon. Many scholars point to Marx and Durkheim, two early sociologists, as some of the first to uncover the relation between the distribution of illness and disease and social conditions (Carson et al., 2007: 5). While health is certainly influenced by individuals themselves, it is to a great extent an outcome of ‘the structures of the society in which they live’ (Carson et al., 2007: xx). With this awareness, social determinants of health has become a common frame through which to describe the ‘non-medical and behavioural influences on health’ (Anderson et al., 2007: x).

Marmot and Wilkinson (2003) summarise ten core factors - also used by the World Health Organisation (WHO) - when referring to the role of social-structural

determinants in health. They are: the social gradient; stress; early life; social exclusion; work; unemployment; social support; addiction; food; and transport. While relevant to Aboriginal and Torres Strait Islander peoples, scholars have noted that these factors are not framed from an Indigenous point of view and omit some other important social determinants when considering Indigenous health (Vickery et al., 2007: 20). Here, Vickery et al. (2007: 21) identify from the broader literature on Indigenous social determinants the following factors specific to Aboriginal and Torres Strait Islander peoples: history and health, racism and marginalisation, place, claims to land, incarceration and the justice system, housing and infrastructure, and family separation.

As a human rights framework illustrates, Booth and Carroll (2005a) assert that rather than showing causality, their results indicated association between socio-economic variables and poor health. Furthermore, the social determinants of health are interrelated and also include embedded issues of politics, geography, economics, culture, and history that cannot be looked at as bounded entities or issues.

Historical and political determinants of health

Australia's history of colonisation, and certain colonial policies throughout that history, is now widely recognised as being a major determinant of Aboriginal and Torres Strait Islander health outcomes today. It is often argued that an understanding of the historical and political contexts embedded in health is significant, as these experiences have impacted upon the mental, physical and spiritual health of Aboriginal and Torres Strait Islander peoples and the way in which Aboriginal and

Torres Strait Islander peoples interact with health services and institutions (Mitchell, 2007; Aboriginal and Torres Strait Islander Health Worker Project, 2011).

Colonialism's impact on health outcomes today can include the impact of food and disease brought to Australia by the British that has contributed to poor physical health, but as will be discussed here, Australia's colonial history can influence health in terms of identity, racism, trauma and loss (Taylor and Guerin, 2010: 47). Neglect, abuse, and social exclusion have been experienced by Indigenous Australians due to past policies and government practices. These adversities have had serious implications for the mental and physical health, education and employment status of Aboriginal and Torres Strait Islander peoples today (Aboriginal and Torres Strait Islander Health Worker Project, 2011). Racism surrounding past policies of assimilation and segregation is one case. Examples range from refusal to permit Indigenous housing in country towns, resulting in unhygienic and overcrowded living situations, to policies of segregated hospitals that would deny health care to Indigenous patients, even Aboriginal women in labour (Mitchell, 2007: 56-57).

While noting the importance of historical policies and their effects, it must be recognised that, to a degree, current policies re-enact these historical experiences today, influencing health outcomes and how Aboriginal and Torres Strait Islander people navigate the mainstream health system. O'Sullivan (2012: 687) argues that descriptions of the variables described above – such as housing, education, and employment – as purely social determinants can 'misleadingly overshadow their inherently political character'. Behind each of the social determinants discussed above, lie policies that contribute to and reinforce prevailing issues of access and the distribution of those risk factors.

Historical systematic destruction of families and culture – seen in such policies as the Child Removal Policy (Stolen Generation), assimilation policies, and segregation policies – persists as a major determinant of poor health outcomes for Aboriginal and Torres Strait Islander people today. This manifests in emotional and psychological health issues around identity, trauma and loss, but also physical health. Furthermore, from such discriminatory policies and experiences, mainstream health services today may have negative connotations for some Aboriginal and Torres Strait Islander people that associate them with a ‘history of racial segregation, institutional neglect, and the Stolen Generations’ (Aboriginal and Torres Strait Islander Health Worker Project, 2011: 18).

Racism as a determinant of health

More recently, racism has been researched as a determinant of health. Gooda (pers. comm., 11 April 2013) argues that those factors that come under what is commonly known as the social determinants of health needs to be expanded so as to include racism and its effects on health outcomes. Specifically, this claim sees racism as expressed on two levels; the institutional and the interpersonal (Larson et al., 2007; Lawrence, 2008; Smedley et al., 2009; Durey, 2010). Institutional racism, which can systematically disadvantage racial and ethnic minorities, is said to be maintained by the policies and practices carried out by government and institutions (Larson et al., 2007: 322). It can relate to the operation of a health care system, and can include cultural or linguistic barriers and fragmentation of the health care system (Lawrence, 2008: 4). Interpersonal racism, or individual factors, can occur between individuals and can ‘take the form of clinical uncertainty when interacting with people from

different racial or ethnic groups and beliefs (stereotypes) held by providers about the behaviour or health of minorities' (Lawrence, 2008: 5). These types of racism can occur both intentionally and unintentionally, yet, in regards to health, racism on both these levels can manifest as one of the many factors when considering the poor health status of Aboriginal and Torres Strait Islanders.

Doctor-patient relationships and engagement is a major factor when considering patient health outcomes, the Australian context being no exception. Aversive racism, or unconscious biases based on race or ethnicity, can be one of the most harmful types of discriminatory action. This can result in 'avoidance behaviour' with doctors often spending less time with the patient (Lawrence, 2008). In Australia, it was found that Aboriginal Australians were significantly more likely than non-Aboriginal people to report that they had been 'physically or emotionally upset by negative racially based treatment in the last four weeks' (Larson et al., 2007). Other U.S. studies have shown that African-American patients have shorter consultations, greater verbal dominance by the doctor, the provision of less information and fewer attempts to engage the patient in joint decision making (Johnson et al., 2004). This can be seen in many cases in Australia, with Lawrence (2008: 9) arguing that 'the worse the relationship, the poorer the recall of medical information, the poorer the adherence to recommended treatment and the poorer the health outcomes'.

PART II: ‘DAILY REALITIES’ – THE IMPORTANCE OF AN INTERDISCIPLINARY AND ALLIED HEALTH APPROACH

The right to health: ‘daily realities’

Often noted in conversations surrounding the complexity around community health is that, when discussing one issue, Aboriginal and Torres Strait Islander communities will often bring multiple other issues to the discussion, pointing to ideas around the interrelatedness of multiple factors and what Tynan et al. describe as ‘daily realities’ (see M Gooda, pers. comm., 11 April 2013; Tynan et al., 2007). Health, therefore, is not separate from issues of racism, land rights, housing, unemployment, education, violence and numerous other factors that can come under the umbrella terms of cultural, social, political and historical determinants of health. Tynan et al. (2007) further assert that the causes and effects of such determinants of health cannot exist in a linear relationship, rather such factors are faced daily by Aboriginal and Torres Strait Islander peoples. They argue that ‘[u]nderstanding this daily negation is the first step in addressing health from a holistic, empathetic and [Aboriginal]-led approach’ (Tynan et al., 2007: 12).

The idea that such issues surrounding health and its determinants are interrelated and multifaceted is often reiterated:

You can’t fix the health gap in the doctor’s surgery alone. And that’s what everyone thinks. You can’t fix it in the health system alone. All these other things, education, housing, environmental infrastructure, waste disposal... you need all those things in place to compliment the work that the health system does (M Gooda, pers. comm., 11 April 2013).

Invoked from the human rights framework are the key notions of availability, acceptability, quality and particularly accessibility to health services and facilities as outlined in the International Covenant of Economic, Social and Cultural Rights (ICESCR cited in Gooda, 2010), not to mention those broader services and facilities. As Gray and Bailie (2006: 449) point out, ‘access can mean more than simply access to health facilities and services’, it can also mean ‘access to the social determinants of good health’. There is a danger in strategies and policies surrounding health that have a narrow focus on poverty and the meaning and determinants of health without noting the broader perspectives offered by equity and human rights. They may fail if they do not take into account those other key factors that influence the relationship and outcomes between poverty and ill-health (Braveman and Gruskin, 2003).

Australia’s current health system is geared towards fixing a disease from the patient’s end, while it should in fact be focusing on power structures, and the role society and politics plays in poor health outcomes. As HealthWest (cited in Sweet, 2013) says; ‘the current focus of programs on changing an individual’s behaviour is equivalent to teaching people to swim to prevent Titanic-like disasters... it is a limited and inadequate response’. Clearly the answers to this problem lie in a much wider setting than the health system, however, within the health system certain measures can be taken to begin to address those broader factors influencing the health of Aboriginal and Torres Strait Islander peoples. As reiterated throughout this paper, it comes from an Indigenous lens, and encourages an interdisciplinary approach to health, and an allied health approach, in order to begin to address the broader determinants of health.

An interdisciplinary approach to health

An interdisciplinary approach has been recently promoted by health peak bodies as a way to begin to address the multifaceted and interwoven factors. In terms of health and addressing the issues explored throughout this paper, a distinction must be made between an interdisciplinary approach and a multidisciplinary approach. A multidisciplinary approach uses the skills and experience of the individual health professional, with ‘each discipline approaching the patient from their own perspective’ (Jessup, 2007: 330). While multidisciplinary teams may provide more knowledge and experience than disciplines operating in isolation, they still meet in the absence of the patient, with professional silos and boundaries maintained (Indigenous Allied Health Australia, 2013d). An interdisciplinary approach on the other hand integrates those isolated disciplines into a single consultation, whereby the patient is present and involved and ‘a common understanding and holistic view of all aspects of the patient’s care ensues’ (Jessup, 2007: 330).

Regarding health outcomes, particularly of Aboriginal and Torres Strait Islander people, an interdisciplinary approach allows for those broader and overlooked determinants of health to be discussed and acknowledged by both the patient and health professionals. Jessup (2007) argues that current siloed health funding mechanisms are not adequate. It is noted that ‘an important structural prerequisite for securing genuine improvements in health outcomes is the unifying of all funding and policy responsibilities for comprehensive healthcare for Indigenous Australians within a single jurisdictional framework’ (Donato and Segal, 2013: 232). Access to health care, a basic human right, and the delivery of coordinated care can be compromised because of poor collaboration between GP and allied and community services (Donato and Segal, 2013). By stepping out of discipline silos, both health

professionals and Aboriginal and Torres Strait Islander people can benefit from the sharing of knowledge, skills and understandings that are essential and embedded in a holistic approach to health. Identified as central to providing an interdisciplinary framework is primary health care, with allied health care vital to enacting this.

Allied health: a means to address the determinants of health

As illustrated and outlined above, ‘you can’t fix the health gap in the doctors’ surgery alone’ (M Gooda, pers. comm., 11 April 2013). Allied health therefore needs to be utilised and recognised in policy, and by doctors and nurses when considering Aboriginal and Torres Strait Islander health care systems. The term ‘allied health’ is used to refer to over a hundred classifications of health care professionals, other than doctors, nurses and health workers (Thomas et al., 2011), such as occupational therapists, physiotherapists, speech therapists and nutritionists, to name a few. Allied health professionals ‘share in the delivery of health care services related to the identification, evaluation, management and prevention of disease and disorders; dietary and nutritional services; and rehabilitation services’ (Indigenous Allied Health Australia, 2013b).

Indigenous Allied Health Australia (IAHA) (2013a) understands allied health as a collective term referring to a variety of healthcare services that contributes to a person’s physical, sensory, psychological, cognitive, social, emotional and cultural wellbeing. Stress on such factors by allied health keep with the definition of health provided by NAHS, cited earlier, and therefore is one approach to a holistic take on health. With the inclusion of those factors, along with a stress on interdisciplinary and inter-professional relationships, allied health has been identified as critical in closing

the gap on health for Aboriginal and Torres Strait Islander peoples (Gooda, pers. comm., 11 April 2013; Indigenous Allied Health Australia, 2013b). Allied health is a component of primary health care - indeed the two terms are interrelated and interdependent - and this paper recognises allied health workers as key players, along with the medical, nursing and Aboriginal Health Worker workforces.

Conclusion

This chapter, by drawing from not only the holistic view of health taken by Aboriginal and Torres Strait Islander peoples but the human rights framework and the right to the accessibility of services and facilities, has uncovered and given a brief overview of the social, historical and political determinants of health, and racism as a determinant of health. These are only some of the broader determinants of health, and geographical and economic determinants must be equally recognised as influencing health outcomes.

When recognising so many factors that influence the health of an individual, family, and even an entire community, the task of where to begin, or which factor to tackle first, can pose a major challenge. Again, the human rights framework can provide practical advice, in the form of self-determination and decision making. This can be used to focus on to the positive approaches needed to tackle the issues outlined above. Phillips (pers. comm., 12 April 2013) asserts that every community has something they are good at and should use this strength as a bridgehead to addressing health issues. An Aboriginal and Torres Strait Islander lens allows for the recognition of broader factors – both good and bad – and should be taken up in order to begin

addressing social, political, environmental, geographic, economic and racial issues evident in communities that underlie poor health.

Scholars note that currently seen are doctors prescribing drugs and medications in response to 'health' problems, particularly mental and emotional problems, when more people are recognising that such prescriptions are merely attempting to try and fix underlying social and economic problems (G Phillips, pers. comm., 12 April 2013; Sweet, 2013). Instead, taking into account social, political and historical factors, and racism as a determinant of health may provide far more insight into the origin of a health problem, as well as sound advice on how to fix them. Furthermore, a holistic approach to such factors allows us to recognise that they are experienced daily by individuals, families and communities, and are by no means in part of straightforward or causal relationships. An interdisciplinary approach and the serious recognition of allied health services can therefore be a means of addressing seemingly disassociated factors as interrelated. An interdisciplinary allied health approach allows not only for this recognition, but for positive action to be taken in the form of more appropriate healthcare practices such as group consultations that involve the patient in decision making and care, for example. As illustrated, a better patient-clinician relationship whereby the patient has agency in decision making and access to all facilities and services results only in better health outcomes.

CONCLUSION

This report has outlined and analysed several of the critical elements needed when taking a strengths-based approach to improving the health of Aboriginal and Torres Strait Islander people. It has argued that community-led strategies founded in a concern for human rights can draw from and encourage positive cultural identities and in this way inform innovative and dynamic approaches to ‘closing the gap’ in the Australian health landscape. In this way the report has not been concerned with outlining particular strategies to health improvement in a top-down way, but has sought to ‘change the conversation’ around experiences of health, illness and wellbeing for Aboriginal and Torres Strait Islander individuals, families, and communities.

This report has suggested that adopting an Aboriginal and Torres Strait Islander lens would likely view experiences of health in a more holistic way, with a multitude of factors regarded as interrelated and interdependent in the constitution of health, wellbeing, illness and the body. While distinctly Western concepts such as the principles of biomedicine are still very important, they need to be placed in social and cultural contexts. Furthermore, current health policies and systems need to be interrogated as much for what they say about the causes and experiences of health and illness as well as their chronic shortcomings.

In keeping with the Close the Gap campaign, this paper has outlined how Australia’s health system could benefit from the adoption of a human rights paradigm in considering health inequality. Chapter One analysed how human rights violations are both a cause and an outcome of poor health. Further illustrated was how rights are being abused in Australia in the form of structurally unequal social, political, and

economic relationships and a lack of access to the opportunities to be healthy. As well, it argued that a human rights paradigm is a vital way of addressing complex and interrelated factors in a more holistic way because it:

...is a framework which enables the public health system and the actors within it to understand that they're not just treating another subject or another automaton or another number, they're treating a person with a whole list of political, historical, social contexts that needs to be taken into account (G Phillips, pers. comm., 12 April 2013).

By using a human rights framework as the basis for thinking about a strength-based approach to health, this report outlined two key findings. First, Chapter Two argued that Aboriginal and Torres Strait Islander-led strategies and conceptualisations of health must be recognised as of fundamental importance. And second, as explained in Chapter Three, the determinants of health are broad, complex, and interrelated.

Drawing from these key findings and working towards more appropriate holistic approaches, the report makes several suggestions for arriving at real strategies to close the gap in health outcomes. To do this, the report argued for the need to support the expansion of an interdisciplinary, culturally responsive allied health workforce and also increased participation of Aboriginal and Torres Strait Islander people within this workforce. If taken up, these recommendations have the potential to address many of the issues and requirements outlined throughout this report.

There is a growing recognition of the need to break down disciplinary siloes that have been built up in isolation from each other by the biomedical system which dominates Australian health. As well, it is now more widely understood that underlying social, political and historical factors, and racism, are all interrelated

determinants of health. For this reason an interdisciplinary conceptualisation of health strategies and services and a larger place for allied health within Australia's health system has been suggested. This approach holds some of the keys to addressing health issues that cannot be fixed by prescribing drugs and would instead encourage clinicians, and the system itself, to be more culturally responsive to patients', families', or communities' specific needs.

This paper has asserted the importance of recognising health issues not only in their political, historical, social and cultural contexts, but also in conceptualising them as 'daily realities' and that rarely is any one particular issue or factor more important than another. For issues of health, many factors that appear outside the health sector may be equally important in considering causes and responses and most factors can and must be seen as 'interrelated in Indigenous people's lives' (G Phillips, pers. comm., 12 April 2013). Taking interrelatedness seriously means attempting to close the gap (whether in health, education, or employment) by adopting a person-centred approach (M Gooda, pers. comm., 11 April 2013). It is this holistic approach that is called upon to address health problems. By doing so, positive and successful approaches can be found whereby strong communities are formed, and the health and wellbeing of Aboriginal and Torres Strait Islander individuals and families improved.

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