# More than a refresh required for closing the gap of Indigenous health inequality

If we are committed to closing the gap, we should be committed to transforming relationships of power between Indigenous and non-Indigenous people

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After over a decade of tabling annual reports of policy failure in Closing the Gap in Indigenous health inequality, the Morrison government announced in 2019 a refresh of the targets, rather than a rethink of the policy approach.[1] This refresh includes a process of Indigenous consultation and codesign via the Coalition of the Peaks (a representative body of about 40 Aboriginal and Torres Strait Islander organisations), which makes for a refreshing change in Indigenous health policy.[2] Whether such engagement will engender the radical reimagining required to transform persisting Indigenous health disparities remains to be seen.

There is a danger that the engagement of Indigenous peaks, many of which are reliant on federal funding, will be used to embellish a policy agenda that effectively maintains the status quo and, further, will be held responsible for any future policy failings in Indigenous health. For many years, the former Aboriginal and Torres Strait Islander Commission (ATSIC) was criticised for not fixing Indigenous health, and this formed part of the rationalisation for its abolition in 2004 by the Howard government who declared self-determination "a failed experiment" despite health not forming part of their portfolio.[3]

However, the failure of the Closing the Gap approach is not so much about apportioning blame for poor outcomes to unsuspecting Indigenous agencies deemed responsible for its implementation, but rather about the prevailing strategy and its ideological underpinnings. Closing the Gap tends to focus our attention disproportionately on the behaviour of individuals, suggesting that health inequalities are a product of Indigenous lack, morally and intellectually, rather than socially determined. The late Bobby Sykes is said to have developed an acid test for thinking about Indigenous health which consisted of two lists: a list of diseases introduced by Europeans to Indigenous people and a list of diseases introduced by Indigenous people to Europeans.[4] There are no items on the second list, but that empty space tells a very potent story.[4] It is a story that sits in stark contrast with the current epidemiological thinking about Indigenous health in which Indigenous peoples are juxtaposed statistically against non-Indigenous people, and simultaneously positioned as at-risk of and the cause of ill health.

A 2001 article described how racial theories were an important feature of epidemiological discourses in understanding the spread of leprosy in the 1900s.[5] Dr Cecil Cook, who occupied the dual role of Chief Medical Officer and Chief Protector of Northern Australia, insisted that the spread of leprosy was the result of the sexual habits of the "salacious Aboriginal" and, in particular, "conjugal relationships" with Chinese lepers and white men, the latter of which he insisted were mere "temporary expedients" owing to the absence of white women on the frontier. We of course now know the flaws of Cook's theory about infectious diseases transmission.[5] However, the explicit and implicit racial imagining, we argue, remains ever-present in epidemiological understandings of Indigenous health inequality that measure and frame Closing the Gap targets and strategies. Cook's fascination with the sexual behaviour of Indigenous women during this time and his depiction of them as a threat to the health of white men masked the routine and systematic sexual violence perpetrated against Indigenous women by white men.[5] Around this same time, Queensland Health listed "gin" and "half-caste" (both derogatory terms for Indigenous women and people) as a source of infection for sexually transmissible infections in Queensland Health department annual reports.[6]

Today, we can observe Indigeneity listed as a risk factor for all manner of lifestyle diseases in well meaning health promotion resources, alongside other risks of smoking and obesity. Less explicit than Cook, there still remains an implicit and residual racial calculus within contemporary epidemiological discourse which constructs population health inequalities as a product of contrasting poorer behaviour between one population and another. While epidemiological thinking has been instrumental in focusing public and political attention on the problem of Indigenous ill health, which had long been ignored,[7] it remains "a powerful social instrument" which "constructs an understanding of Aboriginal people that reinforces unequal power relationships; in other words, an image of sick, disorganised communities can be used to justify paternalism and dependency".[8]

Indeed what followed at the turn of the century after a decade of chronicling alarming and appalling statistics of Indigenous ill health was a renewed paternalism in Indigenous health and social policy.[9] This paternalism was characterised by income management plans and alcohol restrictions, welfare cards, and a mainstreaming agenda which drastically undermined the Indigenous community-controlled sector, not to mention the suspension of the *Racial Discrimination Act 1975* and the proposed compulsory medical examinations for Indigenous children under the

Northern Territory Emergency Response. These new controls were necessary, we were told, because of those alarming statistics. However, ironically, these draconian measures have not eliminated racial health disparities; rather they may well have been exacerbated through overtly racist health and social policy measures.

Epidemiological discourses that describe the gap are limited in their ability to close the gap because the mechanism by which the gap is made real — race — is barely understood by the epidemiologist. Rather than acknowledge the structuring effects of race, race is reproduced uncritically in the routine business of the discipline. The reluctance to consider the social and political context in which health and illness are produced, including researched and theorised, is the knowledge gap that is militating against efforts to eliminate the racialised health inequalities that Indigenous people suffer. Even within the scope of social and cultural determinants discourse, the sociological imagination remains limited because of the epistemological weight of authority afforded the medical practitioner and the epidemiologist. Annual descriptions of racialised inequalities have not inspired an organised examination of the work of race in the production of health disparities or the racialising practices of health research, policy and service provision which account for their persistence. Race remains bound to a statistical category from which we are supposed to infer a host of cultural traits, while racism registers unevenly as a category within the social and cultural determinants of health discourse.

A conceptual grasp of race and its trace in the contours that mark the social determinants and Indigenous health inequality should frame our thinking about how to close the gap.

Despite the National Aboriginal and Torres Strait Health Plan's vision of "a health system free of racism",[10] the National Health Medical and Research Council has yet to invest in a health research agenda committed to understanding and undermining the operation of race and racism in the health system. An analysis of their 5% commitment to Indigenous health since the turn of the century reveals a spreadsheet full of disaggregated Indigenous body parts and behaviour that can be neatly measured, as well as investments in better data collection and surveillance methods to continue to quantify Indigenous ill health.[11] Similarly, the recent announcement of $160 million investment in the Indigenous Medical Research Futures Funds has been prioritised by the Minister (and not Indigenous peoples) to focus on preventable deafness and blindness, as well as earmarking $35 million to develop a vaccine for rheumatic heart disease.[12] While important health issues, there is a strong evidence base that suggests these conditions can be prevented by addressing the socio-economic and environmental factors that make Indigenous peoples more susceptible. Surely, if we are committed to closing the gap, we would be as equally committed to attending to the political levers necessary for improving the socio-economic and environmental conditions of Indigenous peoples as we are to taking stock of Indigenous peoples' hygiene habits.

We remain unconvinced that improvements in Indigenous health will come through refreshed numerical targets or greater financial investments in health research. What is required is a broadening of our intellectual investment in Indigenous health: one that invites social scientific perspectives about the social world that Indigenous people occupy and its role in the production of illness and inequalities. In this way, we would come to understand that race needs to be better conceptualised before we understand the ways it matters to health outcomes.

Through this we might also come to realise the limitations of drawing too heavily upon a medical response to what is effectively a political problem, enabling us to extend our strategies beyond affordable prescriptions for remedying individual illnesses to include remedying the power imbalances that cause the health inequalities we are so intent on describing.

We might then be prepared for the radical reconfiguring of relationships of power between Indigenous and non-Indigenous people that are necessary for achieving better health outcomes, whereby Indigenous peoples could be considered the solution to better health rather than the cause of ill health, where Indigenous research institutions administer Indigenous health research investments rather than be advisors to them, and where Indigenous peoples are the architects of health advancement rather than accessories to failed health policy frameworks. That any of these suggestions might appear as radical propositions is perhaps a more telling and tragic indictment of what little progress has been made in over a decade of the Closing the Gap approach, more tragic than the statistical tale that is told each February on the floors of the Australian Parliament.

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