CAIRNS BASE HOSPITAL

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Thank you for having me here today to talk and thank you for you introduction

Let me first acknowledge the Aboriginal Australian people of the greater Cairns region.

I am sure you are all aware of the 1978 *Alma Mata* declaration. In this declaration it was famously noted that health is 'not simply the absence of disease' but a 'state of physical, emotional, social and mental well-being'.

This definition has since been widely used and accepted as the guiding principle of health care around the world, not just among health practitioners such as yourselves, but among policy and health officials too.

Unfortunately, the apparent consensus around what constitutes 'health' has not always been successfully modelled in practice; the failure to do this has been particularly stark in the case of remote Indigenous communities in Australia. 'Health' for these communities – two of which are within 100km of this very hospital – continues to be characterised by appalling levels of morbidity, and life expectancy well below that of mainstream Australia.

It will not be news to many of you that a majority of the causes of this morbidity and mortality are preventable. However, what I want to stress, is not so much that the diseases themselves are preventable, ***but that their prevention relies on more than just the provision of good clinical care***. It relies on the *enabling* of people in these communities to look after themselves.

This is something that is perhaps more difficult to teach than the diagnoses and prescription of Western medicine. And it is often more unpalatable to practice, since it involves making hard decisions about forcing individuals to take responsibility for their own medicines, their own diets, their own exercise regimen while supporting others to do the same.

But I firmly believe that it is only through this promotion of a physical, emotional and social **responsibility** that these remote communities will actually achieve a genuine 'state of well-being' that the Alma Mata declaration referred to.

But before I delve into this much further, I want to talk a little about the situation in Cape York.

Experiences in Cape York, delivered by Tania Major

Noel often speaks of growing up in Cape York as part of a large family in a small community. What he always emphasises, is that although his father's house was small, and their family relatively poor, the home was a happy one and their environment clean and well maintained. They were healthy as children.

In the last three decades, however, the dysfunction of passive welfare and alcohol have meant that health – as with so many other things – have stopped being the priority they were during Noel's childhood.

Poverty in Indigenous communities is now not the driver of poor health, but just one of a number of compounding factors. Instead, welfare passivity and alcohol are the major drivers of multiple behavioural dysfunctions.

Alcohol abuse has reached proportions that are unlikely to be solved by placing individuals into expensive rehabilitation clinics - although this may form part of a wider solution.

With respect to poor nutrition, problems with access and availability to good food compound the apathy about doing anything to improve individual diets. This has made it almost impossible to prevent problems like diabetes and coronary heart disease developing at alarming rates.

I know that you would all be familiar with appalling health statistics of Indigenous communities. Likewise, you would all know that the poor health status of those living in remote Indigenous communities is linked to both individual choices and social and policy barriers.

But a key question arises – one which is particularly relevant to you as the new generation of medical practitioners. Why, if we know what the key determinants of poor health in Indigenous communities are, have we not been able to address them?

Taking Responsibility: the Cape York Agenda

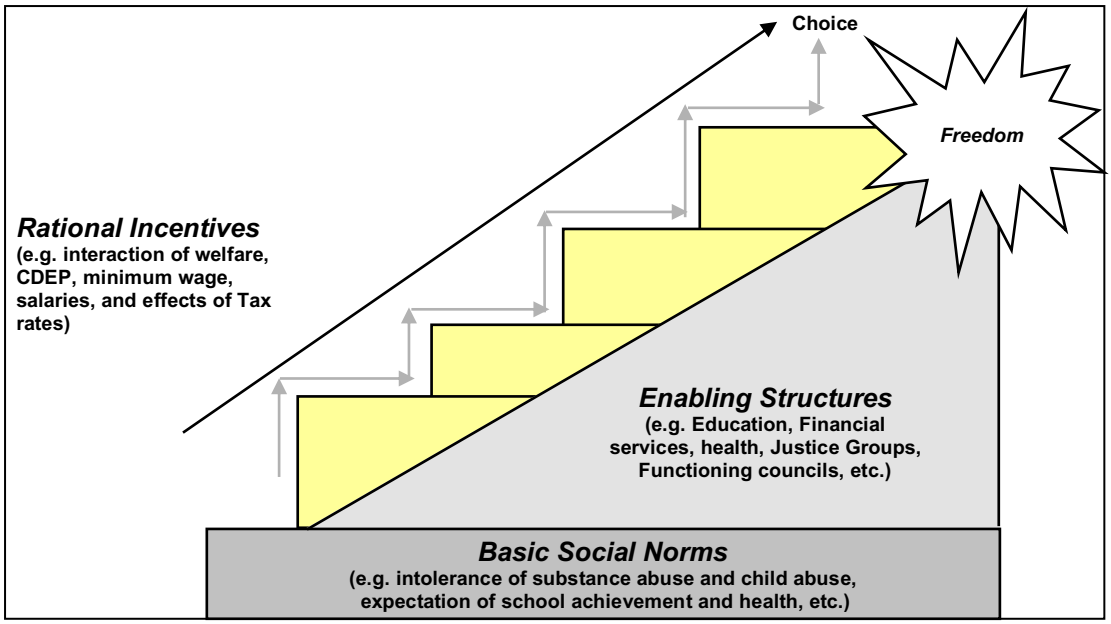
I believe that large-scale and sustained improvements in health, will require interventions that change not only individuals' actions but also community norms, health systems, and the decisions of policymakers.

Achieving these things in tandem is of course larger than any one person. However, understanding this, will be an important step in your contribution to what I believe to be the 'common cause' – helping Indigenous individuals and communities to take responsibility.

Noel's work and that of the Cape York regional organisations are guided by the Cape York Agenda.

At the core of the Agenda is a metaphor for *individual* success – the staircase of opportunity - which provides a blueprint for policy and program development.

Staircase of Opportunity



The base of this staircase is formed by basic social norms. Building on this foundation, enabling structures such as good schools and educational attainment, supportive community organisations and appropriate (non-passive) government services, provide a framework to help individuals develop their skills and decision-making capacity. Finally, rational incentives provide the stepping stones to individual success, with each person making choices about where and how they wish to live and work. The range of choices afforded a person, constitutes freedom.

Let me talk to each of these levels in turn.

1. Social & cultural norms

The foundation for the staircase is the establishment or *re*-establishment of basic expectations around health-related behaviours.

In mainstream Australia, there are a number of social norms which have a demonstrable link to individual and community health. Extreme binge drinking and alcohol-related violence are not accepted; basic hygiene and house maintenance are expected; and domestic and sexual violence is not tolerated.

These health-related social norms are partially upheld by tangible activities and services such as public health messaging, widespread medical facilities, basic law enforcement, and well-integrated health education in schools.

But there are also *intangible* aspects to 'health norms'. These may be seen in the public's understanding of the link between certain behaviours and personal health (for example the effect of smoking). This understanding contributes to and strengthens basic social expectations - such as the expectation that children will be clean and fed when they arrive at school; that houses will be maintained to a certain level of cleanliness; and that domestic or sexual violence are unacceptable and will result in retribution.

These intangible norms not only provide guidance but empower individuals to seek advice and help when they are in need.

Both tangible and intangible aspects of mainstream health-norms act as strong influences upon individual behaviour and help ensure that positive health-behaviours prevail.

In Cape York, by contrast, there is a general social order deficit, part of which is constituted by an erosion of health norms. For example, there is no expectation (and frequently no understanding of the need) to maintain personal or household hygiene. There is no basic social norm to promote a balanced and healthy diet. Domestic and sexual violence are (if not accepted) widespread and unchecked, with knock-on effects for the mental and physical health of multiple generations. And the negative social norm of excessive drinking places pressures on the non-drinkers to join in, endangering not only the drinkers but the families and communities who often suffer the violent ramifications.

There is a clear need for a primary health care model in Cape York which prioritises and facilitates the rebuilding of health-norms. Unfortunately, experience shows us that centralised health systems generally develop primary health care services based on generic models developed for regional and urban Australian settings. Such models fail to take account of the vastly different circumstances of individuals and families in remote Indigenous communities, with the end result being a set of services which are poorly matched to community health needs.

Rather than a set of services determined remotely and with little reference to day-to-day concerns, Cape York needs a primary health care model which develops public health interventions and advocacy programs with the stated aim of promoting individual responsibility through better health norms. Such a model would:

- Make space for public health campaigns targeting high-risk behaviours and absent health norms in any given community.
- Establish services that help re-establish health norms in the family and extended family through:
    - Fostering of good doctor-client relations
    - Providing family-based counselling and support.
- Can establish links with schools, shops, community organisations and reform projects to help develop appropriate expectations
- Sets up regulatory mechanisms around environmental health standards, good dietary and nutrition behaviours and occupational health and safety concerns.

2. Capabilities & enablers

The second part of the staircase involves building on the foundation of better health norms, and developing the capability of Cape York people to exercise good health-related choices. This means that individuals must have both the *knowledge* necessary to make an informed decision, and the *opportunity* to take up clinical and community services that support these decisions.

In mainstream Australia, individuals are able to draw on knowledge and understanding built through a range of experiences and institutional frameworks. Mainstream schools have well integrated health programs. In many areas supplementary public health clinics provide staggered public health messages across the primary school age range. Television and radio programming also include public health messaging.

In addition to basic information, a range of health-services are available in the mainstream which help individual's develop health-capabilities. Access to GPs is generally not a problem. Through regular voluntary visits, a majority of non-Indigenous Australians develop a relationship with, and trust in their doctor.

This relationship allows both knowledge and information transfer ***and*** behaviour-change. It is an *enabler* for individuals making healthy decisions through access to appropriate clinical services and ongoing family and community support.

The same situation cannot be said to exist in Cape York. The break down in health norms outlined in the previous section both results from *and* exacerbates poor health-enabling structures at the family, community and regional level.

A poor level of basic health knowledge among individuals and family units is the starting point. Schools are also a poor conduit for important health messages because of poorly integrated curriculum, poor attendance and low morale among teaching staff and students. And although mainstream public health messaging on radio and television may be aired, these messages often fail to account for the structural barriers to behaviour-change in remote Indigenous communities. For example, messages about improving diet assume access to a regular and affordable source of fresh fruit and vegetables. In Cape York such access is often not guaranteed, especially during the wet season.

Physical health-enablers are also problematic in Cape York. Access to GPs under the current system of health clinics is unreliable. High staff turn-over and poor screening of appropriate clinicians has meant that a level of trust between residents and doctors, nurses and health workers is often not established.

There is a clear need for a primary health care model in Cape York which seeks to develop an appropriate health enabling framework. The purpose of such a framework is not to displace responsibility, but to provide the information and develop the networks and support structures necessary to enable individuals' to develop healthy behaviours. Current services are often unable to generate such an 'enabling framework'.

A number of factors common to remote Indigenous health settings contribute to this situation:

- Poor communication (many clients for whom English is not first language)
- Lack of remote-area experience / tolerance by posted medical personnel
- Insufficient funding for appropriate equipment, medication and administrative resources.
- Poor staff-client relations due to high case-load, insufficient administrative support, high stress conditions and inappropriate staffing.

- High staff turn-over due to isolation, high stress conditions and insufficient remuneration.
- Poor level of staff-client trust due to communication difficulties.
- Low rates of voluntary presentation for regular health checks due to apathy and sense of pointlessness.
- Increased presentation of acute-care needs due to poor basic knowledge of health and fewer check-ups.

Through investment in enabling structures an alternative model should aim to develop individuals' capacity to make good health decisions by aiming to:

- Improve recruitment and retention of health professionals including Aboriginal and Torres Strait Islander people
- Provide incentives to attract appropriate full time permanent personnel who can gain community trust.
- Ensure increased community presence and responsiveness of primary health care services in town and on outstations, as a hook for individuals to be more proactive about their health.
- Enable progressively sophisticated information transfer to families and individuals through individual and group consultations and training sessions (eg nutrition tours through local shop to pick healthy foods).
- Engage in ongoing training and up-skilling of Community leaders; initiating youth health leaders program.
- Engage in policy advocacy where structural barriers to improved health behaviours are prohibitive (eg insufficient funding for primary care or inadequate water or power infrastructure).
- Develop programs such as grog strategies with community involvement

3. Incentives to be healthy

The third component of the staircase of opportunity is making sure that the incentives to be healthy are clear and tangible. For this to happen, part of the investment in health-capabilities must involve helping individuals understand the benefits of being healthy. Such benefits include having the capacity to work and earn a wage; the capacity to look after elderly relatives and children; and the capacity to travel and visit on country. Other benefits include *not* having to pay the cost of hospitalisation and medication; *not* having to pay for damage to property (in the case of alcohol related violence); and thus having more security and disposable income. If these linkages are rational, they will constitute incentives for people to make good decisions relating to their health.

The incentive to be healthy is an implicit part of everyday life in mainstream Australia. In other words, the *right* to good health is taken for granted and so too are the pathways and behaviours which are necessary for establishing this. In Cape York, however, such pathways are not necessarily clear and current primary health services are doing little to make them more accessible. Services are underfunded, under staffed and clinically-oriented. They are, in other

words, in a poor position to provide the education, advice and support necessary to **make** healthy behaviours an incentive in Indigenous communities.

Conclusion

In your role as doctors, you must think carefully about how you will contribute to the common purpose of achieving health, as a 'state of well-being'. You must recognise that the circumstances and mechanisms which make this goal possible in mainstream settings will differ VASTLY from the circumstances and mechanisms which make it possible in remote Indigenous communities.

To achieve that state of wellbeing in Indigenous communities, we must first acknowledge the root dysfunctions which are the cause of poor health among these communities, and address these. Addressing the symptoms will do little.

For you as doctors, this will inevitably involve difficult decisions. Passivity in relation to health – as with employment, housing and many other basic social and economic factors – is characteristic of many if not most Indigenous communities in Cape York. Combating this passivity in your medical role, will thus involve experiences which are personally threatening, and professionally and ethically confronting.

However, I believe the common cause is that of enabling the people of Cape York to take charge of their own communities and their own problems. It is *not* perpetuating systems of passive service delivery.

Your role – whether as doctor, advocate or policy adviser – is to remember this and work towards it in whatever manner possible.

Thank you.