

# Killers in the bush

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Three senior Chief Executives of acute hospital trusts in the UK recently visited the Northern Territory (NT) and South Australia (SA) to study remote and rural health care in general – and Aboriginal health in particular. As with all other aspects of Aboriginal life, the subject of health status is highly charged and generates heightened emotions and intense political debate across the country but particularly in the NT and SA where many of the remote indigenous people live. Every “mainstream” Australian has an opinion on the trials and tribulations of the indigenous people.

The field study was part of the NHS Leadership Centre’s Senior Chief Executives’ Development Programme. It comprised a longitudinal journey across the continent from Darwin (NT) through to Alice Springs to Tanunda in the Barossa Valley and then on to Adelaide following the route of the 2,500 kilometre Stuart Highway. It involved visiting rural health services, and meetings with Aboriginal leaders, academics, health practitioners and senior officials of the SA government.

A specific research topic was to understand how practitioners working in extreme environments, and delivering long-term programmes of care, can maintain their morale and motivation.

## Healthy signs

Quite recently, the Minister of Human Services for SA gave the keynote address to a prestigious conference in Adelaide attended by health service managers, clinicians, and representatives of the non-statutory organisations (Brown D 2001). With State elections in the offing, the Minister was upbeat and strident. He was able to announce big hikes in dollars for the State’s hospitals, to sideswipe the UK’s performance on cancer survival rates when compared with his country’s justly impressive record, and to declare the average life expectancy of the “Australian” male as now being 78 years.

## Killers in the bush

In sharp contrast is the life expectancy for Aboriginal males. Data from the Epidemiology Branch of the Territory Health Services shows that, in the NT, it is only 58 years. 50% of indigenous males fail to reach 50 years of age. The biggest killers are the usual suspects in deprived and marginalised communities the world over – coronary heart disease and stroke, respiratory diseases, neoplasms and diabetes – together with Outback hazards such as poisoning and injury (House of Representatives Standing Committee on Family & Community Affairs 2000). The SA experience is broadly the same.

The profile of the indigenous male is gross and stark but is merely emblematic of widespread health inequalities which span the age spectrum and which do not respect the gender divide. Off-the-graph levels of substance abuse, child and family psychiatric illness, domestic violence, and child mortality complete a bleak picture and demonstrate the enormity of the health gap that must be bridged.

## Variations and marginalisation

How can one of the world's most wealthy countries account for such variations in health? And why should a country, which is demonstrably one of the world's most successful importers and integrators of ethnic minorities, appear to marginalise "its own" people?

Comprehensive answers to these two searching questions are inevitably beyond the scope of this short paper but there are probably two principal reasons that shed a little light. Firstly, there is the geo-politics of Australia itself. Secondly, there is the profound dissonance between the indigenous and the mainstream cultures.

## "The Splendid Nothingness"

The island which is a country which is a continent which is Australia has spawned a thousand travelogue clichés. The country has a population of 18.5M with over 12M living in the nine largest coastal cities and towns. The vast interior of desert, semi-desert and rural terrain is largely unpopulated. The largest sheep farm – comprising arid scrub – is the size of Belgium. Indeed, the term "the tyranny of distance" has been coined to describe the compelling logistical difficulties of supply and communication across such geography. Thus the concept of such remote living is totally alien and almost beyond the comprehension of the UK citizen. Commonplace health care terms in the UK such as "community" and "primary care" are barely recognisable and require radical redefinition.

## Cultural disharmonies

The indigenous people of mainland Australia represent a living but fragile social anthropology which co-exists cheek by jowl with a mainstream Western culture that constantly threatens to obliterate it. The concept of time and, more specifically, the forward movement of time have no meaning in "classical" clan culture. Spoken English is a second or third language. A subsistence economy, migration (hence the term "walkabout") and highly complex kinship and clan ties are fundamental structures which bind these disparate peoples and which give order to their lives. In the NT there are 39,000 Aborigines (a density ratio of 13 square miles per aborigine). In SA there are 14,000 Aborigines (a density ratio of 26 square miles per aborigine).

Traditional culture has been dis-assembling since the arrival of the New World Australians over two hundred years ago. The 19th century saw the widespread clearance of the clans from the rich pastoral lands – very much akin to the Highland clearances of the 18th century in the UK. Subsequent history is peppered with bruising encounters between the two societies and the results for the indigenous people – fragmentation, welfare dependency, poverty, chronic unemployment – are plain to see. Thus there is a slide from traditional forms of living and a drift to the towns and cities – a trend which is well established and increasing inexorably. In the shopping mall at Alice Springs, scores of Aboriginal adolescents can be seen speaking to their barefooted parents in their given languages, and dressed in shoddy, fake soccer kit and baseball caps. This is perhaps a metaphor for the cultural unravelling.

Thus the great variation in health status can best be understood as a problem which is most assuredly gross and stark but which impacts upon only the relative few (of the 18.5 million, that is), and dispersed over thousands of square miles. So it is either hidden from the public gaze of mainstream Australia or, at best, viewed from the other side of a cultural chasm.

## Alien western medicine

In a fairly benign dollar-rich environment, the temptation for the health and community agencies to choose a short-term-top-down-big-bang programme of radical action as a means of closing down the health gap was probably immense. However, such a programme would inevitably have meant an extension of Western technological medicine with interventions and health educational programmes provided by practitioners from the mainstream culture. To have succumbed to such a temptation would have been catastrophic for the intended beneficiaries.

## **An Aboriginal Controlled Health Service**

The genesis for health improvement came from the 1989 National Aboriginal Health Strategy, which recommended “an Aboriginal controlled health service for every indigenous community in Australia”. Against clear enumerations of local and regional health priorities, the strategy is to form strong and coherent alliances between Federal and State Governments (as the funding agents and as the public health providers) and the Aboriginal non-governmental organisations with the clans deciding what should be done. This dialogue and the regional and local plans which flow from it are well advanced – although perhaps more so in SA than in the NT.

## **Building community infrastructure**

Importantly, this evolving and maturing dialogue requires a huge investment of time and effort aimed at raising the level of health literacy amongst the indigenous people in order that they can make informed health choices. Further, it requires the creation and nurturing of cohorts of community leaders – representatives able to mediate between their people and the public service bureaucracies. Self-evidently, the creation of such community-based capability and capacity from such a low base is long haul work in extremis.

## **Aboriginal health workers**

The Praetorian Guard in this battle for health is represented by the Aboriginal Health Workers (AHWs). These are front-line practitioners drawn from the indigenous people who are clinically qualified in western medicine and health education as well as in traditional medicines and remedies. They are then able to translate and provide in a culturally acceptable way the most effective modern low-tech interventions. This important role is now regulated, with incumbents compliant to a nationally determined set of competencies - very much like the NVQ regime in the UK. Again, though, given the long training lead in times, growing the numbers of AHWs in sufficient quantities is heroic and long-term work.

Across Australia, 55% of health expenditure on indigenous people is for hospital care, which is a huge and disproportionate sum. It exposes the gross deficiency in primary, community and dental care services, particularly in the rural and remote areas. In other words, in the main Aborigines either get hospital care or get none at all. The creation of general primary health care in a country subject to the tyranny of distance is proving to be a profoundly challenging task. However, if the indigenous people are to be able to access local services that are culturally sensitive, this must be done. To hi-jack the now famous 1997 UK election slogan the priority is “primary care, primary care, primary care!”

## **Chasing the dollar**

The targeting of resources to clearly identified programmes is now a feature of both the UK and the Australian experience. Programmes for diabetes and renal disease, dental care, substance abuse, coronary heart disease and health education are now in evidence in both the NT and SA. However, many of the programmes are time- and resource-limited and this means that a great deal of time is invested (and huge opportunity costs accrued) by NGOs chasing government dollars to sustain their work. Often NGOs working locally in partnership find themselves competing against each other for the same dollar.

## **Managing complexity and intractability**

Tackling high mortality and morbidity in such deprived, dispersed and marginalised communities represents an enormous challenge to the people of Australia. Similarly, creating empowered communities with strong and vibrant leadership is a Herculean task that will take aeons to accomplish. These grave and sombre issues confront the country's hedonistic “can do, will do” mentality head on.

The creation of AHWs in the numbers required and building primary and community care from such a parlous base must sorely tax the resolve of all those involved in the project. Like it or not, they are running a marathon – not a sprint – and it is fair to say that the majority of those struggling hard will not see definitive and demonstrable success in their lifetimes.

How can practitioners remain committed and motivated when the fruits of their immediate labours may not be harvested for decades to come?

Perhaps it is of value to conceive of their work within the paradigm of complexity. Here the intractability of the problem – of Aboriginal health – is understood and celebrated. The paradigm requires an acceptance of the fact that there can be no “perfect predictability” or “perfect control” of all of the causes or all of the variables, which abound. In this context, benign change is a highly relative concept and improvement can only be brought about incrementally.

This is not something which politicians, who have to justify their efforts to a wider political audience, want to hear. But conceiving of the problem as complex and intractable in this way is potentially comforting and supportive. Perhaps it will liberate hard working, committed and proficient practitioners from the “guilt” of failing to make a positive difference in the very short term.

## **Changing times**

With thoughts of empowerment, cultural sensitivity, and cycles of poverty and ill-health the three Chief Executives returned to the UK, to read of race riots and “no-go” areas in the northern mill towns.

## **References**

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