

# ***SUBMISSION TO NT GOVERNMENT SOCIAL POLICY STRATEGY***

## ***ACTIONS THAT MEAN A DIFFERENCE***

A commentary on the need for social change to improve the health status of Australian Aborigines living in remote communities.

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## **RECOMMENDATION**

That the NT Government revisits the *Australian Assistance Plan* formulated by the Social Welfare Commission of the 1972-1975 Australian Labor Government and considers its introduction as a way of healing and building strength to remote living Australian Aborigines.

## **JUSTIFICATION**

An urgent need exists to build a social infrastructure for communities that will enable the following to be achieved:

- Positive approach to building better communities
- Better housing conditions
- Improved attendance at schools
- Less substance abuse
- Less domestic disturbances leading to domestic violence
- Job opportunities
- Greater food choices
- Reduced consumption of addictive substances
- Improved health outcomes

The health status of Aboriginal people will not improve while the social circumstances they are living in is dysfunctional, un –“healthy” and of a high risk nature. Social harmony will only exist when the people themselves are able to decide the type of community they want to live in and are given the incentive to build this for themselves.

## **Projected outcome**

The introduction of self-determined social priorities and goals to achieve these priorities will give the members of a community motivation to be involved in activities they have determined.

A pride will be seen in the people for the achievements they are making to achieve the objectives.

The introduction of the social development process will give individuals in communities the opportunity to:

- Be a part of formulating a vision for their community in (say) five years time.
- Have a say in how this vision will be achieved.
- Help to decide how “seed” funds should be used to start initiatives towards the vision.
- Develop a pride in the achievements of the community.
- Foster interest among the young generation towards education and job opportunities.

## **Method**

Establish a Commonwealth Government funded program, administered through the most suitable authority, to mirror the Australian Assistance Plan of 1972-75 and be for remote Aboriginal communities.

Provide through this “Aboriginal Assistance Plan” an amount of money to initiate the establishment of “social development” groups in each community. This group would be asked to encourage the painting of a vision for the future of the community which would include identification of needs; prioritise needs; plan action for achieving needs; allocate resources and review progress towards building better communities.

Funding to be available to be used as needed to encourage the initiation of projects that will foster training, employment, education and above all

## **...a more healthy social environment.**

Government should establish a Department (Agency) for Social Development to conduct this program.

## 1. ABOUT THE AUTHOR – a personal statement

I submit as a pharmacy/public relations consultant, who has spent all my working life in and around the pharmaceutical industry. The exception was in 1973 when I was fortunate enough to follow an interest I had in community development to work for the most ambitious program undertaken by an Australian government towards reforming the way welfare is handed out.

My interest stemmed from my involvement on a voluntary basis with social problems in communities, especially around the inner suburbs of Melbourne, through an organisation known as Apex Clubs of Australia. We were young men who enjoyed the opportunity to meet and work alongside others of different interests and professions, and who found doing something to help others most rewarding.

Marie Coleman, Chair of the Social Welfare Commission, established by the Whitlam Government, was given the task of setting up pilot programs that would test the theory that communities could decide for themselves where the social priorities lay to make their world a better place. The task was to market a product called the *Australian Assistance Plan* or *AAP* as it soon became known.

The aim was to use resources from the Federal, State and local government agencies, which along with NGOs, could direct its efforts to priorities established by the communities and regions themselves. My task was to assist them to understand the strategies needed to bring the parties together and form "Regional Councils for Social Development", along boundaries predetermined by the (then) Department of Urban and Regional Development. Each region in the pilot program had an amount of money to establish a Secretariat for Social Planning with a Director, and to set up the infrastructure to decide on options for spending a Federal grant equivalent to \$2 per person per region. The region I had most to do with was in the South West of Western Australia where it had \$250,000 to disperse.

History will say the AAP was a failure. It was ahead of its time. The principles were as right then as they ever will be. It was more the political forces between the three levels of government that brought about its demise, together with a desire from each elected Member of Parliament to want their electorate to be a part of the "pilot program". The number of "pilot" regions went from originally six to 18 and then to 35 out of a possible 77 regions, as part of an experiment. The working of Government was unable to carry the burden of this amount of development with no proper guidelines established.

My work in the NT has been in pharmacy - firstly in retail pharmacy and then in the government service initially doing the supply function of medicines to the Aboriginals living in remote communities. This was in the Katherine region in 1997. Following three years in Darwin as the senior pharmacy policy officer I joined the Tiwi Health Board as a consultant to advise and implement a "pharmacy upgrade project".

I am grateful to the Tiwi people for giving me the opportunity to live and work amongst them. This was a challenge I could not fulfill while working in the confines of the public service. This has given me the opportunity to work towards change with an organisation that has the ability to make decisions quickly.

The more time I spend on the Tiwi Islands, the more I realize that the "health system" is not changing the health status of the people in a general sense to any great degree. The way they live has to change for anything to be of significant benefit. This has lead me back to the thinking which made the Australian Assistance Plan. Encourage the people to work out their own priorities for social change and give them the resources to "seed" small projects from which big things may grow.

I urge you to consider this submission as a recipe for change to the point of considering an NT Aboriginal Assistance Plan to build better communities.

## 2. BACKGROUND –advocates for change

The author has been taking a close interest in this subject for the past six months and much of what is included here was contained in a presentation made to a conference on Remote Health in Sydney on 30<sup>th</sup> August 2002.

**Noel Pearson** - in his book "Our right to take responsibility"<sup>i</sup> said the following:

*"Our society today is clearly unsuccessful"*

*"Some of the signs our society is not functioning successfully (are)..."*

- *Our people die more than 20 years earlier, on average, than other Australians*
- *Health is by far the worst of any group in the Australian community*
- *(They) suffer from diseases that other Australians simply do not have*
- *(They are) most vulnerable to new health threats, like HIV*
- *Children do not participate in the education system anywhere near as successfully as other Australian children*
- *(There is) more violence amongst our people than in other communities in Australia."*

Noel Pearson wrote that the provision of money through welfare handouts has resulted in spending towards a lifestyle which acts against good health.

**Richard Trudgen** in his book "Why warriors lie down and die"<sup>ii</sup> Supported the "welfare dependence as being a contributor to the present community malaise. He wrote:

- *"Welfare leads to a level of dependence that is crippling and creates loss of roles, loss of mastery and, above all, hopelessness. And hopelessness in turn translates into destructive social behaviour - neglect of responsibility, drug abuse, violence, self-abuse, homicide, incest and suicide."*

**Dr Gary Robinson – Centre for Social Research – NT University** – presented a paper to the Menzies School of Health Research in Darwin in 2002 in which he spoke of the "social determinants" of ill health as being the direction to seek change in the future. Gary highlighted the following:

- The social determinants to health go deeper than previously considered.
- Improvement of health in Aboriginal people has concentrated too much on fixing a tired system with money, and measuring the reasons for poor health in terms of limited access and poverty.
- More money is not the solution... rather an examination of the social structure surrounding Aboriginal people.

Dr Robinson believes that the social structure will not improve, and with it health, until

- Health professionals cease to be driven by policy determined on past practices.
- Recognise that children are subject to high level risks in their developmental years.
- Health professionals acknowledge the need for improved social circumstance from within the community structure...

He added that health would not improve from just providing larger services which have already been shown to be ineffective.

**Children are particularly at risk**, according to Dr Robinson, and this is an outcome of a "fragile social structure". An early intervention program for children at risk<sup>1</sup> has shown:

- Majority experience multiple sources of difficulty
  - Current family violence
  - Conflict between parents
  - Sibling conflict
  - Recent deaths including suicide in close family
  - Separations and fostering
  - Poor cognitive and emotional development
  - Withdrawn behavior
  - Communication and learning difficulty

The conclusion reached from the above is that health is unlikely to improve without a change in the social infrastructure of the remote Aboriginal communities.

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<sup>1</sup> "Exploring Together" – Tiwi Health Board, Tiwi Islands 2001-

### 3. Our world – their world

The backdrop against which we (western culture) live is vastly different to that of the Australian Aborigine in a remote community.

The generations pass by and we are inspired by those ahead of us to set a standard we then strive to reach and lift to better heights. The gap between our generations lengthens as new ways of combating diseases are discovered. Our life expectancy reaches heights that would have been thought of as impossible just 50 years ago.

Our image is something we are sensitive about and we do our best to impress others. We want to feel fulfilled as individuals through achieving our goals and aspirations on a personal, social and workplace level.

Our world is

- A developed one with plans, strategies, timelines and endless rewards for achievement.
- An educated one with more rewards for higher achievement and countless opportunities to improve ourselves.
- A healthy one where risks are taken, but we are educated enough to balance those risks against likely benefits.
- One which contains massive amounts of money spent on marketing consumer products to us through the many media available as we are taunted to try new tastes, flavors, feelings and emotion.
- Controlled by rigorous regulations which protect us against high risk events, activities, pastimes and we respect those law makers for looking after us.
- Full of pleasures and opportunities and we work steadfastly to protect our place in it.

Australia is the “lucky country”. Overseas travel assures us on our return how lucky we are.

To the Australian Aborigine living in a remote place none of the above is true.

This submission sets out to show that the social infrastructure in which these people live is a high risk one with poor education, opportunity and lacking in a vision for the future which is so necessary for well tuned social and economic development.

The result of this is not “good health” as we know it, but bad health by comparison.

Comparisons are often made, and we are constantly reminded of the poor outcomes of the present health care system.

It is a system. A combination of plans, strategies, timelines and a severe lack of rewards as the incidence of chronic diseases continues to rise and the age at death remains low.

These people are in a world surrounded by conditions that we cannot comprehend as being “normal”. But to them it is “normal”.

“Good health” to the Aborigine in remote Australia is poor health to us.

The years between generations is reduced due to a low maternal age, and a high incidence of deaths in the years between 30 and 45 years<sup>iii</sup>.

Children are born into a society with a relaxed mode of pleasures that centre on social interaction at a high level between families, clans, tribes and skin groups.

Their world is a small one, in their own country to which they have a strong affiliation due to the traditions of previous generations.

Yet with the inter generational gap becoming less in years, the links to the past are at risk, and a new world is growing in the countries they love and respect so much.

This new world is one in which they had no say in as it developed.

It is a world as much a result of previous failed programs rather than strategically developed plans. Programs that have failed to acknowledge the need for social development.

It is not possible to build a new culture from an ancient one without acknowledging the need to build on the strengths of the past.

The past systems have failed, however it is still possible to read that the “problems” in Aboriginal health are indicators such as poverty, housing, nutrition, substance abuse, education and violence.

So long as statistics are used to measure the health status of a community there will be no improvement. This is a qualitative problem and not one that should be quantified without qualification.

The analysis which follows is a response to a draft statement issued by the National Rural Health Alliance (NRHA)<sup>iv</sup>.

**Taken from NRHA draft paper on Indigenous Health Policy (in italics)**

**1. Low employment rate or unemployment** - *23% compared to 9% for other Australians.*

**Comment** – all people need a motivation to work. Personal and community goals can assist in giving people a reason to work. CDEP is a worthwhile community based program that provides this opportunity. Participation in planning community goals may provide the motivation to want to contribute towards achieving a better place to live. Low employment is as much a sign of poor motivation to work as anything else. Given the motivation the work will be forthcoming.

**2. Education** - *the number of Indigenous people having tertiary education is only one fifth of that of other Australians.*

**Comment** - The opportunity for education depends on encouragement and access to facilities. Immediate family relationships should provide the encouragement with community goals being promoted across all age groups. Personal goals may then follow within the community infrastructure program. Until there are the activities in a community there is no incentive for children to learn in order to help those activities prosper. It is not possible to provide hope when there is none around. Poor education is the sign of a lack of incentive to be educated as anything else.

**3. Housing** - *7% of Indigenous people live in large (10 or more) households compared with 0.14% of other people and are more likely to live in smaller dwellings. Approximately one third of all improvised dwellings, such as sheds and humpies, are occupied by Indigenous households.*

**Comment** - The desire for close living "families" dictates this as well as the availability of size of dwelling. The need to have larger houses is evident, and along with this must be improved personal hygiene. It must be acknowledged that the housing is provided for the indigenous people without them having to do or say very much towards the provision. The "welfare" state has given them housing with no responsibility towards the maintenance and upkeep. Housing must be provided but only to a point when the community can take on its own responsibility for maintaining a system it has been a part of formulating..

**4. Nutrition** - *27% of adult Indigenous people would be classified as obese compared with 19% of all adult Australians.*

**Comment** - Availability is as important as encouragement given to "healthy eating". Advertising from mainstream Australia influences purchasing decisions. The priority of spending disposable income may result in insufficient money being available for adequate nutrients. When the disbursement of money is on other items than food, it is not possible to divert enough to go that extra step of good and wholesome food. (See next Section Mixed Messages)

**5. Drugs and other harmful substances** - *Cigarette smoking is almost twice as prevalent in Indigenous adults as Non-Indigenous adults. "Although there is little data regarding the use of illicit drugs and other harmful substances such as petrol there is growing concern on these issues by Indigenous people."*

**Comment** - There needs to be an understanding of the place these substances have in the social fabric of communities. Tobacco, gunja and alcohol occupy a significant role in social interaction opportunities. The lack of goals towards social improvement rule against arguments in favor of abstinence. Opportunities to meaningful tasks with personal rewards are required to stop the boredom state that currently drives people to alternative substances to abuse. It is as much a matter of "something to do" as anything else.

**6. Violence** - *In 1997/98 Indigenous females suffering physical violence represented 46 % of all female hospitalisations. "Self harm" or "external causes" are a leading determinant of deaths across the population, especially in the 30-45 year age group.*

**Comment** – The causative factors leading to violent situations are the result of one or more of the preceding indicators. Violence is the outcome of social abuse, brought about by the social environment. While the factors causing domestic violence are still predominant there will be little impact on reducing violent instances in communities. The violence is a symptom of a cause/effect relationship, and not the cause itself.

#### 4. "Good Health" to a person in poor health

Our culture is attuned to circumstance which leads to a state of "good health". Their (the Aborigine) in today's world may not have experienced "good health".

"Good Health" is defined as a state of well being that enables the individual to carry out daily life to best of ones ability.<sup>v</sup> Health is defined in WHO's Constitution as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.<sup>vi</sup>

It (good health) is what allows us to reach our aspirations in life. Adequately motivated, we assume greater responsibilities and reach goals we may have otherwise not been able to had we not been in "good health".

"Good health" can only be achieved when it is realized that the way people live causes ill health.

It is the place in which they live, the food they eat, the substances they consume, and the whole social environment that surrounds them every day. This includes the relationship infrastructure that governs the culture they have inherited.

These indicators create high risks to "good health" and when mixed with the newly available lifestyle choices, these indicators create an environment for breeding ill health.

The result is too many generations that have not experienced "good health" as we know it.

It is the lifestyle choices that need to be examined, not the statistics which measure the onset of the symptoms of the choices being made.

Building a revised culture from of an old culture means that the "health" of the community must be maintained and if anything this is more important than bricks and mortar, hospitals and new health clinics. A healthy community is a happy one where its inhabitants are pleased to live, work and play. The social infrastructure maintains this health community and must be nurtured.

Regrettably the cultural aspects in the development of this new culture have been overlooked and instead replaced with the bricks and mortar of a western society. The oppressive regimes of past governments has failed to build on the strengths of the ancient culture and rather suppressed its features in an attempt to have them replaced with new standards and practices.

Dr Fiona Stanley, Director of the WA Telethon Children's Foundation, and speaking on ABC radio<sup>2</sup>, said that she believed we place too much emphasis on hospitals and prisons and downstream things.

*"Let's look at the whole of society, the whole of the problem and maybe we can start to fix things earlier where it's going to be more effective and where it's going to make a more profound and sustainable difference"*, she told the ABC listening audience.

This should be the goal of policy in a social development context to build linkages and structures that will prevent social dysfunction and thus improve health.

The product known as "good health" needs to be promoted to the remote living Aboriginal as aggressively as the multi national consumer products manufacturers market their products which are contributors to the poor health status of Aboriginal people.

The challenge lies in reducing the number of deaths occurring at a young age (say between 35 and 45 years old) rather than keeping old people alive longer. The life expectancy will always remain low while there are such a large number of premature deaths.

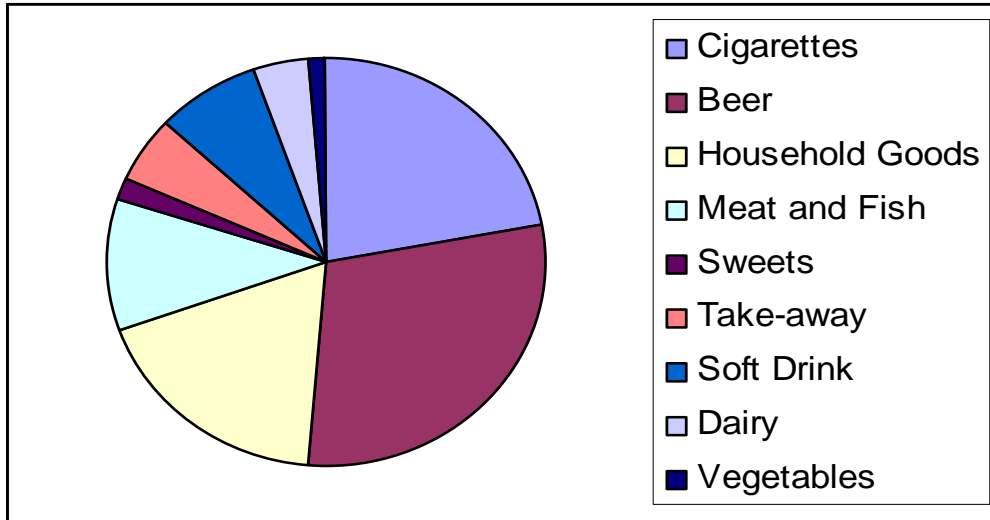
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<sup>2</sup> ABC Radio Wisdom Interviews – Fiona Stanley interview with Peter Thompson 4 August 2002

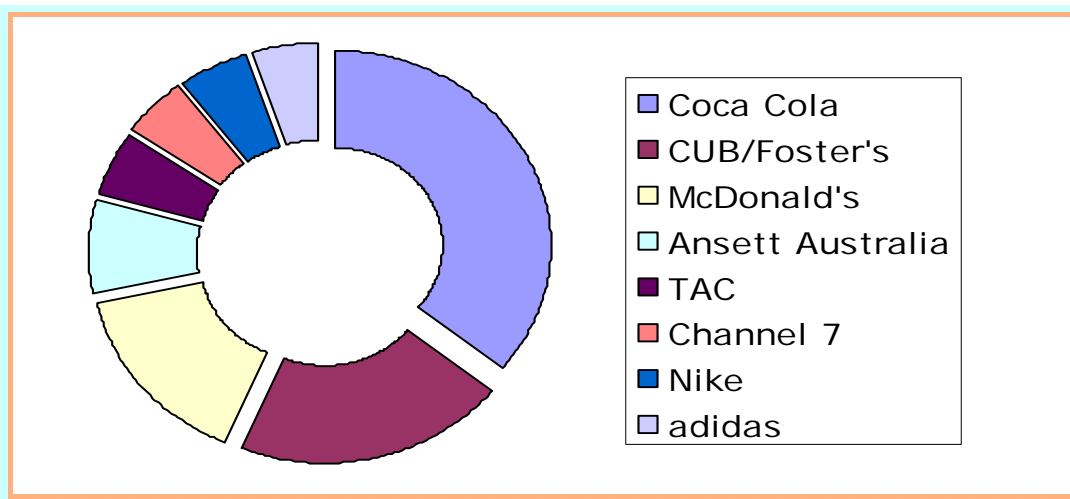
### 5. Mixed messages

Mixed messages surround the Aboriginal person all day, and particularly on weekends during the Australian Rules football season. It is on the telecasts of matches played across Australia that interest is shown for the football but at the same time receive "mixed messages".

Figures such as the following presented to the NTG Parliamentary Public Accounts Committee (1996) indicate the manner in which personal spending is directed. The figures are from the store and club at Nguiu, Bathurst Island.<sup>3</sup>



This spending pattern may be blamed on the messages received during football telecasts where research shows that the three most recalled consumer products seen by the viewer are as Coca Cola, McDonalds and Carlton and United Beer<sup>4</sup>.



The social impact this spending has on the life of a community is considerable and impacts on the individual, their children and their ability to lead a "healthy" lifestyle. The health system is not able to spend and promote against this TV exposure. The result is that products which have the ability to induce disease are used to excess by people unable to assess the risks they are exposing themselves to on a daily basis. Others, such as children are deprived of the necessities for a healthy life.

<sup>3</sup> Menzies submission to PAC 1996

<sup>4</sup> Sweeney Sports Market Report Winter 2001

## 6. A Plan for Social Development

A person in good health is able to work.

Work will happen if there is interest in the work.

Interest will be achieved if the goal of the work is towards something the individual wants.

A lot of individuals working towards a common goal of building a better community will provide the example to younger people. A work "ethic" will be encouraged and the community as a whole benefit.

### Social planning means that

There is coordination between agencies in the the setting of community goals and priorities.

Education, employment and self improvement among Aboriginal people will occur when **social goals** are in place with self determined priorities.

Governments in committing resources to social planning illustrate their commitment.

Funds will then need to be 100% for spending on priorities determined by local people so they are empowered to build a better community and have the resources to get that started.

Some money will be needed to administer the "group" that is to be initiating the activity towards social planning. To be successful this will need:

- Leaders support
- A "council" for social development
- Communication lines to people.

## 7. Conclusion

There is the need for more research into the social determinants to ill health. Health professionals need to be convinced that not everything they are currently doing is making a significant difference to the statistics measuring improved health status.

It is posited that stress can be a causative factor towards ill health. If this is proven then the Aboriginal living in a remote place is surrounded by stressful situations. This is supported by Paradies and Cunningham when looking at the health of Australian Aborigines in an international context.<sup>vii</sup>

Their lives are full of stressful things:

- Illness and death to close relatives.
- Domestic violence among immediate family and near neighbors.
- Suicides to close family and friends, particularly at a young age say 15 to 25 years.
- Money worries and an inability to manage finances. This is not assisted by western culture being unable to appreciate the circumstances of remote living and poor communication links.
- Addiction to marihuana, cigarettes, alcohol causing disturbing behavior and placing pressures on immediate family.
- Children being raised without immediate parent due to low maternal age, high death rate among young adults, family disruption leading to single parent situations.

These stressful situations may make a significant contribution to ill health. It is possible that there is a link between the onset of diabetes, high blood pressure, kidney failure, asthma and heart disease.

- Ill health is caused by **social circumstance** which brings on disease factors.
- The **social infrastructure** of communities needs to be understood before the promotion of "good health" will succeed.
- **Social planning** in communities is needed
- Government **department** for social planning established
- Create **indigenous assistance plan**
- **Devolve spending** to local community level
- Provide **training for indigenous facilitators**

## ENDNOTES

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- <sup>i</sup> "Our right to take responsibility", Noel Pearson 2000. Goanna Print
- <sup>ii</sup> "Why Warriors Lie Down and Die", Richard Trudgen 2000. Openbook Publishers
- <sup>iii</sup> Australian Social Trends 2002. ABS Canberra
- <sup>iv</sup> NRHA draft paper on Indigenous Health Policy. Website 2002
  
- <sup>v</sup> Australian and NZ Public Health Association
- <sup>vi</sup> Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.
  
- <sup>vii</sup> Yin Paradies and Joan Cunningham Aust N Z J Public Health 2002; 26: 11-6