

## Acknowledgments

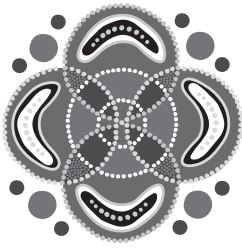
This monograph is the culmination of a body of work commissioned by the Cooperative Research Centre for Aboriginal Health (CRAH) as part of the development of its Social Determinants of Health Research Program. The series of papers were presented at a workshop, held at Flinders University, Adelaide, 6–7 July 2004.

The editors would like to thank the many people involved in the workshop, especially the authors and presenters of the papers. More than fifty participants from around Australia came to Adelaide for the two days and special thanks go to the organisers of the workshop, in particular Helma Hooper, from the South Australian Community Health Research Unit, who provided tireless administrative support.

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## Glossary

<b>AARE</b>	Association for Active Educational Researchers	<b>CARPA</b>	Central Australian Rural Practitioners Association
<b>ABC</b>	Australian Broadcasting Corporation	<b>CAT</b>	Centre for Appropriate Technology
<b>ABS</b>	Australian Bureau of Statistics	<b>CDEP</b>	Community Development Employment Program
<b>ACA</b>	Aboriginal Councils and Associations	<b>CDIP</b>	Cultural Diversity and Inclusive Practice
<b>ACWA</b>	Association of Children's Welfare Agencies	<b>CRANA</b>	Council of Remote Area Nurses of Australia
<b>AECGs</b>	Aboriginal Education Consultative Groups	<b>CRCAH*</b>	Cooperative Research Centre for Aboriginal Health
<b>AGPS</b>	Australian Government Publishing Service	<b>CRCATH*</b>	Cooperative Research Centre for Aboriginal and Tropical Health
<b>AIHW</b>	Australian Institute of Health and Welfare	<b>DDBBB</b>	Danila Dilba Biluru Butji Binnilutlum [Medical Service]
<b>AITAC</b>	Australian Indigenous Training Advisory Council	<b>DEST</b>	Department of Education, Science and Training, Australian Government
<b>AIATSIS</b>	Australian Institute of Aboriginal and Torres Strait Islander Studies	<b>DETE</b>	Department of Education, Training and Employment, SA
<b>AHM</b>	Australian Health Ministers	<b>DEWR</b>	Department of Employment and Workplace Relations, Australian Government
<b>ALRC</b>	Australian Law Reform Commission	<b>DEWRSB</b>	Department of Employment, Workplace Relations and Small Business, Australian Government
<b>AMSANT</b>	Aboriginal Medical Services Alliance Northern Territory	<b>DFAT</b>	Department of Foreign Affairs and Trade, Australian Government
<b>ANTA</b>	Australian National Training Authority	<b>DFCS</b>	Department of Family and Community Services, Australian Government (now FaCSIA)
<b>ANTaR</b>	Australians for Native Title and Reconciliation	<b>DHA</b>	Department of Health and Ageing, Australian Government
<b>ANU</b>	Australian National University	<b>DOJ</b>	Department of Justice, Victoria
<b>APS</b>	Australian Public Service		
<b>ATSIC</b>	Aboriginal and Torres Strait Islander Commission		
<b>ATSIS</b>	Aboriginal and Torres Strait Islander Services		
<b>CAA</b>	Carers Association of Australia		
<b>CAAC</b>	Central Australian Aboriginal Congress		
<b>CAEPR</b>	Centre for Aboriginal Economic Policy Research		

<b>FaCSIA</b>	Department of Families, Community Services and Indigenous Affairs, Australian Government	<b>NSW</b>	New South Wales
<b>HoNOS</b>	Health of the Nation Outcomes Scale	<b>NSWHD</b>	New South Wales Health Department
<b>HR</b>	House of Representatives, Australian Parliament	<b>NT</b>	Northern Territory
<b>HREOC</b>	Human Rights and Equal Opportunity Commission	<b>NTA</b>	Native Title Act
<b>IHS</b>	Indigenous Health Survey	<b>NTLRC</b>	Northern Territory Law Reform Committee
<b>KAMSC</b>	Kimberley Aboriginal Medical Services Council	<b>OATSIHS</b>	Office of the Australian and Torres Strait Islander Health Services, DHA
<b>KHPC</b>	Koori Health Partnership Committee	<b>OHAA</b>	Oral History Association of Australia
<b>KHT</b>	Koori Health Unit	<b>PAR</b>	Participatory Action Research
<b>KHT Inc.</b>	Koorie Heritage Trust Incorporated	<b>PRA</b>	Participatory Rural Appraisal
<b>MAC</b>	Management Advisory Committee	<b>RACGP</b>	Royal Australian College of General Practitioners
<b>MCEETYA</b>	Ministerial Council on Education, Employment, Training and Youth Affairs	<b>RACP</b>	Royal Australian College of Physicians
<b>MHCA</b>	Mental Health Council of Australia	<b>RCIADC</b>	Royal Commission into Aboriginal Deaths in Custody
<b>NACCHO</b>	National Aboriginal Community Controlled Health Organisation	<b>SA</b>	South Australia
<b>NAHS</b>	National Aboriginal Health Survey	<b>SACE</b>	South Australian Certificate of Education
<b>NAHSWP</b>	National Aboriginal Health Strategy Working Party	<b>SES</b>	Socio-Economic Status
<b>NAIHO</b>	National Aboriginal and Islander Health Organisation	<b>SDQ</b>	Strengths and Difficulties Questionnaire
<b>NATSIS</b>	National Aboriginal and Torres Strait Islander Survey	<b>SHRG</b>	Social Health Reference Group
<b>NATSISS</b>	National Aboriginal and Torres Strait Islander Social Survey	<b>SNAICC</b>	Secretariat of National Aboriginal and Islander Child Care
<b>NSFATSIH</b>	National Strategic Framework for Aboriginal and Torres Strait Islander Health	<b>THS</b>	Territory Health Services
<b>NGO</b>	Non-Government Organisation	<b>VET</b>	Vocational Education and Training
<b>NHMRC</b>	National Health and Medical Research Council	<b>UNICEF</b>	United Nations International Children's Fund
<b>NHS</b>	National Health Survey	<b>WA</b>	Western Australia
<b>NIIRV</b>	National Inquiry Into Racist Violence	<b>WHO</b>	World Health Organization
<b>NILF</b>	Not in the Labour Force	<b>WPAHBH</b>	Working Party of Aboriginal Historians for the Bicentennial History

*\* The CRC for Aboriginal Health was established in 2003 following on from the CRC for Aboriginal and Tropical Health. It is a virtual organisation that brings together the Aboriginal health sector, government health agencies and research institutions to ensure that research conducted into Aboriginal health is driven by priorities set by Aboriginal people themselves; is of practical use and transferred expeditiously and accessibly to the Aboriginal health sector; and results in the development of research capacity within the Aboriginal community itself ([www.craah.org.au](http://www.craah.org.au)).*



# Introduction

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*In the National Aboriginal Health Strategy, Aboriginal and Torres Strait Islander peoples linked their health to 'control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity (Human Rights and Equal Opportunity Commission 2005:26).*

That social and economic factors determine health status has been acknowledged for centuries. It would, in all likelihood, come as a shock to the ancestors of Aboriginal people<sup>1</sup> in Australia that there could ever have been any doubt that what happens in everyday life and one's position within society would have a massive impact on health. For them, health was a concept indivisible from life itself. While modern medical science has brought many benefits, it has also resulted in a situation where what happens to individuals and their bodies has become abstracted from their social, economic, cultural and community context. Increasingly, health researchers and activists are re-learning the importance of a holistic approach to health and there has been a resurgence of interest in the social and economic factors underpinning health outcomes.

This renewed interest on the role of social and economic factors in health is well demonstrated by the World Health Organization's (WHO) establishment in 2005 of the Commission on the Social Determinants of Health (CSDH). The CSDH has expressed a determination to be driven by evidence, including successful action and research on social determinants that has resulted in improvements in population health. The Commission's encouragement for action on the social determinants of health has also provided a research framework for the work of the Cooperative Research Centre for Aboriginal Health (CRCAH). This focus fits well with the CRCAH's central goals of ensuring that research into Aboriginal health is driven by priorities set by Aboriginal people themselves; is of practical use and accessible to the Aboriginal health sector; and results in the development of research capacity within the Aboriginal community itself.

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<sup>1</sup> Throughout this Introduction we have used the term 'Aboriginal' when referring to Indigenous Australians. Many of the issues raised are also relevant to Torres Strait Islanders.

This monograph, commissioned by the CRCIAH, presents a perspective on how a range of social and economic factors—including culture, law, education, employment, models of governance, and social and community interactions—affect the health of Aboriginal Australians. It also suggests fruitful directions for further inquiry into how these factors can be made more health promoting.

## Social determinants of health and wellbeing

Social determinants, then, has become the commonly used term to describe the non-medical and behavioral influences on health. The CRCIAH uses the term for one of its four program areas (for details of the programs see [http://www.crciah.org.au/research\\_program\\_areas/](http://www.crciah.org.au/research_program_areas/)). However, this is done uncritically and we are aware that using the term 'determinants' implies a rigidity and certainty that does not capture the less deterministic nature of the constellation of factors that create health and wellbeing. In practice, population health and wellbeing reflect fluid processes that result from political decisions or non-decisions. This means that the factors labelled as 'determinants' are not rigid or fixed in the sense that they cannot be changed. In fact, they are open to influence through policy changes.

In the past few years, and particularly since the publication of the *Little Children Are Sacred: Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse 2007*, policy debates in the Australian media have presented Aboriginal issues as if they are unsolvable and intransigent and caused by 'deviant' characteristics inherent in Aboriginal communities. The policy light is rarely shone on the people with power and resources, as was clearly demonstrated in the August 2007 debate around the Federal Government's new legislation in response to this report. This response was strongly criticised for ignoring evidence on the broader determinants of health. Such indifference

emphasises the need to understand current debates about the social and economic determinants of health within an historical context. It is not possible, in our view, to understand the persistent poor health status of the original custodians of Australia since the time of European arrival and invasion, without situating this understanding within the history of dispossession, colonisation, failed attempts at assimilation, racism, and denial of citizenship rights.

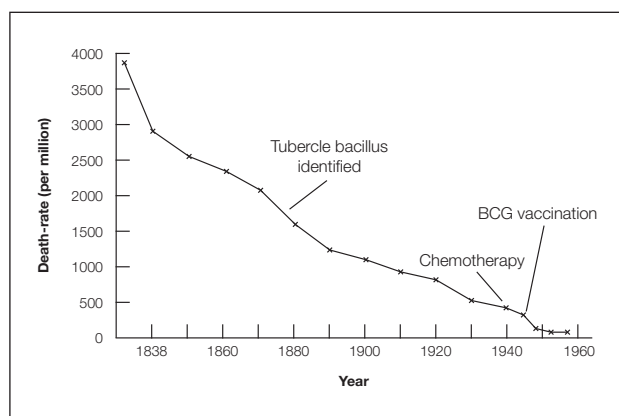
Nor does the current debate take into account the long-term trends in Aboriginal health. In those regions where we have quality longitudinal data we are now able to demonstrate that there have been significant health gains despite the continuing disparities. In the Northern Territory, life expectancy for the years 1967–2001 has improved for both Aboriginal men and women: from 52 to 60 years for men, and from 54 to 68 years for women (Wilson, Condon & Barnes 2007). There has been significant and demonstrable gain in the mortality outcomes for children under five years of age. For example, the work of Freemantle *et al.* (2006) in Western Australia has shown that infant mortality rates for Aboriginal children have improved from a rate of 25.0 in 1980–84 to 16.1 in 1998–2001. It should be noted that despite the gains in infant mortality, the more recent pace of improvement has not kept up with gains in the broader Australian community so that the gap has widened.

When we examine cause-specific trends the pattern is more complex. In the Northern Territory mortality due to infectious diseases has improved significantly over the past four decades. Patterns with respect to chronic diseases show that even these have been increasing at a much slower rate since 1990 (Thomas *et al.* 2006). It is difficult to make clear attribution for the positive changes, but most commentators acknowledge the role of both improved housing quality and the physical environment. It has also been suggested that better access to health care (including preventative programs such as immunisation) has contributed to these advances.

## History of social determinants approach to health

An approach to health based on the social determinants of health is not new. Nineteenth-century social and public health reformers (for example, Virchow in Germany and Snow in the United Kingdom) were well aware that the main causes of illness were rooted in social and economic infrastructures (see Baum 2002 for details). In one of the most quoted examples of public health action, Dr John Snow took away the handle from a water pump because he had established that the water from that pump was causing its users to contract cholera. Similarly, Dr Rudolf Virchow identified the working conditions that resulted in ill health among workers in Silesia. Other social reformers in the nineteenth century pointed out that the working and living conditions in rapidly growing urban areas resulting from the industrial revolution were the cause of much ill health. For instance, tuberculosis was in part spread by the close proximity in which people lived in crowded housing, thus proving that tuberculosis is a disease of poverty. Some of the strongest evidence in support of the social determinants of health comes from the decline in rates of tuberculosis in the United Kingdom. McKeown (1979) shows that this decline occurred prior to the availability of medical therapies (Figure 1).

**FIGURE 1:** Respiratory tuberculosis—mean annual death rates (standardised to 1901 population, England and Wales)



Source: McKeown 1979:92

This important analysis does not necessarily hold for Indigenous populations for whom significant declines in infectious diseases mortality occurred after the introduction of effective public health programs such as in tuberculosis control and immunisation (Kunitz 1994). There is now a body of research that demonstrates a link between health care (and primary health care in particular) and population-level health outcomes. In this context, the health outcomes documented fall into four main categories:

- reduced prevalence and incidence of communicable diseases that are susceptible to immunisation programs;
- reduced complications of chronic disease through effective chronic disease management programs;
- improved maternal and child health outcomes;
- reduction in social and environmental risks through effective local public health advocacy.

It is likely that some of these outcomes require coordination between general practice and other components of the primary health care sector (DHA 2005).

For these reasons, it is generally now accepted that access to health care is an important social determinant. However, this is not a focus that is developed in this collection, and research in this field is taken up by the CRCAH Comprehensive Primary Healthcare, Health Systems and Workforce program. The goal of this program is to improve the performance of health systems with a particular focus on comprehensive primary healthcare services in order to maximise health gains for Aboriginal Australians.

For Aboriginal people, the impact of social and economic factors on health was evident from the time of the European invasion. Colonisation of land, such as Australia, was a process through which European countries sought to gain extra territory and, through it, wealth. Such was the disregard for the rights of the traditional owners of the land that the official position of the British government was of *terra nullius*—Latin for 'land of no-one'. For any people, the refusal to recognise occupation of land as a basic determinant of health would be crucial, but is even more so for a people who had lived so closely to the land in a stable culture for hundreds of thousands of years.

The dispossession of Indigenous peoples from their land continued throughout the nineteenth and twentieth centuries, although the form varied according to current government policy. Aboriginal Australians were consistently treated as

less than human and denied basic human rights. Some key examples demonstrate this: the failure of the Australian Constitution of 1901 to establish the legislative conditions in which Aboriginal Australians could be treated as full citizens; the policy of pulling together people from different tribal backgrounds into missions in the first half of the twentieth century; and the removal of children from their home 'for their own good'. Over the past decade or so, the impact of this history as a social determinant of health has been recognised. Perhaps this happened most powerfully in the *Bringing Them Home* report of the Human Rights and Equal Opportunities Commission's National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families in which the harms done to the 'stolen generation' were documented.

Having said this, the CRCIAH's aim is not simply to dwell on the past, but to use an understanding of the past to contribute to a healthy future for Aboriginal people in which social, emotional and economic wellbeing is the norm rather than the exception. This monograph seeks to make a contribution to this process.

## Current attention to the social determinants of health

While there has been a consistent strand of public health that has recognised the power of social and economic determinants of health, in the early twenty-first century their importance seems to be reasserting itself (Solar & Irwin 2007). In Australia, the Human Rights and Equal Opportunity Commission's *Aboriginal and Torres Strait Islander Commissioner's Social Justice Report* (2005) put considerable emphasis on the role of social determinants, and stressed that land and culture were important to health and that racism was detrimental to health. The report positioned the relatively poor health of Indigenous peoples as a human rights issue. It also contributed to the formation of a national campaign 'Close the Gap' (<http://www.oxfam.org.au/campaigns/indigenous/action.php>), which has as one of its three main planks of action 'Addressing critical social issues such as housing, education and self-determination which contribute to the Indigenous health crisis'.

This growing recognition of the social determinants of health has also been recognised internationally as signified by the decision of the late Director General of the WHO, Dr Lee Jong-wook, to launch a Commission on the Social Determinants of Health. Its chairperson, Sir Michael Marmot, has stressed that the work of this Commission is to consider the 'causes of causes of ill-health' (Marmot 2006). In launching the Commission, Dr Lee (2004) noted

*The goal is not an academic exercise, but to marshal scientific evidence as a lever for policy change—aiming toward practical uptake among policymakers and stakeholders in countries.*

This focus on action parallels the determination of the CRCIAH Board to emphasise, in its research program, not just an understanding of the social determinants of Aboriginal health but also an identification of which interventions are likely to improve Aboriginal health and wellbeing. This focus will be vital but, in all likelihood, hard to achieve because there has been so little investment in building an evidence base for the social determinants of health in Australia or overseas. This is especially the case when compared to the massive worldwide investment in the development of medical and pharmaceutical interventions, as the Global Forum for Health Research consistently points out (GFHR 2004; Mattin 2004). Others have noted that there is little in the way of efficacy research—testing interventions in a controlled setting—or implementation research—the 'how' of translating current research knowledge into practice within existing health and social systems (Sanders *et al.* 2004). Ågren (2003:20) states that public health research comes a very poor second to bio-medical research and comments that:

*Research policy reflects both an over-confidence in the medical care services' ability to solve fundamental health problems and the strong economic interests that exist in the field of medical treatment. An individual and often deep-rooted biological approach dominates within the field of medicine, resulting in socially determined health discrepancies being studied relatively seldom or in many cases being ignored completely.*

Part of the difficulty in researching the social determinants of health is that evaluation of the interventions is challenging both practically and methodologically. Practical problems concern the need to develop partnerships with agencies that will be funding, planning and implementing interventions, and that sourcing funding for the evaluations is difficult. While the National Health and Medical Research Council (NHMRC)

has changed its funding priorities to some degree, social determinants are still under-represented in the type of projects that it funds. It is significant too that the latest classifications of research used by the NHMRC, the draft 'health streams' presented in 2005–06, do not contain a specific category for social determinants. By contrast, biomedical research interests were represented in each of the streams. We are conscious that the kind of evidence needed about the social determinants of Aboriginal health will not be available until some significant national investment is made into researching them. The main focus of the research needs to be either on retrospective studies of occasions and instances in which health has improved in response to social or economic interventions, or on prospective evaluations of interventions based on improving social and economic determinants designed to enhance wellbeing.

In April 2007 the CRCAH hosted an International Symposium on the Social Determinants of Indigenous Health, which was endorsed by the Commission on the Social Determinants of Health. The symposium confirmed the central importance of social factors to Indigenous health status and drew on case studies from around the world to explore the unique nature of the ways in which these social factors have an impact on Indigenous peoples in (post)colonial societies (for report see <http://som.flinders.edu.au/FUSA/SACHRU/Symposium/>). We return to the themes from this symposium in the conclusion of the monograph, but note here that one of the important themes was the call for applied research.

This monograph resulted from an earlier CRCAH seminar held in 2004 as part of the process to establish priorities for research on the social determinants of Aboriginal health. The papers it contains set the scene for further research on the social determinants of health and strengthen the case for greater research investment to establish which interventions work best. The monograph does this by summarising existing research on the social determinants of Aboriginal health, and by suggesting directions for a future research agenda.

## The process of compiling this monograph

Authors (individuals and/or groups) were commissioned to review the literature on particular aspects of the social determinants of Aboriginal health and then, on the basis of this review, to make recommendations for future CRCAH research priorities. Draft papers were prepared and presented

to a seminar held at Flinders University in June 2004. The papers were pre-circulated to seminar participants so that discussions could be based on a full reading of the papers. The presentations were made to plenary sessions but the discussion occurred primarily in small groups. Subsequently, the literature reviews and recommendations were sent out for peer review and authors were invited to revise their papers in light of reviewers' comments. The information from the reviews and the seminar has been used to inform the evolving agenda for the CRCAH's Social Determinants of Health research program which is discussed further in the conclusion of this monograph.

## The contents

This monograph contains sixteen chapters, each including components of literature review and recommendations for future research. The first two chapters present Koori perspectives of the social determinants of health. Chapter 1 by Tynan *et al.* is based on interviews with Koori people about their health and the ways in which social and economic factors and processes influence their health and wellbeing. The authors found that day-to-day relationships to social processes are closely connected and that 'upstream'/'downstream' and macro/micro factors are experienced simultaneously in a complex and multi-faceted way. Chapter 2, by Vickery *et al.*, concerns the way in which oral history can be used to provide decolonised voices to demonstrate the impact of historical experiences on health. These chapters provide an essential background to those that follow because they serve as a reminder that the dominant voices in the social determinants literature in Australia have been those from non- Aboriginal Australians.

A crucial aspect of the CRCAH agenda is, and will be in the future, funding research that allows the Aboriginal voice to present the complex intersections of social determinants that affect all populations (including education, housing, employment, income, and environmental quality) and those that affect Aboriginal people in particular (culture, a special relationship to land, a history of dispossession, and unique forms of social organisation).

Chapters 3 and 4 are concerned with education and its impact on health. Bell *et al.* (Chapter 3) review international evidence that demonstrates the central role of education in the creation of health. They also consider the intersections between health and education in Australia, how education can be understood both as a determinant of health and

as an active intervention to address health inequalities, and set out an agenda for research based on community development principles. Askill-Williams *et al.* (Chapter 4) make a passionate plea for understanding education as a transactional process and as an essential element of wellbeing. They argue that education is required to achieve both the imperative for conceptual change, and conceptual change itself at multiple sites throughout the system.

Chapters 5 to 7 look at the material social determinants of income, poverty, employment and the physical environment. Walter (Chapter 5) demonstrates that Aboriginal Australians are more likely than other Australians to live in poverty and argues that this poverty can only be understood by considering Aboriginality. By this she means the lived experience of being Aboriginal in contemporary Australia, and suggests that future research takes into account the social, political and economic consequences of being in this position. Chapter 6 by Lowry and Moskos is written from the perspective of labour market experts and describes the ways in which Aboriginal Australians participate in a labour force in which they occupy a less advantaged position than other Australians. They conclude that further research would enable a richer understanding of Aboriginal perspectives of labour force status and its impact on health. Wayte *et al.*, in Chapter 7, provide a detailed review of the literature on the physical environment and Aboriginal health. They show how common it is for the basic infrastructure that so many Australians take for granted to be lacking in Aboriginal communities. Their chapter also provides a framework to guide future research on this topic. In particular, they recommend that the development and implementation of programs and interventions should be guided by sound research into Aboriginal peoples' perceptions and behaviours in relation to the physical environment, and the determinants, outcomes and relationships between environmental factors and health outcomes.

Chapters 8 to 11 concern the less visible, but vital, aspects of Aboriginal experience in Australia such as social and emotional wellbeing, the importance of community development, effective means of governance, and the value of social capital as an analytical tool. Each of these chapters stress that health status is about much more than simply meeting physical needs. This complements the work of Marmot (2004:1), who notes that even among people who have jobs, good housing, education for their children, access to nutritious food and clean water, there is still a gradient of health—in his words, 'the remarkable finding is that among all of these people, the higher the status in the pecking order, the healthier they are likely to be'. It is among these less visible determinants of health that the reasons for health gradients are to be discovered.

Chapter 8, by Henderson *et al.*, provides a thorough and detailed review of the literature on social and emotional wellbeing, including the means of measuring and assessing this wellbeing. They also outline a research agenda that is being used to inform the CRCAH Social and Emotional Wellbeing Research Program. Campbell *et al.* in Chapter 9 review the literature relating to the use of community development strategies in Aboriginal communities, they determine how these strategies have been used, and identify where they have, and have not, been successful in bringing about sustainable change. The chapter provides a critical view of empowerment, while recognising its central importance to the promotion of Aboriginal peoples' health. In Chapter 10 Sullivan and Oliver provide a critical review of governance and its impact on the life and health of Aboriginal Australians. They include a consideration of Aboriginal political life and custom, and the ways in which Australian society seeks to govern Aboriginal people. Their investigation of how mainstream organisational cultures limit their ability to work effectively with Aboriginal communities is highly relevant in 2007 as the Federal Government seeks to reshape its relations with Aboriginal communities in the Northern Territory. In Chapter 11 Brough *et al.* consider social capital and its potential role in understanding, and acting upon, the social determinants of health. They point out that the concept of social capital is slippery but has been used to produce a considerable amount of social epidemiology, suggesting that social processes involving trust, reciprocity and cooperation are good for health. They call for greater consideration of how this knowledge can be used to inform health policies and programs.

Chapters 12 and 13 are concerned with law and justice. Reynolds *et al.* provide a thorough overview in Chapter 12 of constitutional rights issues for Indigenous peoples, demonstrating that legal frameworks set the broad societal context within which impacts on health occur. The questions of rights is important given that in Canada, New Zealand and the United States of America, where prior Indigenous interests are formally recognised, Indigenous health, though worse than the average, is substantially better than in Australia. In Chapter 13, Smith considers the links between Aboriginal people and the justice system through a case study of the Koori Court in Victoria. This chapter is especially helpful in highlighting the complex and intersecting problems faced by Aboriginal people, and how addressing social justice issues may also have significant health benefits.

The final three chapters describe aspects of culture as it impacts on the health of Aboriginal Australians. In Chapter 14, Bond and Brough examine the ways in which the concept of culture is used in the public health literature: in terms of being about biology, being a label, being a description of behaviours or representing an ideology that can offer an alternative to dominant thinking. They also found culture positioned as a surrogate for racism or socio-economic disadvantage and, finally, as a panacea that can assist cure both through its role in making programs more effective and through the way in which it might empower people. They stress the importance of appreciating these complex understandings of culture and how the interpretations affect research and practice.

Morrissey *et al.* in Chapter 15 also discuss the complexity of culture and argue that a deeper understanding of culture is required in Aboriginal health research if it is to be a useful guide to social determinants of health responses. They note that serious engagement with Aboriginal culture, while essential to understanding Aboriginal health, is complex because doing so means engaging in a social process that is dynamic, shifting and interrelated. Finally, in Chapter 16 McDonald examines the ways in which the cultures of health services can impede effective service delivery. She explores examples of racism, the assumption of whiteness as the dominant paradigm, and the dominance of biomedical understandings of health. McDonald recommends an increase in cultural competence and cultural awareness training.

## Call for action

The body of research in this monograph provides the foundation on which the current CRCIAH Social Determinants of Health research program has been built. The work demonstrates the complexity of social determinants research and indicates that research that considers intersections between determinants will be important for the future. It also makes clear that while there is a body of research that describes the impact of the determinants of health, there is little that considers the question of what works in this area. A further lesson learnt from this collective work, is that research designed to address the question of what works must be built on a sophisticated understanding of social and cultural processes.

The CRCIAH is committed to conducting research that will make a difference to the wellbeing of Aboriginal people and believes that research designed by Aboriginal people can direct the type of interventions and programs that will improve health. Our hope is that this monograph will contribute to greater attention being focused on social determinants of health, and that it will add to the pressure for concerted and evaluated government action to address these determinants.

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