

## Is 'Close the Gap' a useful approach to improving the health and wellbeing of Indigenous Australians?

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### ABSTRACT

There is widespread enthusiasm for the Australian government's commitment to 'Close the Gap' in Indigenous disadvantage, health status and life expectancy. Yet despite the rhetoric, the pursuit of statistical equality for Indigenous Australians is not a novel or particularly promising approach. It is also an approach that reduces Indigenous Australians to a range of indicators of deficit, to be monitored and rectified towards government-set targets. This illustrates a substantial imbalance in power and control over the Indigenous affairs agenda in Australia, which is the 'gap' that must be addressed for the health and wellbeing of Indigenous Australians to improve.

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## INTRODUCTION

On 20 March 2008, representatives of the Australian federal government, peak Indigenous health bodies and the Aboriginal and Torres Strait Islander Social Justice Commissioner signed a Statement of Intent ‘between the Government of Australia and the Aboriginal and Torres Strait Islander peoples of Australia ... to work together to achieve equality in health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by the year 2030’ (Human Rights and Equal Opportunity Commission 2008). While Indigenous disadvantage has been evident for quite some time in Australia—approximately 220 years—and has been a matter for public concern to varying degrees through this period, this event marked a milestone in a concerted public awareness and advocacy campaign, spearheaded by a coalition of non-government organisations including Oxfam, GetUp and Australians for Native Title and Reconciliation (ANTaR).

In the brief period since the ‘Close the Gap’ campaign began life as a grassroots-flavoured movement in April 2007—complete with t-shirts, wrist bands, petitions and celebrity endorsement—the concept has gained widespread currency as a mainstream ideal. ‘Close the Gap’ is now an ubiquitous term in Indigenous policy statements, health and community service providers’ strategic planning and performance reporting, and in media commentary on Indigenous affairs. While the Australian government was the primary target for the Close the Gap Coalition’s advocacy campaign, its success in securing the newly-elected Rudd Government’s recognition and endorsement involved a transfer of power to define goals and targets for closing the gap, and to determine the means by which they are to be achieved. The Australian government now firmly sets the agenda for policy formulation, performance monitoring and the reporting of outcomes for closing the gap in Indigenous disadvantage, health status and life expectancy.

In its first report, *Closing the Gap on Indigenous Disadvantage: The Challenge for Australia*, the federal government specifies a series of ‘gaps’ for action and progress monitoring, in Indigenous life expectancy, child mortality, early childhood education, educational outcomes more broadly, and employment. The report outlines seven areas for investment as a strategy to address the disparity in outcomes—early childhood, schooling, health, economic participation, healthy home, safe communities, and governance and leadership—as ‘the evidence indicates that ... improvements in these areas will have the greatest impact’ (Department of Families, Housing, Community Services and Indigenous Affairs 2009). The Report states that this is the first time the Australian government and state and territory governments have jointly committed to clear, measurable targets in addressing Indigenous disadvantage.

The Australian government pledged to report annually on progress against the ‘gap’ targets; though whether such a report will supplement or replace existing biennial

reports such as the *Overcoming Indigenous Disadvantage: Key Indicators* report (Steering Committee for the Review of Government Service Provision 2007), the *Aboriginal and Torres Strait Islander Health Performance Framework* report (Australian Institute of Health and Welfare 2009), and the *Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples* report (Australian Institute of Health and Welfare 2008) is unclear, given that these reports already present a comprehensive account of the available data on the target 'gap' issues.

While such a clear articulation between governments, Indigenous organisations and community groups of a shared vision and goal may be novel, the core intent of the 'Close the Gap' approach is really not so new. The goal of statistical equality for Indigenous Australians has a long and disappointing history in Australia (Altman, Biddle & Hunter 2004). This history shows that regime change engenders renewed campaigns for achieving statistical equality, whilst condemning previous campaigns—including those with virtually identical features, such as the Howard Government's 'practical reconciliation'—as failures (Hunt 2008). Yet the ideal of statistical equality itself remains 'virtually beyond opprobrium' (Altman & Sanders 1991, p. 9).

Given this history, the distinguishing features of the Close the Gap approach are more a matter of emphasis than of substance. The goal of statistical equality, and the 'evidence based' methods by which it is to be achieved, are stated more plainly in Close the Gap rhetoric than in any prior approaches. The evidence base—quantitative data based largely upon biomedical and socioeconomic indicators—is the starting point and the guide to action, to the point where action may only be taken where there are data available to support it. Jenny Macklin, Minister for Families, Housing, Communities and Indigenous Affairs, put it this way in her speech to the National Press Club on 27 February 2008, at which she presented the Close the Gap strategy:

Inevitably there will be difficult decisions but all these decisions will be driven by one single criterion – evidence. This is the Government's obsession and we make no excuses for it. It is my abiding fixation and I readily acknowledge it. All our policy decision-making will be based on a thorough, forensic analysis of all the facts and all the evidence. Once implemented, all programs will be rigorously and regularly evaluated. This is a principle I will impose across my portfolio.

Its clarity and simplicity, political neutrality and promise of measurable progress, along with its imagery of Indigenous and non-Indigenous Australians working together to achieve a common goal, gives the Close the Gap approach tremendous appeal across government and community sectors. Perhaps given the optimism and sense of solidarity the campaign has generated, there have been few attempts to

subject the approach to more rigorous examination.<sup>1</sup> Yet the potential of this ‘evidence-based’ approach to explain and resolve the crises of Indigenous Australia’s health and wellbeing, and the validity of the ‘evidence’ by which success or failure is to be attributed, are due for greater scrutiny—because history has clearly shown that good intentions must be accompanied by critical reflection, particularly within the area of Indigenous affairs (Neil 2002, p. 30).

### **WHAT’S MISSING? A PROBLEM WITH STATISTICAL MEASURES OF THE ‘GAP’**

Jane Dixon and Colin Sindall (1994) note that a problem with the health indicators commonly adopted as the evidence base for population health interventions is that they tend to measure shifts in individual attitudes and behaviour, and lack measures of changes in the broader social dynamic. While there is increasing recognition of the role of social determinants in Indigenous health, and while the literature makes frequent mention of ‘Aboriginal and Torres Strait Islander communities’, the statistical indicators with which progress in closing the gap will be measured represent Indigenous Australia not as a society, but as a *population* comprised of *individuals*, that may be grouped in geographically bounded ‘communities’ for the purposes of analysis or interventions. Such a framework does not account for the dynamics within Aboriginal and Torres Strait Islander societies, or of the structural conditions and relationships between Indigenous and non-Indigenous Australia.

The famous Whitehall study demonstrated that, when virtually all health behaviours, environmental conditions and social determinants of health are equalised, those of a lower status within a hierarchical structure, with a consequently lower degree of control over their circumstances, will have poorer health than those higher (Bosma et al. 1997). Conversely, studies of the health impacts of social inequality have found the individualistic biomedical model inadequate for explaining health disparities. A study of socioeconomic disadvantage, health risk behaviour and mortality, using nationally representative data from the American’s Changing Lives survey, found that ‘despite the presence of significant socioeconomic differentials in health behaviours, these differences account for only a modest proportion of social inequalities in overall mortality’ (Lantz et al. 1998, p. 1707). Similarly, a study of social inequality, ethnicity and cardiovascular disease concluded that ‘racism and social inequality can be conceptualised as social causes of excess cardiovascular mortality that may not be measurable at the individual level’ (Cooper 2001, p. 48).

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<sup>1</sup> A recent paper by Altman, Biddle and Hunter (2008) titled ‘How realistic are the prospects for ‘closing the gaps’ in socioeconomic outcomes for Indigenous Australians?’ is one of very few examples. To greatly over-simplify, their analysis found that the statistical equality goals envisioned within the Close the Gap approach were highly unrealistic.

The Whitehall study also demonstrated a link between lower social status and a diminished sense of control over one's circumstances, which in turn is related to poorer health status (Tsey et al. 2003). The World Health Organisation defines health promotion as 'the process of enabling people to increase control over, and to improve, their health' (Ziglio 1997, p. 29). This would suggest that a key strategy for closing the gap in Indigenous health, wellbeing and life expectancy would be to address structural power imbalances and increase Indigenous Australians' sense of control over their circumstances. This in turn would suggest that the framework for monitoring progress in closing the gap would include a substantial suite of indicators measuring the degree to which power and control increases and is collectively exercised within Indigenous Australia.

Yet the framework of indicators used to monitor progress in closing the gap does not give a great deal of consideration to measures of Indigenous Australians' sense of control over either their health or their life circumstances more generally, other than as a measure of an individual's mental health or 'social and emotional wellbeing' (Australian Institute of Health and Welfare 2009, p. 388). Similarly, while the National Aboriginal and Torres Strait Islander Health Survey includes a measure of individual respondents' experiences of racial discrimination (Australian Bureau of Statistics 2006), there is no corresponding measure in national collections of the prevalence of racist or discriminatory attitudes towards Indigenous Australians within the broader Australian population. The Indigenous individual's experiences of racism or low sense of control over his or her life circumstances remains *their* (individual) problem. Because no broader social problem or structural inequities are measured, there is no evidence of a broader problem to be addressed.

'Culture' is another factor that the statistical framework largely positions within the private sphere of individual behaviours (such as participation in cultural events, using a traditional language or practicing a traditional craft), or within the semi-private realm of community-based events or organisations. Michael Morrissey and colleagues point out that this process of quantification and measurement is unable to account for culture as a dynamic value system, worldview and way of life. Ultimately culture, like racism, is reduced to a problem of the individual; they either 'have culture' or they do not, and 'having culture' makes an individual either healthier or sicker, depending upon his or her personal qualities and circumstances. Morrissey and colleagues argue that the relationship of culture to the health of Indigenous peoples can only be understood within the context of a people's degree of power over their circumstances (Morrissey et al. 2004).

Colin Tatz's study of Aboriginal, Maori and Inuit youth suicide offers an illustration of the shortcomings of a blanket biomedical conceptualisation of Indigenous health and wellbeing. He describes how Indigenous youth suicide is commonly understood and addressed via the mental health model: depression, substance use and various

stressors are identified as causal factors in the high rates of suicide within Indigenous populations, and mental health interventions are delivered as the potential solution. The biomedical approach to Indigenous youth suicide is to view the problem individualistically, in both its causes and solutions. Yet Tatz posits Indigenous youth suicide as more a *societal* than an individual problem. In describing the various factors and pathways leading to suicide, he concludes that ‘most of these forms embody neither badness, madness or illness. They certainly involve sadness. That their worlds are in disorder is certain—but social disorder is not synonymous with mental disorder, DSM-IV-TR notwithstanding’ (2004, p. 22).

The biomedical model’s individualistic approach to the improvement of health—focusing on individual behaviour change, addressing physiological and environmental risk factors as well as various social determinants of health such as employment and education—may go some way towards improving the health outcomes of the Indigenous Australian population by increasing the number of ‘healthier’ people within it. However, in the absence of a critical focus on structural inequities, collective power and control, and the dynamics of the relationship between Indigenous Australia and the rest of the nation, the Close the Gap approach is unlikely to achieve healthy Indigenous Australian *societies*, adequately equipped to manage and sustain the health of its members.

### **IS THIS A NEW WAY FORWARD, OR BUSINESS AS USUAL?**

Jon Altman and Will Sanders’ (1991) historical overview of successive Australian government approaches to Indigenous affairs demonstrates that the pursuit of statistical equality according to biomedical and socioeconomic indicators is not a new concept, nor is the conflation of statistical equality with social justice and Indigenous self-determination. Tim Rowse’s (2006) history of Indigenous statistics in Australia traces the pre-1967 monitoring of Indigenous Australians for the purposes of protection and assimilation, and the post-referendum increase in demand for reliable data for the purposes of monitoring government performance and outcomes in servicing the Aboriginal and Torres Strait Islander population. Rowse identifies a point in time where the improvement of data on Indigenous Australians was expected to lead to an improvement in their circumstances; greater statistical visibility was seen to have improved mortality for Maori and Native Americans, and this gave greater impetus for increasing the range and quality of data on Indigenous Australians (p. 5).

This is an example of the wishful thinking around the power of statistics that seems to be at work in Indigenous policy circles in Australia: that improved and increased data will magically translate into improved and increased health and wellbeing for Aboriginal and Torres Strait Islander people. In the absence of a nationally representative Indigenous body, best positioned to provide the link between data, theory and policy development, such a translation may indeed have to be magical.

This faith in the power of data to enhance the dominant non-Indigenous majority's knowledge and understanding of Indigenous Australian's lived experience—and the faith that this will in turn transform Aboriginal and Torres Strait Islander lives for the better—is in itself a cultural artefact, with its roots in the white/western ideals of scientism and positivism. The power of these traditions is evident in their almost universal, unquestioning acceptance, despite the fact there is little evidence of the efficacy of the quantitative, goals-and-targets approach to population health (Baum & Sanders 1995) that continues to dominate the Indigenous health and social policy landscape.

Jane Dixon and Colin Sindall (1994) suggest that Australia's relative strength in collecting high-quality survey and administrative data on individual behaviours and outcomes may also be an influencing factor in our enthusiasm for biomedical and socioeconomic data as the basis for policy formulation in Indigenous affairs. They suggest that in Australia, our ability to meaningfully measure and understand the relationship between social and structural dynamics and the health of populations is less developed relative to other nations. In this sense, rather than a new way forward, the Close the Gap approach may simply be Australia continuing to play within its strengths.

The monitoring of Indigenous programs and interventions through quantitative data collection does serve a number of essential functions. Comprehensive and reliable data are important for setting benchmarks and monitoring progress in the achievement of rights-based goals (Calma 2006), for budgeting and managing the performance of Indigenous community organisations and other agencies delivering services to Indigenous Australians (Anderson & Brady 1995), and for the monitoring of government commitment and accountability (Altman & Hunter 2006). It makes no sense to propose the discontinuation of quantitative goal-setting and performance monitoring, but it is reasonable to call for an end to the excessive *privileging* of these approaches (Morrissey et al. 2004, p. 247).

Public policy goals—for better or for worse—are generally based on a mix of theory, values, popular opinion, historical experience, political expediency and international examples, as well as the available statistical evidence. Data serve as guidelines for policy planning, and as progress monitors in policy implementation and evaluation. Yet with the Close the Gap approach, data has become both the means and the ends; statistical gaps define the targets for policy action, and changes in the size of the gap will be taken as evidence that the action is working, or not working. Such a policy approach, though 'evidence-based', is virtually devoid of theory and exists outside of historical, social and cultural context.

This absence of theory and context does not render the Close the Gap approach apolitical, however. Louise Humpage's (2008) analysis of Indigenous affairs policy approaches in New Zealand and Australia suggests it not surprising that Australian governments (whether the current Labor government or the previous Liberal-

coalition under the banner of ‘practical reconciliation’) have so enthusiastically taken responsibility for Closing the Gap. The adoption of monolithic performance management frameworks, populated with statistical reports of outputs and outcomes is a means for governments to retain control over an agenda, through setting the criteria for ‘success’ and ‘failure’ and managing its measurement and reporting. Such a strategy is particularly appealing in the management of Indigenous affairs, as it effectively depoliticises Indigenous issues by marginalising difficult and unquantifiable concepts such as ‘self-determination’.

In a similar vein, Karen Bridget Murray demonstrates how ‘neoliberal sensibilities that seek to individualise a wide range of social ills’ (2004, p. 50) have shaped Canadian approaches to ‘vulnerable populations’ such as Canadian Aboriginal people. Murray argues that such vulnerable populations are defined by their deviance from norms of health, housing, economic participation and so on, and that governments increasingly devolve responsibility for the resolution of the conditions of vulnerability onto both the individual and the communities in which they live. Vulnerable people are obliged to build their capacities and reduce their risk-taking behaviours, while communities—which are ‘construed as a private domain, separate from political authorities’ (p. 62)—are obliged to mobilise to address the social and economic needs of their more vulnerable members with minimal government intervention. We can see the manifestation of a neoliberal sensibility in the Close the Gap approach, in its diminishing acknowledgement of broader social and economic structures that lie beyond the control of the individual or their community.

The Close the Gap approach can also be linked to the emergence of a ‘population health’ approach to public health and health promotion in the early 1990s in countries such as Canada, the United Kingdom and Australia. This new approach was driven by an increased interest in inequalities-based health research, and was characterised by reliance on data to the exclusion of theory, and a preference for quantitative research methods using large data sets (Labonte et al. 2005). Christine Porter’s (2006) analysis of the World Health Organisation’s shift from the ‘new social movements’ discourse of the 1986 Ottawa Charter to the ‘new capitalist’ discourse of the 2005 Bangkok Charter illustrates the trajectory of this ideological transformation in public health. According to Porter, the Bangkok Charter is characterised by a greater emphasis on quantifiable goals and targets, technical interventions and monitoring tools, in contrast with the Ottawa Charter’s recommendations of community education and enablement. The Bangkok Charter also represents a retreat from the Ottawa Charter’s overarching social justice ideals, to more modest goals of ‘improved opportunities’ and ‘reduced risks’. Porter concedes that the lowered ambitions of the Bangkok Charter may be more applicable in the immediate life-and-death health contexts of developing countries, yet her central thesis remains that there has been a substantial ideological shift within international public health towards a more managerialist and conservative approach. In affluent Australia,

Porter's charge that the Bangkok Charter is merely 'coping with the messes we are making without stopping to question their sources' (p. 78) could be equally applied to the Close the Gap approach.

All ideas have a cultural heritage. The Close the Gap approach has strong links to certain venerable traditions, such as the positivism and empiricism of the biomedical model, and the persistent white/western cultural faith in the power of the scientific method to heal social ills. Close the Gap is also a pragmatic approach, with a focus on the abundant and relatively high-quality data available on the Indigenous Australian population, circumventing the more nebulous cultural, political and moral issues that are difficult to quantify or measure progress in. Close the Gap also reflects a neoliberalist philosophy, in its emphasis on individual responsibility, opportunity and redemption. Finally, the Close the Gap approach demonstrates that Australia remains current with international health and social policy trends. In the light of all this, Close the Gap appears less like a new way forward and more like business as usual.

### **WHO IS THE PROBLEM AND WHO NEEDS TO CHANGE?**

This discussion has so far focused on the shortcomings of the Close the Gap approach as a vehicle for explaining and potentially resolving the dramatically poorer health and wellbeing of Indigenous Australians, and has considered the historical, ideological and political contexts from which this approach has emerged. While a failure to create substantial and sustainable improvements in the circumstances and wellbeing of Indigenous Australia would be tragedy enough, we suggest that such emphasis on statistical equality also carries potential for further harm.

Karen Bridget Murray contests that social policy formulated with the aim of rectifying statistical inequality can come to define a people by their limitations, disadvantage, or deviance, 'creating social identities based on paternalistic notions of powerlessness and victimisation' (2004, p. 64). Martin Nakata (2006) describes the means by which Aboriginal and Torres Strait Islander people, as a subjugated minority, are forced to participate in the reduction of their identities to a series of indicators, because it only through such indicators that the dominant majority is able to recognise and acknowledge Indigenous Australians as 'real'—both in terms of existence and authenticity. Yin Paradies (2006) notes that such reductionism and essentialism of Indigenous identity requires Indigenous people to either conform to the prevailing depiction of Indigenous status—to be sick, poor, under-educated, marginalised and oppressed—or cease to exist as an 'authentically' Indigenous person.

The defining features of Indigenous Australians according to the Close the Gap approach are, of necessity, deficits. Performance measurement in Closing the Gap requires a range of baseline data on what is *wrong* with Indigenous people. Deficit data then forms the basis of what is *known* about Indigenous people. This in turn sets the strategic goals for action to *fix* Indigenous people. Because the deficits are clearly

situated within Indigenous Australians, progress is measured by the extent to which Indigenous Australians change for the better, thus insulating existing institutions, systems and power structures from an expectation to change also, or change instead. 'Success' is defined by the extent to which Indigenous Australians conform to a set of pre-determined, measurable characteristics of the non-Indigenous ideal, while 'failure' is any outcome that falls below, or manifests outside the scope of these ideal indicators. The measurement of progress in Closing the Gap relies on comparable data; there is little use for indicators unique to Indigenous Australians without a comparative dataset from the non-Indigenous population. This means that anything that may be uniquely positive about being an Aboriginal or Torres Strait Islander person is of little relevance to the 'evidence base'.

Gillian Cowlishaw describes the tensions that arise when Australia's anxiety to 'help' Indigenous people manifests as the imposition of authoritarian solutions, with anxiety turning into impatience and frustration when the recipients of such benevolent intent stubbornly refuse to improve. Cowlishaw links such 'failures' to the issues of power and control: 'Rejecting our proffered solutions to their problems could be seen as a way in which Indigenous people assert their autonomy from the state's suffocating solicitude' (2003, p. 111). In constructing Indigenous Australia within the narrow confines of statistical disadvantage, the Close the Gap approach creates a dichotomy between a state of 'sickness=Indigenous' and 'whiteness=health'. It places a moral imperative upon Indigenous Australians to transform themselves—to distance themselves from those characteristics of disadvantage that have come to define them, and to strive towards another set of characteristics that currently belong to the dominant, non-Indigenous ideal. What will be the moral judgement upon Indigenous Australians if they do not transform themselves to meet the Close the Gap targets, despite the opportunities placed before them to pursue healthy lifestyles, longevity and prosperity? Will they be deemed recalcitrant and undeserving of further assistance, or incompetent and incapable of helping themselves?

## **CONCLUSION**

Evidence from health research shows that social and structural conditions are as influential on the health of a population as are the behaviours and characteristics of the individuals of which the population is comprised. The problematic nature of the Close the Gap approach lies firstly in its predominantly individualistic focus, which fails to account for an imbalanced distribution of power and a limited degree of control exercised by Aboriginal and Torres Strait Islander Australians (both individually and collectively) over their own circumstances.

A second concern with the Close the Gap approach is that, despite the rhetoric, it is not a new or particularly revolutionary concept; rather, it is an approach with a fairly disappointing track record to date. 'Close the Gap' is also an approach that bears a

distinct ideological heritage (again, despite an appearance of neutrality and simple rationality), reflecting certain trends in social policy and public health more broadly. While these concerns do not themselves render the Close the Gap approach untenable, they would suggest that governments, community organisations and all participants and supporters of this approach should maintain ongoing critical reflection and debate on precisely what it is we have all agreed to do.

These two concerns are essentially a complaint about how the Close the Gap approach constructs the problem and the solution to the ongoing crises in the health and wellbeing of Indigenous Australia. Our third concern regards the way the Close the Gap approach constructs the *people* of Indigenous Australia—as statistical units containing a range of indicators of deficit, which are to be measured, monitored and rectified. This tendency of the dominant majority to continually reduce Aboriginal and Torres Strait Islander people to the demoralising and disempowered status of a numeric problem shows the true nature and magnitude of the ‘gap’ between Indigenous and non-Indigenous Australia. There remains a vast imbalance in power and control over the Indigenous affairs agenda and over the ways Indigenous Australians are constructed and represented.

If we, as a nation, feel a need to measure our performance in closing a gap, perhaps we should be attempting to measure and monitor progress in the delivery of power and control over the Indigenous affairs agenda into the hands of Indigenous Australians. This is likely to be more difficult to capture than the biomedical and socioeconomic indicators we currently rely upon to measure what the dominant non-Indigenous culture regards as ‘progress’. However, such an attempt to understand and change the relationship between Indigenous Australia and non-Indigenous Australia can only help to bridge the gulf that continues to divide us.

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