

# Reproducing injustice? The roles of social institutions and policy actors in the persistence of inequalities in Aboriginal and Torres Strait Islander life expectancy

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## Dedication

### **We Indigenous people are stronger than we believe and smarter than we know**

Excerpts from the 2016 acceptance speech of Professor Chris Sarra, NAIDOC (National Aborigines and Islanders Day Observance Committee) Person of the Year Award. (Sarra, 2016, pp. 14-17)

‘For as long as I can remember, thanks to my mum and my dad, I’ve always known that being Aboriginal was awesome. That I was no better or worse than any other. And that hard work, service and compassion was my obligation. That even in the face of inhumanity, I should treat people as I wanted to be treated. Those values and beliefs strengthen my core and kept safe my soul.

Armed with this truth, even when victimised, no one could make me their victim ... not the government, whose laws stole the land that my grandfather Broome was promised in return for his hard work’.

‘To those of us who feel broken or insufficient, who feel anything but powerful, remember this: of all the billions ever born, it is we, Australia’s first people ... we alone share the blood of the world’s oldest civilisation on the planet.

And to this end, this note, I have a message for Jack Dempsey, mayor of Bundaberg, to Anastacia Palaszczuk, premier of Queensland, and to Malcolm Turnbull, who will probably be the prime minister of Australia. I am a descendant of the Gurang Gurang and Taribilang Bunda people. And when you are ready, and when you have the courage and you are bold enough, I am ready on behalf of my people and my people are ready to speak with you about a treaty.

For tens of thousands of years, our sovereign nation shared borders, trade and travel. Our laws were strong. Our faith was deep. And our songs enchanted. Culture enlightened our souls, and dreamings lit the way. The past 200 years, by contrast, were everything the past 50,000 years were not. In the blink of an historical eye we were banished to the edges of the world we'd governed for eons.

‘My brothers and sisters, believe me when I say this. We are stronger than we believe. And smarter than we know.

Solidly anchored by an honourable past, more than any other human beings on the planet, we can take our place in an honourable future. We have survived – and now we must thrive.’

### **The Redfern Park Statement**

Excerpted from the speech at the Australian launch of the International Year for the World's Indigenous Peoples. (Keating, 1992)

‘Because, in truth, we cannot confidently say that we have succeeded as we would like to have succeeded if we have not managed to extend opportunity and care, dignity and hope to the Indigenous people of Australia - the Aboriginal and Torres Strait Island people.

We simply cannot sweep injustice aside. Even if our own conscience allowed us to, I am sure, that in due course, the world and the people of our region would not.

And as I say, the starting point might be to recognise that the problem starts with us non-Aboriginal Australians. It begins, I think, with that act of recognition. Recognition that it was we who did the dispossessing. We took the additional lands and smashed the traditional way of life. We brought the diseases. The alcohol.

We committed the murders. We took the children from their mothers. We practised discrimination and exclusion. It was our ignorance and our prejudice. And our failure to imagine these things being done to us. With some noble exceptions we failed to make the most basic human response and enter into their hearts and minds.

We failed to ask – how would I feel if this were done to me?’

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attentive care. It has all mattered – every word and deed – and all that listening. I am grateful, and I thank you from the bottom of my heart.

And finally, to Noah and Maeva Thomasset Hearn, whose futures this is about – we want the world to be a better place for you, sweethearts.

## Statement of authentication page

This thesis is submitted to Western Sydney University in fulfilment of the requirement for the degree of Doctor of Philosophy.

The work presented in this thesis was performed by the candidate under the supervision of Professor Jane Ussher from the Centre for Health Research at Western Sydney University.

The work in this thesis is, to the best of my knowledge and belief, a result of my own research endeavour, original, except as acknowledged in the text.

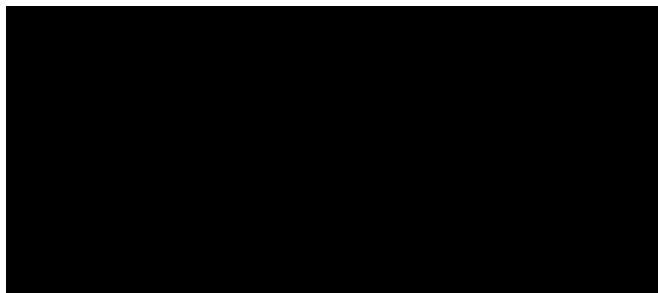
I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

Marilyn Joyce Wise

Western Sydney University

2019

Signature:



Date: ...27 September 2019 .....

## **Declaration of External Support**

Ms Mary Sinclair provided professional copy editing support in preparing this thesis for submission.



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## Abbreviations

AIATSIS	Australian Institute of Aboriginal and Torres Strait Islander Studies
AIHW	Australian Institute of Health and Welfare
COAG	Council of Australian Governments
NACCHO	National Aboriginal Community Controlled Health Organisation
NAIDOC	National Aborigines and Islanders Day Observation Committee
SCRGSP	Steering Committee for the Review of Government Service Provision
WHO	World Health Organization

# Glossary

## **Belief**

Beliefs typically describe enduring, unquestioned ontological representations of the world and comprise primary convictions about events, causes, agency and objects that subjects use and accept as veridical (Connors & Halligan, 2015). Belief systems provide the mental scaffolding for appraising the environment, explaining new observations, and constructing a shared meaning of the world (Halligan, 2007).

## **Cognitive beliefs**

Taken for granted descriptions and theoretical analyses that specify cause and effect relationships, that reside in the background of policy debates and that limit the range of alternatives policy makers are likely to perceive as useful (Campbell, 2002). Cognitive beliefs can be formed and exercised deliberately and consciously; they can also be exercised implicitly (as unconscious biases) – based on images stored in their memory (Dovidio & Gaertner, 2004; D. Williams & Mohammed, 2013). Cognitive frameworks influence the ways in which humans see the world, and allow people to take mental shortcuts when interpreting information and making decisions.

## **Colonialism**

Colonialism is defined as ‘a form of domination that includes the forcible takeover of Indigenous peoples’ land, the exploitation of the land and the people, and ignoring the laws, customs and rights of the people’ (Australian Museum, 2015; Horvath, 1972).



## **Colonisation**

Colonisation can be defined simply as ‘the act of sending people to live in and govern another country’ ("Cambridge Dictionary," 2020). However, this definition illustrates the power of cultural dominance – reflecting, as it does, the perspective of the country ‘sending people’ to ‘live in and govern’ another, and making no reference to the ‘act’ being hostile. Colonisation, as experienced by Indigenous Australians, meant violent vanquishment, dispossession and death, the denial of the existence of the peoples and the nations by those who came to live and govern in their place (Grant, 2019; J. Harris, 2003).

## **Critical realism: ontological domains of reality**

Critical realism stratifies reality into three ontological domains: the empirical, the actual and the real. The first, *the empirical*, is comprised of our experiences of what actually happens (i.e. it is the domain of experiences). The second, *the actual*, is constituted by all the things which happen, independently of whether they are observed or not (i.e. events). The third and deepest level of reality is *the real* - constituted by mechanisms with generative power – the deep structure of reality (Danermark, 2002, p. 57).

## **Culture**

A set of practices and behaviours defined by customs, habits, language and geography that groups of individuals share (Napier et al., 2014) .

## **Generative mechanisms**

Mechanisms are at the centre of a critical realist methodology. They are something we find in the ontological domain of the real, and that exist beneath the empirically observable surface and associated events. They have the power to describe events that are produced in highly complex contexts (Bygstad & Munkvold, 2011; Danermark, 2002, p. 59). A

mechanism may produce an outcome in one context, and another in a different context. This contingent causality (M. Smith, 2010) is inherent in all open systems and ‘warns us that we can mainly use mechanisms to explain phenomena, and **not** to predict them’ (Bygstad & Munkvold, 2011, p. 4).

## **Governance**

Governance is the processes, structures and institutions (formal and informal) through which a group, community or society makes decisions, distributes and exercises authority and power, determines strategic goals, organises corporate, group and individual behaviour, develops rules and assigns responsibility.

## **Inequality**

Inequality is a description of observable, measurable differences in the distribution of phenomena in groups or societies that are not inherently unfair or unjust (Heywood, 2000, p. 128).

## **Inequity**

Inequity is a description of inequality in the distribution of any natural or social resource that is judged to be a consequence of unfair, unjust social treatment and that is potentially avoidable (Kawachi, Subramanian, & Almeida-Filho, 2002).

## **Institutions**

Institutions are organisations or structures within which stable, recurring patterns of behaviour develop among policy actors (Goodin, 1996, p. 22).

## **Key components**

Key components are structures that are generalisable across all the public policies that have been identified as events (that have generated empirical outcomes) and that transcend any single public policy.

## **Marginalised ascriptive groups**

Marginalised ascriptive groups have four characteristic features: (1) patterns of social and political inequality are structured along the lines of group membership; (2) membership in these groups is not usually experienced as voluntary; (3) membership in these groups is not usually experienced as mutable; and (4) generally, negative meanings are assigned to group identity by the broader society of the dominant culture. Historically marginalised ascriptive groups are groups that have possessed these features for multiple generations (M. Williams, 1998, pp. 15-16).

## **Policy actors**

Policy actors are individuals and groups, both formal and informal, that seek to influence the creation and implementation of public policy.

## **Policy paradigm**

A policy paradigm is a conceptual framework that can be used to identify and compare normative and cognitive ideas intersubjectively held by policy actors. In this thesis the framework used is comprised of four fundamental dimensions (P. Daigneault, 2013, p. 2). The framework is a tool to use in making transparent (and comparable) foundational ideas about social justice that underlie the goals of specific policies, the kinds of instruments that can be used to attain them, and the nature of the problems they are meant to be addressing (P.-M. Daigneault, 2014, p. 2; Hall, 1993, p. 279).

## **Privilege**

Privilege in this context is assumed to be a manifestation of power. Dowding argues that individuals (and groups) can get what they want through luck or through power. They can get what they want because their own preferences and those of others favour their own interests. Or they can get what they want because they have the means to overcome potential resistance. (Dowding, 2016).

## **Public policy**

In this thesis, public policy is conceptualised as a mechanism that defines who is to receive what resources, through what means and instruments, and under what conditions. Although public policies are, for the most part, formal and tangible, they can be informal and intangible – social norms that may not be written but that nonetheless shape behaviours. In this thesis, however, public policies are conceptualised as any law, mandate or regulation that distributes social resources or opportunities to the public. It is assumed that these policies are established through formally constituted social structures and political processes. The public may be the whole population or it may be a subset of the population. The policies may be formulated by any social institution in any sector – not only by governments and their agencies.

## **Racism**

Racism is an organised system premised on the categorisation and ranking of social groups in races and devalues, disempowers and differentially (and avoidably) allocates desirable societal opportunities and resources, including power, to social groups regarded as inferior (Agoustitos & Every, 2015; Bonilla-Silva, 1996; C. P. Jones, 2000; Paradies, 2014; DR. Williams, 2004). Racism manifests in beliefs, stereotypes, prejudices and discrimination. It can be internalised or occur on interpersonal or institutionalised and systemic/structural levels (Australian Indigenous Doctors' Association, 2017; Bailey et al., 2017). Empirical evidence

confirms the negative impact of racial discrimination on the lives and health of peoples against whom prejudice (racism) is directed

## **Resources**

Resources are anything that can be used to influence an outcome.

## **Schema**

A schema is a cognitive framework that helps to organise and interpret information – an interpretive system through which individuals process information and make sense of their experiences (Weick, 2001).

## **Social institutions**

In this thesis social institutions are taken to be organisations or structures established to solve collective problems. They are assumed to be possessed of three dimensions – structure, function and culture (S. Miller, 2019) (Institutions and Agency chapter).

## **Social structures**

Social structures are both institutional and relational. Social structures are patterned systems of social relationships among actors (Parsons, 1953; W. Scott, 2001, p. 83). They are social systematic aspects of a society - patterns of thought and behaviour that, as they become normative, comprise social institutions and their powers. The knowledgability of agents is central to the way in which the powers of social structures to generate events are exercised (W. Scott, 2001, p. 83).

## **Standard Operating Procedures**

Within institutions, standard operating procedures are standardised processes that have been established to ensure quality and predictability in the actions of different agents across time.

The standard operating procedures may be formal codes of practice, rules, standards, administrative codes or professional guidelines. They may be formally or informally constituted conventions.

### **Unconscious bias**

‘Normal human prejudice about people or groups of people, triggered by making quick assessments of people and situations based on our own background, culture and personal experiences’ (Australian Public Service Commission, 2016).

### **Worldview**

A worldview can be expressed as the ‘fundamental cognitive, affective and evaluative presuppositions a group of people make about the nature of things, and which they use to order their lives’ (Hiebert, 2008).

## Abstract

Using critical realism as a philosophy and methodology, this thesis seeks to identify underlying social structures, powers and mechanisms that could contribute to the persistence of inequality in the average life expectancy at birth between Aboriginal and Torres Strait Islander peoples and the non-Indigenous population of Australia in the 21<sup>st</sup> century.

In 2018 Australians were among the world's longest-lived populations. However, the gap in life expectancy at birth between Indigenous and non-Indigenous Australians is ten years (Australian Institute of Health and Welfare, 2018b, p. 29). Social determinants are estimated to be responsible for more than one third (34%) of the gap, health behavioural risk factors are estimated to account for about one-fifth of the health gap, but almost half the gap (47%) is due to unexplained factors (Australian Institute of Health and Welfare, 2018b, p. 32). This is from the 'in brief Australia's Health).

I begin this thesis with a discussion of ontology and epistemology in order to set the scene for the methods of investigation I adopt. I outline the critical realist method that I adopted in the thesis, based on a six-step framework developed by Bendik Bygstad and Bjørn Erik Munkvold (Bygstad & Munkvold, 2011, p. 5). I then draw on epidemiological and routine administrative data to describe a social phenomenon in the *empirical domain* – inequalities in the average life expectancy at birth, in health, and in access to social determinants of health between the Indigenous and non-Indigenous Australian populations. Analysis reveals a pattern of statistical regularity – the inequalities are systematic across all the indicators. They have persisted despite the Indigenous and non-Indigenous populations living in the same

country, under the same constitution and under the same governments. Contemporary theoretical explanations of determinants of inequalities in the health of populations do not wholly explain reasons for their persistence. They do not identify mechanisms available to people and institutions with political and social power and privilege that are being activated to perpetuate inequalities across generations.

I select all public policies (taken together) through which Australia has been governed as *events* in the *actual domain* that have contributed to the persistence of the systematic patterns of inequalities reported in the empirical domain. I identify key components of the events that are generalisable across them all. I conduct a critical realist review of transdisciplinary literature. Through the process of abstraction, I develop a theoretical framework of generative mechanisms and structures that could plausibly explain how the events contribute to the persistence of the systematic patterns of inequality described in the empirical domain.

From theoretical perspectives on institutionalism, social justice, racism, colonialism, and power I identify candidate mechanisms in the *real* domain. I assess (and confirm) through an interview study that the mechanisms could be practically adequate indicators of underlying powers being activated by contemporary policy actors to influence public policy decisions (events); and that the contribution of the mechanisms to explanations of the events (and outcomes) could be validated in future research.

Social institutions both enable and constrain the formulation of public policies. The worldviews of policy actors shape policy decisions and reproduce or transform the institutions. All policy ideas are filtered through the institutions and actors that have power to govern. The subordinate value ascribed by the colonisers to Indigenous Australian peoples and cultures was used to exclude them from access to power and authority to govern, and from participation as peers in society. The injustices became institutionalised in law, policies



and professional practice and normalised in the worldview of the citizenry. Despite some positive progress over time, the hard fact of the inequality in life expectancy that has persisted into the 21<sup>st</sup> century cannot be ignored.

Indigenous peoples have used all possible avenues available to them to resist and reverse injustices and to create positive change – sources of injustice or barriers to change are already clear to them. This research instead seeks to expose underlying mechanisms through which social institutions and policy actors with power and authority to govern perpetuate injustices of the past. The exposed mechanisms are avenues through which to reverse the injustices - working authentically with Indigenous peoples and nations, by sharing power and authority to govern, by achieving representative and cultural justice in all policy spaces. Meeting Indigenous Australians' demands for power to co-create the policy table, to determine socially just public policies, and to co-create Australia's future is not only a moral obligation - it is necessary to life itself.

# **Chapter One. Persistent inequality in average life expectancy at birth between Aboriginal and Torres Strait Islander and non-Indigenous Australians: a critical realist response**

There is extensive empirical evidence describing inequalities in the average life expectancy at birth between Aboriginal and Torres Strait Islander (hereafter referred to as Indigenous in this chapter) and non-Indigenous Australians in the 21<sup>st</sup> century. In 2015- 2017 the life expectancy of Indigenous Australians was 71.6 years for men and 75.6 years for women (Australian Institute of Health and Welfare, 2019a), 8.6 and 9.5 years respectively less than the non-Indigenous population. In 2015 the average life expectancy of the Australian population was among the highest in the world: 80.4 years for men and 84.5 years for women (Australian Institute of Health and Welfare, 2018a, p. 30). Despite a 17% narrowing of the gap in mortality between Indigenous and non-Indigenous Australians between 1998 and 2012 (AIHW Indigenous Observatory, 2015) the inequality in life expectancy has persisted.

As well there is extensive evidence of the determinants (behavioural and social) of the health of the population and, in particular, growing evidence of the determinants of Indigenous health (Australian Institute of Health and Welfare, 2018b; Carson, Dunbar, Chenhall, & Bailie, 2007; Fredericks & Legge., 2016; K. Griffiths, Coleman, Lee, & Madden, 2016; Paradies, 2016; Sherwood, 2013). There are significant inequalities in the distribution of the social and behavioural determinants of health between the Indigenous and non-Indigenous populations.

The inequalities have persisted across generations. They have persisted despite improvements in the life expectancy of the whole population (including Indigenous Australians). They have persisted despite the multiple initiatives undertaken by Indigenous peoples and by governments, NGOs, the private sector and community organisations to reduce the difference.

In short, despite there being a significant body of evidence of a large, avoidable, unfair and unjust inequality in life expectancy, health risk factors and access to the social determinants of health, in 2018 the AIHW calculated that 47% of the gap between Indigenous and non-Indigenous Australians is unexplained .

In any population a proportion of the inequalities in health (and life expectancy) can be explained by randomly occurring factors, and a further proportion can be explained by behaviours adopted by individuals and groups. An additional proportion of health inequalities in populations is socially produced – as an outcome of decisions made through socially constructed structures and processes about who gets what resources, through what means and instruments, and under what conditions. The systematic patterns of inequalities in life expectancy and health experienced by Indigenous Australians point to the disparities being socially produced – and, as an oft-unspoken consequence, their being avoidable. Their persistence into the 21<sup>st</sup> century – despite multiple, varied and variously effective initiatives to reduce the inequalities – gave rise to the research question.

In this thesis I adopt a critical realist methodology to address the following question: what structures, powers and underlying mechanisms could contribute to the persistence of the inequality in average life expectancy at birth between Indigenous and non-Indigenous Australians in the 21<sup>st</sup> century?

Critical realist methodology, as defined by Bygstad and Munkvold, ‘rests on *abstract research* which aims at developing a theoretical description of mechanisms and structures that, if found to be practically adequate and theoretically plausible, enable researchers to hypothesise how observed events can be explained’ (Bygstad & Munkvold, 2011, p. 5). The critical realist method is based on the identification, capture and expanded understanding of the interaction of largely existing philosophical ideas and scientific research (P. Harris, 2013, p. 41).

The perspective taken in this thesis is ‘critical in the sense that criticism is targeted at forms of social intervention and social justice’ (Edgley, Stickley, Timmons, & Meal, 2016, p. 318). I follow a structured process proposed by Bygstad and Munkvold (2011, p. 5) through which to identify generative mechanisms in the *real domain* that, when activated, explain the relationship between events in the *actual domain* and the social phenomenon described in the *empirical domain* (observable inequalities in life expectancy, health, and in the distribution of social resources and opportunities experienced by Indigenous Australians).

I begin the thesis with a discussion of ontology and epistemology, in order to set the scene for the methods of investigation I adopt (Chapter One). I then use epidemiological data to describe a social phenomenon in the *empirical domain* - inequalities in the average life expectancy at birth between Indigenous and non-Indigenous Australians in 2018. I follow with a summary of socio-demographic, epidemiological, and administrative data describing inequalities in the distribution of behavioural and social determinants of health and life expectancy between Indigenous and non-Indigenous Australians (Chapter Two). Analysis of these data reveals systematic patterns of statistically regular inequalities across all outcomes. The patterns persist despite the Indigenous and the non-Indigenous populations living in the same country, under the same constitution and the same governments.

I conduct a critical realist review of contemporary theoretical explanations for such inequalities, identifying the limitations of these in the Australian context (Chapter Three). I follow that review with a critical realist analysis of transdisciplinary literature to identify events in the actual domain – public policies – through which all social resources and opportunities are distributed to the Australian population. I identify key components of these events and in Chapters Four to Eight I explore ‘theories and ideas which embody notions of social justice or a critique of underlying assumptions about social organisation (Edgley et al., 2016, p. 320) – seeking to be critical in a broader sense in order to identify actions that could prevent the social production of avoidable inequalities in the distribution of social resources and opportunities to Indigenous Australians. The critical realist review results in the formulation of an integrative theoretical framework (Chapter Nine) from which to derive mechanisms in the real domain (Chapter Ten) that could, when activated, plausibly explain the relationship between events and the persistent, systematic patterns of statistical regularity described in the empirical domain. I then describe the results of an interview study in which I assess the practical adequacy of the mechanisms by seeking from contemporary policy actors, descriptions of the influences on policy decisions in their own policy areas.

A detailed description of the methodology following Bygstad and Munkvold (2011, p. 5) is outlined here.

**Step One.** The identification of events that are ‘clusters of observations that have been made by researchers or other informants’ ((Bygstad & Munkvold, 2011, p. 5; Sayer, 1992) of things that have happened in the actual domain that are positively associated with the outcomes reported in the empirical domain – persistent patterns of inequalities in the average life expectancy at birth (and in the distribution of its behavioural and social determinants), between Indigenous and non-Indigenous Australians in the 21<sup>st</sup> century.

**Step Two.** A literature search and theoretical analysis to identify key components of the events. The key components are structures that are generalisable across all the events, and transcend any single event. They are mechanisms that, when activated, can plausibly explain the relationship between the events and the persistent, systematic patterns of inequality revealed in the empirical domain. The key components are selected using a theoretical framework derived from the literature (Bygstad & Munkvold, 2011; Danermark, Ekstrom, Jakobsen, & Karlsson, 2002).

**Step Three.** This step describes the characteristics of the structures and agents that constitute the mechanisms which they shape events in the actual domain that are positively associated with the persistent, systematic patterns of inequalities that have been observed in the empirical domain.

This step concludes with a process of abduction to reframe and redescribe the persistent, systematic pattern of inequalities (the case) with the purpose of increasing theoretical sensitivity and understanding the events in more depth (Bygstad & Munkvold, 2011, p. 6).

**Step Four.** Through a process of inference, the retroduction step identifies candidate mechanisms emerging from a theoretical redescription of the mechanisms that, when activated, explain how the events are capable of producing the phenomenon of concern in the study (Sayer, 1992, p. 107).

**Step Five.** An interview study to assess the practical adequacy of the candidate generative mechanisms identified in the retroduction step as of the mechanisms being activated in real-world policy settings.

**Step Six.** The iterative process undertaken in this step brings together the findings of the retroduction step (Step Four) and the findings of the interview study (Step Five) to discuss

whether the candidate mechanisms are plausibly adequate indicators of structures and processes that are being activated in contemporary policy spaces. If the mechanisms are found to be practically adequate they could be used in subsequent studies to validate their explanatory power, thereby adding depth to what is, as yet, a non-empirical part of a potential causal chain (Collier, 1994, p. 10, cited in Harris, 2013, p. 48). The implications for future research and for actions on the part of contemporary policy actors and institutions are discussed.

## **Social science, ontology and epistemology**

### **Social science**

The selection of a method to address the research question was based on the assumption that the persistence of the significant difference in average life expectancy at birth between the Indigenous and non-Indigenous Australian population cannot be explained from the perspective of a single discipline, nor by the application of a single theory.

In this section, I begin with a brief overview of the origins, purposes and methods of science and social science. I go on to describe the significance of ontological and epistemological positions taken by researchers in determining the aims, questions, methods, and conclusions from their research. I move on to explain the rationale for adopting critical realism as a meta-theoretical framework for the thesis. I conclude with a description of the implications of the adoption of a critical realist approach for the focus, methods, and analysis that are argued and substantiated in this thesis.

Science is the production of organised knowledge, and evolved as a set of methods to overcome errors in everyday reasoning (Schutt, 2012). Scientific research is ‘a systematic exercise in categorising the world to advance knowledge of it’ (P. Harris, 2013, p. 41). The

basic concern of social science is ‘how to explain the things people do?’ (Koelble, 1995, p. 231). A critical realist perspective on that purpose seeks to explain the things people do as an outcome of the interaction between agency and structure – through a transformational model of social action (Archer, 1995; R. Bhaskar, 1998b; Bygstad & Munkvold, 2011, p. 2).

The discourses and practices of modernity are characterised by a commitment to human progress and a faith in rationality and science as the means of its realisation. The search is for knowledge that is certain, with fixed reference and anchoring points (Punch, 1998, p. 145). However, there are, within the scientific community, wide differences in belief about the nature of reality and about methods of inquiry and analysis that result in depth in knowledge about that reality. The differences in ontological and epistemological belief determine what phenomena researchers look for, where they go to look and how they look. These differences determine, too, what are intended to be the outcomes of scientific research.

The natural sciences are based on a foundationalist ontological position that there is a real world that is independent of humans’ knowledge of it. They are also based on a positivist epistemological position that objective observation is the independent test of the validity of a theorised causal relationship between phenomena. For proponents of positivism the aim of science is to produce objective, generalisable findings - natural causal statements, which specify that under a given set of conditions there are regular and predictable outcomes. The purposes of the theories born from such research explain and predict natural phenomena and causal relationships among them, and lead to the development of laws that hold across time and space (Marsh & Furlong, 2002, pp. 20-22).

Social sciences, however, are not based on a single ontological position. Instead, different social scientists hold differing views about the nature of the natural and social worlds. The difference centres on the question of whether there is a real world that is independent of



human knowledge of it, or whether the world (that we can know) is wholly socially constructed? Social sciences aim to enhance our ability to explain the social world and our understanding of it (Gorton, 2014).

Different epistemological positions then follow based on the differences in the ontological positions adopted by researchers. Different theories of knowledge are based on different views about whether an observer can identify real or objective relations between social phenomena, whether it is possible for an observer to be objective, and whether real relationships between social phenomena can be observed, directly, or whether there are some relationships that are not directly observable (Marsh & Furlong, 2002, pp. 18-19).

Finally, some, although not all, social scientists believe that science has an inherently emancipatory intent – seeking to provide new knowledge that can be used to overcome unfair, unjust social treatment or oppression.

The ontological and epistemological positions taken in the development of this thesis needed to encompass three facts from which this thesis emerged. First, that differences in life expectancy between people are real (essential differences) that can be observed, that can persist over time, and that are common across cultures and places (Marsh & Furlong, 2002, p. 18). Second, that some of the differences are an outcome of random, naturally occurring molecular or biological phenomena; some are a consequence of freely-chosen personal behaviours, and some are socially produced. Third, that a significant proportion of inequality in life expectancy between social groups within populations is an outcome of socially constructed phenomena. By implication, the socially constructed differences are not inescapable or unavoidable (Marsh & Furlong, 2002, p. 18).

This research is based on an ontological position that what can be known about the world at any given time in history is particular to the historical and social context within which the research is taking place. The epistemological position taken is that, although living in the same social and historical context, researchers (and people) from different disciplines, cultures and experiences develop and use different theories to explain socially produced phenomena. As the researcher I took the view that I could not claim to be an objective observer of the phenomenon of concern or its determinants, my cognitive beliefs having been formed by the social world from which I have come.

In the sections that follow I trace the path I took to arrive at the decision to adopt critical realism as a metatheory.

### **Ontology and epistemology**

The ontological and epistemological positions that researchers adopt have profound implications for their work. Over time, the social sciences have had to confront the fact that ‘knowing the world is not as simple as looking, listening, touching, and tasting. Obtaining knowledge is more difficult than that’ (Moore, 2001, p. 2). The articulation and defence of a perspective on knowledge in the social sciences (political analysis in particular) require researchers (and advocates) to be able to identify and state clearly their ontological and epistemological assumptions (Hay, 2007, p. 116).

The most important distinction within the ontological and epistemological positions of scientists has been between those whose principal interest is to *describe and explain* the social world (modernist/positivist) and those whose principal interest is to *understand* that world (postmodernist/interpretivist).

*Ontology* is concerned with what exists, and what it means to exist. ‘Is there a real world out there, a world that is natural and/or social, that is independent of our knowledge of it?’ In other words, what can be known about the world (Stoker & Marsh, 2002, pp. 9,18)? The *foundationalist* ontological position is that there **is** a real world, and that humans can trust their senses to observe that world. From this perspective, the world (including all the elements of which it is comprised, including social phenomena) is there to be discovered – even if humans have not yet discovered it. At the core of this ontological position is that all phenomena about which it is possible to know (natural and social), whether discovered yet or not, are observable and measurable. It is assumed that the phenomena are universal, and that science is a method to identify causal relationships between phenomena (Moore, 2001). It is assumed that science is a method through which to develop theories and laws about the relationships that hold true across time and space including into the future (Hollis & Smith, 1991). From this perspective, theories and laws arising from the application of a scientific method are value-neutral contributions to human progress. They exist consistently across time and place, independently of who is observing them; and they exist independently of the values and beliefs of observers or participants, or of the contexts in which they are occurring. Finally, they exist independently of the uses to which the new knowledge is put.

Researchers holding an antifoundationalist position, however, argue that there is not a real world that exists independently of the meanings that actors attach to their actions, and that it is not possible for observers to be objective. They assume that social phenomena are social constructions – there is not, and cannot be, one truth or certainty about the world; instead there are many reasonable but distinct understandings of the world (Moore, 2001). This ontological position is that although natural and social phenomena may be observable and measurable they can differ depending on who is observing and measuring, and on the context,

place and time in which they are occurring. At the core of this position is that social science seeks to identify social phenomena, to identify relationships (causal relationships and associations) among phenomena in particular contexts at particular times, and to understand the meanings of the phenomena to social actors in that place, at that time (Marsh & Furlong, 2002, p. 24).

Dawe (1971) suggests that two sociologies emerged in response to the Enlightenment. The first takes as its problem the establishment of social order and asserts the ontological primacy of social structures over social actors. The second takes as its problem the question of how humankind can achieve control over institutions that it creates – and asserts the ontological primacy of social action, will and agency – based on the assumption that society is the creation or construction of its members, and that it is *not* a reified entity or reality *sui generis* (S. Williams, 2003, p. 43). In short, humans' knowledge of the world is fallible and theory-laden – the ontological position taken by an observer is a critical antecedent to the selection of theory and method used to conduct research.

In keeping with the view of Marsh and Furlong I believe that it is necessary to understand both external reality and the social construction of that reality if it is to be possible to explain relationships between social phenomena (Marsh & Furlong, 2002, p. 31).

***Epistemology*** is a theory of knowledge. Different epistemological positions reflect researchers' perspectives on what we can know about the world – on whether an observer can identify real or objective relations between social phenomena, and if so, how? (Marsh & Furlong, 2002, p. 19). Positivism and interpretivism are two of the most influential epistemological positions considered by social scientists when deciding on their approach to inquiry.

A positivist epistemological position holds that all phenomena of interest are observable and measurable, and that it is possible to claim the objectivity of the observation and of the findings. The methods used begin with a priori, inter-subjective agreement among scientists about the phenomena and relationships being scrutinised. For those who hold this position, quantitative methods are the preferred research tools, generating univocal data that lead to the development of knowledge that is generalisable and replicable, and that can be used to develop explanatory and predictive models of behaviour. Some social scientists have adopted this positivist epistemological position and use the methods of the natural sciences to:

detect [] regularities in nature, propose a generalisation, deduce what it implies for the next case and observe whether the prediction succeeds. If it does, no consequent action is needed; if it does not, then either discard the generalisation or amend it and [test the] fresh [predictions] (Hollis & Smith, 1991, p. 50).

I adopt an interpretivist position that assumes that what can be known about the world is the *meaning* given to phenomena by different actors in different contexts. In this thesis in the abstract research of the literature, the focus is on identifying meanings given to phenomena by different actors in the same context – that is, two social groups living in the same nation and sharing the same governance structures and policy actors, but who bring different meanings to understanding the phenomena. It is followed by an interview study in which the focus is on identifying meanings given by the researcher to phenomena described by policy actors in contemporary policy settings. Social scientists working from this perspective assume that it is not possible to establish a single, objective generative mechanism (causal relationship) that could hold true across all time and space (Marsh & Furlong, 2002, p. 20).

Interpretive approaches study beliefs, ideas or discourses as they perform within, and frame the actions and practices of, institutions (Bevir & Rhodes, 2002; Marsh & Furlong, 2002, p.

26). At the heart of this approach is the identification of the ways in which the *comparison* of beliefs, values and self-definitions of those engaged in social discourse leads individuals and institutions to question their own and others' worldviews, and then, through dialogue, to reach understanding of social phenomena and the relationships between them.

Rather than the mono-vocal (often quantitative) data used in the natural sciences primarily to construct or test theories, social scientists use multi-vocal data from the social world – composed of intentions, beliefs, values, rituals and practices among a variety of actors.

Although these data are frequently qualitative they are not always so. It is, however, through the interpretation of the multiple sources and types of data that knowledge is produced.

The knowledge produced is specific to the time, context and place in which it is produced – and reflects the interpretations of the actors involved (including the researchers). The description, exploration, explanation or evaluation of social phenomena (and relationships between them) are undertaken with the intention of contributing to the production of new knowledge that can contribute to the achievement of social justice.

### **The researcher**

Postmodernism also reconceptualised the role of the researcher, 'not as an objective, authoritative, politically-neutral observer standing outside and above the text, but instead as an historically positioned, locally situated observer of the human condition' (Denzin & Lincoln, 1994). The researcher is not and cannot be objective.

However even that reconceptualisation does not acknowledge fully the influence of differentials in power in the research cycle. As Usher and colleagues argue:

research can be an enactment of power relations between researchers and researched or between researchers and the world. Who does the interpreting, who are the sense-

makers, and who decides what the data mean? It is by denying the place of values and power that science can become a form of mystification and a source of oppression (Usher, Bryant, & Johnston, 1997).

Gorton (2014) explains the importance of the legacy of Foucault's concern with the relationship between political power and social science. The social sciences were set up and prospered because of the needs of governments and their agents for more information on the population. More information they argued would be used for more effective government, helping to stabilise emerging political and societal structures (Deacon, 2002, p. 445). However, Foucault argues that such structures are likely to be oppressive because the institutions and people that are already powerful are able to exercise further power (through the genesis and use of social scientific research) and in that way, to prevent other humans from achieving genuine liberation and emancipation (Gorton, 2014).

Even some of those who disagree with this argument, (Caldwell, 2007) for example, acknowledge that Foucault's analysis plays a major role in illuminating how vital it is to pay attention to questions of power in generating research questions, in conducting research, in interpreting and analysing results, and in generating theories that explain the occurrence of, and relationships between, social phenomena. Even if it is possible, in principle, for all people and social and cultural groups to undertake research to generate new knowledge it does not mean that the opportunities to do so are distributed equitably. Nor does it mean that each has equal opportunity to analyse and interpret results or to generate new theories.

I am a researcher of non-indigenous descent. I believe that what I know about the world is bounded by my worldview arising from my professional roles, from my gender, and from my individual and shared experiences. That worldview is not fixed – it can and does change over time. At any given time it is influenced by the socially constructed institutions within which I

work and by the relational social structures and the normative social patterns within which I live and work.

In seeking to identify underlying generative mechanisms that could add to existing explanations of the persistence of the inequalities in the life expectancy of Indigenous Australians in the 21<sup>st</sup> century, I focus on the roles of existing social structures (in some of which I have worked), and of policy actors (of whom I am one). From those experiences I have concluded that there are ways in which the structures and actors in the institutions contribute to the persistence of what was a socially produced phenomenon. I understood that to identify what were unobservable mechanisms would require me to challenge my pre-existing values, knowledge and experiences because they influence what I would be able to see. Seeking new, underlying mechanisms would require a conscious search to identify perspectives of researchers and writers from disciplinary, philosophical, and cultural perspectives beyond the boundaries of my own profession and worldviews.

### **A critical realist ontological and epistemological position**

Liam Stanley argues that ontology for researchers in the social sciences is not a view about ‘the world as it really is’ but rather, a view about ‘the world as researchers assume it to be at this point in time’. He proposes that ‘in order to explain the political world it is necessary – whether implicitly or explicitly – to commit to a certain (ontological) view of what is possible in social reality’ (Stanley, 2012, p. 95).

My review of ontology and epistemology explains their significance in determining the purpose, method and outcome of scientific inquiry in general and of the theoretical analysis and empirical study in this thesis in particular.



The differences in the ontological and epistemological perspectives of researchers (and policy makers) on the origins of social phenomena and on causal mechanisms have significant implications for this thesis. I began work assuming an anti-foundationalist ontological position and an interpretivist epistemological position based on the view that the social phenomena (and relationships among them) that were the focus of inquiry were social constructs that would be observable only in the discourses of contemporary policy actors. However, in time I recognised that the anti-foundationalist ontological position could not account for the objective reality of death as an independent, observable outcome.

I decided that critical realism as a philosophy and metatheory, with its three ontological domains of reality, and its recognition of a realist ontology and a pluralist, interpretive epistemology, might constitute the most appropriate method to use to explain the phenomenon about which I am concerned (Bygstad & Munkvold, 2011, p. 1). I understood that realists reject the fact-value divide, and give equal weighting to both structure and agency as underlying mechanisms that could explain the social production of a phenomenon such as the persistence of the unequal life expectancy at birth between Indigenous and non-Indigenous Australians (Wainwright & Forbes, 2000, p. 259).

Critical realism offers a series of philosophical positions on a range of matters including ontology, causation, structure, persons and forms of explanation (Archer et al., 2016, p. 1; Gorski, 2013). Bhaskar's critical realist philosophy includes four main features.

The features are the importance attached to (1) generative mechanisms; (2) the stratified character of the real world; (3) the dialectical interplay between human structures and agency; and (4) a critique of the prevailing social order. The first two features are held to apply to the social as well as the natural world, whilst the uniquely

reflexive character of the social world is recognised in the third and fourth features (McEvoy and Richards (2003, p. 412).

Critical realist ontology of both the natural and social world provides a common framework for the pursuit of knowledge (Wainwright & Forbes, 2000, p. 270). From a critical realist perspective, scientific work in the social world seeks to identify generative mechanisms (structures, powers and relations) that explain how things work beneath a surface (observable) appearance (McEvoy & Richards, 2003, p. 412). Rather than seeking to define universal regularities or laws, critical realism seeks to reveal underlying generative mechanisms operating at particular times and in particular places (Gorski, 2013, p. 669). Critical realism does not aim to uncover general laws, but seeks to understand and explain underlying mechanisms – objects and structures in the real domain that give rise to powers, called generative mechanisms, which cause the events that we may observe (R. Bhaskar, 1998a; Bygstad & Munkvold, 2011, p. 3).

A mechanism may produce an outcome in one context, and another in a different context. ‘This *contingent causality* (M. Smith, 2010) is inherent in all open systems, and warns us that we can mainly use mechanisms to explain phenomena; not to predict them’ (Bygstad & Munkvold, 2011, p. 4).

Critical realism as a metatheory is based on an ontological position that there is a real, natural world that exists ‘that is not contingent on human perception’ (McEvoy & Richards, 2003, p. 412). Expressed another way, the realist ontological tenet is that ‘***the world is independent from our thoughts about it***’ (Sayer, 2000, p. 10). However, critical realism accepts that ***our knowledge of that world is (and can only be) socially produced*** and is reflexive. Our concepts of the world change as knowledge evolves (Gorski, 2013, p. 664). Our thoughts about it, our concepts and theoretical explanations of the connections between science and

reality are fallible and, over time, may require change or refinement if they are to adequately explain the object of interest (Sayer, 2000). ‘This means that the world can only be explained through available descriptions or discourses’ (Sayer, 2000), which in turn are ‘culturally and historically situated and are fallible because they are human’ (Potter & Lopez, 2001).

Although critical realists accept that there are objective realities in the world that can be seen, they also accept that the realities that *are* seen at any point in history and in any context are dependent upon who is observing and upon what philosophical positions, theories or discourses they are using.

Critical realism stratifies reality into three ontological domains: the empirical, the actual and the real. The first, the empirical, is comprised of our experiences of what actually happens (i.e. it is the domain of experiences). The second is constituted by all the things which happen, independently of whether they are observed or not (i.e. events). The third and deepest level of reality is constituted by mechanisms with generative power – the deep structure of reality (Danermark, 2002, p. 57).

The levels of reality are assumed to be hierarchically ordered and each of the lower levels is assumed to create conditions for a higher level (Danermark, 2002, p. 57). The mechanisms with generative power may be operating behind the backs of contemporary social structures and their agents, and, arguably, of researchers and of citizens. The mechanisms may not themselves have been observed, although their impacts may be observable (Danermark, 2002, p. 57). It is also the case that mechanisms may be observable to some, but not all members of a population. That means that it may be necessary to look beyond what is there (including in statistical or existing theoretical explanations) to what is not there in the existing statistical description or empirical literature (Danermark, 2002, p. 57).

This thesis is therefore constructed on the assumption that it is only by identifying and exposing underlying generative mechanisms that it will be possible to act to eliminate the determinants of the persistent, socially produced inequalities experienced by historically marginalised social groups in the future (M. Williams, 1998). It is only by discovering generative mechanisms that they can they be exposed to scrutiny, analysis and transformation. The aim of the thesis is to contribute to creating a future in which Indigenous Australians share equally, and rightfully in the collective and personal freedoms of all Australians, and lead lives that they value and have chosen freely.

The critical realist epistemological position is that the only ways reality can be known are mediated by human language and social power – given that ‘many of the determinate and important features of the world are not, necessarily at any given time, empirically verifiable or quantifiable, and may in fact resist articulation into theory, language, numbers, models, or empirical scrutiny’ (Archer et al., 2016, p. 5). The view that known (or accepted) reality is always mediated by human language and social power is assumed in this research. This assumption is based on the understanding that the identification of generative mechanisms identified in the real domain depends upon who is looking for them, who is seeing them, and who is interpreting their relationship to the identified problem and deciding on the implications for action. Or, put another way, it is based on who is exercising social power when the mechanisms are being identified and activated. Because the mediating roles of human language and social power may not always be observable (or at least not universally observable), ‘critical realists often concern themselves with relatively abstract or philosophical questions that arise from, and undergird, our empirical investigations’ (Archer, Sharp, Stones, & Woodiwiss, 1999).

However, ‘while critical realism has attracted much interest as a philosophy and a social theory, empirical work using this approach in social science research’ has been limited (Dobson, Myles, & Jackson, 2007) including research on the production and persistence of health inequalities. Limited guidance is available on the use of critical realism as a methodology to inform the collection and analysis of data that would be needed to answer a research question, and to enable a ‘creative approach to analysis and thinking that embraces the breadth, depth and originality necessary for innovation’ (Edgley et al., 2016, p. 316).

‘Critical realism as a methodology rests on largely *abstract research*, which aims at a theoretical description of mechanisms and structures, in order to hypothesise how the observed events can be explained’ (Bygstad & Munkvold, 2011, p. 3). For this thesis I undertook an interview study to assess whether it is possible to identify candidate mechanisms being activated in contemporary policy spaces. If they are found to be practically adequate indicators of powers that are being activated by actors in policy areas, it would then be feasible to conduct future research to validate their contribution to existing theoretical explanations of the events that result in the persistent, systematic patterns of inequality that is the subject under investigation in this thesis.

### **A critical realist literature review**

Critical realist methodology uses *abstract research* of the literature to provide the data, analysis of which seeks to develop a theoretical description of candidate mechanisms that can explain the relationship between events (in the actual domain) and observable outcomes reported in the empirical domain. The purpose of the *abstract research* is to enable the development of hypotheses positing explanations of observed social phenomena (Bygstad & Munkvold, 2011, p. 3).

The review of the literature in this study is based on an organic process (T. Greenhalgh, Thorne, & Malterud, 2018), an intellectual and personal journey on my part, in which the pathway is created as a direct result of my own critical choices (Edgley et al., 2016, p. 327).

The real challenge for the researcher is to determine how to organise all the material they have collected into something that answers a question and follows a logical path, given that there is no given organisational structure to delineate the journey. The logic and structure of the report is determined by the position taken by the researcher on debates contained within the research (Edgley et al., 2016, p. 326).

This review begins with books and edited volumes from disciplines that offer potential relevance by pulling together evidence and debate on relevant issues, concepts and policy concepts and furnishing pointers on debates, theories and ways of seeing that can offer me novel insights (Edgley et al., 2016, p. 324). The review is ‘not systematic, does not have explicit criteria for inclusion, exclusion or evaluation, is never partial, and seeks to bring conceptual innovation or theoretical development to the issue under analysis. This form of review is critical in the sense that the criticism is targeted at forms of social intervention and social justice’ (Edgley et al., 2016, pp. 317-318).

Such a method generates themes for further exploration through a reflexive, iterative process, so that through small or particular searches theories and arguments unfold. The method also means searching across disciplines and theoretical perspectives. This strategy is based on the assumption that it is necessary to think creatively about how one body of literature can throw light on another (Edgley et al., 2016, p. 324) in order to move beyond the limitations of explanations generated from within a single discipline or theoretical perspective. The analysis and synthesis of combinations of knowledge from different disciplines are conducted to generate a deeper knowledge and identify underlying mechanisms (Danermark, 2002, pp. 56-

57) that could generate the empirically observed outcomes reported in the empirical domain (Chapter Two).

I explain the logic of the literature review below. I began with analysis of existing theoretical explanations of the genesis and persistence of inequalities in health – and of the genesis and persistence of inequalities in Indigenous health. I used texts and review articles (primarily from the population health discipline, but also from sociology and Indigenous studies) to identify key references. I searched the SCOPUS and PROQUEST databases to identify further references.

I then turned to literature from which to identify events in the actual domain of reality that could plausibly contribute to explanations of the persistence of the systematic patterns of inequality identified in the empirical domain. I selected public policies (as a generic category) as the events for analysis, on the grounds that ‘public policy is the mechanism that defines who is to receive what resources, through what means and instruments, and with what conditions’ (P.-M. Daigneault, 2014, p. 3). I then searched for and selected public policies from across postinvasion Australian history as examples of public policies (together and with all others) that have resulted in the persistent, systematic pattern of inequalities affecting the Indigenous population.

The next step was to identify key components that are generalisable across all the events and that have powers that, when activated, could plausibly explain the relationship between all the events and the patterns of statistical regularity in the outcomes described in the empirical domain of reality. Resulting from the review of the literature I selected new institutionalism as an organising framework (its normative and historical perspectives in particular)(Lowndes, 2002, pp. 96-108), assuming that both structures and their actors shape public policy decisions, and that there is a reflexive, interactive relationship between them.

The next step in the review was to use a deductive, emergent approach to describe philosophical and theoretical perspectives on the characteristics of structures and agents through which they shape public policy decisions. I drew on literature from the disciplines of political philosophy, history, postcolonial studies, sociology, population health, psychology and political science in this section.

To complete the review of the literature I developed a theoretical framework that integrates normative theories of institutionalism, social justice, racism, colonialism and power from which to identify candidate mechanisms in the real domain of reality that contribute to explanations of the influence of institutions and policy actors on public policies. The literature was drawn from political philosophy, political science, sociology, population health, history, psychology, anthropology, political economy and critical theory.



## **Chapter Two. Inequalities in life expectancy, health, and its social determinants between Indigenous and non-Indigenous Australians in the 21<sup>st</sup> century**

### **The empirical domain of reality**

In this chapter I present evidence of observable outcomes in the critical realist empirical ontological domain. The sociodemographic and epidemiological data are derived from administrative sources. Epidemiological and sociological data from empirical research are used to describe the distributions of determinants of health in the Australian population. The analysis compares the distributions between Aboriginal and Torres Strait Islander (hereafter referred to as Indigenous in this chapter) and non-Indigenous Australians. The chapter concludes with a critical analysis of the data and discussion of statistical regularities that emerge.

### **Demography**

In 2018 the total population of Australia was 25.2 million (Australian Bureau of Statistics, 2018a), of whom 798 400 (3.3%) are Indigenous peoples (Australian Bureau of Statistics, 2019). More than seven million Australians (29%) were born overseas (Australian Bureau of Statistics, 2018b). The Indigenous population is culturally diverse – with more than 200 communities with different languages, lore and law, knowledge and history.

In 2012, seventy percent (70%) of Australians lived in the east and south east of the country in major cities in 2013, while 9% lived in outer regional areas, and 1% lived in remote or very remote areas (Australian Institute of Health and Welfare, 2014a, p. 13). Almost half

(45%) of all people living in very remote areas and 16% of people living in remote areas were Indigenous (Australian Institute of Health and Welfare, 2014a, p. 14). However, more than one third (35%) of Indigenous Australians lived in major cities, while 22% lived in each of inner and outer regional areas and the remaining 21% lived in remote or very remote areas (Australian Institute of Health and Welfare, 2014a, p. 15).

### **Average life expectancy at birth**

The size and scale of the achievement in improving the average life expectancy of populations across the world in the 19<sup>th</sup> and 20<sup>th</sup> centuries is a profound human achievement, one that continued into the 21<sup>st</sup> century. Between 1881-90 and 2011-2013 the average life expectancy of Australians at birth increased by 32.9 years for men and 33.5 years for women (Australian Institute of Health and Welfare, 2013a), an average of 0.25 years per year (Kennedy & McGill, 2009). By 2015-2017 the average life expectancy of the Australian population was among the highest in the world: 80.5 years for men and 84.6 years for women (Australian Institute of Health and Welfare, 2018a, p. 30).

In contrast, in 2010-12 the life expectancy of Indigenous Australians was 71.6 years for men and 73.7 years for women (Australian Institute of Health and Welfare, 2014c, p. 7), 8.6 and 7.8 years respectively less than non-Indigenous Australian men and women (Australian Institute of Health and Welfare, 2019a). Between 1998 and 2012 there had been a 17% narrowing of the gap in mortality between Indigenous and non-Indigenous Australians (AIHW Indigenous Observatory, 2015). Between 1998 and 2014 Indigenous child death rates declined by 33% so that the difference between Indigenous and non-Indigenous child death rates narrowed by 34% (Commonwealth of Australia, 2016, p. 5).

However, in 2008-12 the Indigenous mortality rate was still 1.6 times that of non-Indigenous Australians (Australian Institute of Health and Welfare, 2015b, p. 110). Two-thirds of deaths

among Indigenous peoples occurred before the age of 65, compared with 19% of deaths among non-Indigenous people between 2008 and 2012 (Australian Institute of Health and Welfare, 2015b, p. 110).

There continue to be inequalities in the life expectancy of social groups within the non-Indigenous population – between men and women, between groups in high and low socioeconomic quintiles, and between people living in urban and rural locations (Australian Institute of Health and Welfare, 2014a). In New South Wales between 2001 and 2015 inequality in the average life expectancy of men and women *within* each socioeconomic quintile decreased. However, in the same period, inequality in life expectancy between men and women in the highest and lowest socioeconomic quintiles increased to 3.8 years (for men) and 2.9 years (for women) (HealthStats NSW, 2015).

All those inequalities, however, are significantly smaller than the average inequalities in life expectancy at birth between Indigenous men and women and the Australian population in 2010-12. In 2009 it was predicted that at current rates of progress it would take more than 100 years for Indigenous men and almost 50 years for Indigenous women to reach the same average life expectancy at birth as their non-Indigenous counterparts (Altman, Biddle, & Hunter, 2009, p. 241). Five years later in 2014, it was reported that average annual Indigenous life expectancy gains of between 0.6 and 0.8 years would be necessary in order to eliminate the difference between Indigenous and non-Indigenous life expectancy by the year 2031 – three times the average annual increases achieved by the whole population in the last 25 years, and double that of the most recent rate of progress in the Indigenous population (Australian Health Ministers' Advisory Council, 2015, p. 62).

## **Inequalities in health**

The inequality in life expectancy identified in the section above is mirrored by a similar pattern of inequality in the incidence and prevalence of specific diseases, of injuries from all causes and in all-cause mortality.

On measures of the incidence and prevalence of chronic diseases (cardiovascular disease, respiratory diseases, diabetes, chronic kidney disease, cancer) and injury and poisoning, age-specific rates are significantly higher among Indigenous compared to non-Indigenous Australians; Indigenous Australians are also twice as likely as non-Indigenous Australians to have severe or profound disability (Australian Institute of Health and Welfare, 2015b, pp. 80-81).

Indigenous adults report experiencing physical or threatened violence in the previous 12 months (before interview) at 2.5 times that reported by non-Indigenous adults – and that difference increased between 2008 and 2014-15 as a result of a decrease in non-Indigenous rates (SCRGSP (Steering Committee for the Review of Government Service Provision) 2016, 2016, p. 4.101).

Between 2000 and 2015, inequality had widened between Indigenous and non-Indigenous rates of incidence and prevalence of mental illness, suicide and self-harm, and illicit drug and other substance use and harm (SCRGSP (Steering Committee for the Review of Government Service Provision) 2016, 2016, p. xxviii). There was no significant decline in suicide rates among Indigenous Australians between 1998 and 2012 although there was a 25% decline in rates among non-Indigenous Australians (Australian Institute of Health and Welfare, 2015b, p. 86). In 2012, the suicide rate for Indigenous Australians was almost twice that of non-Indigenous Australians (Jorm, Bourchier, Cvetkovski, & Stewart, 2012).

In 2012-13 Indigenous adults were 2.7 times more likely than non-Indigenous adults to have high or very high levels of psychological distress (Australian Institute of Health and Welfare, 2015b, p. 86). In 2012-13, almost half of Indigenous adults reported that either they or their relatives had been removed from their natural family (Australian Institute of Health and Welfare, 2015b, p. 50).

In 2014-15 Indigenous Australians were 2.7 times as likely to be a current smoker as non-Indigenous Australians (age standardised). Indigenous mothers were 3.6 times as likely to smoke during pregnancy as non-Indigenous mothers (24% compared with 12%). Indigenous adults were less likely than non-Indigenous adults (age standardised) to have met sufficient physical activity levels in the last week (rate ratio of 0.8), and more likely to be inactive (rate ratio of 1.3) (Australian Health Ministers' Advisory Council, 2017).

These data provide a summary overview of the patterns of illness, injury, and premature mortality in Indigenous and non-Indigenous populations of Australia. However, the pattern of inequality is systematic and routine – across all causes of disease and injury, across all causes of death, and across all behavioural risk factors, Indigenous Australians experience higher rates of illness, injury and premature death than their non-Indigenous peers, and are at greater risk of illness and injury in every age group. Although there are some signs of positive progress (Australian Indigenous HealthInfoNet, 2018) the pattern of inequality persists.

### **Distribution of social determinants of health**

Social determinants of health are defined as the circumstances in which people grow, live, work, and age. They can be measured by indicators in individuals' personal situations – such as income, education, employment and levels of social support and social inclusion. For Aboriginal and Torres Strait Islander Australians social determinants also include cultural identity, participation in cultural activities, and

access to traditional lands (Australian Health Ministers' Advisory Council, 2017; Australian Institute of Health and Welfare, 2018a, p. 335).

For some Indigenous Australians ‘good policy has made a difference to life – has removed impediments and opened debate, and has ensured the kind of national grounding that addresses injustice and provides a vision for the future’ (Enoch, 2016, p. 11). Having created and seized opportunities arising from such policies, Indigenous peoples are increasingly participating in all areas of society and have established a wider range of platforms (including mass and social media) from which to act to achieve their goals and aspirations (Grant, 2016b) .

For example, between 1996 and 2006 the number of Indigenous Australians employed in professional occupations increased by 74% (more than double the increase in the non-Indigenous population, although from a much lower base) (Lahn, 2013, p. 8). In 2016 there were around 30 000 Indigenous university graduates in Australia, up from fewer than 4000 in 1991 (Grant, 2016b, p. 72). Of the 550 000 Indigenous citizens identified in the 2011 Census, 65% (360 000) were employed and living lives that were in material terms comparable to those of non-Indigenous Australians (Hudson, 2016, p. 1).

However, there are continuing causes for deep concern. Indigenous Australians continue to be over-represented in the most economically and socially marginalised group within the population. They are likely to experience deprivation and exclusion for longer periods than non-Indigenous Australians with similar socioeconomic status (Cruwys et al., 2012, p. 5; McLachlan, Gilfillan, & Gordon, 2013, p. 12) and that deprivation and exclusion is reflected not only in the health of the population, but also in their interaction with the justice system. Although comprising 2% of the population aged 18 years or more, in 2016 Indigenous Australians made up 28% of Australia’s total full-time adult prison population (Australian

Bureau of Statistics, 2016). In 2015, rates of over-representation were even higher in juvenile detention, with a 10-17-year-old Indigenous child being around 24 times more likely to be in detention than a non-Indigenous child of the same age (Australian Institute of Health and Welfare, 2015c, p. 2).

The data below describe and compare the distribution of the social determinants of health and life expectancy between Indigenous and non-Indigenous Australians.

### **Socioeconomic status**

Four indicators are commonly used to calculate the socioeconomic status of Australians: education, income, employment and housing.

**Education.** Between 2004 and 2014 there was a 70% increase in the number of Indigenous students in higher education award courses compared with a 43% increase for all domestic undergraduate students (Commonwealth of Australia, 2016, p. 25).

There is almost no employment gap between Indigenous and non-Indigenous university graduates. In 2014, 77% of Indigenous graduates were in full-time employment following completion of their award compared with 68.1% of all graduates (Commonwealth of Australia, 2016, p. 25).

In 2015 the overall school attendance rate for Indigenous students nationally was 83.7% compared with 93.1% for non-Indigenous students. The Indigenous attendance rate in very remote areas (67.4%) is very much lower than in metropolitan areas (86.5%) (Commonwealth of Australia, 2016, p. 15).

The year 12 apparent retention rate for Indigenous students was 59% in 2014, an increase from 36% in 2000, and the gap between Indigenous and non-Indigenous students decreased

by 12 percentage points between 2000 and 2012 (Australian Institute of Health and Welfare, 2015a, p. 124).

The long-term trends in Indigenous participation in education are positive – in primary and secondary school and higher education – with all indicators showing narrowing gaps. The target to halve the gap in year 12 attainment or equivalent for Indigenous Australians aged 20-24 years by 2020 is likely to be met (Commonwealth of Australia, 2016).

**Employment.** In 2011, 65% of Indigenous adults were in employment (Hudson, 2016, p. 1). Between 1996 and 2006 there was a 75% increase in the number of Indigenous graduates employed as professionals in a variety of industries (Lahn, 2013, p. 8) making up a growing Indigenous middle class.

However, in 2011 Indigenous people aged 15 – 64 were less likely to be participating in the labour force than non-Indigenous people of the same age – a difference of 20.5% (55.9% compared with 76.4%). In 2011 Indigenous people aged 15-64 were three times more likely than non-Indigenous people in the same age group to be unemployed (17.2% of those in the labour force compared with 5.5% - a difference of 11.7%) (Australian Bureau of Statistics, 2014).

**Income.** In 2011 33% of non-Indigenous Australians reported having an equivalised weekly household income of \$1000 or more compared with 13% of Indigenous Australians (Australian Institute of Health and Welfare, 2014b, p. 78). Average disposable income for Indigenous people aged 15 years or more increased from \$391 per week in 2006 to \$488 per week in 2011 (taking inflation into account). However the ratio of Indigenous to non-Indigenous average income remained steady at 0.7 over the period. In 2011 more than two-thirds of the Indigenous population had a total weekly income below \$600, compared with



slightly more than half of non-Indigenous population (Australian Institute of Health and Welfare, 2015b, p. 37).

In 2012-13, 6% of Indigenous adults had an equivalised gross household income in the top quintile compared with 22% of non-Indigenous adults. The proportion of Indigenous adults in the lowest quintile of equivalised gross household income varied from 52% in the Northern Territory to 19% in the ACT, and from 36% to 46% in all other jurisdictions (Department of the Prime Minister and Cabinet, 2014a, p. 94).

**Housing.** Of the estimated 209 000 Indigenous households enumerated in the 2011 census, 36% were homeowners, 11% of whom owned their home outright, and 25% of whom were home owners with a mortgage. These numbers compared with 33% of all other households who owned their home outright, and 35% of whom had a mortgage. About 59% of Indigenous households rented their home, compared with 29% of non-Indigenous households; 26% lived in social housing, compared with 4% of non-Indigenous households. Similar proportions of Indigenous and non-Indigenous households were private renters (Australian Institute of Health and Welfare, 2014d, p. 3). The gap in home ownership had narrowed between 2001 and 2011 by 5% (to 32%). Although the gap in overcrowding had narrowed by 2.8% in the same period, Indigenous households were more than three times as likely to be overcrowded as non-Indigenous households (Australian Institute of Health and Welfare, 2014d, p. 18).

On Census night in 2011 the rate of homelessness among Indigenous people was 14 times the rate for non-Indigenous people, although the rate of homelessness had fallen between 2006 and 2011 (Australian Institute of Health and Welfare, 2014e, p. 7). In 2015, 11% of young Indigenous people had moved home five times or more in the last three years compared with 2% of non-Indigenous young people (Mission Australia, 2016, p. 11).

## **Imprisonment and juvenile detention**

In 2015 Indigenous Australians made up more than 27.4% of the adult prison population. The rate of imprisonment for Indigenous adults was 13 times the rate for non-Indigenous adults. Between 2000 and 2015, the Indigenous adult imprisonment rate increased by 77.4% - the non-Indigenous rate increased by 15.2% in 2014-15 (SCRGSP (Steering Committee for the Review of Government Service Provision) 2016, 2016, p. 20). In 2018 nearly 3 in 5 young people aged 10-17 in detention were Indigenous – despite making up only 5% of the general population in that age group (Australian Institute of Health and Welfare, 2015c, p. 2).

## **Social mobility**

Over one decade almost 60% of a cohort of Australian adults who had been living in circumstances of extreme social and economic marginalisation in 2001 had managed to exit that marginalisation by 2010 – after they had been able to acquire or had been supported to use social resources. However of the cohort identified in 2001 the risk of remaining extremely marginalised for the whole of the decade was 12 times greater for the Indigenous adults than it was for any of the other cultural communities within the cohort (Cruwys et al., 2012, p. 5).

A Productivity Commission report on deep and persistent disadvantage in Australia found that one of the populations at highest risk of experiencing deeper or multiple forms of disadvantage were Indigenous Australians (McLachlan et al., 2013, p. 12).

Although there had been steady improvements in access to socioeconomic resources by Indigenous Australians between 1971 and 2008, the length of time until the convergence of average Indigenous and non-Indigenous socioeconomic outcomes (based on analysis of trends through eight censuses) was in 2008 predicted to be more than 100 years for many indicators (Altman et al., 2009, p. 241).

Through analysis of these data, the unequal access to material resources and opportunities essential to health that are available to the Indigenous population compared with their non-Indigenous counterparts in the 21<sup>st</sup> century is revealed to be consistent, routine and systematic.

What follows is a descriptions of the persistent exposure of all Indigenous peoples to social treatment that is harmful to their health – and to which other social groups are not exposed.

### **Racism and discrimination**

The ascription of unearned, negative meaning to some cultural groups by dominant cultural others has been a characteristic of societies across the whole of human history. This form of negative discrimination has everywhere translated into systemic and systematic categorisation and ranking of social groups by dominant political and cultural communities into denigration of cultural value and to the ascription of inferior social, economic and political status. These views have been used then as justification for the differential allocation of desirable societal opportunities and resources (including political power) to those dominant racial groups (Berman & Paradies, 2010; Bonilla-Silva, 1996; DR. Williams, 2004; D. Williams & Mohammed, 2013).

The immense psychosocial stress and distress arising from repeated encounters with the stigmatising gaze of culturally dominant others (racism) cause multiple harms to the physical and mental health of the individuals and social groups that experience that gaze routinely (Paradies, Harris, & Anderson, 2008; DR. Williams, 2004).

In 2014 just over one-third (33.5%) of Indigenous Australians aged 15 years and over felt that they had been treated unfairly at least once in the previous 12 months, because they were of Aboriginal and Torres Strait Islander origin (Australian Bureau of Statistics, 2015). A

study of 755 Indigenous Victorians reported that nearly all respondents (97%) had experienced at least one incident they perceived as racist in the preceding 12 months, with 35% reporting experiencing an incident within the past month (Ferdinand, Paradies, & Kelaher, 2012, p. 2).

A study of more than 1000 non-Indigenous Australians aged between 25 and 44 provided a snapshot of the awareness, attitudes, intentions and behaviours in relation to discrimination against Indigenous Australians, and found a general lack of awareness of what behaviour is considered discriminatory, although discrimination had been commonly witnessed. Forty per cent had seen others avoid Indigenous Australians on public transport, 38% had witnessed verbal abuse of Indigenous Australians, and 20% believed that it is acceptable to discriminate. Almost one-third of respondents had witnessed employment discrimination against Indigenous Australians and 9% said that they, themselves, discriminated in this context (Department of the Prime Minister and Cabinet, 2014b, p. 15).

Three out of four Indigenous Australians regularly experienced race discrimination when accessing primary health care, and racism and cultural barriers led to some Indigenous Australians not being diagnosed and treated for diseases in the early stages when treatment is most effective (Paradies et al., 2008, p. 9).

There are some signs of positive change. An Indigenous academic pointed out recently that although he, like many other Indigenous Australians and minority groups had experienced racism first-hand, “there is much goodwill in Australia towards Indigenous people. Acknowledging that goodwill, combined with the message that ‘racism is not welcome in this country’, will go a long way towards making this a better country for all (Dillon, 2015).

However, despite some change, the overwhelming weight of evidence points to the sobering extent and power of racism as an every-day, lived experience for most Indigenous Australians. The evidence also points to the extent to which non-Indigenous Australians continue to be either unaware of or unconcerned by everyday racism they inflict upon their Indigenous peers, and unaware of their tolerance of the inequality experienced by Indigenous peoples.

### **Denial of rights and power to exercise own intellectual traditions**

There is little acknowledgment in the official documentation of Australia's history of the separate, pre and postinvasion histories of Indigenous Australians. The active exclusion from the rights and power to exercise the intellectual traditions that sustained the Indigenous peoples for millennia – from the right to tell their own history - was one of the means by which the colonisers established dominance. Tuhiwai Smith, speaking of the experience of indigenous peoples in colonised nations, pointed out that

indigenous populations share experiences as peoples who have been subjected to the colonisation of their lands and cultures and the denial of their sovereignty, by a colonising society that has come to dominate and determine the shape and quality of their lives (Tuhiwai-Smith, 1999, p. 7).

It took more than two centuries after invasion for an Indigenous Australian definition of health to be officially acknowledged (National Aboriginal Community Controlled Health Organisation, 1989), a definition that was later expanded upon (Milroy, 2002). It was not until 2007 that social determinants of Indigenous health defined by Indigenous Australians was published (Carey, 2013; Carson et al., 2007).

Despite the efforts and predictions of colonising governments and settlers, Indigenous peoples survived and continuously sustained and reclaimed their cultures and languages, communities and families, institutions, and decision-making structures and processes. The intellectual, cultural, and environmental knowledges, traditions and processes that have been developed by Indigenous peoples, enabling them to survive and thrive in Australia for more than 60 000 years, are only slowly beginning to be acknowledged by non-Indigenous society as a critical part of Australia's history, and as essential to the future of the nation (Delaney, 2016; Hill et al., 2012; Pascoe, 2014).

### **Limited representation in parliament**

The first Indigenous Australian to sit in any Australian Parliament, Neville Bonner, was appointed and subsequently elected to the Senate in 1971. A second Indigenous Australian, Aden Ridgeway, was elected to the Senate of the Federal Parliament in 1999. In all, by 2019 there have been ten Indigenous Federal Parliamentarians – seven elected to the Senate and three to the House of Representatives. The 45th Parliament, elected in 2019 includes five Indigenous parliamentarians, three senators and two members of the House of Representatives.

There has only ever been one Indigenous Member elected to each of the Parliaments of the ACT, New South Wales and Tasmania. No Indigenous Australians have been elected to Parliament in Victoria although two have acknowledged Indigenous ancestry. There have been four Indigenous Members of Parliament in Western Australia, and three in Queensland. In the Northern Territory there has been one Aboriginal Premier and twenty-two Indigenous Members of Parliament.

In 1994 the Torres Strait Regional Authority was established to represent Indigenous people living in the Torres Strait, with a Board made up of representatives elected as Chairpersons of

their local Island Council, and two representatives elected directly (Australian Electoral Commission, 2016).

Alongside direct parliamentary representation, federal governments have established (and disbanded) a range of structures to provide advice on Indigenous policy. The Federal Council for the Advancement of Aborigines and Torres Strait Islanders was established in 1957. Its funding was cut in 1978. The National Aboriginal Consultative Committee was established in 1973 and 27 000 Indigenous people elected 41 members. It was replaced in 1977 with the National Aboriginal Conference. The Aboriginal and Torres Strait Islander Commission (with elected Regional Councils) was established in 1989 to make decisions on policy and funding. It was dissolved in 2005, followed by the appointment of the National Indigenous Council. That was abolished in 2007 (National Museum of Australia, 2016). The Prime Minister's Indigenous Advisory Council was established in 2013, with a government-appointed membership.

In 2010 the National Congress of Australia's First Peoples was established as a company. It is a member-led organisation open to all Aboriginal and Torres Strait Islander individuals and organisations and is governed by a member-elected National Board. It is an independent national voice (National Congress of Australia's First Peoples, 2016) but it is not elected by a universal Indigenous vote. The Abbott government established an Indigenous Advisory Committee and cut funding to the National Congress, which still receives no funding from the present Coalition government.

In 2015 there was still no universally recognised, directly elected national Aboriginal representative body (Lucashenko, 2015, pp. 12-13). Indigenous leaders and communities have long argued strongly 'for the constitutional reform which properly defines the place of Indigenous Australians in the nation' (Pearson, 2011, p. 20).

The steps toward a treaty between Aboriginal and Torres Strait Islander nations and the Commonwealth of Australia have been taken by Indigenous peoples themselves. The Uluru Statement from the Heart was prepared in 2017, following lengthy, Widespread and inclusive consultation by the Referendum Council with Aboriginal and Torres Strait Islander peoples on their views of meaningful recognition. The 12 First Nations Regional Dialogues culminated in the National Constitutional Convention at Uluru in 2017. Aboriginal and Torres Strait Islander representatives ‘from all points of the southern sky’ came together at Uluru and developed a consensus position on the form that constitutional recognition should take. The Uluru Statement from the Heart called for

the establishment of a First Nations Voice enshrined in the Constitution, and a Makarrata Commission to supervise a process of agreement-making between governments and First Nations and truth-telling about our history (Referendum Council, 2017a).

History though, was repeated, as the Commonwealth Government dismissed the ideas without discussion. For the first time, an Indigenous Australian Minister was appointed to Federal Cabinet. Negotiation of a Treaty between local First Nations and the Victorian Government has begun. Progress is slow and hard-won.

### **Representation in public sector employment**

Although far from being the only indicator of Indigenous representation in the nation’s workforce, the public sector (federal, state and territory) is one of the nation’s largest employment sectors, and has a significant role in the design and implementation of public policies of particular importance to Indigenous Australians, such as health care, housing, income support and environmental services. The data have been included here as a proxy



indicator of participatory parity in public sector policy settings, although they do not describe the roles played by the Indigenous employees within the public sector organisations.

In 2015 Indigenous employees in the Commonwealth Public Sector (CPS) comprised 2.2% of the total CPS workforce. Some of the agencies did not have a single Indigenous employee (Department of the Prime Minister and Cabinet, 2015). The target in 2015 was to have 3% Indigenous employees comprise 3% of the Commonwealth public sector workforce by 2018.

In 2016, 3.1% of employees in the New South Wales public sector identified as being Aboriginal or Torres Strait Islander (NSW Public Service Commission, 2016). Of government senior executives 25 (0.6%) were Indigenous, although across all public-sector leaders, 63 people identified as being Aboriginal (NSW Public Service Commission, 2016). In Queensland, 2014, only 2.03% of the Queensland public service workforce were Aboriginal or Torres Strait Islander, although Indigenous people made up 3.6% of the Queensland population (Queensland State Government, 2014).

The data describing the distribution of social determinants of health in the Australian population confirm that despite some reductions in the size of the unequal distribution of these social determinants between Indigenous Australians and their non-Indigenous counterparts, the systematic pattern of inequality in access to material resources and opportunities, and in experiences of racial discrimination and exclusion from the governance of the nation, persists.

## **Conclusion**

It is important to set in a historical context the failure to eliminate the inequality in average life expectancy at birth between Indigenous and non-Indigenous Australians in the 21<sup>st</sup> century. Because the significant difference in life expectancy has persisted through the same

time period when Australia has become one of the wealthiest nations in the world, and with one of the longest-lived populations. The gap has not been closing (Mitrou et al., 2014). Over 230 years governments, social institutions and policy actors have been responsible for creating social conditions that have resulted in significant improvements in the wealth, health and health of the majority of Australians. The same governments, social institutions and policy actors have created social conditions that have, in the second decade of the 21<sup>st</sup> century, resulted in the ongoing inequalities in the wealth, health, and life expectancy of Indigenous Australians compared with all other citizens.

The evidence of the systematic patterns of inequalities refutes the view that the inequalities in life expectancy and health are wholly a consequence of the self-determined lifestyle choices of Indigenous peoples, or of an inherent, genetic or biological predisposition that makes them more vulnerable to ill health and premature death. The AIHW has calculated that 34% of the 'health gap' between Indigenous and non-Indigenous Australians is attributable to differences in access to social determinants of health, and that a further 47% of the gap is due to factors as yet, unexplained (Australian Institute of Health and Welfare, 2018b, p. 32).

Governments, organisations, communities and individual citizens have known about the inequalities for decades. If we have known so much about the situation for so long, the underlying question is why does it persist? What could be additional determinants of the persistence of the statistically regular patterns of inequality experienced by Indigenous Australians compared to non-Indigenous Australians?

## **Chapter Three. Contemporary theoretical explanations of inequalities in health and their persistence**

### **The evolution of understanding determinants of inequalities in health**

Inequalities in health are not a new social phenomenon - poor health and high rates of premature mortality in newly urbanising populations in industrialising Europe were identified in the 18<sup>th</sup> and 19<sup>th</sup> centuries. Inequalities in mortality rates between Aboriginal and Torres Strait Islander (hereafter referred to as Indigenous) and non-Indigenous Australians were clearly observable throughout the 19<sup>th</sup> and 20<sup>th</sup> centuries.

The industrial revolution saw the rapid urbanisation of populations and the growth of living and working conditions that were unhealthy and dangerous. Gradually, scientists, engineers and social entrepreneurs identified problems and solutions, and, together with policy actors, began to take actions that resulted in improved health and life expectancy for the populations of western Europe and North America in particular. In 19<sup>th</sup> century industrialising Europe, Louis-Rene Villerme, Edwin Chadwick, Friedrich Engels and Virchow all identified poverty as a determinant of health but had different ideas about how to mitigate its health impacts. They each recommended different social responses to poverty (including improved medical care, improved living conditions and increased political will), but they all recognised that poverty was a socially produced condition requiring a societal response (Birn, 2009, p. 171). In the 20<sup>th</sup> century there was a shift in health policy to an emphasis on discovering and responding to microbiological causes of disease, to investment in improved medical science

and technologies and in improved delivery of health care. The advances resulted in the significant decline of deaths as a consequence of communicable diseases and an increase in the incidence and prevalence of chronic diseases. Early health policy responses focused on changing health behaviours and lifestyles, an approach that became associated with victim blaming (Milio, 1976) and that did not acknowledge socially produced determinants of health or of inequalities in health.

From the late 20<sup>th</sup> to the early 21<sup>st</sup> century, researchers from population health and other social scientific disciplines have identified socially created resources and opportunities (items) as social determinants of health. Inequalities in the distribution of access to these items within populations are now widely recognised as having a significant influence on the distribution of health and premature mortality within and between populations. A combination of scientific and technological advances in a range of fields (for example, education, housing, transport, agriculture and health care), and the implementation of public policies increasing population-wide access to these advances have resulted in continuous improvements in the average life expectancy of the populations of western liberal democratic countries. In 2003, the role of democracy in those continuous improvements was rediscovered by a contemporary historian. Szreter found that

significant health improvements only began to appear *when the increasing political voice and self-organization of the growing urban masses finally made itself heard* (emphasis added) (Szreter, 2003, p. 424).

However, although there were continuous improvements in the average life expectancy of the populations of western, liberal democratic states throughout the 19<sup>th</sup> and 20<sup>th</sup> centuries, in the late 20<sup>th</sup> century empirical evidence confirmed that significant inequalities in health had

persisted. Over time, multiple theories have been developed to explain the relationship between inequalities in access to social resources and opportunities and health.

### **Contemporary theoretical perspectives on determinants of inequalities in health**

Krieger, reflecting on epidemiological studies of inequalities in health, writes:

... as to which theories we rely on, which questions we ask, which studies we conduct, which data we believe are worth obtaining, and which data we even recognise when confronted with unanticipated findings: this is where values enter and worldviews leave their indelible mark (Krieger, 1992, p. 421).

Krieger did not, at the time, explain that the values and worldviews include differences by cultural group and not only by discipline or profession or personal history or preference; or that the dominance of the worldviews of one group over those of another or others also influences the data we believe worth obtaining and that we recognise (across cultural, professional, disciplinary and personally defined ideological boundaries).

I describe and analyse theories that have been developed by population health researchers to explain causes or determinants of inequalities in the health of populations and to guide policy responses.

‘In health inequalities research and more broadly, the number of theoretical contributions, pales in comparison to the growing number of empirical studies’ (K. Smith & Schrecker, 2015, p. 219). Nonetheless, multiple theories have been developed seeking to explain the genesis of inequalities in health in populations, and to propose remedies (Wainwright & Forbes, 2000, p. 259) although the theories underpinning the conduct of empirical research are rarely described (Garthwaite, Smith, Bambra, & Pearce, 2016; Raphael, Bryant, & Rious, 2006; K. Smith & Schrecker, 2015; Wainwright & Forbes, 2000, p. 59).

Empirical evidence now confirms many items, access to which is socially determined, and access to which, determines health – material resources and opportunities to acquire and use them; social status (respect, dignity, self-esteem and the esteem of respected others); and the freedom to choose behaviours and lifestyles commensurate with health.

Empirical evidence also exposed inequalities in the distributions of socially produced items within and between populations and revealed positive associations between the ability to access the items and the distribution of health in a population.

The distributions are not random, but are, rather, routine and systematic. In Australia, the patterns were similar to those in other high-income welfare states – with inequalities in the health of populations being most commonly mirrored by inequalities in socioeconomic status. However, the patterns of systematic inequality affecting Aboriginal and Torres Strait Islander (hereafter referred to as Indigenous) Australians explicitly and with more harmful effects were also widely recorded.

Further research and theorisation were therefore needed to explain the relationship between the unequal access to social determinants of health and health outcomes. It was necessary to determine the mechanisms through which unequal access to social determinants of health resulted in unequal health outcomes. Researchers working from within a Eurocentric cultural perspective and research tradition use three major theoretical frameworks to inform their research and their policy responses:

- a) a political economic perspective draws on the ideas of Marx, Engels and Weber, and on empirical evidence to explain the unequal distribution of material resources within societies and the relationship between access to these resources and unequal health outcomes. From this perspective there is recognition of the relationship between access to material resources and the opportunities to acquire and use them and health. They

advocate that there are absolute levels of access to resources (e.g. education, housing, employment and income) necessary for health and longevity.

A political economic perspective gives precedence to material resources (and opportunities to acquire and use them) as being fundamental to the health of individuals and populations, and that the unequal distribution of these is primarily responsible for the genesis of inequalities in health. There is growing recognition that the ideology and theory of social justice to which they give preference shape policy actors' distributive intentions and the outcomes of public policies that influence health outcomes (McCartney, Collins, & Mackenzie, 2013).

- b) a psychosocial perspective drawing on the theories of Taylor, Wilkinson and Marmot to explain the link between unequal economic status, social status and health outcomes. This explanation of inequalities is based on theories and empirical evidence that inequalities in health within a population arise from relative differences in access to economic resources together with differences in perceived social status associated with greater or lesser access to wealth and power. This perspective has given rise to the concept of a social gradient along which individuals and groups can place themselves and others and compare their status.
- c) a behavioural perspective associating differences in personally chosen health behaviours (lifestyles) with unequal health outcomes has had a powerful influence on health policy in particular. From this perspective, inequalities in health arise from differences in the health behaviours and lifestyles chosen freely by individuals exercising their personal liberty (K. Smith & Schrecker, 2015).

Raphael (2012a) (Table 1) summarises the implications of these theoretical approaches. He identifies seven interpretations of empirical evidence and theories explaining causes of health

inequalities in populations and, linked with each, the primary approach to prevention or reduction (at least) of inequalities that is, then, indicated. The final column describes likely outcomes that will be achieved.



Table 1: Determinants of health inequalities in populations

<b>Health inequalities interpretation</b>	<b>Key concept for addressing health inequalities</b>	<b>Primary approach for addressing health inequalities</b>	<b>Practical implications of the approach</b>
Health inequalities result from <i>genetic differences and biological dispositions</i>	Health inequalities can be reduced by identifying the genes and processes causing disease.	Carry out more and better biomedical research.	Medicalization of health inequalities and endorsement of the social status quo.
Health inequalities result from differences in <i>access to and quality of health and social services</i> .	Health inequalities can be reduced by strengthening health care and social services.	Create more and better health care services in hospitals, clinics, and social service agencies.	Focus limited to promoting the health of those already experiencing health inequalities.
Health inequalities result from differences in important <i>modifiable medical and behavioural risk factors</i> .	Health inequalities can be reduced by encouraging people to make ‘healthy choices’ and adopt ‘healthy lifestyles’.	Develop and evaluate healthy living and behaviour modification programs and protocols.	Healthy lifestyle programming that ignores the material basis of health inequalities can widen existing health inequalities.

<p>Health inequalities result from differences in <i>material living conditions</i>.</p>	<p>Health inequalities can be reduced by improving material living conditions.</p>	<p>Conduct research and disseminate results of how differences in living conditions create health inequalities.</p>	<p>Assumption that governmental authorities are receptive to and will act upon research findings.</p>
<p>Health inequalities result from differences in <i>material living conditions shaped by public policy</i>.</p>	<p>Health inequalities can be reduced by advocating for healthy public policy that reduces disadvantage.</p>	<p>Analyse how public policy decisions impact health (i.e. health impact analysis)</p>	<p>Assumption that governments will create public policy on the basis of its effects on health.</p>
<p>Health inequalities result from differences in <i>material living conditions that are shaped by economic and political structures and their justifying ideologies</i>.</p>	<p>Health inequalities can be reduced by influencing the social structures that create and justify health inequalities.</p>	<p>Analysis of how the political economy of a nation creates inequalities identifies avenues for social and political action.</p>	<p>Requirement that reducing health inequalities requires building social and political movements that will shape public policy.</p>

<p>Health inequalities result from the <i>power and influence of those who create and benefit from health inequalities.</i></p>	<p>Health inequalities can be reduced by increasing the power and influence of those who experience those inequalities.</p>	<p>Critical analysis empowers the majority to gain understanding of and increase their influence and political power.</p>	<p>Requirement that these social and political movements recognise and shift imbalances of power within society.</p>
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Each of the interpretations and concepts identified in the left-hand column in the table reflects a different cause of inequalities in the health of populations. Depending upon the assumption about cause, the primary approaches proposed as responses range from changes in health-care design and service delivery, to changes in health behaviours, in public policies and/ in ideas informing these, and to the activation of social action to demand and achieve distributive justice (including health equality).

The determinants of the inequalities in health reflected in each of the interpretations identified reflect differing views on causality, from biological and genetic, to behavioural, to socially produced causes or determinants. However, none of the interpretations of causality or determinants of inequalities in this table includes racism, colonisation or state-supported discrimination that follows including the stigmatisation and denial of equal value of Indigenous cultures, or of the sociopolitical exclusion that have been particular to Indigenous Australians (and to the indigenous populations (minorities) of other colonised nations).

In short, none of the interpretations of the causes or determinants of health inequalities includes an interpretation of cause that accounts for patterns of inequality that are systematically particular to an historically marginalised ascriptive group within a culturally and numerically dominant population.

### **Theories explaining the persistence of inequalities in health**

Mackenbach sought to identify theories that offer plausible, researchable explanations for what he terms the paradox that has arisen in Western European welfare states during the last three to four decades. That is, that health inequalities not only persisted while welfare states were being developed, but on some measures have even widened. Nor are the inequalities smaller in European countries with more generous welfare arrangements (Mackenbach, 2012, p. 761). He regards this paradox as one of the great disappointments of contemporary public

health (Mackenbach, 2012, p. 761). He explains that welfare systems had been established in many European states with the purpose of redressing unfair, unjust inequalities in the distribution of material resources across populations. As evidence of the strong positive relationship between access to such resources and health and life expectancy grew, it was assumed that in states that had achieved greater equality in the distribution of those resources there would be an equal, positive response in the health of the population. However, Mackenbach's analysis found that the assumption was not borne out in the evidence.

In seeking an explanation he analyses nine relevant theories from which to select those that could offer the most plausible hypotheses to guide further research on explanations of the persistence of health inequalities in high-income welfare states. The nine theories, described in Table 2 are: mathematical artefact, fundamental causes, life course perspective, social selection, personal characteristics, neo-materialism, psychosocial factors, diffusion of innovations and cultural capital (Mackenbach, 2012, p. 763).

Table 2. Evaluation of theories of the persistence of health inequalities in high-income countries with extensive welfare arrangements

<b>Focus of theory</b>	<b>Main proponents</b>	<b>Short description</b>	<b>Evaluation</b>
Mathematical artefact	Scanlan (2001) Vagero and Erikson (1997)	Increasing relative inequalities in health outcomes are inevitable when the over-all level of the outcome falls, and persistence of health inequalities is an artefact of the focus on relative inequalities in negative outcomes.	Relative inequalities in mortality tend to be higher when over-all mortality is lower, but this is not a mathematical necessity. Paradox also applies to absolute inequalities in mortality.
Fundamental causes	Link and Phelan (1995) Phelan, Link, and Tehranifar (2010)	Socioeconomic position involves access to resources which can be used to avoid disease risks or to minimize the consequences of disease once it occurs, regardless of what the current profile of diseases and known risks happens to be.	Reformulates the problem without identifying the specific pathway linking socioeconomic position and health. However, refocusing attention on fundamental aspects of social stratification is useful.
Life course perspective	Wadsworth (1997) Bambra, Netuveli, and Eikemo (2010)	Health at adult ages is partly determined by exposure to biological and social factors at the start of life, and the roots of health inequalities may therefore lie in inequalities experienced in the womb and during childhood and adolescence	May explain why health inequalities at adult ages respond with long delays only to more equal living conditions. However, there is no evidence that health inequalities are smaller in generations exposed to more extensive welfare arrangements.

Social selection	<p>Department of Health and Human Services (1980). The Black Report.</p> <p>West (1991)</p>	In modern societies, people are socially mobile, and are sorted into social classes on the basis of health ('direct health selection') or health determinants ('indirect health selection')	Evidence for 'direct' health selection mainly limited to income-health relationship. 'Indirect' health selection difficult to measure, but may explain paradox if it has increased over time or is associated with welfare policies.
Personal characteristics	<p>Batty, Der, Macintyre, and Deary (2006)</p> <p>Mackenbach (2010)</p>	In modern societies, socioeconomic position is strongly associated with personality, cognitive ability and other personal characteristics which affect health.	Empirical support is growing. may provide pathway for 'social selection' theory, and may explain paradox if relative importance of 'personal characteristics' for health has increased over time.
'Neo-material' factors	<p>Lynch, Davey Smith, Kaplan, and House (2000)</p> <p>Davey Smith, Bartley, and Bane (1994)</p>	Inequalities in material resources, both at the individual and community level, are still universal, and lead to accumulation over the life course of exposures and experiences which affect health.	Persistence of inequalities in material resources is well documented, and availability of material resources still affects health, but cannot explain trends over time or geographical patterns within western Europe.

Psychosocial pathways	Marmot (2004); Wilkinson (2005)	Socioeconomic position is still strongly associated with psychosocial stress, e.g. through variations in exposure to demand-control imbalance or through relative deprivation.	Persistence of inequalities in exposure to psychosocial stress is well documented, and psychosocial stress does affect health, but cannot explain trends over time or geographical patterns within western Europe.
Diffusion of innovations	Rogers (1962) Victora (2000)	Increasing inequalities in health outcomes result from a faster rate of improvement in higher socioeconomic groups, which is due to earlier adoption of new behaviours and earlier uptake of new interventions.	Supported by a lot of evidence, but theory does not identify the specific pathways linking socioeconomic position and adoption of new behaviours or uptake of new interventions.
Cultural capital	Bourdieu (1984) (Abel, 2008)	In modern societies, socioeconomic position is still strongly associated with cultural factors such as normative beliefs and knowledge on health risks, which strongly affect health because the latter is largely determined by lifestyle.	Empirical support is limited, but may provide specific pathway for 'diffusion of innovations' theory. May explain paradox if relative importance of 'cultural capital' for health has increased over time.



Mackenbach begins with the assumption that the magnitude of health inequalities in a society could be a function of (i) social mobility, and a resulting difference between the personal characteristics of individual members of different social strata; (ii) resource distribution, and the resulting differences between social strata in access to material and immaterial resources, and (iii) resource benefits – i.e. the value of the resources for the avoidance of health problems that are prevalent in that society.

Following an analysis of the nine theories, he concludes that if the resource distributive policies adopted by modern welfare states had abolished the economic and social structures that produce unequal lives, health inequalities would probably have largely disappeared. He discounts the contributions of mathematical artefact, fundamental causes, life course, neo-materialist and psychosocial theories as explanations for the persistence of inequalities in health in welfare states on the following grounds: although they each contribute explanations of ways in which inequalities in the distribution of social resources and opportunities affect health unequally, he argues that they do not explain the persistence of inequalities in health in democratic, welfare states.

He concludes that the theories of social selection, of diffusion of innovations and of cultural capital offer promise and proposes two intersecting hypotheses for further testing. The first hypothesis is that generations of upward social mobility achieved through access to social resources and greater capability to use them have meant that lower social strata have become more exclusively composed of individuals with personal characteristics - low cognitive ability and less favourable personality profiles – that pose greater risks to health. The second hypothesis is that welfare states have succeeded in distributing material resources sufficiently equally to improve the quality of life and health of most citizens so that further health improvement depends to a greater extent than previously on individuals' behaviours.

Mackenbach goes on to explain further that this may have increased the importance of immaterial factors like cultural capital<sup>1</sup>, and of the personal capabilities of individuals as explanations for the persistence of inequalities in health. These factors, he suggests, may be more socially differentiated than before because they have largely been untouched by the policies of the welfare state (Mackenbach, 2012, p. 766).

Mackenbach may be right. However, none of the theories he selects has made reference to the composition of the population in the lowest stratum other than socioeconomic status. His analysis does not consider the evidence that, in colonised countries, some social groups (historical, ascriptively marginalised groups) are systematically over-represented (as a group or population) in the lowest social stratum. He is seeking to explain a phenomenon occurring in European welfare states – the populations of many (although not all) of which do not include colonised indigenous peoples. The theories he selects for inclusion do not include any that offer an explanation of the roles that racism or colonialism play in determining who is in the lowest social stratum, independently of the role of socioeconomic deprivation that has occurred as a consequence of purposeful, unequal social treatment.

Moreover, the welfare state is intended to ensure more equitable access to material resources within populations, but not, to the non-material resources that affect particular social groups (for example, personal and social respect, freedom from discrimination and racism) that are

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<sup>1</sup> Cultural capital explains inequalities in consumption behaviour from differences in attitude, knowledge and competency between socioeconomic groups, which are transmitted across generations. The differences arise partly from the need for social distinction – and the capacity of people in higher socioeconomic groups behave differently to show off their social position (Mackenbach, 2012).

also social determinants of health. Mackenbach's analysis does not account for the possibility that, for members of historically marginalised social groups such as Indigenous Australians, being stuck in the lowest socioeconomic group could not be resolved by the redistribution of material resources alone. Nor does the analysis consider the stigmatising impact of being a welfare recipient and its potential, at least, to cancel out some of the health benefits of increased material support. The redistributive role played by the welfare state has been reframed, in some countries, to become a source of humiliation, indignity and disrespect, with social payments (welfare) being viewed as an undeserved handout to lazy or ignorant people, and kept at levels that deny opportunities to achieve equal social status. In Indigenous communities, the role played by the welfare state has been to create dependence on unearned income and has, in the Indigenous leader and commentator Noel Pearson's view, eroded self-respect and other capabilities over time (Cape York Institute for Policy & Leadership, 2005).

In other words, a solution based on the identification of maldistribution of material resources as the problem has generated an additional problem. The solution that was put in place (that is, a welfare state) is seemingly a logical and effective response. However, neither of the hypotheses about the determinants of the persistence of inequalities in health proposed by Mackenbach considers that some social groups are over-represented in the lowest (or lower) social strata for reasons other than their personal attributes, characteristics and personal behavioural choices.

There is concern within the population health sector that existing public health theory and practice in relation to addressing inequalities in health appear to have reached their limits (Bhatia, Weintraub, Farhang, Yu, & Jones, 2010, pp. 296-297; Bloss, 2010, pp. 241-242). Existing theories explaining the social production of inequalities in health in welfare states are proving insufficient to understand the production of health inequalities or to guide

potential policy and programmatic responses (K. Smith & Schrecker, 2015, p. 219). There is growing awareness that progress in reducing or preventing the persistence of inequalities in health will require a broader understanding of theories and evidence from a variety of social and scientific fields (Pedrana, Pamponet, Walker, Costa, & Rasella, 2016, pp. 8-9), requiring researchers and policy actors to move beyond disciplinary divides in order to seek new knowledge and explanations (Goldberg, 2016, p. 978). The challenge is to ‘produce deep explanations for the phenomena of concern and not only understanding’ (Wainwright & Forbes, 2000, p. 270).

The problem we are dealing with here is not caused by the poor, but is caused more fundamentally by the actions of the rich and powerful (Birdsall, 2007; Raphael, 2012a, pp. 14, 21; Stewart-Brown, 2000, p. 233). Navarro gives clear voice to the need to identify mechanisms and powers through which people who are rich and powerful influence policy decisions, and to identify ways to challenge and change these mechanisms. He wrote:

we know about the killing and the processes by which it occurs, and the agents responsible. But we need to act to expose the fact inequalities arise as a consequence of decisions by people who are responsible for creating them, and for perpetuating them, and who benefit from the inequalities that kill (Navarro, 2009, p. 440).

Other population health researchers, too, have recently sharpened their analysis and language, pointing to the roles of people (and organisations) whose wealth, power and social influence are used to create and defend public policies that distribute social resources and opportunities unequally, and thereby, protect themselves from poor health (Scott-Samuel & Smith, 2015). McCartney et al. (2013, p. 225), having reviewed the predominant theoretical explanations for the growing inequalities in the health of populations in the 21<sup>st</sup> century, concluded that the inequalities arose as a consequence of the weakening of broader democratic controls over the

interests of the rich and powerful. Implicit in this conclusion is that the values of rich and powerful people and their power to assert those values through public policies are responsible for the public policies that, when implemented, result in the current patterns of inequalities in health. In their view, that meant that health inequalities are first and foremost an emergent effect of political decisions, and the collective processes and actions within societies which shape those decisions (McCartney et al., 2013, p. 225).

There has been some work to better understand how researchers have failed to project evidence on health inequalities into the policy imagination and to suggest the need to make space for visionaries who can help us speculate about possible future alternatives to current social, political and economic arrangements (K. Smith & Schrecker, 2015, p. 223).

There has been little focus on why inequalities persist in the populations in which social and economic policies have been implemented to create what are known as welfare states (Mackenbach, 2012). Conceptual frameworks developed recently by Mantoura and Morrison (2016, p. 8) and Garthwaite et al. (2016, pp. 473-475) describe policy ideas to guide policy actors' decisions about effective remedies for inequalities in health. Among the ideas are building social and political movements (Raphael, 2012a, p. 14), strengthening the capacity of public health advocates and advocating for the empowerment of marginalised groups to enable them to participate in policy making or program design and delivery (Mantoura & Morrison, 2016, pp. 11-16; World Health Organization, 2008, pp. 202-206). Broadly, however, theories explaining inequalities in health have been focused on the relationship between the unjust distribution of material resources and opportunities, and on describing pathways by which the unjust distribution affects health (and life expectancy). Necessary though such theories are, they do not explain the persistence of systematic inequalities (in life

expectancy, health, and in access to all social determinants of health) experienced by the indigenous populations of colonised nations.

### **Race and racism**

There is extensive empirical evidence confirming the negative impact of racism on health and longevity of minority populations that experience it. The impacts are both direct and indirect and they are significant (Bailey et al., 2017; C. P. Jones, 2000; Paradies et al., 2015). Despite the weight of empirical evidence confirming the role of racism as a social determinant of health, many academics, policy makers, scientists, elected officials and others responsible for defining and responding to the public discourse remain resistant to articulating racism as a root cause of health inequalities (Bailey et al., 2017). That resistance is linked, as well, with colonialism.

### **Colonialism**

Colonialism is an expression of constructs that become embedded in the worldviews, policy and praxis of dominant cultural groups (Bamblett, Myers, & Rowse, 2019; K. Griffiths et al., 2016; Paradies, 2016; Sherwood, 2009). The taking of land, the deconstruction and disruption of nations, societies and cultures, the removal of children, and the denial of presence and voice in social and political life are expunged from the beliefs of recent generations of non-Indigenous Australians. These occurrences are understood, at best, as regrettable but inevitable and necessary actions that are justified as foundational to the establishment of a successful nation state (Blainey, 2014). The acts undertaken in the process of colonisation are manifestations of racism in action, and are independent determinants of health. They are the unrepaired consequences of the colonial history upon which the wealth of the postinvasion Australian nation has been built.

Colonialism is insidious in its impact, as successive generations of non-Indigenous Australians develop and express love for the country and deep connection to the land, and strong attachment to the good life that has been made possible by the forms of governance created by their forebears. Colonialism and racism have infested the structural and cultural contexts within which contemporary policy decisions are still being made.

The Mabo decision, the Native Title Act and successful Native Title claims, and the formation of the Aboriginal and Torres Strait Islander Commission (ATSIC) have all been successful challenges to the colonialist state. The disbanding of ATSIC, however, was an example of the reassertion of the colonialist thinking of a subsequent government. More recently, the summary dismissal by the current government to consider the call for the establishment of a First Nations voice enshrined in the Constitution and the Makarrata Commission is a further example of colonialist thinking.

## **Critical reflection**

Existing theories of inequalities in health have played significant roles in furthering scientific knowledge of determinants of inequalities and acknowledgment that the inequalities are socially produced. The theories have also been significant in identifying items (social resources and opportunities) which all humans must access in order to achieve and sustain optimal health. And they have been significant in shaping responses, although it has proven to be challenging to obtain political acceptance of the proposition that inequalities in health are socially produced, and that all sectors (not only the health sector) have roles in the production and distribution of resources and opportunities necessary to health.

However, there are unexamined assumptions implicit in the theoretical perspectives described above. From within the population health field there continues to be an assumption that in

order to ‘address inequalities in health’ new policy ideas are needed – based on pre-determined evidence of what constitute effective interventions.

Non-Indigenous researchers in many disciplines, it would seem, have been ‘slow to recognise the importance of understanding the way in which colonial effects are perpetuated through knowledge control’ (Cunneen & Rowe, 2014, p. 49), or to examine historical and institutional factors that contribute to the continuing subjugation of Indigenous knowledges and methodologies. Indigenous researchers have long argued for recognition of their own intellectual traditions and methodologies (Hart, 2010; Simpson, 2004; Tuhiwai-Smith, 1999). The differences in perspective are clear to them.

Researchers working in the western scientific paradigm take for granted their own culturally and professionally defined normative beliefs (about a good life and social justice) in developing theories explaining social problems and in developing empirical evidence of remedies for use by policy actors. Researchers do look for and see inequalities in the distribution of determinants of health in populations – but have focused primarily on behavioural determinants and on the distribution of access to material resources.

Determinants of health such as exposure to racism, the insidious impact of colonialism on worldviews, and the lack of representation (coupled with power and authority) of marginalised social groups in policy spaces are rarely recognised. The systematic, routine, persistent patterns of inequality affecting some social groups point to underlying mechanisms, turning the gaze of research from questions of what is being distributed unequally, and in what ways the unequal distribution affect health to questions of who is deciding on the distribution of social resources and opportunities, using what criteria.

We know that a toxic mix of poor social policies, unfair economic arrangements and bad politics is responsible for inequalities in health ((World Health Organization, 2008) but we



have not identified (or acknowledged) mechanisms leading to the formulation of the poor public policies that have the unfair, unjust impacts, or that explain the roles of the social institutions that are responsible.

## **Chapter Four. Events in the actual domain**

### **The actual domain of reality: what are events?**

A critical realist view of events is that they are clusters of observations of social mechanisms that, when activated, could plausibly explain a social phenomenon. In this thesis, the phenomenon is the persistent patterns of statistical regularity that have been identified in the empirical domain (in Chapter Two).

Events take place in the actual domain of reality. The events described in this chapter are public policies. Just as genetic inheritance affects the lives and capabilities of individuals, so policy inheritance (transmitted through social institutions and the worldviews and cognitive beliefs of agents) affects the life chances and opportunities afforded to particular social groups within societies and across whole populations (Rose, 1990, p. 264).

The events have been observed and recorded by communities and individuals, by researchers and policy actors, by historians and story tellers, by leaders and journalists, by Aboriginal and Torres Strait Islander (hereafter in this chapter referred to as Indigenous) Australians and by non-Indigenous Australians over more than 230 years.

I began this thesis with the presentation of epidemiological, sociodemographic, sociological and psychological information describing a social phenomenon in the empirical domain. In writing this chapter I have assumed that the systematic patterns of inequalities are an outcome of historical and contemporary policies and practices that have had (and continue to have) an impact on the health outcomes of Indigenous Australians (Kunitz, 1990). Or, from

another perspective, of the ‘toxic mix of poor social policies, unfair economic policies, and bad politics’ identified by the World Health Organization (2008).

The distribution of health within populations is determined primarily by socially determined access to socially produced resources and opportunities. Public policies are the vehicle through which societies deliver these resources to their members. Their impact is interpreted as social treatment. The policies are plans of action adopted by an individual, group, business or government that are an output of a political process (Heywood, 2000, pp. 31-32). The policies represent ideas about how we should live together (Fischer, 2003, p. 12) and emerge from political debate about the good life and the preferred means of realising it (Fischer, 2003, p. 26).

The systematic patterns of inequality, the persistence of which this thesis is seeking to explain, began from the point at which the Australian state was invaded and colonised. One nation but two societies were formed on the grounds of cultural and racial differences that were used to justify distinctly different social treatment (De Bono, 2018).

For much of the twentieth century there were really two Australias – north and south – that were represented and governed differently; and two sovereignties – one kin-based, the other state-based - that have posed considerable challenges to each other, right up to the present (Johnson & Rowse, 2018, p. 125).

There was on the part of the settlers, a normative ambition to ensure a high degree of cultural homogeneity in the modern nation state of Australia (Gellner, 1996). Rowse argues that there is room for a more nuanced understanding of the motivations for and outcomes of policies employed by the colonisers (Johnson & Rowse, 2018). There have also been shifts in policy paradigms adopted by successive governments to shape Indigenous and universal policies

that have positive impacts on the lives, health and life expectancy of Indigenous Australians. However, the systematic patterns of inequality have persisted.

The patterns of statistical regularity in the empirical domain could not be explained wholly by any single (or any group) of public policies. Rather, the persistent, systematic, routine inequalities affecting the Aboriginal and Torres Strait Islander population, points to there being underlying, transcendent, generalisable mechanisms influencing all public policy decisions.

In the following sections I describe examples of events (public policies) that have contributed to the patterns – some negatively, some positively. It is the cumulative impact of all policies that forms the focus of the analysis with which this chapter concludes.

### **Aboriginal and Torres Strait Islander public policies**

Across the whole of postinvasion history, governments have formulated and implemented public policies specifically to shape the lives of Indigenous peoples, separately and differently from those for the rest of the population.

Before the invasion and colonisation by the British and over 60 000 years, more than 200 Indigenous nations had developed sophisticated, complex structures and processes of governance that had been adapted successfully in response to major shifts in the environment, in the availability of and access to resources, and in social circumstances throughout all parts of the vast continent. The nations had developed laws, lore, social systems and norms to deliver justice and health care, to protect the peace, to develop and carry knowledge and skills across generations, and to manage social roles and the division of the land's wealth (Pascoe, 2014, pp. 130-131). They had constructed pan-continental forms of governance that enabled the multiple nations to co-exist successfully, and Indigenous Australians became the world's oldest continuous population outside Africa (Grant, 2019; Rasmussen et al., 2011);

(Attwood, 2003; B. Griffiths, 2018; K. Griffiths et al., 2016). That achievement stands in contrast with the failure of other societies to adapt successfully to the changing environmental and social circumstances that have characterised human and planetary evolution over millennia (Diamond, 2005).

The British claimed possession of the land without permission to settle - no-one consented, no-one ceded (Davis & Williams, 2015).

The destruction of Indigenous social and economic systems began in 1788 (Rowse, 2017) with the arrival of the First Fleet and the establishment of the penal colony. The process of colonisation was set in motion: the early colonisers deconstructed the existing cultures, systems and structures through which Indigenous nations governed, and established an unequal distribution of political and social power between Indigenous and non-Indigenous Australians that continues into the 21<sup>st</sup> century (K. Griffiths et al., 2016).

In 1788 Captain James Cook claimed possession of the eastern part of the Australian continent on behalf of Great Britain, providing the catalyst for the dispossession of the Indigenous nations of their lands, and the displacement of Indigenous laws with British law. Traditional Indigenous systems of tribal land ownership were neither recognised nor acknowledged (Australian Electoral Commission, 2017). The denial of the right to observe Indigenous customary laws and practices was complete. ‘Australian law, civil and criminal, substantive and procedural, was to be applied to Aborigines to the exclusion of their own laws except in the rare cases where legislation made specific provision to the contrary’ (Australian Law Reform Commission, 1986). Colonial and later, national development were based exclusively on the British legal system (Australian Electoral Commission, 2017).

In 1829 British sovereignty was extended to cover the whole of Australia and everyone born in Australia, including Indigenous people, became British subjects by birth. From 1850 the

Australian colonies became self governing. The states of Victoria, New South Wales, Tasmania and South Australia framed their constitutions in the 1850s and gave voting rights to all male British subjects over 21 years, including Indigenous men. In 1895 in South Australia, women were first given the right to vote and to sit in Parliament, except for Indigenous women. Only Queensland and Western Australia then explicitly barred Indigenous Australians from voting (Australian Electoral Commission, 2015).

Indigenous peoples were actively excluded from any part in the formulation of the Constitution of the Australian Commonwealth. The first Commonwealth Parliament (in 1901) had to decide who was entitled to vote. The 1902 *Franchise Act* gave women a Commonwealth vote but Aborigines and other 'coloured' people were excluded unless entitled under section 41 of the Constitution that said that anyone with a State vote must be allowed a Commonwealth vote. Although this seemed to mean that Indigenous people (except those in Queensland and Western Australia) were guaranteed the right to vote in Federal elections, in practice, the decision was interpreted to mean that the right to vote would be extended only to people who were already State voters in 1902. Commonwealth officials not only refused new enrolments; they began (illegally) to take away the rights of Indigenous peoples who had been enrolled since the first election in 1901 (Australian Electoral Commission, 2015). Not until the 1940s did governments begin to challenge this interpretation of the law. However, Indigenous people were not informed of the confirmation of their right to vote (if they were eligible to vote in their States) and, having been told for so long that they could not vote, most continued to believe that they did not have the right to vote.

Not until 1962 did the Commonwealth and Western Australia legislate to give Indigenous Australians full, equal rights to vote (and the associated full rights to citizenship); those rights

were not legislated in Queensland until 1965. It was not until 1967 that overwhelming support for the 1967 Referendum supporting Constitutional change saw section 127 of the Constitution being struck out in its entirety, allowing Indigenous Australians to be counted in the Commonwealth Census, and section 51 of the Constitution was amended to allow the Commonwealth to make special laws for Indigenous people (Australian Electoral Commission, 2015). Not until 1971 was an Indigenous Australian elected to the federal parliament, just one indicator of the inter-generational impact of the original exclusionary policies and practices. In 2019, for the first time an Indigenous Member of Parliament has been appointed as a Minister and member of Cabinet.

The British armed forces, colonists, convicts and settlers arrived with their own cultures, knowledge, experiences, aspirations and beliefs about appropriate governance of the new colonies (and, ultimately, of the Commonwealth). They acted upon beliefs that ‘Aborigines appeared to lack law, property, government, and moral decency’, and asserted the superiority of the British law and moral system over the Indigenous order of governance (Rowse, 2017, pp. 14-17). From those initial policy decisions flowed

the catastrophe that killed law-makers and diplomats, warriors and grandmothers, artists and philosophers. It forced remnant Aboriginal nations together in the mess and anguish of missions and reserves. Languages, Indigenous government and religion were forbidden. Children were systematically taken away. A continent was stolen (Lucashenko, 2015, p. 11).

And the fact that we were

a people of law, a people of lore, a people of music and art and politics. None of it mattered because we were not here according to British law (Grant, 2019, pp. 24-25).

The Indigenous peoples and all that they had constructed and nurtured and achieved were rendered worthless, and invisible and the people were viewed as subhuman (Grant, 2019, p. 25). No part of Indigenous cultures, systems and structures was left untouched. Indigenous children were removed forcibly from their families and communities; land was stolen; people were killed and enslaved; nations, clans and families were dispersed and removed from the lands of which they were (and are) custodians. Government policies determined peoples' disconnection from their Indigenous identity, traditional lands, languages and cultures. Policies mandated intrusive regulation of every aspect of the daily lives of Indigenous people. In the 21<sup>st</sup> century government regulation and management of incomes and of community governance has continued (K. Griffiths et al., 2016, p. 16; Tauli Corpuz, 2014, pp. 6, 10).

The era of invasion, settlement and conflict that followed was catastrophic for the life expectancy and health of Indigenous peoples. The armed forces, convicts and settlers introduced a combination of the diseases, alcohol and violence that, in the first hundred years of settlement, led to the decline of the Aboriginal population from an estimated 300 000 to 60 000 people (Australian Law Reform Commission, 1986). The long period from the 1860s until the 1970s was characterised by Stanner (2010) as The Great Australian Silence, a silence on the part of the people and institutions responsible for governance about the conditions of Indigenous Australian life. 'Until the 1960s Australian national identity had been constructed partly in opposition to Aborigines and the other non-white races' (Byrne, 1996, p. 99).

The Great Australian Silence, though, did not mean that the period was characterised by the lack of public policies governing the lives, access to social resources and opportunities of Indigenous peoples. Barred from voting and from land ownership, and denied full protection before the law, Indigenous peoples were excluded from all social decision-making about the



institutions, institutional arrangements and processes by which the entire Australian population was to be governed (Bennett, 1991, p. 3). The Great Australian Silence was imposed or adopted by the people and agencies who were responsible for the governance of the nation, and of the wider citizenry. Through policies of state-sponsored discrimination against Indigenous cultures, nations and peoples, patterns of exclusionary social treatment were set in motion and manifested themselves in large and small ways.

Policies to remove Indigenous children from their families<sup>2</sup>, to deny Indigenous returned servicemen the rights to land grants and admission to Returned and Services League, Australia (RSL) clubs or pubs, to withhold wages, to segregate schools and public facilities (cinemas, swimming pools, housing and access to health services being some of these), to deny children the right to use their own languages at school, and permitting the systematic use of Indigenous men as slave labour in the agricultural industries in Western Australia and the Northern Territory were all enacted (or remained unrepealed) between 1860 and the 1960s. The legacies of those policies live on, through subsequent generations (Kelsey-Sugg & Quince, 2018). The shadow of the influence of the paradigms of assimilation and normalisation from the past is being repeated in 21<sup>st</sup> century public policies (Australian Indigenous Doctors' Association & Centre for Health Equity Training Research and

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<sup>2</sup> It has been estimated that as many as one in three Indigenous children were taken from their families and communities between 1910 and 1970; they were brought up in institutions or foster homes, or adopted by white families (Nogrady, 2019).

Evaluation, 2010; Dudgeon, Milroy, & Walker, 2014). Indigenous peoples have through the whole of postinvasion history, as warriors, organisers and activists, advocates, researchers and practitioners, professionals and volunteers, succeeded in harnessing the powers of governments, the law, of public outrage and wider social movements that have resulted in significant legal and constitutional changes, and changes in social and economic policies that have increased their access to resources and opportunities that are essential to health and wellbeing.

The 1965 Freedom Rides, the design and adoption of the Aboriginal and Torres Strait Islander flags, the Wave Hill strike and demand for equal pay, the Tent Embassy, the 1967 Referendum, the legal and moral recognition of ownership of lands and waters (Land Rights), the Mabo decision by the High Court and the Native Title Act (1993) that followed, the Wik decision, and the success of claims to the Native Title Tribunal (AIATSIS, 2019) are just some of the outcomes of the activism of Indigenous Australians demanding the rights and resources to which they are entitled as Australians (Attwood, 2003; Grant, 2016a; Pascoe, 2014; Rowse, 2010; Wright, 2016; Yunupingu, 2016).

The Referendum shifted responsibility to the Commonwealth Government to make laws and spend money on Indigenous services and programs. Governments, through all sectors, began to establish national and regional Indigenous policies to improve access to housing, employment, education and health. Over time, the Australian Government and state and territory governments have, implemented multiple, sector-specific and comprehensive policies, of which the National Indigenous Reform Agreement is the most recent. That Agreement focuses on early child development education and training, healthy lives, economic participation, home environment, safe and supportive communities and other government services (Australian Institute of Health and Welfare, 2019b). But progress

toward achieving its targets has been slow. In 2015-16, although government expenditure for each Indigenous Australian was estimated to be twice the rate for non-Indigenous Australians, the proportion of expenditure on Indigenous-specific services had declined by 22.5% since 2008-09 (SCRGSP (Steering Committee for the Review of Government Service Provision) 2017, 2017).

There is empirical evidence of the characteristics of public policies that might be capable of overcoming Indigenous disadvantage (SCRGSP (Steering Committee for the Review of Government Service Provision) 2016, 2016), including linking Social Justice and Native Title (Australian Human Rights Commissioner, 2015). Public health policies developed with and for Indigenous communities have been shown to result in increased access to comprehensive primary health care through community-controlled health services (National Aboriginal Community Controlled Health Organisation, 2016; Panaretto, Wenitong, Button, & Ring, 2014). A growing body of Indigenous controlled, health-relevant research is emerging (The Lowitja Institute, 2017). Empirical evidence of the characteristics of intervention policies and programs that have positive impacts on the health of Indigenous communities or groups is now becoming available (Osborne, Baum, & Brown, 2013).

At the population level a reduction in the inequality in rates of infant mortality between Indigenous and non-Indigenous infants has been observed, and the inequality in childhood immunisation has been eliminated (Australian Institute of Health and Welfare, 2015b; Commonwealth of Australia, 2016; Grant, 2016b; Hudson, 2016; Lahn, 2013).

In partnership with governments (Hudson, 2016), NGOs, the private sector (The Westpac Group, 2010) and voluntary agencies, some communities have reported increases in access to appropriate housing (Habibis et al., 2013), to primary, secondary, and tertiary education (Behrendt, 2012; Sarra, 2016), to health care (Australian Institute of Health and Welfare,

2015b; The Fred Hollows Foundation, 2017), to employment and income, to land rights (Yunupingu, 2016), and to self-determined governance (Dodson & Smith, 2003).

Although the inclination of non-Indigenous Australians to exclude Indigenous people from every part of social, economic and political life has modified in recent decades, the ‘goodwill is often not reflected in behaviours’ (Reconciliation Australia, 2016, p. 5). In 2016, only 28% of non-Indigenous Australians feel that the wrongs of the past must be rectified before all Australians can move on (Reconciliation Australia, 2016, p. 13). By 2015 evidence of some positive progress in some Indigenous people’s access to some of the material resources and opportunities necessary to health and longevity was being collected.

Successes have been hard won (Davis, 2016b; Grant, 2016a; Lucashenko, 2015, p. 15). And they can be reversed or undermined. Through it all, the fact remains that neither the implementation of universal public policies nor the implementation of Indigenous-specific policies intended to increase access to economic advancement, health care, culture and capability, to land and to safety and wellbeing (Hudson, 2016, p. 8) is leading to accelerated rates of progress towards closing the gap in health inequality between Indigenous and non-Indigenous Australians (Commonwealth of Australia, 2017). The then Prime Minister commented on the limited progress: ‘While we celebrate the successes we cannot shy away from the stark reality that we are not seeing sufficient national progress on the Closing the Gap targets’ (Commonwealth of Australia, 2016).

Australia’s Indigenous citizenship policies over more than 150 years were among the most extreme and coercive of the colonial settler states (Australia, Canada, New Zealand).

Aboriginality in Australia went hand in hand not only with political exclusion (Murphy, 2008, p. 187), but also with social, economic and cultural exclusion.

Most Indigenous communities lost their autonomy in the wake of the incursion of the European colonisers (Attwood, 2012, p. 161). Indigenous peoples were not passive victims of the invasion and theft of their lands, the colonisation of their communities and the attempted destruction of their cultures. From the beginning they exercised agency, ensuring the survival of an autonomous Indigenous world, and adapting to the dominance of the colonial presence (Attwood, 2012, p. 139).

Exercising that agency saw Indigenous activists, leaders and communities resist and oppose the colonial presence. Through organisation, activism, personal and political advocacy they began to exercise influence on public policies to break the Silence, reverse oppressive policies (e.g. Terra Nullius, stolen generations), and achieve positive policies (e.g. the 1967 Referendum, Native Title). Indigenous communities organised, developed systems of governance in response to the colonial presence, and exercised their capacity to negotiate successfully to formulate or change policies in the direction of achieving self-determination. Unsurprisingly, differences within the Indigenous Australian population in aspiration, in political engagement and in the distribution of resources within communities became evident. Throughout, the ‘exercise of Indigenous governance is a process that must constantly attempt to renegotiate the balance of domination, subordination and contestation in its interactions with the Australian State’ (Attwood, 2003; Pels, 1997, p. 163, in Hunt, Smith et al., 2008, p.4-5). The negotiations to find a new balance between Indigenous peoples and the peoples and institutions of the colonial state have lain at the core of Australia’s postinvasion political, policy and social history (Attwood, 2003; Austin-Broos, 2011; Rowse, 2017). The nature and extent of the negotiations and the outcomes emerging from the organisations and people who have been engaged in public policy formulation are an ongoing source of debate among politicians, historians and within both the Indigenous and non-Indigenous populations (Rowse, 2010).

What is incontrovertible is that negotiations do occur and the colonial presence has evolved over time. Indigenous peoples have exercised a political presence, representing their diverse constituencies and political agendas and negotiating with successive governments (and other social institutions) to achieve changes in the values, ideological preferences and worldviews of policy actors about Indigenous peoples and their places in Australian society. Within the Indigenous population there are diverse histories, worldviews and policy ideas that must be negotiated, as well as the desire to shape institutional responses by the state (Rowse, 2010, p. 81).

### **Universal public policies**

The public policies that have been formulated intentionally to shape the lives of Indigenous Australians, are not though the only policies that have had a profound and lasting impact on their lives. Across the same postinvasion policy eras as those identified in the section above, the institutions and people responsible for the governance of the Australian population were formulating universal public policies that have also had profound impacts on the lives and life expectancy of Aboriginal and Torres Strait Islander Australians. The formation of the institutions responsible for governance set in motion the cultural dominance of positions of power and authority by people of originally British and more latterly Anglo-European descent. The public policies developed to govern the colonies and then, the Commonwealth, were derived from the worldviews and cognitive beliefs of the armed forces and convicts, colonists and settlers, seeking to fulfil their own needs and aspirations and to secure their futures.

Through institutions they established and the policy actors in whom they vested power and authority, the British put in place public policies to govern the colonies and, from 1901, the Commonwealth of Australia. The policies governing the treatment of convicts were brutal.

But over two centuries, policies on land ownership, immigration, education, trade unionism, welfare, economic development and more saw the developing nation navigate and negotiate through climatic, geographic, economic and social changes to a point in the 21<sup>st</sup> century at which it is one of the wealthiest, healthiest nations in the world (Blainey, 2014; Grant, 2019; Hughes, 1987; Neill, 2002; Summers, Woodward, & Parkin, 2002; Ville & Withers, 2014).

The universal public policies that shape the nation's life are products of political processes and reflect the worldviews and cognitive beliefs of social groups (political parties) holding political power and authority at different points in history. The policies reflect the structural and cultural contexts of different social and economic eras, changing domestic conditions and changes in global trends and ideas. Although there are always inequalities in the distribution of social resources and opportunities within populations, the cumulative impact of public policy decisions made in the 19<sup>th</sup> and 20<sup>th</sup> centuries enabled significant proportions of each generation to live lives that were, at least, economically more secure than those of the last. For non-Indigenous Australians the cumulative impact of the public policies (taken as a whole) has been, largely, positive: life expectancy has increased continuously and the population is, on average, among the happiest in the world (Megalogenis, 2015; Ortiz-Ospina & Roser, 2018; Ville & Withers, 2014).

From the distance of the 21<sup>st</sup> century Blainey describes how policies supporting economic development and the expansion of the wool industry (for example) to meet the demands of industrialising Europe saw Indigenous Australians become 'the silent victims of the sheep moving farther inland' as 'white men knowingly occupied black lands, waterholes and springs, and unknowingly let their sheep and cattle trample on sacred ground' (Blainey, 2014, p. 45). Historians point out that Governor Phillip arrived in Botany Bay in 1788 with goodwill toward Indigenous people, and that other colonists who followed also made

attempts to ‘civilise them’, giving the lie, Blainey argues, to the ‘myth that initially the Indigenous peoples were ‘universally despised’ (Blainey, 2014; Clendinnen, 2003). However, despite some, particular instances of respectful, positive relationships between some of the colonists and some of the Indigenous peoples whom they encountered, the century that followed was characterised by public policies and actions that denied the cultures, histories, laws, lore, intellectual and social knowledge, rights and freedoms of Indigenous peoples (Ryan, 1996).

Novelists have also written moving and deeply troubling stories of first contact in different parts of Australia (Grenville, 2005, 2008; K. Scott, 1999, 2010; Treloar, 2015). Giving a glimpse of the thinking of some in the dominant cultural group that were responsible for the public policies that govern the Australian state, Blainey wrote in 2014 that although most Indigenous people had the right to vote under democratic (state) constitutions by the 1850s ‘few Aborigines had an interest in the ballot box’. He concluded that ‘when many Aborigines were later deprived of vital civil rights, it was largely because they, understandably, had not earlier accepted the chance to become Europeans in attitudes and way of life’ (Blainey, 2014, pp. 48-49). Blainey and Howard (and others) hold the view that ‘in the absence of colonisation the resources of the uncolonised continent would have remained under-used by a relatively small Aboriginal population’ (Rowse, 2017, p. 133). ‘The British did not doubt that their civilisation in the widest sense was superior to that of the Aborigines’ (Blainey, 2014, p. 51). ‘Although we must acknowledge and regret the immediate destructive impact of colonisation on Indigenous Australians, we should take a long-term view in which it is possible to say that colonisation turned the Australian continent into a productive asset of benefit to the entire world and of benefit, in particular, to all who now live in Australia and share in its prosperity (Blainey, 2001) or as John Howard believed, ‘although harm was done



to Indigenous Australians, colonisation's balance-sheet was positive' (Rowse, 2017, p. 133). For whom is not discussed.

Stephens and Broinowski (2017, pp. 238-239) argue for the burial of the myth that Australia was settled (rather than invaded and colonised), in order that Australia becomes a country where all Australians see Indigenous history and culture as a key part of the nation's history'. However, Grant (2019), reflecting on the experiences of contemporary Indigenous Australians, is sure that it is only when we see Indigenous history and cultures as a central part of our nation's future will it be possible for 'Australia to become a space that is big enough to hold a nation – a space in which if we are smart enough and forgiving enough we can write our laws and our stories and we can make place of peace there in the space between us'.

For 60 000 years before the British invasion, colonisation and settlement, Aboriginal peoples adapted successfully to all the changes through which they lived – in climate, in landscape, in vegetation, in water sources, in food supplies; in the systems they developed for education, employment, health care and shelter, and in the social norms, lore, laws through which they governed. And despite the traumatic devastation that followed invasion, across all post settlement history, Indigenous people

grasped their futures in this new world, a world that brought devastation that they met with fierce resistance and accommodation. They found a new place in the new economy and, in the 21<sup>st</sup> century, they are people who can stand in the Dreaming and in the Market (Grant, 2019, p. 93).

Each of the public policies enacted in Australia by social institutions has contributed to the systematic pattern of inequalities in the average life expectancy at birth between Indigenous and non-Indigenous Australians. Each of the policies is an event in its own right. Each of the

policies is formulated through an institution that has power and authority to create and distribute social resources and opportunities, access to which determines the environments within which individuals and social groups live, work and play, and within which they make decisions that influence their health, life expectancy and wellbeing.

It is inarguable that many of the public policies through which Australia has been governed have had positive impacts on the lives and health of all Australians, while some have had differential impacts on the Indigenous and non-Indigenous populations, and that some of the policies have had negative impacts on members of one or both of the population groups. The evaluation of the impact of specific policies on the social issues to which they were directed is an ongoing, vital task for researchers and policy actors seeking to generate more effective policy ideas to resolve (and prevent) complex social problems. Individual social problems particularly those with complex causes require specific policy solutions arising from the development and discussion of new policy ideas.

Using other methodologies for the research the focus could be on the relationship between specific events (such as protectionist legislation) and measuring outcomes for Indigenous peoples (see for example Rowse discussing Windschuttle's analysis of the impact of the removal of Aboriginal children from their families) (Johnson & Rowse, 2018, p. 130). Or the focus could be a comparative study of interpretations of the intent of public policies by different policy actors; or an oral narrative description of the impact of public policies specific to education (for example) on the life and health of a contemporary, urban Indigenous family.

## **The cumulative impact of the public policies enacted across postinvasion Australian history**

However, instead of aiming to generalise at the level of events to identify characteristics of those which are most and least effective in achieving their intended goals and to enable the prediction of outcomes, critical realism aims to theoretically describe mechanisms and structures that can explain phenomena, not predict them (Bygstad & Munkvold, 2011, p. 4).

The inescapable conclusion from the analysis of the data in the empirical and actual domains is that the impact of all the public policies that have shaped the creation and distribution of the nation's social resources and opportunities has been to enable the lives and life expectancies of one cultural group of Australians to flourish at the expense of another.

All the things that have happened to contribute to the statistical regularity of the inequalities reported in Chapter Three have arisen from the thoughts of humans, bounded by the institutions they have established through which to govern, and the actions they have taken as a result. The events have all been generated within the context of Australia's foundation as a colonised nation, whether generated by Indigenous or non-Indigenous policy actors from outside or inside the formal systems of governance. That colonial history and the policies to which it has given rise have shaped the inheritance of experience of all Australians over more than 230 years since the first contact between the Indigenous peoples and the British arriving by boat.

The exclusion of Indigenous Australians from the legislative, executive and judicial institutions that are the sources of the political power and authority of government in western liberal democracies meant that they have had to negotiate with and harness the power and authority of the social institutions that are responsible for Australia's governance in order to achieve positive public policy outcomes. These are the same institutions to whose formation

Indigenous peoples had been denied access. The overwhelming majority of the contemporary agents of those institutions are still of non-Indigenous origin.

The history of interactions and negotiations between the people and organisations (both Indigenous and non-Indigenous) responsible for the governance of Indigenous Australians has been complicated and complex (Grant, 2019; Lucashenko, 2015; Pearson, 2011; Rowse, 2010; Wright, 2016). Indigenous people's rights to their own histories before and since invasion and colonisation of the times, the events, the meanings of the events, and explanations of the relationships between the events, and their wellbeing, health and life expectancy are only slowly being acknowledged by non-Indigenous Australian institutions, policy actors and citizens.

In 2019 Indigenous people are participating in all industries and sectors of society, including research, health, journalism, the arts, sports, politics, housing, education and land management; as business people and station owners, as professors, lawyers, police and counsellors, as board members, and as parliamentarians, opera singers, artists, doctors, teachers; as parents, as volunteers and as citizens. Indigenous Australians are contributing as they have always done, to the intellectual, cultural and economic life of the nation.

However, even those who have achieved socioeconomic security and status are not free from the threat of humiliating disrespect from non-Indigenous citizens in day-to-day life. The threat of everyday racism and disrespect are never far away; the historical racism and disrespect for Indigenous peoples and their cultures that were inserted into the foundational legal and institutional structures and processes of the modern Australian state have not been remedied (Grant, 2019).

There are some signs of change in attitudes toward Indigenous peoples. Almost all Australians (93% of Indigenous and 77% of non-Indigenous Australians) agree that

Indigenous cultures are important to Australia's national identity (Reconciliation Australia, 2016, p. 7). And there are signs of improved health and access to social resources and opportunities by the Indigenous population. Governments express commitment to closing the gap in health inequality, and to enabling all Indigenous Australians to achieve their aspirations. Slowly, social institutions including some in the private sector, are committed to creating and supporting increased opportunities and resources to be accessible to Indigenous Australians to enable them to achieve self-determined aspirations.

But underlying truths about the stigmatised place of Indigenous peoples (their histories and cultures and contemporary roles) in society continue unacknowledged by many non-Indigenous Australians. There are continuing reminders in the 21<sup>st</sup> century of the distance between the two societies. And there are continuing reminders of what is needed to eliminate that distance.

Indigenous-settler engagements could be reconfigured, including in plural legal systems (Balaton-Chrimes & Stead, 2017, p. 13; Simpson, 2011).

The subaltern can become not an object of sympathy and bearer of pain in need of remedial recognition, but an actor with an equal part in the construction of power and social life. The settler figure, on the other hand, becomes not a taken-for-granted bearer of the power to recognise, but instead, becomes one of many players in a broader game (Balaton-Chrimes & Stead, 2017, p. 13).

Indigenous people who have worked for change for a long time are expressing frustration, despair and anger at the slow progress. 'Governments have failed to listen to the work, ideas and research of Aboriginal and Torres Strait Islander communities' (Davis, 2016a, p. 78; Dodson, 2016; Lucashenko, 2015). 'Aboriginal people are sick and tired of being consulted. It's about time governments started to implement what we see works and what we know

makes a difference' (Ah Chee, 2016). 'Why is it that there has never been the will in the country as a whole to listen to an Aboriginal-defined vision for their futures?' (Wright, 2016, p. 65).

A framework developed by Habibis et al. (2013) describes paradigms that framed ways of thinking that informed the policies formulated by the people and institutions that have been responsible for the governance of postinvasion Australia. It also explains the reflexivity that has resulted in changes in broad policy goals, significant differences in the policy instruments that are selected to achieve them, and significant shifts in the conditions imposed on Indigenous communities and peoples as a result. Critical analysis reveals the application of two broad theoretical perspectives on the interpretations of the institutions and policy actors of the sources of the inequalities being experienced by Indigenous Australians, and of appropriate remedies. On one hand, it is considered that limited access to material resources and opportunities points to increasing access to education, employment and housing (for example); on the other, it is considered that affording communities the right to self-determination is the preferred remedy. However, through all the policy decisions made by culturally dominant policy actors, the moral trigger that they use to decide on any action to eliminate inequalities in health (and in the distribution of all socially produced resources) is rooted in beliefs about what constitutes a socially just society and about the obligations of the state in achieving this.

The changes in policy goals illustrated in Habibis et al.'s paradigm reflect the decisions of the institutions responsible for governance that were initially made without Aboriginal and Torres Strait Islander participation. Even in recent decades the decisions have continued to be taken by the dominant cultural group through the institutions responsible for governance. Habibis et al.'s paradigm illustrates the power of institutions to determine public policies

both because they carry inherited ideas (as rules and norms) between generations, and because they decide who is eligible to make the rules, who is to be included and whose ideas are given weight in framing policy ideas and in determining which policies are adopted.

All policies are an outcome of ideas about the good life and means of realising it (Fischer, 2003, p. 26) and these ideas play significant roles in the behaviour of political leaders.

Fischer (2003, p. 25) points to evidence that ‘although people (policy actors) act simply on the basis of their perceived self-interest, they are motivated as well by values, purposes, ideas and goals, and commitments that transcend self-interest or group interests’. He goes on to argue, therefore, that the beliefs of political leaders ‘can be better explained by their ideological orientations than by their social or demographic characteristics’, including the priority they assign to the value of equality as an indicator of a good society (Fischer, 2003, p. 26). Changes in thinking (in ideas) and in institutional arrangements can have significant impacts on public policy goals and instruments.

Critical realism recognises that the ways of thinking that influence public policies may emerge at a deeper level of reality emerging from reflection upon the events and the key components about what could be generative mechanisms that produce the persistence of the systematic patterns of inequality that are the subject of this inquiry.

Each of the events (public policies) represents a policy idea. The ideas have been generated by people whose cultural, professional, experiential and foundational beliefs about social justice and a good life frame the policies they formulate and implement. The ideas have been translated into policies through institutions and processes that are socially constructed. The institutions are not only those of government; they can be private, non-government or in the voluntary sector.

The institutions set boundaries for inclusion eligibility of policy actors; the criteria used to select policy ideas for inclusion on the policy agenda; the guidelines for framing ideas and the engagement of negotiating agents among competing options, and the criteria to select the options to be enacted. The institutional arrangements at any given point in history are inherited by successive generations of policy actors and, through these, the standard operating procedures, rules, norms and values (interpreted as policy paradigms) influence policy actors' ideas and behaviours. It is possible for policy actors to change institutions – the structural and cultural contexts within which policy decisions are being made – but the influence of historical decisions is powerful. Through institutions, the ideas of previous generations are carried forward.

Theoretical explanations of the persistence of inequalities in the life expectancy of Indigenous Australians have been dominated by two distinct ideas: the first is that access to material goods and services (for example, education, health care and housing) is a prerequisite for achieving equitable socioeconomic status and by extension, equitable health status; the second is that self-determination bounded by the aspirations, values, norms and rules of non-Indigenous Australia is a prerequisite for achieving equal social status. In each case, the stated goal is equality but it is conceived of only through assimilation. Paradigms based on each of these two ideas are manifestly failing.

Now, after more than 230 years, evidence that Indigenous Australians cannot thrive within the boundaries set by existing institutions and the existing worldviews of policy actors who are framing and shaping both universal and Indigenous-specific public policies is becoming more assertive. Indigenous peoples have long since identified what they need, not just to survive but also to thrive. The trouble is that they have been excluded from the institutions and from participation as policy actors responsible for governance of the nation in creating



the public policies that would result in positive outcomes for them. The power to change what we think, the responsibility to look for and look at our own (non-Indigenous) roles in creating and perpetuating the injustices of the past, and the need to see and act to change what we do lies with those of us who have and who benefit from the power to shape the public policies.

The future will require theories explaining the persistence of systematic, group-structured inequality in the distribution of social resources within societies; it will need to include explanations of ways in which ‘colonialisation (and racism) shape the contours of the racialised health inequalities’ that are persisting in Australia in the 21<sup>st</sup> century (Fu, Exeter, & Anderson, 2015a, p. 223). That requires looking for and seeing mechanisms through which political and social power and privilege are created, inherited and maintained (Fu, Exeter, & Anderson, 2015b, p. 27).

## **Chapter Five. Key components of the events: mechanisms in the real domain**

### **The real domain of reality: mechanisms with generative powers**

Through the layered ontology of a critical realist methodology the next step is to look for regularities at the level of objects and structures that are generalisable across events to identify mechanisms that are structures or powers that can trigger events and that could plausibly explain the relationship between events and outcomes in the empirical domain. The key components (mechanisms) are regularities at the level of objects and structures associated with the nature of the object of study (in this case, and not with the attributes of events (Bygstad & Munkvold, 2011, p. 5).

Political scientists are concerned with the arenas within which politics (the contest of ideas) take place and with the social processes through which power is distributed and struggled over, and the impact of the distribution of power on the creation and distribution of resources, life chances and wellbeing (Stoker & Marsh, 2002, p. 9). From a search for normative theoretical perspectives in political science I selected new institutionalism, with its view that agents or actors, structures, interests and institutions (Goodin, 1996, p. 107; Lowndes, 2002, p. 107) and the interactions among them are the driving forces of political behaviour, in the case of this research, of the formulation of public policies.

These key components of events must be sufficiently conceptually robust to account for the fact that the persistent, systematic patterns of inequalities have arisen between two population groups living in the same country, being governed by the same policy actors and subject to

the impacts of public policies formulated and implemented over the course of more than 230 years. The colonisers claimed the power to govern and, through the institutions they established and the policy actors they appointed, distributed power and authority over the population, including the peoples whose existence they denied.

New institutionalists question the argument of rational model policy theorists that the formulation of public policy is (or should be) based on empirical assessment of problems, quantitative (cost-benefit) assessment of options for solutions, and the selection of the most effective and efficient alternative (Fischer, 2003, p. 5). Rather than policy development being a rational process, a neo-institutionalist view is that ‘particular policies come into existence because people (policy actors) have beliefs about what they take to be the right course of action and struggle to influence and shape decisions in light of them’ (Fischer, 2003, p. 26). Neo-institutionalists accept the ‘view that political and policy making practices are grounded in institutions that are, independently of contemporary actors, driven by pre-existing ideas, rules, procedural routines, roles, organisational structures and strategies that construct meanings that shape actor’s preferences, expectations, experiences and interpretations of actions’ (Fischer, 2003, pp. 28-29). Individual (and groups) policy actors bring their own beliefs to policy-making, but they are influenced by (and in turn, exert influence on) the institutions on whose behalf they are agents.

New institutionalism provides an explanation of the ways in which policy ideas can be transmitted between generations – through the beliefs of policy actors and through institutional political and policy-making practices. In addition, new institutionalism explains a route by which a social structure can create procedures, rules and norms that obscure ‘the veiled ideological nature of mainstream policy analysis and its complicit dominance by political elites’ employing purportedly value-neutral positivist methods to frame and

implement public policies and to conceal dominant interests (Fischer, 2003, p. 36). By denying access to policy-making spaces, and by denying access to space in the public sphere in which citizens can openly discuss political agreements to resolve public problems, social institutions can actively conceal the dominant interests of one cultural group over another and can initiate and perpetuate state-supported forms of discrimination (M. Williams, 1998).

Based on new institutionalism as a framework, I selected social institutions and policy actors as key components of the events in this case, and include the reflexivity and the formulation of policy paradigms as mechanisms through which they are linked to shape public policies.

In the sections that follow I expand on each of the key components to explain the powers they can activate to shape the events that have resulted in the social phenomenon that is the object of the research.

### **Institutions and the mechanisms through which they influence public policy**

Institutions are social structures comprised of patterned systems of social relationships among actors (Parsons, 1953, p. 230). As patterns become normative they become organised as social institutions (Goodin, 1996, p. 22). Institutions are socially constructed structures through which actions are guided, regulated and channelled to solve collective problems using powers, relationships and processes (Plumtre & Graham, 1999, p. 3). Although institutions are not always organisations they have been assumed to be organisations in this research. The power and authority to formulate public policy is vested most openly in the institutions of governments, but all social institutions in the public, private and non-government sectors and in civil society, including the health-care system, make public policies through which they distribute social resources and opportunities (Stoker & Marsh, 2002, pp. 9-10). Institutions as key components of the events in the actual domain play roles

in guiding the actions of policy actors, enabling and constraining their actions, but not wholly determining them (Archer, 1995; Sayer, 2004) .

New institutionalism evolved as a framework for ‘seeing political and policy making practices as being grounded in institutions dominated by ideas, rules, procedural routines, roles, organisational structures and capacities that shape actors preferences, expectations, experiences, and interpretations of actions’ (Fischer, 2003, p. 26; Hall, 1993). Through their institutional arrangements and the composition and activation of standard operating procedures, paradigms, rules and norms, institutions constitute the structural and cultural contexts within which policy actors formulate public policies. The institutional arrangements include decisions about who is eligible for inclusion as policy actors, whose policy ideas are selected for inclusion on the public policy agenda, and how policy options are framed, debated and adopted. Institutions adopt policy paradigms that, incorporated into standard operating procedures and into the rules and norms governing the behaviours of agents, influence the underpinning theory of social justice, values, goals and instruments of public policies.

New institutionalists argue that structures and policy actors can (and do) change reflexively in response to both intentional actions and to unintentional consequences. In formulating public policies at any given point in history, agents are influenced by the pre-existing social structures and pre-existing cultural contexts within which they are working. Conversely agents influence the institutions through the exercise of their independent power and ideas (values and ideologies) (Archer, 1995; Sayer, 2004, cited in Bygstad and Munkvold, 2011, p. 2). The changes are not necessarily linear, and are not necessarily a consequence of direct, explicit actions. They may occur over short or long periods of time (Archer, 2000).

Investigating the residual effects of history is vital when describing and explaining the social world at any given point in time (McEvoy & Richards, 2003, p. 413).

The subordinate value ascribed to Aboriginal and Torres Strait Islander (hereafter in this chapter referred to as Indigenous) cultures and people by the British colonists and their successors has been translated into the social construction of institutions from which they were excluded as agents, and into the development of policy paradigms that were, arguably, inimical to meeting their self-determined needs and aspirations (K. Griffiths et al., 2016; Habibis et al., 2013).

Archer's model of reflexivity (see below) explains that agents (policy actors) can and do change institutions: each of the structural characteristics of institutions (as described above) can be changed, as can the culture of organisations. The critical realist analysis, here, then focuses on the question of who the agents at any given point in time are and who at any given point in time are eligible to be agents.

Indigenous Australians have exercised agency independently of the state through long-fought, hard-won successes in establishing institutions through which they have power to exercise agency to formulate public policies free from the subordination to non-Indigenous policy actors in particular sectors in local, state and territory jurisdictions, such as health, justice, housing and Land Councils. However, within the institutions of the state the historical decisions of the colonisers and settlers who wrote the constitution and who established the institutions through which the nation is governed continue to shape contemporary public policies into the 21<sup>st</sup> century.

## **Reflexivity**

Political philosophers and political scientists have long debated the roles of structure and agency in explaining political events (McAnulla, 2002, pp. 271-272). I share the view of those who argue that there is a clear, analytical distinction between structure and agency, and that they work in different ways over time (McAnulla, 2002, p. 285). Archer argues that people are not puppets of structures because people have their own emergent properties which mean they can either reproduce or transform social structures (Archer, 1995, p. 1).

McAnulla (2002, pp. 286-287) explains Archer's model of the relationship between structure and agency over time – a model of a three-phase cycle of change that begins with the assumption that actions (at any time in history) take place within a set of pre-existing, structured conditions (structures) that affect the interests people bring to the policy cycle; agents, although strongly influenced by such structured conditions, also exercise their own abilities and skills in the policy-making process to further their own interests and to affect outcomes. By engaging in processes of negotiation with other agents in the policy-making process they change the pre-existing structural conditions either minimally or profoundly, and either in the short or longer term. In addition to her model of the reflexive relationship between structure and agency, Archer takes the position that the relationship between culture and agency is similar to that between structure and agency. She contends that policy-making actions at any point in history take place within cultural conditions that, as normative beliefs and cognitive frameworks (and as institutional arrangements), emerge as a result of past actions (based on ideologies, conceptions of right and wrong, and societal views on social status including societal views on the relative value of cultures and cultural groups). Archer's model then explains that, although strongly influenced by pre-existing cultural conditions, agents retain powers to effect cultural change bringing their own sets of values to the policy

debate. As a result, the cultural context is modified or transformed in some respects (McAnulla, 2002, pp. 288-289).

In order to exercise agency to transform cultural contexts, agents must be present within the structures and have power and authority to engage in the policy-making process. Through a process of reflexivity it is possible to achieve change but it requires the presence of people with different cultural perspectives, and their having power and authority to influence public policy decisions.

New institutionalism and Archer's model of reflexivity, provide the framework through which to identify key components that are generalisable to all the events described in the actual domain (in Chapter Four). However, missing from the analysis is recognition that, in a colonised nation such as Australia, agents representing one social group were denied, historically and systematically, a place in forming the institutions through which public policies are formulated, and a place as a policy actor within the institutions. The racial prejudice against Indigenous peoples, and the systematic subordination of Indigenous cultures were codified within the structures and within the normative and cognitive beliefs of agents responsible for the governance of the postinvasion Australian state. The structural and the cultural conditions that were established by the colonists resulted in the almost complete exclusion of Indigenous peoples from any part in the formal political and much of the social life of Australia for more than a century. That did not mean, however, that Indigenous peoples and their communities did not take action to influence the policies that were shaping their lives. It did not mean their passive acceptance of the exclusion or of the efforts to destroy their cultures. In multiple large and small ways Indigenous peoples acted purposefully against the oppression, denigration, racism and separatism that characterised postinvasion history. And they succeeded in preserving their cultural values and in reforming



the structural and cultural conditions that frame the decisions of policy actors about who gets what. The exclusion of Indigenous peoples from formal representation in policy spaces, and hence, from the power and authority to influence public policies continued until well into the 20<sup>th</sup> century.

Reflexivity as a concept, however, provides an explanation for changes in institutional arrangements and policy paradigms over time. As new policy actors enter institutions, bringing new (or at least alternative) ideas, they are able to influence the institutional arrangements and standard operating procedures (including policy paradigms) of the institutions. Conversely, as institutions respond to changes in social, economic and environmental conditions, they are able to change their arrangements (seeking new actors, for example) and their paradigms.

Habibis et al. (2013, p. 76) in Table 3, illustrate shifts in the broad policy paradigms shaping Indigenous policies of successive governments and the consequential shifts in policy goals and instruments that have occurred over time. The shifts are an illustration of reflexivity as changes in the structural and cultural contexts within which policies are being formulated interact to create new policy goals.

That such changes can and do occur in such paradigms is positive. However, the structural and cultural contexts within which the changes in these paradigms have occurred have only relatively recently in the history of the postinvasion Australian state begun to include formal, routine Indigenous people's influence from within.

Table 3. Characteristics of successive policy paradigms throughout Australia’s postcolonial history

<b>Policy paradigm – preferred policy goals</b>	<b>Rationale – cognitive beliefs about the place of Indigenous Australians in Australian society</b>	<b>Theory of change</b>	<b>Recognition of Indigenous cultures, systems and preferences</b>	<b>Strategies</b>	<b>Enabling programs</b>
Protectionism	Indigenous people are dying out and the survivors require protection	Meeting basic needs should result in compliance with social control regimes	Exclusion from citizenship rights. No recognition of culture or Indigenous governance organisations	Forced mobility & relocation on mission stations & reserves	Not applicable
Assimilation	Indigenous people must conform to Anglo-Australian norms or live outside mainstream society	Social assistance benefits are only provided if Anglo-Australian cultural norms and lifestyles replace Indigenous ones	Formal exclusion from citizenship rights but some social assistance. No recognition of culture of Indigenous governance organisations	Housing provision on edges of, or spread thinly across, urban centres under scatterisation policies	Life skills programs; financial management training; some training in construction
Normalisation	Welfare expenditure must be curtailed. Indigenous people	Tough conditions will reduce welfare claims and	Formal recognition of citizenship rights subject to	Mainstreaming of Indigenous services. Housing provision	Life skills programs; financial management

<b>Policy paradigm – preferred policy goals</b>	<b>Rationale – cognitive beliefs about the place of Indigenous Australians in Australian society</b>	<b>Theory of change</b>	<b>Recognition of Indigenous cultures, systems and preferences</b>	<b>Strategies</b>	<b>Enabling programs</b>
	must reduce welfare dependence and develop self-responsibility. The state must treat all groups the same.	encourage self-responsibility. Indigenous living standards will improve if they accept citizenship obligations to attend school and find employment in the mainstream economy.	meeting mainstream behavioural standards. No recognition of culture or Indigenous governance organisations.	close to employment opportunities. Compulsory income management. Three strikes policies.	training; mainstream tenancy support.
Adaptation	Indigenous aspirations to live differently are valid. This desire needs to be achieved without compromising Indigenous living standards or national goals of social inclusion.	Goals of social inclusion and improving Indigenous living standards are best met through flexible, enabling policies that have some alignment with Indigenous lifeworlds and which build	Establishment of recognition spaces that pay equal attention to responsibilities attached to each of three spheres of the state, Indigenous citizens, and	Arrangements for housing delivery and management that provide for participation of Indigenous governance organisations while ensuring adequate resources and accountability; flexible policies that acknowledge	Specialised support services; capacity building approach to Indigenous Community Controlled Organisations; identification and support positive Indigenous social capital; partnerships with local services for knowledge

<b>Policy paradigm – preferred policy goals</b>	<b>Rationale – cognitive beliefs about the place of Indigenous Australians in Australian society</b>	<b>Theory of change</b>	<b>Recognition of Indigenous cultures, systems and preferences</b>	<b>Strategies</b>	<b>Enabling programs</b>
		Indigenous governance capacities.	Indigenous governance arrangements.	core, culturally-sanctioned behaviours.	sharing and support strategies.

Habibis et al. (2013, p. 76)

## **Policy actors and mechanisms through which they influence public policy**

‘What they think determines how humans behave’ (T. Greenhalgh, 2016). In his famous work *Ways of Seeing* John Berger wrote:

The way we see things is affected by what we know or what we believe. We can only see what we look at. To look is an act of choice. As a result of this act, what we see is brought within our reach – though not necessarily within arm’s reach. We never look at just one thing; we are always looking at the relation between things and ourselves. Soon after we can see, we are aware that we can also be seen (Berger, 1972, pp. 8-9).

All research and policy formulation starts with philosophical assumptions and researchers’ and policy actors’ worldviews, paradigms, or sets of beliefs that inform the ways in which policies are formulated. Researchers and policy actors bring to the process interpretive frameworks based on normative beliefs (worldviews) and theoretical perspectives (cognitive beliefs) that influence the identification of social problems, the investigation of causes, the selection of ideas for solutions and debates about these causes, and the selection of policy instruments. Three elements (assumptions, worldviews, and theoretical frameworks) frequently overlap and support each other’ (Graham, Brown-Jeffy, Aronson, & Stephens, 2011, p. 81).

Policy actors are individuals or groups that in formal or informal roles, influence the creation and implementation of public policy (Theodoulou & Cahn, 2013, p. 199) so that

if we really wish to understand the dynamics of social policies we need to identify the cognitive and normative beliefs (worldviews) of policy actors (P.-M. Daigneault, 2014, p. 1).

In any context (structural or cultural, formal or informal) people's worldviews and cognitive beliefs shape what they are looking for (Berger, 1972; Jack, 2019; Krieger, 1992; McKee & Stuckler, 2016) - both as problems and as solutions. 'Individuals see what they see from their own particular perspectives and their perspectives change over time' (Clendinnen, 2003, p. 12).

In this thesis, policy actors are taken to be agents of socially mandated institutions that have power and authority to shape public policies through which social resources and opportunities essential to health and longevity are created and distributed across populations (in Australia in particular). The institutions can be in any sector and are not confined to those of governments.

Public policies are formulated by actors who bring their views about other peoples and about the relative value of their own and others' cultures, societies, histories and aspirations to their policy making. The policy actors also bring their normative beliefs about what a good society is, about social justice and equality, the nature of reality, the causes of social problems, and about the responsibility of the state or society for remedying social problems. In the sections that follow I describe worldviews and cognitive frameworks and through an emergent process, identify elements of these that could be generative mechanisms that contribute plausibly to explanations of the relationship between events and the social phenomenon that is the subject of inquiry in this thesis.

### **What are worldviews?**

Worldviews are normative 'beliefs and assumptions by which an individual makes sense of experiences that are hidden deep within the language and traditions of the surrounding society' (Clark, 2002, p. 5). The worldviews are the shared values and assumptions on which rest the customs, norms and institutions of any particular society and they 'set the ground

rules for shared cultural meaning' (Clark, 2002, p. 5). 'A worldview reflects what generations of people have experienced, before any conceptual notions. These preconscious experiences have been and continue to be translated into comprehensible orderings which subconsciously explain how the world ontologically is, becomes or is experienced.' (Note, Fornet-Betancourt, Estermann, & Aerts, 2009, p. 1). 'Within an intercultural global setting, an unconditional conviction of the trueness and justness of one's own basic convictions hampers the possibility for a genuine polylogue between cultures' (Note et al., 2009, p. 2). Racism, stereotyping, and stigmatisation arise from such convictions based on views about the relative status of other peoples on the grounds of race, or skin colour, or religion (for example).

Worldviews exist before facts and are based on people's vision of a good society (Kahan & Braman, 2006). They constitute normative beliefs (taken for granted assumptions) about what constitutes a good life, a socially just society, about priority social values, about the causes of social problems, and about the role of the state in remedying such problems.

There has been little research to investigate mechanisms through which the colonialist social structures and agents perpetuate racism and remain blind or indifferent to the institutionalised patterns of cultural value and the denial of representation that underpinned the foundation of the postinvasion Australian state and are continuing in the 21<sup>st</sup> century (K. Griffiths et al., 2016).

From a critical realist perspective, worldviews have a conditioning, mediating role in knowing (Naugle, p. 44), in framing what we know and in determining what we see and believe to be real (or right) in any given context.

## **What are cognitive frameworks?**

Cognitive frameworks form as humans learn and make sense of the world, helping to process information and to act (Bourdieu & Wacquant, 1992). The frameworks have practical value in helping people to take mental shortcuts to interpret information and make decisions. Within all such frameworks there are cognitive biases that determine the decisions humans make about what values to prioritise, what information to seek out, what information to pay attention to, how to interpret information and whose interests to privilege when making decisions (Campbell, 2002; McKee & Stuckler, 2016, pp. 79-80).

Cognitive frameworks derived from (or contributing to) theoretical perspectives shape the decisions of policy actors seeking to resolve social problems (such as inequalities in health) . The systematic, routine patterns of unequal social treatment delivered to different social groups within populations confirm that worldviews and cognitive beliefs are not only the preserve of individuals, but can (and do) become patterned and institutionalised as normative beliefs.

In the sections that follow I (i) explore the characteristics of institutions through which they exert influence on public policy decisions; (ii) identify what different normative and theoretical assumptions contribute to explanations of the occurrence and persistence of the patterns of inequality described in the empirical domain; and (iii) consider Archer's model of reflexivity as an explanation for the evolution of policy paradigms in relation to Indigenous policies across postinvasion Australian history.

In Chapter Six I describe and analyse differences in ontological, theoretical and ideological perspectives implicit in worldviews and in contemporary theoretical explanations of inequalities in health and in their persistence over time.



Seeing, believing and understanding the worldviews of others is challenging. Krieger (1992, p. 412) explained that public health researchers need to reflect on the ways in which their own worldviews (including ontological, epistemological and theoretical perspectives) and those of others, influence scientific inquiry, policies and practices, adding that ‘If you don’t ask, you don’t know, and if you don’t know, you can’t act’. Krieger did not add that people’s worldviews include beliefs about the relative value and status of their own and other cultures. Dominant cultural groups control the development of new knowledge and subjugate Indigenous (and other minority groups) knowledges and methodologies to those of western science (Cunneen & Rowe, 2014, p. 49).

Cognitive beliefs are, arguably, more consciously acquired understandings about the world than worldviews and are reflected in theoretical perspectives adopted to explain social phenomena and to shape preferred responses to social problems.

In short, the normative beliefs of policy actors seeking to resolve social problems such as inequalities in health (Raphael et al., 2006, p. 11), and embedded in the policy paradigms of the institutions they represent, influence decisions at every point in the policy cycle, from selecting social problems for inclusion on the policy agenda, to framing the problem and deciding who is to be included in debating policy goals, strategies and preferred policy instruments, and in deciding which of the options to adopt.

If it is to be possible to see and more, to *understand* the interplay of mechanisms that have produced the systematic pattern of inequalities described in Chapter Two, ‘we have to look through other people’s masks if we are to see anything of the world we want to fathom’ (Clendinnen, 2003, p. 13).

## **Policy paradigm: an analytical framework to compare the influence of differences in normative belief on policy options**

‘Public policy is the mechanism that defines who is to receive what resources, through what means and instruments, and with what conditions’ (P.-M. Daigneault, 2014, p. 3). Daigneault developed an organisational framework that describes a policy paradigm, setting out steps to guide a critical analysis of public policies to identify what are often invisible ways of thinking that underlie the formulation of public policies. The construct of the policy paradigm can be operationalised as an analytical framework to use to critically analyse public policies to identify underlying, normative worldviews, cognitive beliefs and theoretical perspectives on social justice, preferred ideologies and values and their influence on decisions at each point in the policy cycle (P.-M. Daigneault, 2014, p. 2). Table 4 presents a comparative analysis of three paradigms of social assistance.

The exclusion of Indigenous representation from the settings within which policy paradigms are constructed has resulted in the exclusion of the cultural knowledges, histories, intellectual traditions, experiences and aspirations of Indigenous Australians from the formulation of paradigms that inform public policy decisions even in contemporary Australia. And over time, it has left unchallenged the worldviews and cognitive beliefs about Indigenous Australians that were (and are) shaped by the intrusive gaze of colonialising cultures (Dodson, 1994). This perspective misrepresented and dehumanised Indigenous peoples (Sherwood, 2009, p. 29), resulting in the racial stereotypes that continue to be used within all aspects of the Australian western culture in the 21<sup>st</sup> century: the academy, the football field and in board rooms (Dodson, 1994; Grant, 2016b; Riseman, 2013; Sherwood, 2013).

Although, through the processes described as reflexivity by Archer in response to different structural and cultural contexts, paradigms have changed over time (Habibis et al., 2013), the

absence of Indigenous agents from policy-making spaces means that the formulation or revision of policy paradigms continue to be the preserve of the people with power and authority, the overwhelming majority of whom, in Australia, continue to be non-Indigenous.

Daigneault’s framework enables critical analysis and comparison of different normative beliefs and the influence of the differences on public policy decisions. Although the paradigms adopted by institutions in their standard operating procedures, values and norms are often implicit it is possible to critically review existing public policies and to determine the normative beliefs that are influencing the policy goals, strategies and selection of policy instruments (see Table 4, below) (P.-M. Daigneault, 2014, p. 3).

Table 4. An example of the influence of worldviews and cognitive beliefs on policy paradigms: a comparison of three paradigms of social assistance

<b>Dimensions of policy paradigms</b>	<b>Entitlement paradigm</b>	<b>Workfare paradigm</b>	<b>Activation paradigm</b>
<b>Values, assumptions, principles</b>			
Ideological roots	Social democratic thinking	Conservatism with accents of neoliberalism	‘Third Way’ with accents of neoliberalism and of a social investment perspective
Paramount values	Solidarity and egalitarianism (equality and equity)	Individual independence and responsibility (liberty)	Reciprocity, equality of opportunity, prioritarian egalitarianism, and productivity
Balance of rights and responsibility	Emphasis on individual rights: welfare is a social right	Emphasis on individual responsibility: welfare is a privilege	Balance between individual rights and responsibilities: welfare is a contract

## Policy problem

Policy focus	Economic insecurity, poverty, and inequality	Culture of dependency	Insufficient incentives to work and lack of human capital
Origin of policy problems	Primarily structural: socioeconomic transformation and economic downturn	Primarily individual: clients' inadequate values and attitudes, which result, in part, from prolonged welfare use	Primarily policy-based: disconnect between social and economic policies

## Policy ends

Main objectives	Reducing poverty by guaranteeing a decent level of income and decommodification	Improving the work ethic, attitudes, and self-esteem of welfare claimants	Boosting the economic activity rate, enabling to work, and reducing poverty in work
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## Policy means

Generosity of social assistance benefit	High	Low: 'less eligibility' principle	Moderate: low basic benefit but relatively generous income supplements
Preferred policy instruments	Unconditional cash transfers	Cash transfers are conditional on work-related requirements (including workfare) and control measures	Unconditional cash transfers, conditional income supplements (e.g. training, job search assistance)
Targeting (i.e. who is targeted by policy)	Low: few distinctions are drawn between clients (i.e. broad-based or universal eligibility)	High: segmentation of assistance between 'deserving' and 'undeserving' clients	High: income supplements are restricted to clients who comply with work-related conditions

Critical analysis of the example used by Daigneault to explain the use of the framework exposes the power of worldviews and cognitive beliefs in determining goals, means and distributive impact of public policies. The differences in the values, assumptions and principles described by Daigneault all arise from western liberal philosophical and theoretical traditions and assume that the items being distributed are material resources and opportunities to acquire and use them. Furthermore, the assumptions implicit in Daigneault's example expose two consequences that can be mechanisms through which public policies result in the persistence of the systematic patterns of inequality in average life expectancy at birth between Indigenous and non-Indigenous Australians in the 21<sup>st</sup> century.

The first is that in Australia both racial prejudice and underlying theories of social justice were foundational ideas upon which the colonial state was established. The result was the ongoing separation of the two cultural groups, forming two societies within one country with different worldviews, cognitive beliefs, needs and aspirations. Having been excluded deliberately and systematically from inclusion as actors within the institutions responsible for governance, and having had their self-defined aspirations, needs, values, and their knowledges, experiences, assumptions and principles assigned subordinate status in the worldviews of the dominant culture, Indigenous peoples and nations have had little influence in determining the policy paradigms of the nation state. Without representation as policy actors, the histories and contemporary experiences of Indigenous peoples are not acknowledged, their cultures, intellectual traditions and aspirations are ignored, interpretations of need are confined to material resources and to heavily bounded, self-determination (as if the two are mutually exclusive needs). There is no platform upon which to build a shared future.

Reflecting on the failure of separate paradigms based on one hand on the commitment to self-determination as a means of protecting Indigenous rights, and on the other, on a commitment to economic advancement, Myers (2011, p. xvii) – an anthropologist – concluded that ‘our paradigms are collapsing’. Other researchers variously explain the failures of successive paradigms and the policies to which they give rise as being a consequence of a lack of consensus within government and within the Indigenous population on policy goals (Jordan, Bulloch, & Buchanan, 2010); an enduring tension between self-determination based on the maintenance of culturally informed differences in aspirations and life choices, and socioeconomic security as preferred policy solutions (Kowal, 2008; Myers, 2011, p. xvi); and limited evidence of pathways into and out of disadvantage (Hunter, 2007).

Carey (2013, p. 182) comments that contemporary ‘Australian government policy could be seen to be more focused on gently steering Indigenous Australians to adopt a Western style of living rather than providing opportunities for them to live lives of personal meaning and value’. Austin-Broos (2011, p. 137) concludes that the need is to reconcile the politics of cultural difference and equality.

### **Critical reflection**

Using institutionalism as an organising framework I selected institutions and policy actors as the key components of events in the actual domain. I then identified the characteristics of each of these key components through which they shape public policies.

The significance of institutions lies in their stability as organisations responsible for governance – carrying decisions made by one generation of policy actors to the next (and to subsequent generations). Through decisions about who is eligible for inclusion within organisations and, within policy spaces within them, and through policy paradigms and standard operating procedures, rules and norms, institutions influence the decisions of policy

actors. Cultural dominance is perpetuated through institutions as subsequent generations come to accept rules and practices as ‘normal’ – universal – and colonialisation is a result.

Indigenous researchers and theorists express concern that contemporary policies based on the idea of recognition of Indigenous cultures and people are making recognition conditional upon the acceptance of the existing political and intersubjective arrangements by the actors and structures of the state, leaving unchallenged the policy paradigms, institutional arrangements and power of the colonialist state (Balaton-Chrimes & Stead, 2017, pp. 6-7).

The evidence confirms that nothing short of transformation of the institutions and their actors will be enough.

Taking as an example, a federal and state government Indigenous policy initiative in Australia in 2016 was to close the gap in health and social indicators between mainstream and Indigenous populations within a generation (Australian Government Department of Families, 2009). Closing the gap in inequality is an undisputedly urgent policy goal, but the paradigm upon which it is based and the policy instruments through which it is being implemented are heavily weighted toward social and economic development. It is therefore yet another government policy initiative based on the cognitive belief that access to material resources is the most efficient strategy to achieve improved Indigenous health outcomes. That Indigenous peoples want and need secure access to sufficient (and relevant) material resources to have a positive impact on their health is not at question.

However, the data in the empirical domain show clearly that, first, without direct Indigenous Australian participation in public policy formulation, it will be impossible to ensure equitable access to sufficient, relevant, accessible material resources and opportunities to support health and wellbeing. And second, factors other than material resources and opportunities are affecting the health of the Indigenous population (Australian Institute of Health and Welfare,

2018c). Unless efforts are devoted to addressing these other salient drivers of ill-health current initiatives will continue to fail (Buttenheim, Goldman, Pebley, Wong., & Chung, 2010; Carrington, Shepherd, Jianghong, & Zubrick, 2012, p. 108).

There is slow, growing understanding among non-Indigenous Australians of the urgency and significance of the need for a shift in paradigms that can be achieved only with the full inclusion of Indigenous peoples in the country's governance. A newspaper editorial in response to the release of the Prime Minister's Closing the Gap report in 2017 assigns responsibility for the limited progress toward achieving its targets to the people and structures responsible for the governance of the country, and to non-Indigenous citizens. The editorial identified

‘lack of political will and funding; the complexity and range of actions needed to eliminate the inequalities and the lack of ready solutions; White Australians’ refusal to engage with the history of dispossession, theft, and genocide; racism and the indifference of the Australian community to Indigenous disadvantage’ (The Editor, 2017, p. 14).

In summary, using a framework such as Daigneault's to construct and critically appraise policy options makes it possible to see the relationship between underlying theories and perspectives on social justice, causality and the role of the state and public policy decisions. The worldviews and cognitive beliefs of the actors responsible for the paradigms matter. The integration of paradigms into the standard operating procedures, values and norms of institutions matters.

All the events (public policies) in the actual domain that have together resulted in the persistence of the social phenomenon that is the subject of this thesis are therefore individually and together outcomes of policy ideas. They are based on the normative beliefs



of policy actors from a dominant cultural perspective, amplified and shaped by the norms, rules and values of the institutions through which policy ideas are selected for inclusion on the public policy agenda, framed, debated and adopted. In the Australian context, the policies are an outcome of the exercise of political power and authority through institutions dominated by the perspectives and interests of one cultural group to the exclusion of the other.

The enforced exclusion of Indigenous peoples from the political and social life of the nation for over two centuries is both an outcome of pre-existing worldviews brought to Australia by the British colonists, and a cause of the worldviews of their descendants. In Chapter Six I describe the perspectives of philosophers in the post enlightenment, western liberal democratic tradition on what constitutes social justice, and ideological and value preferences, on causality (of social problems) and on the obligations of the state or society to remedy social problems. Differences in the theoretical and ideological preferences are described, and their implications are critically appraised.

## **Chapter Six. Worldviews on what constitutes a good life and social justice**

In this chapter I explore foundational ideas about a good life, social justice, preferred ideologies and values and differences in perspective on these ideas that inform the normative beliefs of policy actors. The chapter closes with a critical analysis of the impact of cultural dominance of the worldviews of policy actors about what constitutes a good life and social justice on public policies. Through the filter of their own worldviews, policy actors select social problems for inclusion on the public policy agenda and frame debate on policy goals and strategies, and select preferred policy instruments.

The focus in this chapter is on identifying core elements of worldviews of the cultural group that has been dominant in Australia since invasion and colonisation to identify normative beliefs that are rarely transparent but that shape all policy decisions across postinvasion history.

Some people's worldviews take for granted the view that inequalities in health are a social problem, that they are inherently unfair and unjust and that it is a social and state responsibility to act to reduce or preferably eliminate them. However, that worldview is disputed by others who draw on different theories of social justice that mean that they do not necessarily assume that inequalities in health are cause for social concern.

For people whose worldview includes seeing inequalities in health as a social problem that inherently merits a response by the state and society, it is challenging to learn that this is not a universally held perspective. Whether inequalities (in health or in the distribution of any

other social resource or opportunity) constitute a social problem is a choice: the decision to act or not is a choice; the decision of when to act is a choice; the decision as to who is to act is a choice; and the decision as to what actions are to be taken is a choice. In short, inequalities in health are not inherently a trigger for action on the part of social institutions and there are wide differences in worldviews on what actions can and should be taken and by whom. Worldviews can be invisible to those who hold them. The sections that follow describe differences in thinking about inequalities in health and their causes.

(Kawachi et al., 2002, p. 648) describe the distinction between distributions of health in populations that are unequal and those that are inequitable.

The crux of the distinction between inequality and inequity is that the identification of health inequities entails normative judgment premised upon (a) one's theories of justice; (b) one's theories of society; and (c) one's reasoning underlying the genesis of health inequalities.

In the sections that follow I describe different theories of social justice (and embedded constructs) that constitute normative beliefs (worldviews) that influence the decisions of policy actors. In this section the theories of social justice are assumed to be normative ideas that form the worldviews of individual policy actors, and that shape the policy paradigms of social institutions. The worldviews (including cultural beliefs) of predecessors are reflected in the institutional arrangements, standard operating procedures, rules and cultural norms of institutions, carried across generations.

## **Theories of social justice**

Theories of justice and causality shape the decisions of institutions, policy actors and citizens about the causes of inequalities in life expectancy and health and appropriate remedies for

these inequalities. Different theories of justice have differing implications for the duties and obligations of the state, its institutions and its actors (Ruger, 2006, p. 98). Deeply entrenched ideas about how governments should respond prevail in the field of public policy (P.-M. Daigneault, 2014, p. 1).

Policy actors frame causes and consequences in terms of their underlying worldview, including what is accepted as evidence about what will work. The interpretation of social justice which is being used to inform policy formulation is rarely implicit, despite the fact that different theoretical positions can have significant influence on decisions about what is considered to be a fair distribution of social resources and the state's role in maximising personal agency (O'Sullivan, 2011b, p. 692). Although many public health policy makers, researchers and practitioners assume that social justice is a foundational principle of modern welfare societies, there is wide variation in theories of social justice.

The principle of equal dignity and respect is now accepted as a minimum standard throughout mainstream Western culture – a value to which most people (at least in those countries where citizens' views are known, including Australia) ascribe – the view that all people are born equal and have equal rights to live in states that foster and protect liberty and freedom (Kymlicka, 2002, p. 1).

Any theory of justice in the contemporary world could not have any plausibility if it did not value equality in some space (Sen, 1991).

However, all theories of social justice turn on the answers to the questions 'equality of what?' and 'equity in what form?' (Sen, 2010, p. 58). What constitutes social justice and equality are in practice choices, and 'within any given context the populations concerned must (and do) decide on what are to be the subjects of social justice, on what is considered to be equality, and how it is to be achieved (D. Miller, 1999, p. 7). Sen argues that for populations and

nations, health is among the most important considerations of human life. He believes that any conception of social justice is bound to include consideration of the distribution of opportunities that persons and populations have to achieve good health. For Sen, one of the most serious violations of social justice is the lack of opportunity that some may have to achieve good health because of inadequate social arrangements (Sen, 2010, p. 59). Although most Australians might agree in principle with Sen, the unequal distribution of wealth, and other material resources of health and life expectancy and of political power and authority points to there being significant variations in practice.

The section that follows describes different theories of social justice and the impact of these on the decisions of policy actors.

On the basis of the findings of a recent systematic review of the literature some authors defined social justice as

the full participation in society and the balancing of benefits and burdens by all citizens, resulting in equitable living and a just ordering of society. Its attributes include: fairness; equity in the distribution of power, resources and processes that affect the sufficiency of the social determinants of health; just institutions, systems, structures, policies, and processes; equity in human development, rights and sustainability; and sufficiency of wellbeing (Buettner-Schmidt & Lobo, 2012, p. 948).

However, this definition is based on a Rawlsian theory of societies' obligations to their citizens in relation to equality and social justice (Rawls, 1971). Another political philosopher presents a different theory of social justice, the application of which leads to significantly different decisions on the aims of public policies and about the strategies to achieve them. Each is quite different in its views on its aims and on the strategies to achieve these aims.

Rawls argues that a socially just distribution of social resources has been achieved when (1) a fair process for the distribution is in place; and (2) when the benefits of that distribution are fairly and justly distributed, that is, when people at the lowest point in society are not harmed by inequality, and when all people have access to the resources they need to live with self-respect. Rawls' theory of justice reflects an egalitarian ideology favouring distributive policies that guarantee everyone some access to socially created resources (Stone, 2002, p. 59). Rawls argues, in other words, for substantive fairness as the measure of social justice. Nozick on the other hand, adopts a libertarian position, arguing that a distribution of social resources is socially just if it comes about by a voluntary and fair process that does not violate legal rules of society. In other words, he argues that social justice has been achieved when procedural fairness has been implemented. In his view, liberty is the 'freedom to use and dispose of one's resources as one wishes without interference.' From this perspective, property owned by individuals is a reward for effort, and material deprivation is regarded as necessary to stimulate individuals to work (Stone, 2002, p. 57).

Each of these perspectives on social justice implies very significant differences in the limits of societies' obligations to their citizens. Some of the profound consequences of difference in belief about what is considered to be socially just social treatment, about the obligations of the state, and about the values given priority in setting policy goals, and in deciding upon policy instruments can be illustrated by analysis of the earliest decisions of the colonisers of Australia.

The seizure of Aboriginal and Torres Strait Islander (hereafter referred to as Indigenous) land by the British was, under British law, legal and, thus would meet Nozick's criterion of procedural fairness. Nozick's definition does not consider that the laws were in this context unjust. Nor does he consider the possibility that the law or rules may change over time; what

is considered to be procedurally fair in one context may not be in another. The act of seizing Indigenous land may have been legal, but would not fulfil Rawls' criteria of distributive fairness whereby the benefits should be fairly distributed so that people at the lowest point in society would not be harmed by inequality. Even this simple analysis exposes the powerful impact that different theories of social justice have on decisions about what constitutes fair and just social treatment.

From the earliest decisions upon which the postinvasion Australian state was founded the worldviews of the British invaders and colonisers about social justice denied Indigenous peoples from having any part in deciding the legal (and ultimately, the constitutional) foundations of the state. What is now identified as Nozick's libertarian perspective on social justice predominated. The Mabo decision in the late 20<sup>th</sup> century found the philosophical and legal base upon which the colonisation of Australia had been justified by the British to be invalid. However, the worldview of Indigenous peoples is shaped by a Rawlsian perspective of social justice, so that in the 21<sup>st</sup> century they are seeking constitutional recognition, sovereignty and legal rights of full, self-determining participation in the governance of their country. This perspective on social justice is that upon which the postinvasion Australian state was founded but that was denied to Indigenous peoples.

In contemporary Australia there continue to be tensions between the foundational ideas of procedural fairness and substantive fairness as measures of a social justice. The arguments being used to frame current policy ideas seeking constitutional and full participation in governance for Indigenous Australians are still being shaped by these foundational views of social justice. On the one hand, there are arguments that procedural fairness will be achieved by applying the same laws and rules to everyone without reference to race or differences in starting point (the playing field). On the other hand, there are arguments that substantive

fairness can be achieved only when there is recognition of and appropriate action about what is sufficient to meet differential starting points.

### **Preferred ideologies**

Three ideologies have exercised considerable influence over the decisions of policy actors in the past and over contemporary public policies in the Australian context. Utilitarianism and egalitarianism are moral theories expressing a view of what constitutes a good society; neoliberalism is an economic theory that takes the view that there is no society beyond individuals. Each of these ideologies has been and continues to be influential in shaping policy discourses and in determining the policy paradigms adopted by political parties and the governments they form, and by all social institutions engaged in governance.

*Utilitarianism* is concerned with maximising the overall wellbeing of populations but is not concerned about distributional differences. Inequities in the distribution of social resources is not a trigger for a social response. As long as the average health (or life expectancy) of a population increases, it is of little or no concern whether the greatest benefits have been accrued by poor or rich people (Peter, 2010, p. 75). The priority value associated with this ideology is efficiency.

*Egalitarianism* is based on a belief that while it is impossible to distribute all social resources equally in a society, or to achieve equal outcomes in, say, life expectancy, all persons should, as far as possible, be given access to the opportunities society can provide to enable them to achieve equitable health, social and economic status (Peter, 2010, p. 76). The intended outcome is improvement overall, but especially for those who are initially least well off. Society is obliged to ensure that everyone has the opportunities they need to achieve equitable health and life expectancy outcomes. The priority value associated with this ideology is equality.



*Neoliberalism* began as a laissez-faire liberal economic model that has no substantive social goal. From this perspective, a socially just state provides conditions within which individuals can compete to maximise personal benefits. The priority values are efficiency and liberty. Those who believe in neoliberalism as a social theory (rather than just as an economic theory) see society as having no obligation to assure social justice for its citizens.

The influence of these ideologies changes over time. During an era in which egalitarianism was the more dominant ideological driver of policy paradigms in the UK, there was progress toward the achievement of substantive justice in the distribution of all socioeconomic resources by the mid 20<sup>th</sup> century in high income countries (Atkinson, 2015, pp. 54-81). However, public policy in the 21<sup>st</sup> century has been dominated increasingly by neoliberal ideology and the view that distributive and substantive justice are neither social goals nor social responsibilities (Atkinson, 2015, pp. 123-132). However, others point out that although inequalities in health have persisted (and are, in some countries, growing), this condition is of little concern to those whose worldview includes a belief in neoliberal ideology (Escudero, 2009; Raphael, 2012b; Scott-Samuel & Smith, 2015).

In summary, different ideologies frame the perspectives of social institutions and policy actors about the limits of their responsibilities to their constituents and to society. Although rarely articulated, ideological positions reflect views of a good society that have very different implications for actions to reduce or eliminate inequalities in health. Only one of the three ideologies reflects any moral concern about such inequalities and accepts that it is a social and state responsibility to take action to redress them. The ideologies are significantly different platforms upon which public policy decisions are made about whether, when and how societies, through their institutions and agents, should act to resolve a social problem such as inequalities in health, and what actions they take.

However, not all inequalities in health are avoidable, and, depending upon the criteria used, not all are unjust or unfair. Even if substantive justice and egalitarianism do form the ideological platform upon which the decisions of policy actors are based, there are further choices about the criteria used to decide when and how to act.

### **Equality and equity: what constitute socially just policy outcomes?**

Equality is a description of the distribution of phenomena in a society. Equality in different forms is a defining feature of modern political thought (Heywood, 2000, p. 128) embedded in all modern theories of what makes a just or free or good society (Kymlicka, 2002, p. 3). The view that ‘all citizens are entitled to equal concern and respect’ and that ‘the interests of each member of the community matter and matter equally’ does not however resolve the question of the social, economic and political conditions under which citizens are considered to have been treated as equal (Kymlicka, 2002, p. 4).

‘Science alone cannot determine which inequalities are also inequitable, nor what proportion of an observed inequality is unjust or unfair’ (Kawachi et al., 2002, p. 648). The judgement as to when inequalities are unfair and unjust depends upon who decides, bring into play their preferred theory of social justice and their preferred ideological platform (Kawachi et al. (2002, p. 648).

Heywood (2000, p. 128) developed a typology of equality, reflecting different views on the social, economic and political conditions that would constitute equal social treatment.

*Foundational equality* – the belief that humans are born equal, and that their lives are of equal moral value.

*Formal equality* – the formal rights and entitlements of individuals in a society. Its clearest expression is in the form of equality before the law, and it includes political

equality expressed as universal suffrage, one person, one vote, and one vote is equal to one value.

*Equality of opportunity* – the belief that all humans should have the same starting point or equal life chances. Within this belief, people distinguish between inequalities that arise from unequal social treatment and those that arise from an unequal distribution of merit, talent and willingness to work.

*Equality of outcome* – the equal distribution of rewards that can include social equality, and the equal distribution of income, wealth and other social goods.

Heywood's hierarchy reflects differences in the ideologies discussed in the previous section. Each of the categories in the hierarchy reflects a perspective of the implied limit of a socially just society's obligation to its citizens.

The decisions of policy actors, institutions, and citizens about who gets what, about the equality (or inequality) of the resulting distribution, and about the fairness and justice of the distribution (Sen, 2010, p. 58) are based upon the causal theories to which they assign greatest explanatory power. If the causes of inequalities in health are believed to be wholly or predominantly naturally occurring, or if they are an outcome of individuals' personal choices they are not considered to be avoidable or the responsibility of the state or society.

Whitehead (1992, p. 5) differentiates between inequalities in health that have different causes. Whitehead suggests that the first three examples of inequalities in health in the framework below may be considered to be unfair but are not necessarily unjust because they arise from sources that are unmodifiable, or that may be tolerable to individuals and society:

1. natural biological variation

2. health damaging behaviour if freely chosen, such as participation in certain sports and pastimes
3. the transient health advantage of one social group over another when that group is first to adopt a health promoting behaviour (as long as other groups have the means to catch up fairly soon).

However, she adds three examples of inequalities in health that may be considered to be both unfair and unjust because they are socially produced – that is, they are arising from differences in social treatment that are avoidable and morally intolerable. Inequalities arising from these three sources can be considered to be unfair, unjust, and inequitable.

4. health damaging behaviour where the degree of choice of lifestyle is severely restricted
5. exposure to unhealthy, stressful, living and working conditions
6. inadequate access to essential health and other public services.

Whitehead added a 7<sup>th</sup> source of inequalities in health arising as a consequence of illness or injury, pointing out that the availability of health care and social support are also determinants of long-term health outcomes of illness or injury.

Within this extensive review of Eurocentric perspectives on social justice, and the ideologies, values, views on causality and the role of the state, there is no acknowledgment of assumptions about the broad political and social context within which the questions ‘of who gets what, how much, and when’ are being asked and answered. There is no reference to colonialist societies in which the subordinated social group was systematically excluded from both the institutions and the processes through which decisions about whether, and when, and how to act to remedy inequalities in health.

There can be no single, unchallengeable answer to the questions of what constitutes a good life, a socially just society, or when social treatment is unfair or unjust, or about what are considered to be the limits of the obligations of governments and other social institutions to citizens in a socially just society. Differences in the responses to these questions are shaped by worldviews that, in Australia, as a colonised nation, include significant racial biases, negative stereotyping, and the normalisation of a colonialised view of what constitutes a fair, just society.

The theories and perspectives described in this chapter are those of Eurocentric philosophers and researchers, beginning with views on what constitutes a good life, and moving to explore differences in theories of social justice, of equality and equity, of causality and the consequence obligations of the state or society. That these views are significantly different from those of Indigenous peoples both at the time of invasion and in contemporary Australia may seem to be a statement of the obvious. However, there are profound differences in the power and authority available to Indigenous and non-Indigenous Australians to assert their worldview on public policy.

## **Cultural dominance of decisions about a good life, social justice and equity**

Before invasion Indigenous peoples had manifestly identified the elements of a good life. Their understanding of the concept would have been different in different communities and locations, different at different times in the 60 000 years of continuous civilisation, and different as social mores and circumstances required. The breadth of the difference in understanding of what constitutes a good life, of what constitutes social justice, of what constitutes equal (or equitable) social treatment, and of the obligations of society to ensure

socially just social treatment of its members is significant. However, the differences were rendered invisible by the colonisers.

Since their first intrusive gaze, colonising cultures have had a preoccupation observing, analysing, studying, classifying and labelling Aborigines and Aboriginality. Under that gaze, Aboriginality changed from being a daily practice to being ‘a problem to be solved’ (Dodson & Smith, 2003, p. 27).

The colonisers regarded Indigenous peoples as less than human, as having no sovereign rights and as being vulnerable to diseases. This belief gave rise to the doomed race theory (Wolfe, 1999), obviating the need for concern on the part of the state for remedial action. Instead, viewing Indigenous peoples as inferior and problematic, the colonisers regarded themselves as a superior race taking up an empty and untilled land (Reynolds, 1987). That worldview provided justification for the deconstruction of Indigenous cultures with the consequent devastating impact on the lives, health and life expectancy of the peoples. Implicit in the worldview of the colonisers was the prejudicial belief in a biological hierarchy between different racial groups, and in Australia the view that Indigenous peoples were members of a dying race. Pascoe quotes Sturt’s (1849) observation that ‘I have to regret that the progress of civilized man into an uncivilized region is almost invariably attended with misfortune to its original inhabitants’ (Pascoe, 2014, p. 140).

For the colonists, settlers, and their descendants the development of the postinvasion Australian state saw ongoing social and economic progress – fulfilling their views on what constituted a good life, social justice and equitable social treatment. Indigenous Australians’ views about these same questions were considered to be of no consequence.

In the late 20<sup>th</sup> century, as evidence emerged of the relationship between health behaviours and, in particular, the incidence and prevalence of chronic diseases in populations, the

explanation of the causes of inequalities being freely chosen behaviours and culturally or peer-driven choices was applied to both Indigenous and non-Indigenous Australians.

Responsibility for the problem and hence for the responses to the problem lies with the individuals making the unhealthy choices. The perspective that inequalities in health arise from poor choices freely made by individuals is not confined to Indigenous peoples alone. However, that assumption of causality has continued to drive governments' perspectives on Indigenous health policies into the 21<sup>st</sup> century.

The explanation of the normative beliefs described in this chapter points to the priorities and preferences of the colonisers and their descendants in relation to the social resources and opportunities to which they assign the highest value, the ideological preferences that inform the distribution of these resources, and the means by which the distribution is executed. The reality was that Europeans exerted 'control over Aborigines' actions that they (Europeans) required ...to gain access to the land (Grant, 2016a; Pascoe, 2014, p. 131). When the theories of social justice and the utilitarian ideology that were central to the colonisers' worldviews are combined with racial prejudices that become codified through the colonisation of one cultural group by the other, it becomes possible to understand how the worldviews of the invaders, colonisers and settlers had catastrophic consequences for Indigenous peoples. Their worldviews, cognitive beliefs and the societies to which they had given rise over 60 000 years were swept aside in the conflict, violence and systematic deconstruction of cultures, systems and structures by what became the dominant cultural group.

Indigenous theories of social justice, values and ideological preferences, their intellectual, social and economic traditions were, at the point of first contact with the British, widely different from those of the colonisers; differences in what constitutes a socially just society, in the preferred ideology and priority value determining social goals, and in the role of the

state or collective in remedying social problems were all significant. The worldviews and cognitive beliefs had evolved to meet changing environmental, social and economic circumstances, and over the 60 000 years of continuous civilisation demonstrated the skill with which they adapted. And, since invasion and over the following almost 240 years, Indigenous peoples' worldviews have continued to evolve (Grant, 2019) in further expressions of the resilience, strengths and skills derived from the cultures, traditions and structures that had been developed and inherited across millennia.

Racism and colonisation, however, saw the exclusion of Indigenous worldviews on social justice from any consideration by the colonisers. The philosophical ideas that were used by the British to justify the extinguishment of the sovereign rights of First Peoples, to justify the occupation of the land and the dispossession of its owners without compensation were also used as justification to deny the very existence of Indigenous peoples as humans. With these worldviews, the invaders, colonisers and settlers over successive generations colonised a nation, establishing the institutions with responsibility for governance, excluding Indigenous peoples from representation in the processes, and actively denying any participation as policy actors. The racism and colonialism that lay at the core of the worldviews became embedded in the institutions and the worldviews of the people responsible for the governance of the nation.



## Chapter Seven. Worldviews on racism and colonialism

The philosophical underpinnings of colonisation ‘provided the means by which concepts of what counts as human could be applied systematically as a form of classification (Tuhiwai-Smith, 1999, p. 25), used through political action and informed by science ‘to shape relations between imperial powers and Indigenous societies’ (Sherwood, 2013, p. 31; Tuhiwai-Smith, 1999, p. 25).

Captain Arthur Phillip, the first Governor and founder of the British penal colony in Australia, was instructed to make peace with Aboriginal and Torres Strait Islander (hereafter referred to as Indigenous in this chapter) peoples (Clendinnen, 2003). That instruction was soon swept aside as the British took the land and resources, and moved ‘to wage a war of extermination’ on Indigenous peoples (Grant, 2019, p. 24).

In the ten years that followed the arrival of Governor Phillip and the first colonisers of Australia at Sydney Cove it is estimated that the Indigenous population of Australia was reduced by 90% (J. Harris, 2003). In 1837 a Wesleyan Missionary described, hauntingly, some of the consequences of colonisation for Indigenous peoples and nations:

The Government is fast disposing of the land occupied by the natives from time immemorial. In addition to which settlers under the sanction of government may establish themselves in any part of this extensive territory and since the introduction of the numerous flocks and herds. . . a serious loss has been sustained by the natives without an equivalent being rendered. Their territory is not only invaded, but their game is driven back, their marnong and other valuable roots are eaten by the white

man's sheep and their deprivation, abuse and miseries are daily increasing (Tuckfield, 1837, pp. 138-140, 152) .

The depth and extent of the destruction wrought upon Indigenous peoples reached into every aspect of their cultures and the consequences reach across generations: the extinguishment of rights, the theft of the land and resources, the displacement of peoples off their lands, the removal of children from their families (Grant, 2019; K. Griffiths et al., 2016; Human Rights and Equal Opportunity Commission, 1997; Johnston, 1991; Paradies, 2016).

In Australia between 1850 and 1910 European imperialism, slavery and colonial rule over Indigenous peoples created the conditions for the proliferation of social Darwinist beliefs – so-called scientific racism that was used to legitimise, for example, government policies such as the forced removal of Indigenous children from their families and communities (Agoustinos, 2013, p. 2).

Racist assumptions about Indigenous peoples, societies, knowledges and worldviews carried in the worldviews of Australia's colonisers and settlers were used as justification for the discriminatory treatment by the state and society (Paradies, 2016, p. 2). The early beliefs translated into racial subordination and prejudice that were translated in public policies into the unequal distributions of power, resources, capacities and opportunities to Indigenous peoples and nations that have continued into the 21<sup>st</sup> century.

As was true in all colonised nations, racism became codified in the institutions, laws and social norms of the Australian state, and became normalised in the worldviews of the citizenry, intertwined with colonialism to generate the unequal distribution of social resources and opportunities that continue to result in inequalities in the health and life expectancy of Indigenous Australians (Braveman, Krieger, & Lynch, 2000; K. Griffiths et al.,

2016; C. P. Jones, 2000; Paradies, 2016; Sherwood, 2013; Vickery, Faulkhead, Adams, & Clarke, 2007; M. Williams, 1998).

## **Racism**

Having been viewed by some theorists as being a characteristic of the psychology of individuals, racism is now widely recognised as having political and structural determinants that manifest as intergroup hostility. Central to racism is the ability of dominant groups to systematically exercise power over out-groups. The power one group has over another transforms prejudice into racism and links individual prejudice with broader social practices, that is, with structural and cultural contexts within institutions responsible for governance and the worldviews and cognitive beliefs of their agents (Bailey et al., 2017; C. P. Jones, 2000; Paradies et al., 2015; D. Williams & Mohammed, 2013).

Central to racism is the ability of dominant groups to systematically exercise power over out-groups. The power one group has over another transforms racial prejudice into racism and links individual prejudice with broader social practices (J. M. Jones, 1997).

Although there is evidence that in contemporary western liberal democracies it is less openly acceptable to white majority group members to express blunt, hostile, supremacist beliefs on the grounds of race, racial attitudes have become complex and contradictory. Liberal egalitarian values emphasising equality and social justice co-exist with a residual set of negative feelings and beliefs about particular groups (Gaertner & Dovidio, 1986). The reluctance to acknowledge the co-existence of racist feelings and beliefs with liberal egalitarian values is evident in the lack of routine reference to racism as a social determinant in many contemporary theoretical explanations of the genesis of inequalities in health. Despite the large body of evidence of the relationship between racism (including structural

racism) and health, there is also evidence of the resistance of ‘academics, policy makers, scientists, elected officials, and others responsible for defining and responding to the public discourse remain resistant to identify racism as a root cause of racial health inequities’ Bailey et al. (2017, p. 1453). In Australia, racism is intertwined with colonialism with its beliefs based on Eurocentric fields of social thought being transmitted through the ongoing social, political and cultural processes through which knowledge is generated (Cunneen & Rowe, 2014, p. 49) and through which the nation is governed.

## **Colonialism**

Colonialism is defined as ‘a form of domination that includes the forcible takeover of Indigenous peoples’ land, the exploitation of the land and the people, and ignoring the laws, customs and rights of the people’ (Australian Museum, 2015; Horvath, 1972). It is a practice of domination which involves the subjugation of one people to another over time (Kohn & Reddy, 2017). The multiple pathways by which the colonial experiences imposed upon Indigenous Australians have impacts on their health in the 21<sup>st</sup> century are well documented (K. Griffiths et al., 2016; Sherwood, 2013).

The institutions and policy actors responsible for the governance of the evolving colonialist state oversaw the implementation of policy paradigms characterised by conflict and violence (1788–1928), protectionism (1838–1970s), removal of children (1814 – 1980s), assimilation (1937-1969), self-determination (1972-1996) and intervention and apologies (1996-2010). Developing and using these paradigms, the colonial state developed public policies specifically to shape the lives, access to social resources and opportunities of Indigenous Australians (Sherwood, 2013, pp. 32-36). Those policy decisions are a product of the ways of thinking of the dominant social group about the Other, based on prejudices and stereotypes that deny humanity and ascribe subordinate value and status not only to individuals but to all

members of the group. The same thinking is used to justify the displacement and distancing of people from their land and resources, the destruction of people, cultures and languages, and the denial of participation in the political, social and economic life of the nation. The policies reflect a codified pattern of state-supported discrimination that has resulted in the systematic pattern of inequalities reported in the empirical domain.

Manifestly, the public policies through which the non-Indigenous population was separately governed for almost two centuries reflected the pursuit of the interests of the invaders, convicts, colonists, settlers and their descendants, with the opposite impact on health and access to social resources and opportunities. Although the early arrivals faced physical and social conditions that they experienced as harsh and challenging (Clendinnen, 2003) they brought guns, germs and steel (Diamond, 1998) that were devastating to the Indigenous peoples that had survived and thrived for more than 60 000 years (B. Griffiths, 2018). They brought worldviews and cognitive beliefs from a western liberal, democratic, industrialising nation that justified the invasion of the land and the brutal treatment and colonisation of the Indigenous peoples. They established institutions and processes for governance and enacted public policies that were based on their own cultural, social and economic beliefs, experiences and aspirations, that echoed their own social norms, and that served their own interests. The armed forces, colonists, convicts and settlers set up a nation state in which their own cultural group dominated the institutions and processes through which political power and authority were exercised, and reinforced that with the denial of any access to power and authority to Indigenous peoples.

While Indigenous peoples were denied full, equal rights of citizenship until the late 20<sup>th</sup> century, and continue to experience the greatest inequality in average life expectancy at birth of any indigenous population in a colonised state, for the non-Indigenous population, secure

in its rights, power and authority to control the distribution of social resources and opportunities, the same period of history has seen this group succeed in creating economic and social conditions that make the majority of its population among the wealthiest, longest-lived and happiest in the world in the 21<sup>st</sup> century. Although settler colonialism is now recognised as a determinant of indigenous ill health and disadvantage, ‘it is only recently that investigation has begun into the specific pathways by which colonialism and colonisation impact on the health of indigenous peoples’ (Paradies, 2016, p. 84).

### **Colonialism expressed through the discourse of Australian policy actors**

Aldrich et al (2007) conducted critical discourse analysis of the beliefs and values of Australian federal politicians who were responsible over the period 1971-2001 for the health of all Australians. The study is based on recognition that the statements of politicians communicate a view of Indigenous people that influences the public policy environment and the scope of policy thinking - the policy imagination - and therefore, health policy options of the time. The significance of having power to set policy agendas, to determine which policy ideas are selected for inclusion on the agendas, and to advocate directly for, and influence the translation of ideas into policies is illustrated in this and other studies (Aldrich, Zwi, and Short (2007) and Lewis (2006).

Aldrich traces this logic through the history of colonisation, seeing the denial of recognition as legitimate owners of the land, as citizens of the new nation, and the denial of direct representation in the structures and processes responsible for governance; in effect, the denial of political power). These denials became embedded in the legislative, policy and judicial spaces (including the actors) that were established in the colonies and ultimately in the federation of Australia. The consequences of the denials became embedded in the beliefs and values of both the settler society and of Indigenous people themselves.

Aldrich et al found four common principal discourses that characterise the ways in which politicians from different administrations describe Indigenous peoples: competence and capacity; control and responsibility; the ‘other’; and the ‘problem’. However, in speaking about policy options and responses, social democratic and conservative politicians framed each of the discourses differently. The researchers formulate a proposition that ‘if discourse and policy *were* related, discourse which communicated that Aboriginal and Torres Strait Islander individuals or communities were *not* competent to manage, had *not* taken responsibility and whose very ‘*difference*’ had caused problems this might lead to policy sometime later which limited structures and processes for autonomy for Aboriginal and Torres Strait Islander individuals or communities’ (Aldrich et al., 2007, p. 134).

Although the link between politicians’ public discourse and policy is rarely explicit, the discourse leading to the dismantling of the Aboriginal and Torres Strait Islander Commission (in 2004), and the discourse leading to the establishment of the so-called Northern Territory Emergency Response (NTER) (in 2007) do confirm Aldrich et al’s proposition. The discourse of incompetence, of irresponsibility and of difference was clearly significant, and, in the case of the NTER, the potential for health gain was limited by the very focus and scope of the policy and by its genesis (Australian Indigenous Doctors' Association & Centre for Health Equity Training Research and Evaluation, 2010). ‘It is highly probable that the discourses of the public policy environment shape policy emerging from that environment, and that those who participate in the discourse will influence policy content’ (Aldrich et al., 2007, p. 135). It is noteworthy that none of the politicians whose statements were analysed in the Aldrich study were Indigenous Australian, and that all the political discourses represent Indigenous peoples as ‘the other’ (Aldrich et al., 2007, p. 133). Even in the 21<sup>st</sup> century, universal and targeted public policies were being formulated without the formal inclusion of Indigenous policy actors. Aldrich’s study confirms the evidence that, through a combination

of conscious, deliberate, cognitive processes, and implicit (unconscious), effortless, automatic, evaluative processes (worldviews), humans normalise their views about another racial or social group (D. Williams & Mohammed, 2013, p. 1153) and transmit those views across generations. The discourses reflect the views of members of the dominant culture with, at best, limited knowledge of the lived experiences, aspirations and policy ideas of Indigenous constituents. The discourses represent a view of policy making that does not require Indigenous people to be present as peers. They represent a view of policy making that does not acknowledge the lack of respect that this continued denial of presence as policy actors conveys to Indigenous peoples. The policy actors convey, through their failure to include Indigenous representatives in policy making, the lack of intent to challenge and change their own world views, and the lack of value they place on the worldviews and cognitive beliefs of Indigenous Australians.

The shadows of history are long and their influence on the worldviews and cognitive beliefs of members of dominant cultural groups in contemporary generations are invisible unless we seek to look and to see.

The conception of Australia as *terra nullius* became deeply intertwined with the constructions of Indigenous Australians as inferior and problematic, necessitating the notion of a superior race taking up an empty and untilled land (Sherwood, 2013, p. 31).

The assignment of inferior status to Indigenous peoples by the British at the time of invasion and by subsequent settlers (M. Williams, 1998, p. 16) became codified in social structures, public policies, and social norms. The representation and constructional practices embedded within health policy and praxis remain a tyranny for Indigenous peoples (Guba & Lincoln, 1989).



‘The fundamental impact of settler colonialism on indigenous peoples is being recognised in public health discourses (although not, I would argue, in the dominant theoretical explanations of inequalities in health)’ (Czyzewski, 2011). Paradies recognises that although decolonisation, on its own, may not be a panacea for eliminating indigenous health disparities, there is strong evidence that actions to decolonise the structures and processes of governance to enhance cultural continuity do result in significantly improved health outcomes (Chandler & LaLonde, 1998; Crawford, 2014). Sherwood (2009), Cunneen and Rowe (2014) and Simpson (2004) argue for the decolonisation of the discourse that is embedded in the structures and in the worldviews of the majority of contemporary policy actors responsible for governance and for generating new knowledge in Australia.

Indigenous-defined priority policy goals, and recommended policy remedies for the historical and contemporary injustices that have such negative impact on health and longevity have long been available to governments and all social institutions. There have been ongoing demands for access to the resources necessary to ensure economic security, and to enable full participation in social life (Rowse, 2010). There have been continuing demands for and initiatives to build cultural valuing and respect and for the implementation of a process of authentic truth telling to overcome the silence about the nation’s history and its impact on the life expectancy, health and wellbeing of contemporary Indigenous Australians.

Responses of the state and other social institutions and from many non-Indigenous Australians to the ideas, evidence and demands have evolved in support of some of the demands and proposals, albeit slowly. Change occurs only over time, seemingly having to first overcome a tide of resistance. Public policy responses have, however, continued to reflect patterns of cultural subordination that began at first contact of the Indigenous peoples with the British and continued through the birth of the modern nation state of Australia.

That experience had been observed much earlier by Stanner who, commenting on the history of postinvasion Australia, saw the assumption of indigenous inferiority shackling the theories of Europeans to ideology: ‘our intellectuals were looking at a view from a window that was carefully placed to exclude a whole quadrant of the view’ (Stanner, 2010) in (Pascoe, 2014, p. 127).

For contemporary Indigenous Australians the legacies of a colonialist history live on. Perkins spoke of that legacy when he said:

We know we cannot live in the past, but the past lives with us (Perkins, 1975).

Others too, reflect on the impact of history on the lives of contemporary Australians.

It is a troubling business coming to terms with Australian history, both for Aboriginal people and non-Aboriginal people (Pearson, 1997).

If you are not Indigenous, it is impossible to really know what it is to carry this history in our bones, to live with the memory of wounds. I cannot deny that we are still strangers here (Grant, 2019, p. 245).

Australia’s embracing of Aboriginal heritage as part of national heritage has not, unfortunately, meant an end to treating Aboriginal culture as the Other of white Australian culture (Byrne, 1996, p. 100).

For non-Indigenous Australians it is necessary to recognise that ‘colonialisation shapes the contours of racialised health inequalities’ (Fu et al., 2015a, p. 223; Paradies, 2016). If it is to be possible to eliminate such inequalities it is necessary to look for and to see mechanisms through which political and social power and privilege are inherited and maintained in the 21<sup>st</sup> century (Fu et al., 2015b, p. 27).

Colonialism and racism together, were (and have continued to be) responsible for the exclusion of Indigenous Australians from the institutions responsible for the governance of Australians – and hence, from access to the power and authority necessary to shape public policies.

### **How do power and authority influence public policy?**

Lewis seeks to expose such mechanisms in her study of which social group had influence within health policy spaces in Australia. She evaluated which professional groups were the most powerful of the policy actors, based on the premise that ‘policy making is fundamentally shaped by actors who seek to use the resources at their disposal to have their concerns taken seriously’ (Lewis, 2006, p. 2125). Lewis explores the perceived power of the medical profession in the health policy space, asking which actors (individuals and groups) are regarded as influential in health policy and how health policy influence is structured in network terms. In Lewis’s study, influence was defined as ‘a demonstrated capacity to do one or more of the following: shape ideas about policy, initiate policy proposals, substantially change or veto others’ proposals, or substantially affect the implementation of policy in relation to health. Influential people are those who make a significant difference at one or more stages of the policy process’ (Lewis, 2006, p. 2129).

Lewis found that there is intense competition for power within the health policy space and that a single group is perceived as exercising by far the greatest influence. She mapped perceptions of influence among elites and showed that, in the health policy space, men with medical qualifications were powerfully connected through their positions and their work on committees and were considered to exercise the greatest influence on health policy, even if they were not working in formal high-level positions of authority. She pointed out the power of the relationships among those with medical degrees, and that “... the principle of

homophily suggests that it takes greater effort to forge ties with those with different resources and less shared sentiments, making it difficult for others to be seen as influential' (Lewis, 2006, p. 2134). For others seeking to participate in the formulation of health policy this situation presents a major barrier, particularly when there are few shared boundaries between networks, and few opportunities for outsider networks and their aspirations, goals and experiences to be included in the advocacy for, deliberations about, and implementation of effective health policy solutions. This lack of opportunity is of particular significance for Indigenous peoples who must overcome generations of negative discrimination, racism and stigmatisation in order to get into the room and who must then forge ties with other agents to enable them to exercise influence on the policies.

### **The relationship between racism, colonialism, institutions and the power to shape public policy**

The confidence in the superiority of their culture assumed by the colonisers and the western, liberal, democratic philosophies and theories (worldviews) that form the base of that culture was given expression in the institutions established in each of the colonies and, ultimately, in the nation state. The racial prejudices and stereotypes and the assumption of the subordinate value of Indigenous cultural traditions, knowledges, practices and aspirations were built in to the institutions, laws and social norms of the postinvasion nation state and into the worldviews of its policy actors and citizens. Power asymmetry between Indigenous and non-Indigenous Australians was expressed, reflected in and reinforced by actions of the state.

The differences in the normative beliefs of policy actors about what constitutes a good life and a socially just society and the embeddedness of these differences in the social institutions responsible for governance do explain a significant part of the persistent, systematic patterns of inequality experienced by Indigenous Australians in the 21<sup>st</sup> century. However, those

differences are activated only when combined with colonisation (and the assumption of dominance by one cultural group over another), racial prejudices (used as justification for the deconstruction of the subordinate cultural group's cultures and societies) and colonialisation.

Differences in the choices of theories of social justice, in ideologically-framed goals, in preferred priority values, in perspectives on causality, and in preferred policy instruments have a significant impact on distributive outcomes. Racism and colonialisation are further generative mechanisms, that, translated into public policies, contribute to the specific, particular inequalities experienced by Indigenous Australians. However, neither of these two broad explanations fully accounts for the genesis or persistence of the inequalities in average life expectancy at birth today between Indigenous and non-Indigenous Australians.

There is still a need to identify the mechanisms that join these two forms of injustice to create and perpetuate, across generations, between individuals and populations, the pattern of inequalities affecting a whole social group and in particular, a pattern of inequalities affecting Indigenous Australians. Implicit in the analyses of the roles of worldviews on social justice (and related ideas), and of colonisation, racism and colonialism as mechanisms that could plausibly be linked with the public policies that are resulting in the persistence of the systematic, routine inequalities experienced by Indigenous Australians is the control by the dominant cultural group of the institutions and of the selection of policy actors that have the political power and authority to govern. Exclusion from the institutions and from membership as policy actors denies Indigenous Australians access to selecting, framing and shaping public policies that design and deliver the social resources and opportunities that they need to survive and thrive. In addition, exclusion from participation is a powerful indicator of the subordinate value ascribed to Indigenous cultures by a dominant cultural group.

Political power and authority are, therefore, essential mechanisms through which to enable Indigenous peoples to identify, acquire access to and use the social resources and opportunities necessary to achieve and sustain optimal health and longevity. However, having political power and authority is, independently of its instrumental value, a social determinant of health. Participating as agents in all parts of society is a manifestation of autonomy, social respect, esteem and trust. It is the acknowledgment and acceptance of equal status and standing in a society. However, as discussed in Chapter Eight, that recognition cannot be conditional on assimilation into an unchallenged colonialist society (or institution) and its actors. Transformation from within is a necessary step: recognising and acting to reform the normative beliefs that blind non-Indigenous actors to their roles in perpetuating colonialism and racism is a vital pre-requisite to creating a shared future.

Indigenous peoples are also making their own, independent decisions about the future governance of the nation. Some are choosing to work from within existing social institutions to lead and guide their transformation. Others are seeking to create independent sources of power and authority to self-govern under the terms of treaties and sovereignty in a yet-to-be defined relationship with the Australian nation state as it is currently constituted.

## **Chapter Eight. How cultural differences in worldview and cognitive belief influence public policy**

When ideas are being selected for inclusion on the public policy agenda and when public policies are formulated the agents responsible for governance are, whether consciously or not, making decisions that have an impact on the lives and health of their constituents. The social determinants of health that are seen by policy actors and citizens depend upon what they are looking for; their interpretation of evidence of problems, of determinants and of preferred solutions also depend upon what they are looking for. Different people, with different worldviews recognise and give priority to different determinants of health. Different people give different priority to particular social determinants of health when developing (or advocating for) public policies that are intended to reduce inequalities in health (K. Smith & Kandlik Eltanani, 2014, p. 13).

‘If the culture of Aboriginal society is not given sufficient credence it is easy to misinterpret the achievements of those societies. The economic foundations of traditional society were inseparable from the philosophic and religious beliefs’ (Pascoe, 2014, pp. 125-126). If we are to attempt to understand Indigenous philosophy it has to begin with the profound obligation to land. Deborah Bird-Rose comments:

The state of the country, for instance, offers concrete evidence of the responsibility which the owners have been exercising. Responsibility is grave: there is no hiding in a conscious universe...the exercise of will in a situation where the choice to deny moral

action is to turn one's back on the cosmos and ultimately on one's self" (Pascoe, 2014, p. 127).

That there are profound differences in world views is unquestioned. There are, however, many myths about the nature of preinvasion Indigenous societies and cultures. Pascoe introduces some of the experiences upon which the worldviews of contemporary Indigenous Australians are formed.

Indigenous peoples 'built houses and dams, sowed, irrigated and tilled the land, altered the course of rivers, sewed clothes, and constructed a system of pan-continental government that generated peace and prosperity' (Pascoe, 2014).

'Songlines connected clans from one side of the country to another, bringing goods, art, news, ideas, technology and marriage partners to centres of exchange.

Expressions of anger, bitterness, betrayal, revenge and punishment were common and were governed by strict rules – governance was carried out by Elders who had completed complex trials of initiation' (Pascoe, 2014, p. 131).

Beneath it all 'lay the understanding of the relationship between people and the land – the life of the clan was devoted to continuance' (Pascoe, 2014, p. 145). 'Ways of living were based on land held in common, on sharing of cultural knowledge and development, and on social cohesion that allowed people to co-operate in all aspects of food procurement' (Pascoe, 2014, pp. 132,134).

From the time of invasion Indigenous Australians endured brutal, unjust, dehumanising social treatment, and, although modified, the rates of incarceration and of the suicide of young people are indicators of ongoing trauma in communities. However, building on the resistance, intelligence, skills and persistence of their forebears, and slow, hard-won shifts in public policies and the worldviews of some of the non-Indigenous citizenry, an increasing number



and proportion of Indigenous people are participating in and contributing to every aspect of Australian society. Through the shared experiences of recent decades they (and their forebears) exhibit strength and resilience, pride and inspiration and the capacity to survive and thrive against the odds. From the experience of growing up in Australia, leaders have emerged who form strong communities with a generous heart and a passion for change. But a recent anthology confirms that the experience of growing up Indigenous in Australia is still one of having been ‘viewed and treated as second-class citizens, and sometimes even worse than that’ (Grant, 2019; Heiss, 2018).

As was always the case, the Indigenous population is diverse, lives in widely differing environments and communities, and has had different experiences of invasion and colonisation, although all experienced the loss of language, of country, of ways of life, social networks and respect. There are, of course, wide variations in the views among Indigenous Australians about what actions are needed (and by whom) to ensure not only the survival but the thriving of current and future generations (Balaton-Chrimes & Stead, 2017; Davis, 2016a; Grant, 2019; K. Griffiths et al., 2016; Langton, 2016; Lucashenko, 2015; Pearson, 2011; G. Phillips, 2016; Sherwood, 2013; Yunupingu, 2016). The views of these leaders, researchers and activists and the views of multiple Indigenous peoples across all parts of society are the source of the leadership that is now required for the future to define and negotiate for and push and seize what is necessary. Indigenous leadership is needed to define the social primary goods (items) that they regard as essential to enable them to choose and lead lives they have reason to value.

In the section that follows, I again, focus on the worldviews and ideas of the colonisers and their successors in an effort to understand the influence of colonialisation on the

identification of mechanisms to explain the public policies that are producing persistent, systematic patterns of inequality.

Western political philosophers and social scientists have long described items they regard as essential to enable people to choose and to lead lives they have reason to value (Rawls, 1971; Sen, 2000), and to achieve self-actualisation (Maslow, 1954). Rawls (1971) describes social primary goods as things that are very important to all people and that are created, shaped, and distributed by social structures through political processes. Those primary goods Rawls proposes include basic rights and liberties (freedom of thought, liberty of conscience), political liberties, freedom of movement and free choice of occupation, the powers of offices and positions of responsibility, and income and wealth. However, Rawls views dignity and self-respect as central components of social justice. Dignity and self-respect means recognition by social institutions and living in a community where people stand in relations of equality to others (Del Savio & Mamei, 2015, pp. 52-53) from which citizens derive a sense of self-worth and the confidence to carry out their plans (Rawls, 1971). Therborn (2006, pp. 20-35) differentiates between vital items (life and health), existential items (freedom and respect) and economic resources (material and symbolic capabilities) as goods to which all citizens would have access in a socially just society. D. Miller (1999, p. 7) too, identifies material goods and advantages that, in his view, would be uniformly apportioned in a socially just society, such as money and commodities, property, jobs and offices, education, medical care, child benefits and child care, honours and prizes, personal security, housing, transportation and leisure opportunities. He also proposes a group of social goods that are necessary to societies but that are considered to be *disadvantages or burdens* to individuals. Interestingly, he recognises that the distribution of such disadvantages and burdens must also be regulated (equalised) if social justice is to be achieved. The disadvantages and burdens he

identifies are military service, hard, dangerous or degrading work, and care for elderly people.

Sen agrees with Rawls that a socially just society would not only guarantee people access to social primary goods, but argues that justice requires that all citizens have the capability to use the goods. He identifies five freedoms as comprising that capability: social, economic and political freedoms, transparency guarantees, and protective security (Sen, 2000, p. 10).

O'Hearn (2009) questions Sen's liberal economic perspective, pointing out that Sen is arguing that these freedoms are the necessary precursor to enabling individuals to acquire and distribute the social primary goods through the market, and is assuming that the freedoms accrue to individuals without reference to social and collective freedoms. In addition to primary social goods, freedoms, and recognition, Dahl (2006, pp. 9-10) identifies specific civil liberties and foundational rights and entitlements, equal social positions and opportunities, and economic rewards. He includes specific reference to equal political participation, to equal participation as peers in social arenas, and equal opportunities to access or acquire material resources to give the same starting point or life chances to all, in addition to the material, economic and existential items identified by others.

Taylor argues that that recognition of one's dignity and equal worth is an essential prerequisite for individuals (and, by extension, social or cultural groups) to be able to participate fully in their societies (C. Taylor, 1994, pp. 25-73). He argues that equal recognition can be achieved only when there are spaces in which to conduct the politics of difference so as to avoid the unintended consequence of enforcing minority groups to conform to the expectations of a dominant culture. The recognition should not, in Taylor's view, be contingent upon assimilation but should be based, instead, on recognition of equivalent value and status. Another philosopher believes that disrespect injures the positive

understanding of the self that is required for equal and meaningful engagement in social life, in ways that seriously endanger , the identity of human beings, just as infection with a disease endangers their physical life' (Honneth, 1996, p. 137).

Like Rawls and Taylor, Dahl argues that feelings 'are an inescapable part of the process of reasoning and deciding' on what constitutes a good life and a socially just society. Dahl (2006, p. 40) warns that although humans 'have an extraordinary capacity for reasoning, the way the capacity develops and is employed depends greatly on a person's own experience – on nurture, not nature'. That same caveat is arguably true of the marginalised groups in a colonialisised society.

There are powerful common threads through these philosophers' ideas about the social primary goods that are necessary to a good life (and that should be apportioned equally or equitably) in a socially just society. Each of these philosophers points to the need for access to foundational rights and entitlements, civil liberties and freedoms to choose (or not) to participate as peers in social arenas or in seeking powers of public office, and all identify material and economic resources that, in their view, are required by all in a socially just society. However, not all give significant weight to feelings as social primary goods. Dignity, respect and confidence are feelings that are engendered, in the view of Hegelian theorists (Balaton-Chrimes & Stead, 2017, p. 4), from reciprocal relationships of recognition of equal worth across time. Only Taylor appears to question who the recognisers are or who is doing the recognising. He points to the potential distortion of what can pass for recognition when there is a significant asymmetry of power between the parties that are engaged in recognising and those being recognised, in turn.

Two significant issues emerge from an analysis of the ideas of these philosophers about items to which all citizens require access in a socially just society to enable them to choose and lead

a life they have reason to value. The first is the assumption is that the good life is an individual's decision and resource. However, other philosophical and cultural traditions assume that a good life is a collective attribute and resource. A comparison of a western, Eurocentric definition of health and an Indigenous definition of health illustrates the difference clearly. The second is that foundational rights and civil liberties and entitlements, as well as mutual recognition (through a power-neutral interaction) across social and cultural groups (and between individuals) are essential mechanisms through which *feelings* of dignity, respect and self-realisation are generated, and that these are essential components of freedom and self-determination (and health) for individuals and for social groups and populations. Indigenous philosophers, critical scholars and leaders warn that contemporary policies of recognition of Indigenous Australians, being implemented in contemporary society and social institutions, may reproduce rather than challenge and transform, the distribution of power between Indigenous peoples and the settler state. The danger is that recognition can reproduce subordinate status being granted by an unchanged settler state. Removing the power asymmetry is a prerequisite to the formation of a reciprocal relationship between equals as distinct from the bestowal of acceptance by a dominant cultural group of a subordinate other. A further danger is that recognition may be granted conditional upon assimilation without recognition of the possibility of incommensurate difference and the potential for Indigenous sovereignty to co-exist with the settler state (Balaton-Chrimes & Stead, 2017, pp. 6-9). There are recent examples of that assumption on the part of policy actors in the Indigenous policy space.

Indigenous peoples may, in fact, decide that they do not need or want recognition from the Other under such terms, or may approach recognition with a wary but attentive attitude (Balaton-Chrimes & Stead, 2017, p. 14).

In a colonised nation such as Australia, governed by a dominant culture, items that are considered essential to a good life by both the Indigenous and non-Indigenous populations (such as constitutional recognition) have been inherited by the contemporary non-Indigenous population whose preferences are satisfied without their need to act (Dowding, 2016). The colonialist version of what constitutes a good life and social justice does not include freedom from racism among the foundational rights of citizens. It does not, either, acknowledge that a colonialist perspective assumes that the contemporary political community is inherently legitimate as an unchallengeable reality that has power to confer conditional recognition on the Other. The colonialist perspective also resists any suggestion of the need for recognition from the Other, or of the need for transformation of the conditions under which recognition can be conferred. The power asymmetry continues unabated, and the mechanisms responsible for causing the reproduction of injustices of the past go unremarked. Indigenous Australians have inherited institutions and actors with worldviews based on a pattern of state-sponsored discrimination that was set in motion in 1788, a ‘group-structured pattern of distributive and cultural inequality’ (M. Williams (1998, p. 17) that the evidence in the empirical domain confirms is being reproduced into the 21<sup>st</sup> century.

Critical analyses in this chapter and in Chapter Nine illuminate how rights and freedoms and feelings of dignity and respect (as a member of society) that are conveyed by having access to these rights can be taken for granted by those who have them. That another social group within their own society is being denied practical (as distinct from legal) access to the liberties and freedoms and to the capabilities required to use them is, to some people, impossible to imagine or accept. Others, who may accept the need, in principle, however, may assign a lower value to these rights, compared with access to material resources and opportunities to acquire and use them.

The worldviews of culturally dominant policy actors working in institutions that have established arrangements and standard operating procedures, based on colonialist (and racist) histories and on a procedural theory of social justice, are mechanisms through which public policies contribute to the persistence of the systematic patterns of inequality that are the subject of the inquiry in this research.

The clash of systems that began on 18 January 1788 challenged and changed Aboriginal societies forever. Once vibrant communities began to experience dramatic challenges and changes – socially, politically and culturally – which affected the equilibrium of Indigenous society and ultimately contributed to many of the health inequities that Indigenous people continue to experience today (Hearn & Wise, 2004, p. 314).

That clash of systems has never been resolved. The culturally dominant worldviews and cognitive beliefs that informed the foundations of the postinvasion Australian state (its institutions and its agents) have been reflected in the definition of health and in the identification of its determinants. In a further illustration of one nation, two societies, the section that follows describes and compares definitions of health and models explaining items and relationships among social determinants of health, comparing and contrasting models developed by Eurocentric and Indigenous researchers.

### **Definitions of health**

In 1946 the World Health Organization, in the preamble to its Constitution, defined health as ‘a state of complete, physical, mental and social well-being and not merely the absence of disease or infirmity’ (World Health Organization, 2014). This definition is still used extensively to guide public health policy decisions at global, national and local levels. The definition assumes that health is a characteristic of individuals.

In 1989 the Aboriginal National Health Strategy defined Indigenous health as the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total well-being of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life (National Aboriginal Community Controlled Health Organisation, 2006). The definition assumes that the health of individuals is interdependent with the health of the whole community.

In 2002 Milroy proposed a more culturally-nuanced description of Indigenous health and its determinants.

The dimensions of health include the biological or physical dimension, the psychological or emotional dimension, the social dimension, the spiritual dimension and finally but most importantly, the cultural dimension. Within each dimension there are additional layers to consider, including the historical context, the traditional and contemporary view as well as our gaps in knowledge. The potential solutions for healing and restoration of wellbeing come from considering additional factors encompassing issues at the coal face of symptom presentation and service delivery such as education and training, policy, the socio-political context and international perspective. We can only exist if firmly grounded and supported by our community and spirituality, whilst always reflecting back on culture in order to hold our head up high to grow and reach forward to the experiences life has waiting for us. The stories of our ancestors, the collective grief, as well as healing, begin from knowing where we have come from and where we are heading. From the Aboriginal perspective, carrying the past with you into the future is, as it should be. We are nothing if not for those who have been before, and the children of the future will look back and reflect



on us today. When we enable a person to restore all of the dimensions of their life, then we have achieved a great deal. When all of the dimensions are in balance, within the universe, we can break free of our shackles and truly dance through life. (Milroy, 2002, cited in Australian Indigenous Doctors Association and Centre for Health Equity, Training, Research and Evaluation, UNSW, 2010, p.ii).

This definition includes specific dimensions of health and adds the explanation of the significance of the past for the health of individuals and the community in the present and for the people who come after, carrying the past into the future.

Each of these definitions of health describes indicators that are used to measure health (or its absence) but there are significant differences between the WHO and the Indigenous definitions. The emphasis on the health of the community as a prerequisite for the health of individuals and the centrality of the past as a determinant of the present and future are highlighted in the prerequisite definitions. The WHO definition, emerging from western, liberal scientific ideas, gives much more limited weight to the collective and social context within which individuals' health is assessed. Nonetheless, western researchers and practitioners have identified multiple determinants of the health and longevity of individuals and populations, including individuals' genetic inheritance and personal behavioural choices but with growing emphasis on populations' access to socially produced and distributed resources and opportunities (World Health Organization, 2008). These latter, so-called, social determinants of health are the social, economic, environmental and political conditions into which people are born, and in which we grow, live, work and age. Among these social determinants are the social systems put in place to prevent and deal with illness. The differentiation between naturally occurring, personally chosen, and socially produced determinants of the health of individuals and institutions has required decades of research and

interdisciplinary understanding from many different social and scientific fields (Pedrana et al., 2016, pp. 8-9).

It has also taken decades to achieve scientific acceptance that there is a positive, systematic relationship between the distributions of socially-produced resources and opportunities and the distributions of health and life expectancy in groups and populations (World Health Organization, 2008). Arguably, in the wider social and political spheres there continues to be limited understanding and acceptance of the role of social decisions in the distribution of social resources and opportunities in determining the health of individuals and populations. Furthermore, it is proving to be challenging for the population health discipline to recognise that the items identified as social determinants of health at any given point in history may be different for different social groups within nations.

Arguably, thanks to the successes of public policies introduced over a century or more, the role of social, economic and environmental policies, the role of engineering and technological innovations, the role of population-wide literacy and of the universal services and programs and the significance of a political voice and self-organisation that had spread the benefits of innovations to whole populations became invisible to generations who benefitted without having experienced the prior conditions and without having taken part in achieving the changes.

From the late 20<sup>th</sup> century, however, growing evidence of inequalities in the health of populations in high-income, democratic nations saw the resurgence of a focus in the sociological and population health fields on identifying social determinants of health. In the 21<sup>st</sup> century an increasing range of socially produced and distributed items has been

identified.<sup>3</sup> They include material resources such as food, shelter and access to services and amenities such as telephones and the internet (Lynch & Kaplan, 2000). They include universal access to goods and services including education, employment, income, social protection, health care and transport; and they include living and working in environments that are peaceful, safe and sustainable. Having ready access to information and control of the means of its distribution has also been identified as a tangible determinant of health (Canadian Public Health Association/World Health Organization, 1986; Carson et al., 2007; C. P. Jones, 2000; Wilkinson & Marmot, 2003). Solar and Irwin (2010) updated earlier conceptual frameworks to differentiate between structural, social determinants of inequities in health and intermediary social determinants of health inequities (Figure 1) (Solar & Irwin, 2010, p. 6). There are multiple conceptual frameworks describing social determinants of health and relationships between them. Upon reflection, it is possible to distinguish between the worldviews and cognitive beliefs of the authors of the frameworks. Such frameworks are useful in describing ‘what’ are social determinants of health – and how they are related to one

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[https://www.google.com.au/search?q=who+conceptual+framework+on+social+determinants+of+health&biw=1364&bih=623&tbm=isch&imgil=rJEelFjY6zsA5M%253A%253B3YpL4-F\\_xRmzDM%253Bhttp%25253A%25252F%25252Fwww.cdc.gov%25252Fsocialdeterminants%25252FFAQ.html&source=iu&pf=m&fir=rJEelFjY6zsA5M%253A%252C3YpL4-F\\_xRmzDM%252C\\_&ved=0CEcQyjdqFQoTCPWTprGE7sYCFYOwlAod9j4Jxg&ei=5i2vVfWIO4Ph0gT2\\_aSwDA&usg=\\_\\_NFYfcGhTtHg3LzP08n4jpCzfjPA%3D#imgrc=\\_\\_&usg=\\_\\_NFYfcGhTtHg3LzP08n4jpCzfjPA%3D](https://www.google.com.au/search?q=who+conceptual+framework+on+social+determinants+of+health&biw=1364&bih=623&tbm=isch&imgil=rJEelFjY6zsA5M%253A%253B3YpL4-F_xRmzDM%253Bhttp%25253A%25252F%25252Fwww.cdc.gov%25252Fsocialdeterminants%25252FFAQ.html&source=iu&pf=m&fir=rJEelFjY6zsA5M%253A%252C3YpL4-F_xRmzDM%252C_&ved=0CEcQyjdqFQoTCPWTprGE7sYCFYOwlAod9j4Jxg&ei=5i2vVfWIO4Ph0gT2_aSwDA&usg=__NFYfcGhTtHg3LzP08n4jpCzfjPA%3D#imgrc=__&usg=__NFYfcGhTtHg3LzP08n4jpCzfjPA%3D) Accessed 22 September 2019.

another – but they do not describe ‘how’ the determinants are distributed – which is a vital question for those seeking to understand how inequalities in health arise.

Figure 1. WHO conceptual framework on the social determinants of health inequities

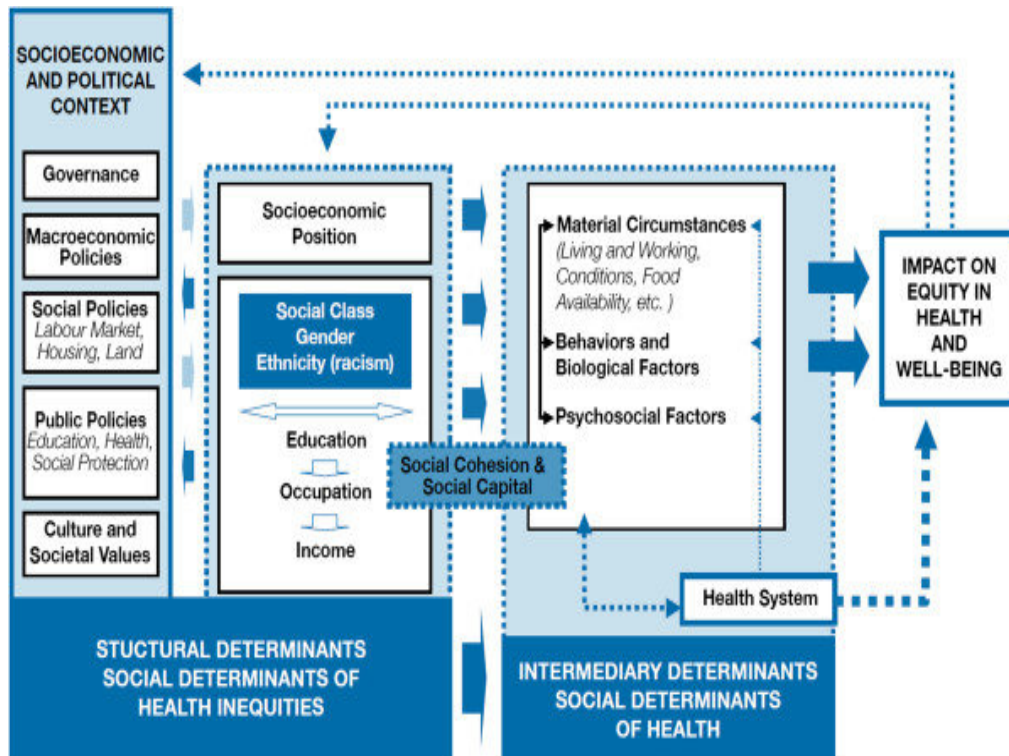
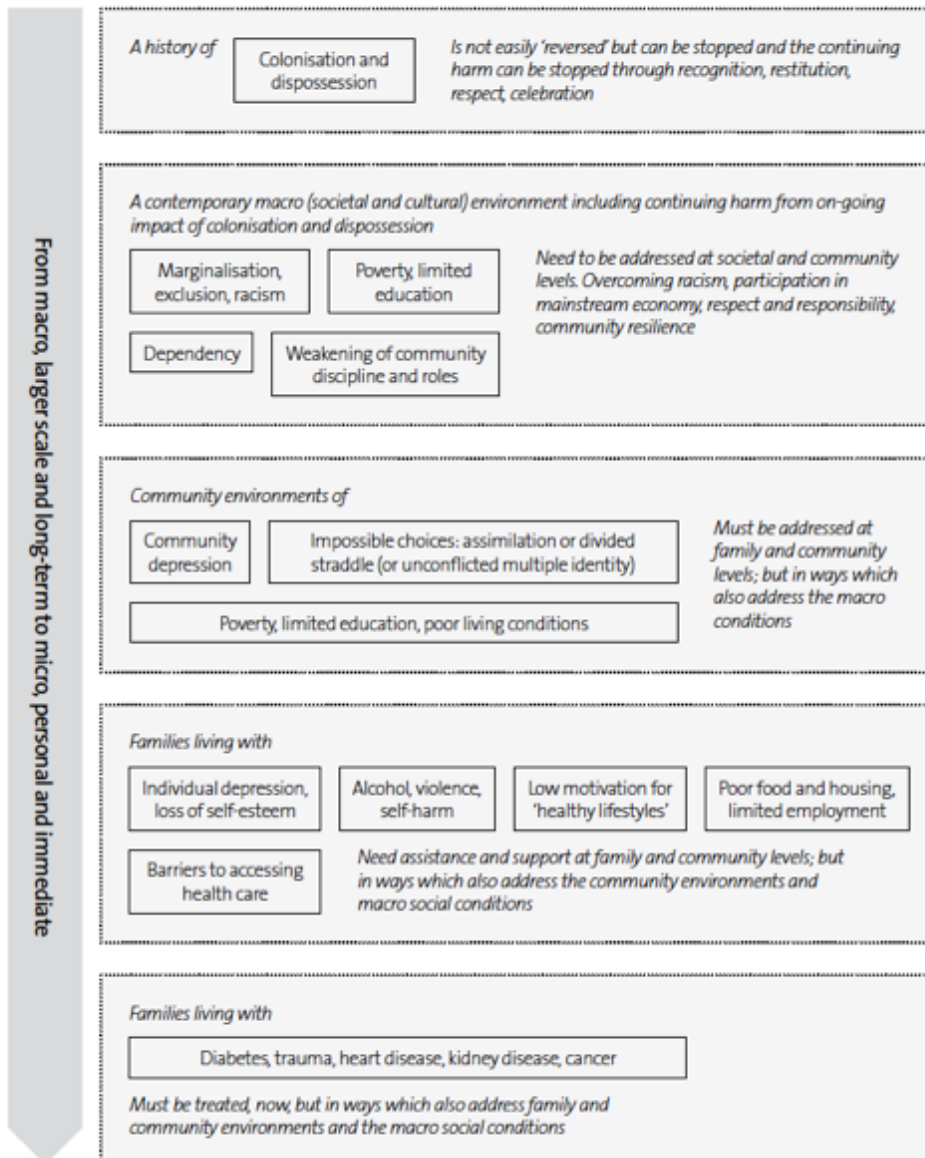


Figure 2. Causal pathways underlying Aboriginal and Torres Strait Islander health disadvantage: from macro and long-term to personal and immediate



In another conceptual framework an Indigenous researcher (and a non-Indigenous colleague) bring an Indigenous interpretation to determinants identified in the Solar and Irwin framework (Figure 2) (Fredericks & Legge., 2016). Comparing the two diagrams, it is possible to see how, in the Solar and Irwin framework, culture and societal values are identified but do not highlight the manifestations of these values in a country such as Australia where there are, in fact, two distinct cultures and two distinct sets of societal values: one set being those of the colonisers and their descendants (and the institutions through which they govern); the other set being those of the colonised peoples. Unless the Solar and Irwin framework is being interpreted by an Indigenous analyst the meaning of the context the authors describe is likely to be lost or, at least, misinterpreted. Or, in another example, Solar and Irwin distance the identification of feelings as psychosocial factors among other determinants of health, while Fredericks and Legge explain that the feelings include those associated with racism, marginalisation and social exclusion, in addition to the psychological stress of demands created by impossible choices between assimilation or divided straddling of two cultures.

Indigenous researchers, leaders and communities have long identified the roles of racism, colonisation and colonialism, the stigmatisation of their cultures, social and political exclusion, dispossession and dislocation from their lands, intergenerational trauma, and the lack of trustworthy governance as social determinants of their health (Cape York Institute for Policy & Leadership, 2005, p. 3; Carson et al., 2007; Davis, 2016b; Dodson, 2016; Fredericks & Legge., 2016, p. 21; Grant, 2016a; K. Griffiths et al., 2016; Mokak, 2016; National Congress of Australia's First Peoples, 2016; Pearson, 1997; G. Phillips, 2016; Sarra, 2016; Sherwood, 2013; Yunupingu, 2016). The United Nations Permanent Forum on Indigenous Issues (UNPFII) proposed indicators to use in measuring progress toward the wellbeing of indigenous peoples. These social determinants included security of rights to territories, lands

and natural resources; integrity of indigenous cultural heritage; measures to protect traditional production and subsistence; partnerships for development on issues relating to indigenous peoples including those intended to improve material wellbeing (including participation in development policy; and in policies, plans and programs to improve indigenous wellbeing) (Jordan et al., 2010). Carrington et al. (2012) explain the significance of the power of the dominant social group when there is such a divergence of interests in relation to contemporary public policy in Australia. The federal government's Closing the Gap initiative has the goal of closing the gaps in health and in access to its social determinants between non-Indigenous and Indigenous Australians within a generation (Australian Government Department of Families, 2009). The goal is important, indeed, urgent. However, the policy is predicated on the assumption that the relationship between increased access to education, housing, employment and income transfers on the one hand, and health outcomes on the other, operate similarly in Indigenous and non-Indigenous populations.

Carrington et al. (2012) argue that, if there is a weak association between any or all of these factors and health among Indigenous populations then government investment, though generally beneficial, is unlikely to result in a significant improvement in Indigenous population health or a substantial reduction in health inequalities between Indigenous and non-Indigenous peoples. If there are other salient drivers of the health of the Indigenous population that are not being addressed through contemporary public policies then it is likely that Indigenous people will be trapped in poor health and the policy expectation will be unachievable (Buttenheim et al., 2010; Carrington et al., 2012, p. 108).

There are other salient drivers of the health of Indigenous Australians arising from the historical separation of the two social groups that have lived in the same country but in two different societies. Even in contemporary Australia, the daily lived experiences of each of the

groups are still heavily influenced by their significantly different histories. Although we are all humans, and share the need for the same items to achieve and sustain optimum health, we do not share the same needs at the same point in history, and we may interpret the items differently. The differences cannot be resolved, either, by the dominant cultural group acting in the name of but with little reference to or overt respect for, the claims and expressed needs of the group it has subordinated for centuries.



## **Chapter Nine. An integrative theoretical framework**

To obtain a complete understanding of reality, a critical realist approach uses an inferential and generative research design that combines theoretical abstraction with empiricism (P. Harris, 2013; Sayer, 1992). After describing observable outcomes (life expectancy, health, behaviours and distributions of social items necessary for health) in the empirical domain, events in the actual domain were described. The events are public policies that, taken together are responsible for the systematic patterns of inequalities experienced by Indigenous Australians in comparison to all other Australians. Critical analysis of the public policies (in total) was undertaken to identify generalisable characteristics (key components) that apply across all the policies that could explain plausibly the relationship between events and the outcomes reported in the empirical domain.

In the next step the analysis moves to identify underlying generative mechanisms that could explain the relationship between events and the outcomes reported in the empirical domain. That is, they could contribute to the formulation of public policies that are resulting in the perpetuation of the systematic patterns of inequalities observed in the empirical domain.

New institutionalism as an organisational framework suggested institutions and policy actors as the key components of events. What, structures and powers are available to institutions and policy actors to be activated to influence public policies.

The theorisation of mechanisms begins with three propositions. The first is that it is axiomatic that the key components of events (structures and policy actors) have socially

mandated power and authority to formulate the public policies through which social resources and opportunities are distributed across the population. The structures are not only those of governments and their institutions – they also include institutions in the private, non-government and community sectors.

The second is that policy actors shape public policies directly – their decisions influenced both by the institutions they represent and by their own worldviews and cognitive beliefs.

The third is that institutions and policy actors have socially-mandated power and authority to shape public policies – including to decide who is eligible for inclusion in policy spaces.

The role of institutions in shaping public policies is theorised in three ways. First, through the institutional arrangements (that is, the mechanisms through which decisions are made about who is eligible to be included as a policy actors, about the process for selecting the actors, and the processes for formulating and adopting public policies. Second, through the development of policy paradigms that frame policy decisions, and the operationalisation of the paradigms in standard operating procedures– shaping the decisions of successive generations of policy actors. Third, through institutional culture: the rules, norms and values that both formally and informally shape the decisions of policy actors..

Aboriginal and Torres Strait Islander (hereafter referred to as Indigenous in this chapter) peoples and communities have established their own institutions through which to formulate public policies and design and deliver services. However, almost all the structures that are created by Indigenous political communities to demand, advocate and negotiate for the recognition, rights, resources and a self-determined, just, fair place in Australian society are largely accorded space only outside the policy making structures of governments and their institutions (Attwood, 2003; Rowse, 2010, p. 75).

The theorisation of mechanisms through which policy actors shape public policies is based on the proposition (and empirical evidence that) what the policy actors are thinking determines their actions.

The initial, postinvasion policy actors translated their beliefs about a good society, about social justice, and about the comparative value of their own and Indigenous cultures, into an organised system within Australia (Paradies et al., 2015, p. 2). ‘When British people looked at us, they saw us as something sub-human, and if we were human at all, we occupied the lowest rung on civilisation’s ladder’ (Grant, 2019, p. 25). The colonisers took the view that ‘civilised societies like Great Britain can be considered to be acting in the interest of less-developed peoples by governing them’ (Kohn & Reddy, 2017).

In the 21<sup>st</sup> century the racism inherent in the foundation of the postinvasion Australian state has persisted. Racial attitudes have become increasingly complex, multidimensional and even contradictory, wherein liberal-egalitarian values that emphasise equality and social justice coexist with a residue set of negative feelings and beliefs about particular social groups (Gaertner & Dovidio, 1986). Although there have been significant changes in institutional arrangements over time, not only racism, but colonialism, too, has persisted and the denial of the laws, customs and rights of the people and subjugation of their cultures continue (Australian Museum, 2015; Horvath, 1972; Kohn & Reddy, 2017).

The power asymmetry between Indigenous and non-Indigenous Australians has been reinforced by actions of the state. Despite the empirical evidence of the relationship between all forms of racism and health, ‘many academics, policy makers, scientists, elected officials and others responsible for defining and responding to the public discourse remain resistant to identifying racism as a root cause of racial health inequities’ (Bailey et al., 2017, p. 1453).

There may be recognition of the harms to health associated with racism and colonialism, but

it is rare to find recognition on the part of the people and institutions responsible for governance that racism, colonialism, marginalisation and intergenerational trauma are all avoidable consequences of public policies they formulate and the institutional arrangements and processes through which they are formulated.

For contemporary Indigenous Australians the legacies of a colonialist history live on. 'We know we cannot live in the past, but the past lives with us' (Perkins, 1975) 'It is a troubling business coming to terms with Australian history, both for Aboriginal people and non-Aboriginal people' (Pearson, 1997). 'If you are not Indigenous, it is impossible to really know what it is to carry this history in our bones, to live with the memory of wounds'. 'I cannot deny that we are still strangers here' (Grant, 2019, p. 245). 'Australia's embracing of Aboriginal heritage as part of national heritage has not, unfortunately, meant an end to treating Aboriginal culture as the Other of white Australian culture' (Byrne, 1996, p. 100).

The extent of the distance between the lived experiences and worldviews of contemporary Indigenous Australians and the worldviews of non-Indigenous Australians was eloquently described by Stan Grant reflecting on his own life as an Indigenous Australian in modern Australia.

Australia still can't decide whether we were settled or invaded. Soon we would lose our names, then our languages were silenced, and soon children would be gone. This is how we disappear. So, my country, these things are important. Faces and names and language and land are important.

These fears, the fear of being laughed at, the fear of being caught out wearing another boy's cast off clothes, the fear of the welfare men, all of this marked the territory

between the world of Australia and me. This was the space that history had made and the place it had reserved for people like us (Grant, 2016a, p. 37).

Because history is ignored, though, because the darkness of our past often goes unspoken, that does not mean it doesn't plague us (Grant, 2016a, pp. 2-5).

The large inequality in life expectancy (and in other measures of quality of life) between Indigenous and non-Indigenous Australians has long been identified, quantified and brought to broad public attention (Gittins, 2014, p. 4; Reeve & Bradford, 2014, pp. 199-217). So too has empirical evidence of the unequal distribution of access to the material resources essential to health and wellbeing such as education, housing, transport, health care and employment. And governments, in particular, have invested in multiple initiatives with the intention of reducing (if not eliminating) the inequalities. However, although there has been positive progress, the outcomes have fallen short of the expectations of communities and of governments.

The limited priority and government attention being given to policies in support of authentic self-determination and sovereignty of Indigenous Australians is challenged in the words of Davis (2016b, p. 10) writing of what she views as 'disastrous Indigenous policy settings'. She calls for 'the right to freely determine [our own] political affairs and pursue our economic, social and cultural development – decentralised arrangements that put power back into the hands of communities. There can be no economic development without freedom'.

What we look for when seeking to understand the causes of a social problem as large, urgent, persistent and complex as the inequality in average life expectancy at birth between Indigenous and non-Indigenous Australians depends upon what we are thinking.

From the theoretical analysis conducted thus far, two critical prior questions emerge before moving to respond to the challenge above. First, who are we, to what cultural group do we belong and what are our worldviews and cognitive frameworks (normative beliefs). The second question is defining what institutions we represent, and the institutional arrangements, standard operating procedures and policy paradigms that influence our thinking.

The idea of reflexivity and the evidence that it occurs provide reason to continue to press for change. Institutions and people can and do evolve as the structural and cultural contexts within which they operate evolve. Change can and does occur on large and small scales. The abstract research described in previous chapters confirms that what humans think determines how they behave and that people see what they are looking for. That humans see and interpret the world in different ways is not at issue here. Through the abstract review of transdisciplinary literature it is possible to identify, from different disciplinary, cultural and theoretical perspectives, normative beliefs that influence public policies. Australia's historical and contemporary experiences confirm that when the institutions responsible for governance have been formed and are controlled by members of a culturally dominant group, and when contemporary policy actors are predominantly (or wholly) from the dominant cultural group, the normative beliefs of non-Indigenous Australians continue to dominate policy decisions.

Archer had recognised that both structural and cultural contexts exercise powerful influences on contemporary policy actors' public policy decisions. In Australia colonialism plays a strong role in both structural and cultural contexts. It is a way of thinking that can be invisible to the dominant cultural group, and all too obvious to the historically marginalised group. In this thesis the focus is on identifying the mechanisms through which the dominant cultural group perpetuates historical injustices. In the next section I describe new institutionalism, Fraser's theory of social justice, and Lukes' three dimensions of power as normative theories.

I conclude by proposing that they form an integrative theoretical framework from which to draw underlying mechanisms through which institutions and policy actors shape public policies.

## **New institutionalism**

New institutionalism identifies three characteristics of institutions through which they shape public policies and transmit them between generations. First, through the institutional arrangements (that is, the mechanisms through which decisions are made about who is eligible to be included as a policy actors, about the process for selecting the actors, and the processes for formulating and adopting public policies). Second, through their role in shaping policy actors' decisions when developing policy paradigms and through the inclusion of the paradigms in their standard operating procedures. And third, through institutional culture with its norms and values that, often informally, shape the decisions of policy actors. Institutions constitute both a structural and cultural context within which public policies are formulated.

However, it is necessary to understand the cultural context in greater depth. As I have explained in earlier chapters, the theoretical, cultural and disciplinary perspectives of policy actors exert powerful influences on their policy decisions.

## **An alternative theory of social justice**

Fraser's theory of social justice includes three forms of injustice - injustices that are rooted in the political economic structure of societies, in the domination of one cultural group by

another<sup>4</sup> and in structural exclusion<sup>5</sup> (Fraser, 1997, p. 37). Fraser went on to include a third dimension in her theory of social justice, arguing that structural exclusion is a further equally significant form of injustice, for which she proposes representation and participatory parity as remedies. She explains that her theory is based on the view that economic, cultural and political power are fundamental, irreducible dimensions of social power (Fraser, 2007, p. 333).

In the sections below the relationship between each of the three forms of injustice and the persistent, systematic patterns of inequalities experienced by Indigenous Australians are described.

### **Maldistribution**

The first form of injustice arises from the economic structure of society (for example, having the fruits of one's labour appropriated for the benefit of others; being confined to undesirable or poorly paid work or being denied access to income-generating labour; and being denied an adequate material standard of living). Fraser called this maldistribution (Fraser, 1996, p. 7).

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<sup>4</sup> Cultural domination (being subjected to patterns of interpretation and communication that are associated with another culture and are alien and hostile to one's own); nonrecognition (being rendered invisible by means of the authoritative representational, communicative, and interpretative practices of one's culture); and disrespect (being routinely maligned or disparaged in stereotypic public cultural representations and in everyday life interactions). (Fraser, 1997, pp. 34-36).

<sup>5</sup> Fraser argues that structural exclusion takes multiple forms, including racism, colonialism, in addition to the exclusion grounded in the political economy, exclusion rooted in the status order, and from the mapping of status hierarchies onto socioeconomic differentials to prevent some actors from participating at all in mainstream arenas of social interaction (Fraser, 2007, pp.316, 317, 318).



For more than 150 years Indigenous peoples were denied access to the material resources required for an adequate standard of living, and, although there are signs of positive progress, the evidence (in Chapter Two) still points to high levels of socioeconomic disadvantage in rural and remote communities in particular. The stigmatisation and indignity associated with welfare dependence add to the harms to health arising directly from poverty.

Having access to material resources and opportunities to acquire them is essential to health and wellbeing – housing, education, transport, health care, nutritious food, and a secure income that is sufficient to live with dignity and respect are some of the resources.

### **Misrecognition**

Fraser's second dimension of injustice is misrecognition – or cultural injustice, arising from two sources. The first source is social patterns of representation, interpretation and communication (Fraser, 2000, pp. 113-114) described as prejudice, stereotyping and stigmatisation by D. Williams and Mohammed (2013, p. 1152) – interpersonal racism on one hand. Fraser saw this as the subordination of a cultural or social group by a dominant cultural group, resulting in members of the subordinate group internalising negative self-images and being unable to develop a healthy cultural identity of their own – internalised racism on the other hand. (Fraser, 2000, p. 109). C. P. Jones (2000, p. 1214) Indigenous peoples across generations have described the toxic effects of the internalised and interpersonal forms of racism and exclusion on their lives (Australian Human Rights Commissioner, 2011; Dodson, 2016; Grant, 2016a; Langton, 2016; Martin, 1962, pp. 6, 8-9; Pearson, 1997; Perkins, 1975; Yunupingu, 2016).

The second form of misrecognition is the systematic subordination of the cultures of a group by a dominant cultural group. This form of cultural injustice is characterised by the denial of

equal status to a culture or cultures – deeming the intellectual, philosophical, and experiential ideas of one to be inferior to that of the dominant other’ (Fraser, 2000, pp. 113-114). It is the assignment of a negative, subordinate value to a whole cultural group and to all individuals within the group, and the institutionalisation of that value in all social settings and policies.

Both forms of misrecognition were inherent in the colonisation of Australia, and are being reproduced in contemporary Australia. For Indigenous peoples, the cultural injustices are all too obvious – a reality that cannot be avoided in day-to-day life.

And the remedies lie, largely, within the control of the dominant cultural group. Only through the decolonisation of their worldviews can there be a chance of authentic recognition – not only of Indigenous peoples, but of Indigenous cultures, including intellectual and spiritual traditions, and of the central part of these in Australia’s future as one nation and one society.

Contemporary initiatives intended to reverse this situation, through recognition, are meeting with concern on the part of Indigenous peoples in colonised nations everywhere. The impossibility of being ‘self’ and also acceptable to the Other’s recognising gaze in the contexts of coloniality was famously raised by (Fanon, 1986).

‘It is in spaces created by turning away from the Other, and towards oneself, that new and alternate expressions of equality and self-realisation (individual and collective) emerge and are strengthened’ (Balaton-Chrimes & Stead, 2017, p. 12).

The remedies for misrecognition cannot be recognition without transformational change (decolonisation and the deconstruction of structural racism embedded within institutional arrangements and historical policies, of racist and colonialist thinking embedded in the worldviews of policy actors, and of the practice of everyday racism by the citizenry.

## **Misrepresentation**

Fraser's third dimension of injustice is misrepresentation, the political dimension of injustice reflecting the distribution of power and authority to govern. This form of injustice arises from the members of a subordinated cultural group being excluded routinely and systematically from rightful and active participation across all major areas of social interaction, including from the settings within which public policies are formulated (Fraser, 2007, p. 330).

Indigenous people were excluded by law from rightful, full and active participation in all major areas of social interaction for more than 150 years after invasion and colonisation. Even after legal and constitutional changes, the institutionalised patterns of cultural value (misrecognition) presents barriers to full participation in all areas of social interaction.

In sum, each of these forms of injustice has a direct impact on the health and wellbeing of peoples and communities. However, contemporary policy analysis seeking to identify effective remedies for the inequalities in health and life expectancy experienced by Indigenous Australians focuses, primarily, on maldistribution (of material resources) as the problem – and on participation in the modern economy as the solution.

Crucially, Fraser argues that distributive, cultural, and representative justice are fundamental, *irreducible* dimensions of social justice (Fraser, 2007, p. 333). Each, although requiring separate action, is vital to the other. Attaining social justice requires deep restructuring of social organisations through the use of transformative remedies.

For Indigenous peoples these ideas are not new; rather, they are restatements of their own experiences, analyses of the causes of inequalities in health and life expectancy, and proposed solutions. However, for contemporary policy actors and their institutions – particularly, but

not only, those in the health sector – significant implications arise from this theory of social justice.

Current Indigenous policy paradigms shaping the policy decisions of the Commonwealth Government are focusing on distributive justice – on providing (or enforcing) routes by which Indigenous peoples can enter the market economy successfully. Health sector paradigms are giving priority to a behavioural view of causality and a consequent focus on behavioural risk factor reduction initiatives.

There are also positive initiatives being taken to achieve recognition within organisations – universities, private companies, government agencies, and non-government organisations are adopting Reconciliation Action Plans – committing to transformative changes in institutional arrangements, and in policy spaces.

Finally, it is a sign of progress to have an Indigenous Minister in the Cabinet – the highest ever Indigenous political representation in Australia’s Federal Parliament. And in all areas of social and economic life, there is increasing Indigenous presence. However, there are few signs, yet, of the transformative changes in the institutions and in the worldviews of policy actors (and the wider citizenry) that are necessary if justice is to be achieved and life expectancy is to be equal.

Fraser’s theory of social justice posits that the three forms of injustice are distinct but *irreducible* components of social justice. Fraser’s theory integrates the theories identified through the abstract theoretical review of the literature and explains how each (including racism and colonialism) contributes to the production and perpetuation of systematic inequalities in access to social resources and opportunities necessary to self-determine a good life in a socially just society.

It is also necessary to add Lukes' three dimensions of power to the integrative framework because, having power and authority is the final necessary step for Indigenous Australians – not only being at the table, but being free to co-create a table that recognises Aboriginal sovereignty and the central role of Indigenous Australians in every part of the life of the nation.

### **Social justice and political power**

Politics is the arena within which ideas about social justice, about the role of the state and society, and about the distribution of material and social goods are contested. It is the arena in which decisions are made about who is eligible for membership of institutions responsible for public policy, institutions found in all areas of social life. Politics is the arena, as well, within which, in Australia, ideas about Indigenous peoples, cultures, rights and aspirations are contested. However, the original exclusion of Indigenous peoples from all political (and originally, all social) arenas continued well into the 20<sup>th</sup> century and the 21<sup>st</sup> centuries.

Indigenous peoples have long argued for the right and respect of representation as policy actors within the structures and processes of governments, in particular (A. Phillips, 1995, pp. 12-21) and (Young, 2008, pp. 10-14). Representation and participation are essential prerequisites to exercising influence in framing policy ideas, in shaping policy options and in deciding on the instrument through which public policies are intended to achieve their goals. They can influence how representation and participation are intended to structure the possible field of action of citizens (Lemke, 2000, p. 5) and the intended distribution of benefits.

Power is also vested within the institutional arrangements and standard operating procedures, rules and norms of social institutions and in the decisions about membership, about the criteria for selecting ideas for inclusion on the policy agenda, in framing social problems and

their causes, and in determining policy goals and preferred strategies and instruments for achieving them. In short, power is not vested only in the agents responsible for formulating public policies, but also within the institutions the agents are representing. Structures and agents each hold power, and each has a role in the political processes through which public policy decisions are made.

### **Theoretical redescription: an integrated framework**

Bygstad and Munkvold (2011, p. 6) describe this step as developing a framework that integrates theories described and analysed in previous chapters, in order to increase theoretical sensitivity and to understand, in more depth, mechanisms through which events (in this case, public policies) contribute to the outcomes in the empirical domain. New institutionalism, as an organising framework, describes mechanisms through which social institutions (in this case, organisations responsible for governance) shape public policies and transmit historical decisions across generations. Through their institutional arrangements they decide who is to be represented in the policy-making process; through their standard operating procedures they establish the rules and processes through which policies are formulated and adopted; through policy paradigms they express ideological preferences and priority values that, in turn, shape subsequent individual policies. Fraser identifies distributive justice, cultural justice, and representative justice as irreducible, essential components of social justice. Lukes (2005) describes three dimensions of power to which people and groups need access in order to shape public policy. Lukes' first dimension of power is the availability of various forums within which expressions of concern can be negotiated by actors and players in a community. That is, that there are social institutions that have a social mandate to make the public policies through which societies distribute social resources (VeneKlasen & Miller, 2002). This form of political power is visible. In

democracies, in particular, there are multiple such institutions with such powers. Not only the institutions of governments, but also those in the private, NGO and community sectors which have responsibility for the creation and distribution of social resources and opportunities. In sum, this form of power is essential to the achievement of distributive justice.

The second dimension of political power (Lukes, 2005, pp. 22--25) is a private face of power that is able to influence which items make it on to the public agenda. This power enables the covert exclusion of the interests of particular individuals or groups from decision-making structures and settings. Because only a few issues can be handled on any agenda at a time, many items simply never make it on to the agenda. Even if items are on the agenda there is no guarantee that they are framed, analysed and resolved in a way that reflects and respects differences in need, experience and preferred responses (Schlozman, 2004; Vos, Sapat, & Thai, 2002). This form of power is essential to the achievement of cultural justice: to achieving needs that are particular to a subordinate cultural group and that are different from those recognised and met needs particular to the dominant cultural group.

Lukes' third dimension of power is the capacity to recognise and formulate one's own and one's group interests free from the domination of others, or, conversely and insidiously, the capacity to dominate groups so profoundly that they are unable to recognise that their interests are at risk and unable to attempt to defend those interests (Lukes, 2005, pp. 144-151). Finally, this form of power is recognition of independent sovereignty, whether activated through formally separated powers or whether activated within existing although transformed institutions of the state.

Indigenous people and communities have long exercised such agency independently of the dominant culture. They have, since invasion, created structures and assembled the capacity through which to formulate, advocate for, and demand that their policy priorities be included

on policy agendas and that their policy solutions be adopted (Rowse, 2010). This was and is a vital expression of cultural power. However, the limited representation within the institutions of the state is both an indicator of cultural injustice (respect), and leaves power and authority to formulate public policies unchallenged from within.

I draw together the normative theories of new institutionalism, Fraser's theory of social justice, theories of racism and colonialism, and Lukes' three dimensions of power to form an integrative theoretical framework. Each of the theories contributes to the systematic inequalities in the health (and in access to its determinants) by Aboriginal and Torres Strait Islander Australians. However, none, on its own, is sufficient to explain the persistence of the systematic patterns of inequalities into the 21<sup>st</sup> century. The integrated theoretical framework links the theories, recognising the explanatory power of each on its own, but strengthening that power by joining it with the others.



## **Chapter Ten. Retroduction: identification of candidate mechanisms**

Through the identification and analysis of events in the actual domain, and the identification of key components shared by all events, I identify plausible generative mechanisms that, when activated, contribute to explanations of the persistence of the systematic patterns of inequality in average life expectancy at birth between Aboriginal and Torres Strait Islander (hereafter referred to as Indigenous in this chapter) and non-Indigenous Australians, and in access to social determinants of health and wellbeing.

Australia's two distinct but intertwined histories have formed ideas and patterns of cultural value that underlie public policy-making and the distribution of goods, services, rewards and burdens in Australia today. The differences in histories and experiences underlie the relationships between cultural communities and political communities, between the minority (non-dominant) and the majority dominant cultural communities. The differences form unconscious (as well as conscious) ideas (including stereotypes and prejudices) that frame personal and social policy decisions, and that have been embedded in the institutional arrangements, rules and norms of the structures through which society is governed. Multiple reasons have been proposed for the persistence of inequalities in the life expectancy of Indigenous Australians. Indigenous leaders have named the reasons for the slow progress as the lack of sovereignty, the lack of a treaty, the lack of constitutional recognition (Davis, 2016b; Pearson, 2011; G. Phillips, 2016), and the silence on Indigenous issues in the policy debates that precede Australian federal elections (Langton, 2016). K. Griffiths et al. (2016, p.

19), in a comprehensive review of the literature on colonisation, social justice and Indigenous health, concluded that ‘current Indigenous health disparities are a legacy of historical and current factors impacting all levels of society, from individual to government. Colonisation deconstructs existing cultures, systems and structures resulting in ongoing unequal power distributions between Indigenous and non-Indigenous people. The legacy of colonisation is social injustice’. These authors argue that the persistence of the social injustice lies in the colonialised policies and practices that are deeply embedded of all social institutions in all sectors of society (K. Griffiths et al., 2016, p. 9).

The still common (and unremarked upon) absence of Indigenous peoples from social and policy arenas is a powerful indicator of the lack of respect for Indigenous peoples and cultures expressed by the dominant culture. Indigenous communities have, across generations, taken action to influence public policy decisions (Rowse (2010), Attwood (2003); Bennett (1991), (Pearson, 2011). However, the power to insert their own worldviews on what constitutes a good life and a socially just society into policy processes to establish and achieve their own policy goals continues to be limited by the institutional arrangements and policy paradigms of social structures and the cognitive beliefs of actors responsible for governance (Davis, 2016a).

The political history of Indigenous Australians is nuanced and complex, and the relationships between Indigenous political organisations and leaders and governments have, over the course of postinvasion history been broader and deeper than is commonly recognised (Rowse, 2010). There has been progress in increasing the access of Indigenous people to material resources and opportunities (Commonwealth of Australia, 2017), and there is evidence of growing self-reported goodwill toward Indigenous people and development on

the part of the non-Indigenous Australian population. But the hard fact remains that that a significant difference in average life expectancy at birth has persisted into the 21<sup>st</sup> century.

The theoretical analysis of the literature confirms that many factors contribute to the persistence of inequalities in life expectancy experienced by Indigenous Australians. That the inequalities and their persistence to the present day are primarily socially produced means that the responsibility for action to eliminate these inequalities lies with the people and social institutions that govern Australia. Leading explanations for the genesis and persistence of the inequalities to date focus on different policy ideas about goals and about instruments, often specific to Indigenous peoples. Beneath the specific policies, however, lie the paradigms of governments and all social institutions based on normative beliefs (racist) about Indigenous peoples and cultures, and about social justice and priority values and ideologies of actors in the past and in the present. It is also based on the assumption that the policy actors and institutions are dominated by the non-Indigenous cultural group thus reflecting worldviews primarily based on western liberal democratic traditions. ‘We see what we are looking for’. Only if *we* [that is, non-Indigenous researchers, policy actors and citizens] look for mechanisms through which we are determining the persistence of the inequalities will it be possible to see them. A theoretical analysis of the literature was conducted to identify what we could look for.

### **Candidate generative mechanisms**

The theoretical analysis of the literature identified theories explaining mechanisms by which social structures and their agents (policy actors), drawing on powers given to them by societies, distribute social resources that are essential to the lives, health and wellbeing of people and societies. The ways in which the structures and agents exercise their powers are described.

Foundational ideas (worldviews) upon which actors base decisions about social goals, about the causality of social problems, about the priority given to equality and equity as social values, and about the extent of the obligations of society and the state to remedy social problems are embedded in both the institutional arrangements and operating procedures of social institutions, and in the worldviews of their agents.

Over time, two main paradigms influencing public policy decisions have emerged. The first interprets social injustice as arising primarily from the maldistribution of material resources that results as a consequence of the failure or unwillingness or incapability of Indigenous people to do what it takes to acquire them, (for example, to move away from traditional lands; participate in education dominated by western intellectual and cultural norms; to accept everyday racism). Policy paradigms based on the analysis of maldistribution of material resources as the problem have favoured remedies intended to variously enforce, support or incentivise changes in the behaviours of Indigenous peoples to fit with dominant paradigms. The second paradigm has been that of self-determination, interpreted by the dominant cultural group as self-management within boundaries and meeting standards and norms set by the dominant cultural group. There is a growing number of Indigenous organisations challenging the assimilationist intent of such public policies (Balaton-Chrimes & Stead, 2017), but the prevailing public policy paradigms continue to subordinate Indigenous cultural self-determination to that of the dominant majority.

The persistence of the systematic inequalities in life expectancy experienced by Indigenous peoples, however, suggests that neither paradigm has been based on explanations of the determinants of the injustices that are being reproduced by the social structures and policy actors responsible for the governance of the nation. Fraser's theory of social justice includes cultural injustice and representative injustice as mechanisms through which contemporary

social institutions are reproducing the institutional and interpersonal racism that are ‘embedded in the colonial structures (of governance) that continue to maintain material and symbolic (i.e. political) privilege’ (Paradies, 2016, p. 84). Although occurring less frequently, Wright describes a way in which cultural injustice continues in the present:

The Aboriginal subject with the story he or she is supposed to own is relegated to being a primary informer, at best, to the professional person who then argues the story on their behalf (Wright, 2016, p. 68).

Chaney, reflecting on contemporary debates about constitutional recognition of Indigenous peoples, wrote recently that he viewed these as being ‘the worst of times to be considering recognition, given the national policy environment’. In Chaney’s view,

‘the ideas and experience of Indigenous Australians are [treated as] subservient to the superior knowledge of politicians and bureaucrats’ and ‘despite valiant efforts by Aboriginal leaders, policy and administration are more centralised than ever before’ Davis (2016b, p. 10).

Underlying the approach was the knowledge that the research (conducted, primarily by non-Indigenous researchers) that had dominated the search for policy solutions to reduce or eliminate inequalities in Indigenous health has focused primarily on characteristics of the people and their living environments, on behavioural choices, or on identifying the felt or expressed needs of communities. There has been limited research looking in the other direction to identify characteristics of the people responsible for making public policy, or characteristics of the organisations they represent to investigate their contributions to explanations of the persistence of inequalities in the life expectancy and health of Indigenous Australians in the 21<sup>st</sup> century.

The characteristics of institutions through which public policies (based on a new institutionalist theoretical perspective) are influenced, Fraser's three forms of injustice (including racism and colonialism in each of their manifestations) and Lukes' three dimensions of power are candidate mechanisms that are used to develop an a priori deductive framework that is used in the empirical study to assess their practical adequacy as indicators of mechanisms as observable phenomena in contemporary policy spaces.

# **Chapter Eleven. Are the candidate mechanisms being activated in policy spaces? An interview study of contemporary policy actors**

## **Introduction**

Critical realism provides a platform from which to explore the ‘interaction of philosophical ideas and scientific research’ (P. Harris, 2013, p. 41). To that end, in this thesis, it is important to situate the interview study as the last step in a structured methodology comprised of six steps. The first five steps are comprised of abstract research – a critical review of philosophical and theoretical ideas in transdisciplinary literature concluding with the identification of candidate mechanisms in the real domain. The interview study is intended to contribute to the development of what is yet a non-empirical part of a causal chain (Collier, 1994, p. 48) It is intended to confirm (or not) whether it is possible to ‘see’ candidate mechanisms being activated in contemporary policy spaces.

## **Research design**

The aims of the interview study were to (i) describe the self-reported perspectives of contemporary policy actors on the roles of their institutions and their own roles in developing public policies related to Indigenous Australians; and (ii) to assess whether it is possible to observe candidate mechanisms abstracted from the normative theoretical framework (identified in Chapter Nine) being activated in contemporary policy spaces.

The study questions were:

1. How do senior and mid-level policy actors in public institutions in three sectors describe their roles and experiences in making and implementing policy decisions with particular reference to policies related to Indigenous Australians?
2. How do senior and mid-level management policy actors in public institutions in three sectors describe the institutional structures and processes that influence policy decisions with particular reference to policies related to Indigenous Australians?

### **Ethics approval**

The research protocol for the study received ethics approval from the University of Sydney Human Research Ethics Committee (11257) in 2008. My initial supervisor relocated to take up a position at Western Sydney University. I resubmitted my research protocol and received ethics approval from the Western Sydney University Human Research Ethics Committee (H8723) in 2010.

### **Sampling and recruitment**

Evidence shows that policy actors who are most influential in public health policy decisions in a UK urban environment are mid-level managers (as distinct from academics and public health professionals) (Oliver, de Vocht, Money, & Everett, 2013, p. 453). I used the following criteria to draw a purposive sample of potential interviewees:

- (i) respondents are contemporary policy actors in senior or middle-managerial positions within public sector structures
- (ii) among the actors would be at least one from a structure in each level of jurisdiction in Australia, local, state and federal
- (iii) actors would be drawn from three sectors



(iv) the actors would represent both Indigenous and non-Indigenous Australians.

Two of the respondents knew me as a professional colleague from the same industry although we had not worked together. I had met each of the others but had not worked with them. I sent each a letter of invitation to participate in the study (Appendix One). One of the actors I invited initially suggested two further policy actors who met selection criteria. I then invited the two additional people to take part in the study. In all I invited eleven policy actors to participate.

Eight people agreed to participate in the research. Two of the people I invited to participate did not respond to my formal letter of invitation or to my follow-up telephone calls. Another responded to say that she was unable to participate. I did not seek reasons for not responding or for the decision not to participate.

I sent each of the eight who accepted the invitation an electronic copy of the information statement about the study (Appendix Two), a request for written consent (see Appendix Three) and a copy of the semi-structured interview guide (Appendix Five). I followed up with telephone calls (Appendix Three) and emails to respond to any questions, and to arrange a date and time for the interview. I conducted five interviews in person and three by telephone. All eight of the people who accepted the invitation to be interviewed gave verbal and written consent.

## **Respondents**

Three respondents were from the health sector, one was from community services, three were from housing, and one was from the local government sector. Three were from the federal level of jurisdiction, three were from state jurisdictions, one was from a regional jurisdiction,

and one was from a local jurisdiction. Two of the participants were Indigenous; six were non-Indigenous. De-identified descriptions of the respondents are included in the table below.

Table 5. De-identified descriptions of respondents

Identifier	Sex	Sector	Jurisdiction	Level
AB	Female	Community Services, Housing	Federal	Mid-level
CD	Male	Community Services, Housing	Regional	Mid-level
EF	Female	Health, Human Services	State	Senior
GH	Male	Health, Human Services	Regional	Senior
IJ	Male	Health, Human Services	State	Senior
KL	Male	Community Services, Housing	Federal	Mid-level
MN	Female	Community Services, Housing	Federal	Mid-level
OP	Male	Local government	Metropolitan	Senior

The de-identified data reported in the portraits below were obtained at interview.

### Pen portraits

AB is a non-Indigenous, middle-aged woman who is a middle manager in the federal jurisdiction of the Community Services, Housing sector. She has more than 20 years' experience in the sector, and is responsible for developing and implementing public policy intended to reduce inequitable access to a social resource essential to wellbeing across the population.

CD is a non-Indigenous, middle-aged man with more than 20 years' experience in a social sector in a state jurisdiction. He works as a middle manager with a regional mandate, and is responsible for developing and implementing policies and programs to enable the needs of

diverse cultural communities (including Indigenous communities) to be met within the boundaries of a universal program.

EF is an Indigenous middle-aged woman with more than 20 years' experience in social sectors in state jurisdictions. She is working in a senior management role in a state jurisdiction and has responsibility for statewide policy and programming specific to the Indigenous population.

GH is a non-Indigenous, middle-aged man who has been in a senior managerial position in a regional jurisdiction for more than 10 years. He is responsible for the development and implementation of universal policies and programming, as well as policy and programming specific to the Indigenous population.

IJ is a non-Indigenous older man who has been a senior manager in federal and state jurisdictions for more than 20 years. In a senior management role in a state jurisdiction he is responsible for universal and Indigenous-specific policies and programs developed and implemented by his sector.

KL is a non-Indigenous, middle-aged woman who is a middle manager in a sector in the federal jurisdiction. She has wide experience in policy research, in the management of the delivery of local programs, and in the development of policies reforming the distribution of a core resource among social groups within the population, including Indigenous peoples,.

MN is an Indigenous, middle-aged man who is a middle manager in the federal jurisdiction of his sector. He has more than 30 years' experience, and is responsible for providing policy advice and programs specific to the Indigenous population.

OP is a non-Indigenous, middle-aged man who is a senior manager in the local government of a metropolitan jurisdiction. He has long experience working in social sectors within state,

non-government and local government institutions. He is responsible for public policy and program development and implementation to increase the participation of marginalised groups in public life.

### **Interview schedule**

The interview schedule (See Appendix Five) was developed based on Peavey's strategic questioning framework and McClain's work on racial minority group access, agenda setting, formulation and public policy (McClain, 1993).

### ***The interview***

1. What is your organisation's core business?
2. What structures and processes does the organisation use to engage the population it serves in setting the policy agenda and in developing, adopting and implementing policy? In what ways does the organisation engage minority population groups in these steps?
3. When your organisation develops health or housing policy, how is the policy agenda established? What issues are given priority on the agenda? How are these brought to your attention? By whom or by which organisations and people?
4. What has been your personal experience in establishing health or housing policy?  
What structures and processes are available to ensure that priorities of groups making up the population are identified, and that their understanding of the causes of problems and potential solutions are considered actively in the deliberation on policy options and solutions? Prompts:
  - a. is it important or not important (inherently or as a matter of principle) in your view to seek the equal participation from minority citizen groups?

- b. do you consider it to be easy or difficult to ensure equal, active participation of minority citizen groups?
  - c. do you consider it to be useful or not useful to have equitable participation?  
That is, in your view, to what extent does equitable participation lead to more effective, efficient policy outcomes?
5. What sources of information about the needs and problems experienced by minority citizen groups and about policy solutions do you trust and why?
  6. How do you feel about the extent to which minority citizen groups' policy priorities, problem framing and solutions influence policy development and adoption by your organisation?
  7. If you think it should be changed, how could it be changed to be as you think it should be?
  8. What actions would be necessary for your organisation to bring about change in the extent and depth of participation of minority citizen groups in the policy process?  
What actions do you need to take to bring about change in the extent and depth of participation of minority citizen groups in the policy process?
  9. What would be the effect of making these changes?
  10. What support would you need to work for this change?
  11. What would it take for you to participate in this change?

### **Data collection**

I conducted two pilot semi-structured interviews. Reflecting afterwards on the interviews and the data collected I decided that the semi-structured interview method was too formal and bounded for the purpose of this study. I was seeking to describe and understand the social reality of contemporary policy actors (Oxford University Press, 2017) from their own perspectives. I chose, therefore, to use a naturalistic, conversational interview method. The

interviews were extended conversations intended to obtain material that had depth and detail (Rubin & Rubin, 2005, p. 101). The conversations were themed around the questions in the interview schedule but were shaped within the context of each interview (Berry, 1999). I conducted all the interviews in October and November, 2009. I conducted five face-to-face interviews and three by telephone. Each interview took between 60 and 90 minutes. I recorded all the interviews and took supplementary notes by hand. I transcribed each of the audio recorded interviews within one week of the interview. I then re-read the manuscripts carefully several times. The fact that I conducted the interviews and did the transcriptions myself meant that together with the careful, repeated readings I became very familiar with the depth and breadth of content. I found no new themes or accounts after eight interviews and assumed that saturation had occurred.

### **Analytical method**

I derived candidate generative mechanisms from the integrative theoretical framework described in Chapter Nine. The interview study was intended to assess whether it possible to verify the activation of the candidate mechanisms in contemporary policy spaces.

To that end, I generated a deductive coding framework comprised of each of the normative theories included in the integrative theoretical framework (described in Chapter Nine, and the candidate mechanisms derived from each (described in Chapter Ten). (See Table 6 below).

Table 6. The deductive coding framework: normative theories and candidate mechanisms in the real domain - what could I expect to see?

<b>Theory</b>	<b>Candidate mechanisms</b>
New institutionalism	Structures and institutions
	Standard operating procedures – rules and norms
	Institutional arrangements
	Policy actors' world views Reflexivity
Policy paradigms	Values, principles, ideologies
Theory of racism	Prejudice Stereotyping Interpersonal racism Structural racism
Theory of colonialism	Tolerance of unequal social treatment of Indigenous peoples
Theory of social justice	Distribution Maldistribution
	Recognition Misrecognition
	Representation Misrepresentation

Lukes' dimensions of power	<p>Selection of social problems and policy ideas to be included on the public policy agenda</p> <p>Framing the problem and shaping policy goals and strategies</p> <p>Networking and influence on policy ideas</p>
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After reading and re-reading the transcripts several times, I coded the responses, first, into one of the theoretical categories in the coding framework and second, as a candidate generative mechanism.

### **Results and discussion**

In the first section of the results I report on the structures and institutional arrangements that respondents identified as shaping their policy choices within which policy actors generated policy ideas and formulated public policies. In the second section of the results I report on respondents' descriptions of the institutional values, norms, and rules that framed the selection of policy problems, that shaped the priority given to individual or social responsibility for social problems, and to different sources of injustice as explanations of the causes of problems. In the third section I report on observable and underlying mechanisms that had been identified by respondents as influencing policy decisions. In the fourth section I report on how respondents identified institutional arrangements, rules and norms as vehicles through which to bring about change within social institutions. The final section reflects on the extent to which it was possible to identify candidate mechanisms being activated in the self-reported descriptions of the influences on their policy decisions by contemporary policy actors.



## **Structures**

Respondents each described the core business of their institution in terms of its responsibilities for public policy development and implementation. With the exception of one institution in the local government sector each of the institutions had established an internal, designated structure specific to Indigenous policy and program development and in some cases implementation. Examples of such internal structures were an Indigenous Advisory Group to provide policy advice, designated offices of Indigenous policy, and, in one case, in addition, an Indigenous leadership program. The structures operated at different levels of authority within the institutions.

## **Powers and mechanisms**

### **Institutional arrangements**

All respondents were senior or mid-level managers within government institutions that were operating at national, state or a local level of jurisdiction. Each of these institutions had expressed commitment to improving the lives of Australians by creating opportunities for economic and social participation by individuals, families, and communities and by ensuring universal access to the services or products or benefits their sector is mandated to provide. Each of the institutions had explicit policies (and investments) in place to provide resources (goods or services or opportunities) to and for Indigenous populations in their jurisdictions. However, not all the institutions had established specific structures and designated positions with responsibility for Indigenous policies and programs.

Respondents described their roles in the development of policies specific to the Indigenous population, and in public policies intended for the whole population. In the examples below,

respondents described the responsibilities designated by their institutions as follow: one had responsibility for Indigenous policy, explicitly; another was responsible for universal policy, and a third had a mixed responsibility for universal policy and a further commitment to leave no-one behind (that included, but was not specific to, the Indigenous population).

...we're the statewide policy and planning arm in Indigenous affairs [within the Ministry or Department]. Our core business is to develop policies and programs to support better service delivery for Indigenous people and looking at how we can improve their lives.[EF]

From where I'm sitting and seeing how government is operating there is a very strong and very clear commitment to making sure that those groups of people do not remain behind the rest of the population ... just the whole language of things like Closing the Gap... [KL]

Our role is reducing preventable risk (to the health of the population), using evidence-based strategies.[GH]

### **Institutional ideologies, values, rules and norms**

Respondents described a variety of influences on decisions that they (and sometimes, colleagues) make about the goals of the public policies for which they are responsible. They described influences of their institutions on their public policy making as being values, rules or norms.

### **Ideology and values: utilitarianism and efficiency**

Although individual respondents expressed a strong personal commitment to equity for Indigenous people, their responses also reflected ideologies and values that had been given

priority in shaping their institutions' goals. Respondents spoke of needing to give priority to the efficient use of public funds and of policy goals that prioritised the distribution of resources to improve the lives of the majority of citizens. One respondent described the rules and norms governing the policy decisions in his institution:

... part of it is historically how we structure notions of recognising performance of bureaucracies and those types of things – recognising where a sector is achieving. If we take the health sector as an example, we now have the third best life expectancy in the world. If we improve the status of a minority group such Indigenous people, for example, to meet that of the rest of Australians we'd have bugger all impact on life expectancy – we'd still be the third best in the world. Moreover, all our performance targets are still fundamentally formed around performance and price. [IJ]

This was an example of the way in which a policy paradigm based on utilitarian ideology guided an institution's decisions about policy goals, ends and preferred instruments to be used to achieve them. The goal is to invest in policies that would lead to improvements in the health of the majority of the population and there is no provision for giving specific attention and more resources to improve the lives of those with the lowest life expectancy with the intention of closing the gap in health inequality.

This respondent went on to say that, in his view,

we should be far less driven to improving our life expectancy as a nation and all other parameters of morbidity, mortality and social wellbeing, and far more driven to reducing the outliers, and we don't have indicators, and targets and incentives which promote and enable that. [IJ]

At the bottom is that democracy is fundamentally about the majority and don't give a stuff about the minority. It's in the way we vote. The key programs to have targets and performance measures and penalties are not predominantly directed to picking up the outliers.[IJ]

Although this respondent disagreed with the utilitarian ideology informing his institution's policy paradigm, the institution's rules and the wider cultural norm that 'the majority rules' constrained his ability to take stronger action to develop policies and programs that were intended to meet the specific priorities of the Indigenous population.

Maybe that's what democracy is – maybe I'm wrong – if you make the majority happy, content, deal with them in this way then – because the consequences of not dealing with the majority ... is that you have differential structures in your core programs – policy might be right but the politics might be wrong.[IJ]

The respondent was reflecting, here, on both institutional rules and norms and the worldviews of policy actors. Public institutions responsible for policies distributing resources to populations are structured to identify and respond to the needs of the whole population. Dividing attention to identify, separately, the needs of and responses required for a small population then becomes a distraction. Moreover, the final point, that the policy may be right but the politics might be wrong is a recognition that the subordination of Indigenous cultures means that there 'are no votes in Indigenous health and advancement'.[IJ]

Indigenous peoples can and do benefit from public policies that are directed toward improving the health and life expectancy of all citizens. However, the persistence of the large inequality in average life expectancy is a powerful indicator that although such policies are necessary, they are not sufficient. Another respondent commented that in his experience, 'the majority always wins, even when the contest is between ideas being considered within a

group, and really, in any setting. There are always diverse views and in the end, those of the majority (almost always) win the day.’ [CD] When the needs, aspirations and goals of a minority population are distinctly divergent from those of a majority population the weight of majority rule can preclude the Indigenous population from winning a vote on an issue of major significance to them that is not also of significance to (or supported by) a majority of the non-Indigenous population.

### **Norms: power to place items on the policy agenda**

Institutional norms make it possible for individuals with political power and authority to put items on the policy agenda independently of organisational priorities. The personal interests of policy actors (ministers or senior bureaucrats) can play a role in determining items that are selected for inclusion on the policy agenda. In the quote below the policy actor identifies the operation of Lukes’ first dimension of power: a person who holds a position of power and authority within, in this case, Parliament, is able to put items onto the public policy agenda directly. One respondent described this explicitly:

Quite often at the more boutique level of policy it may come up because of something that’s happened to the Minister or something that’s happened to a Senior Executive. Or you can have it because someone turns up with that missionary zeal approach and just drives it and the outcomes will fall where they may.[KL]

### **Norms and rules: changes in policy paradigms**

The opportunities to introduce new ideas on to the policy agenda can arise when governments (or institutional executives, for example) change, bringing with them new policy paradigms. In the quote below, the respondent pointed out how a change of government could lead to a

change of policy paradigm, in this case, making it more likely that action to address inequality would become a priority:

A new government can open opportunities for different parts of the population than we had previously. Under this government I think that there is more capacity for bodies such as ACOSS and the various COSSs and there are other structures that have been put in place within different areas.[AB]

Another respondent also spoke of the influence of a change of government on policy paradigms and hence, on the shape of subsequent public policy decisions. All respondents described their work with inherited paradigms and one expressed, clearly, frustration at the difficulty in bringing about change in these inherited situations:.

Not just the bureaucracy that has to change, but we need to ‘unlearn them’ – we need to re-teach people. You’ll have the competition for resources – for three decades we’ve had a system that’s flawed in its direction as much as the bureaucracy is – we have to learn to see things in a more long-term way. [MN]

Here the respondent is describing how a paradigm has exercised a powerful influence over the decisions of policy actors who have shaped service design and delivery for 30 years.

Another respondent spoke of a paradigm shift that had arisen with a change of government that had the potential for a positive shift toward greater investment in Indigenous-specific initiatives. However:

If I think about the most recent policy process that we’ve been through you could look at that and say that there wasn’t terribly much room for engagement with Indigenous people purely because of the politics of ... – how would I describe it? I would think that this government has a very particular agenda that it wants to run and it only had a

window of 12 months before other state governments began to change their colours so it had to do something in that small window...[AB]

The complex mix of a paradigm shift and limited time in which to make use of an opportunity to act to achieve a change in policy means that inherited institutional arrangements and operating procedures continue to dominate in contemporary policy making.

### **Inherited rules, norm, and policies**

Over time the rules and norms of institutions evolve, building on the cumulative experience of the institution and its policy actors through different policy eras. The patterns become embedded in standard operating procedures and in the cognitive beliefs of policy actors – accepted as norms and standards without question. Rose (1990) in his classic paper quantified the extent to which the institutional rules and public policies inherited by governments and their agents placed clear constraints upon their capacity for reform. The power of policy inheritance was confirmed by this study, both in what factors the policy actors said had influenced their current decision-making, and in what they did not say, but assumed.

One respondent explained how the inheritance of institutional norms and rules is continuing to have an impact on contemporary public policies intended to reduce a gap in housing need among Indigenous people.

One of the issues that keeps coming up is that one of the major policy settings for the Australian government and Australian society as a whole is home ownership as a ‘good thing’ – there is a view that life outcomes are better for people who are home owners for a range of reasons...[KL]

The respondent went on to reflect that, because that inherited policy paradigm has become the standard by which policy outcomes are judged, there has been little subsequent

investigation by contemporary policy actors (and researchers) to ascertain whether that idea of home ownership matched the perceived needs (or aspirations) of the Aboriginal and Torres Strait Islander population.

Without Aboriginal and Torres Strait Islander representation in policy settings, generating ideas and participating in the contest among ideas, and without recognition of the equivalent value of culturally defined (and possibly different) housing needs, there is danger that the policy inheritance will reproduce the persistent housing shortfall in many Indigenous communities.

So the (default) setting is that home ownership is considered to be a good thing. Then, we know that Indigenous home ownership is about half that of the general population – so, not so good. There is a range of questions that need to be answered about this – why is the Indigenous population not engaging with home ownership? Is it because they are the poorest and most disadvantaged group and that most of the people who can afford to buy housing are already doing so? Is it because there are some cultural imperatives going on? What is it? [KL]

The norms implicit in the inherited policy settings in such instances are complex. Too few and inadequate, inappropriate houses in rural and remote Aboriginal and Torres Strait Islander communities, in particular, has created a serious problem. The inherited housing policies combined with limited time and money in the contemporary policy context meant that policy actors, among whom were few Indigenous representatives, were approaching the current problem with underlying concerns:

... was ‘is it better to be in appropriate housing now, no matter what the form of tenure? or is it better to invest in making it possible for everyone to own their own



home (or almost everyone), although that may take longer leaving some people in unsuitable, lower quality housing for a much longer time?' [KL]

... government, in the absence of informed answers to those questions, had responded with various forms of rental arrangements. And so Indigenous populations are over-represented in private rental, over-represented in community housing. So is it, in fact, a perverse policy outcome that we're living with now because there was a policy focus on let's get Indigenous people into appropriate housing and not worry about tenure? [KL]

This respondent describes the multiple points at which policy actors make decisions about the distribution of a social resource (in this case, housing) to Indigenous people and communities. The clarity of the questions illustrates how, without formal Indigenous representation in the policy-making process, and without respectful recognition of culturally specific housing demands, the institution (and its actors) do not have the capacity to bring detailed, current advice directly from Indigenous families and communities about what constitutes sufficient and appropriate housing.

### **Policy actors' cognitive beliefs**

The respondent, quoted below, had described how a decision by his institution had resulted in formal Indigenous representation in policy-making for the first time in the institution's history. The consequences of the inclusion had been positive in shaping policy decisions:

... there is far more engagement – far more preparedness to engage and to be active.

But the inclusion had also resulted in conflict within his institution as the shift in power over decisions took hold.

... but there is another dimension to that – an increase and escalation of tension and conflict and breakdown in relationships and that's one of the (not perverse outcome) actually it's a desirable outcome, because in a sense the greater the conflict it means the greater the challenge to the dominant culture – to those of us with power.[GH]

The respondent explains that he views the conflict as a positive step toward decolonising existing operating procedures and the worldviews of existing policy actors. Some respondents identified their personal cognitive beliefs and those of colleagues and people with whom they consult or collaborate in communities or other sectors as influences on their capacity to work with Indigenous colleagues and communities. For example,

It's inappropriate for me as a white fella – to stand up and say that we're going to design this – we can only do this with advice, support, and permission from Indigenous communities and colleagues.[GH]

It's about people's preconceptions and prejudices – where you are is where you've come from, particularly in this sort of area it will define how you look at a problem.[KL]

Quite often, the way you look at the problem actually says more about who you are as an observer than a good articulator – it's come up time and again [KL].

Do we leave too much of it to people who have the value system and commitment, or is it just that there are too many pressures for getting it right for everyone else or do we just slide over it?[IJ]

The last respondent is reflecting upon reasons that policy is not, routinely, focused on ensuring the fair, just distribution of social resources to the Indigenous population. The institution, in the view of this respondent, leaves too much room for policy actors to make

decisions based on inherited worldviews that are racist and that tolerate injustice and unfairness of decisions inherited from the past. Another respondent described how his personal values, knowledge, experience and commitment have been critical to success in inserting two specific provisions to improve distributive justice into his sector's standard operating procedures and policy paradigms. The changes are not specific to Indigenous peoples. However, he describes wider systemic policy changes across the sector that now require transparent reporting on social outcomes, and that have created opportunities to increase commitment to distributive justice in internal organisational policies. He adds that, without his personal intercession based on his own values and beliefs the changes may not have been adopted as fully [OP].

In another example, a policy commitment to increase the diversity of cultural representation on a local representative body, has resulted in the achievement of an elected membership that is closely representative of the cultural composition of the population. It has also resulted in gender parity among representatives. It has been made possible by the explicit commitment of his organisation to representative diversity in local social organisations. This was a policy decision made explicitly with the purpose of enabling diverse (and by implication, marginalised) communities to speak for themselves in a policy space [OP].

Upon later reflection, however, it became apparent that the increased representation of cultural groups in the policy space did not include increased representation from the local Indigenous population. The absence was not discussed. This is a further example of the application of a cultural and institutional norm that accepts as unremarkable, the lack of Indigenous representation in public policy-making.

## **Recognition and misrecognition**

Institutional rules and norms influence the decisions of contemporary policy actors. When the rules and norms have been established through a structure and process that have not included Indigenous representation, it is likely that policy decisions are dominated by the demands of the majority. As an example, one respondent explained that:

... (the health sector) is just providing services to people that need service and I think that's at the heart of the problem. That type of service delivery will never get traction on its own because it's not meant to be developmental, it's meant to deliver services.[MN]

The respondent was expressing frustration that the rules and norms of his institution means that policy decisions that had been shown to fail repeatedly, are being replicated. Although Indigenous communities know that community development under Indigenous leadership is a vital complement to health care,

The health sector as a whole sector – not just the community control part – struggles with the idea of community development as a recognised, evidence-based form of delivery. It's struggled for decades and it's not recognised. [MN]

## **Representation and misrepresentation**

Each of the respondents expressed commitment to formulating policies that distributed social resources more equitably to Indigenous communities. One of the non-Indigenous policy actors identified the desirability (rather than necessity) for the employment of more senior Indigenous colleagues within his own institution,[IJ], and one had negotiated with senior

management to enable appointment of an Indigenous representative to the senior executive board of his organisation.[GH]

One of the Indigenous respondents described the transformative changes she would like to see within social institutions:

At the end of the day the outcomes of the changes I'd like to see [would include having] Aboriginal people in parliament, on TV, and you'd have non-Indigenous people for example, talking a language. And if there's going to be real changes my view would be that you'd need to start a dialogue (and government don't want to hear this) – around what people say is systemic racism – institutional racism and what this actually means – because it's the system that has set up that disadvantage in a range of areas, including negotiation with communities, that whole notion of bringing ideas into the policy development process.[EF]

One of the non-Indigenous respondents spoke of the need for more representation by Indigenous colleagues with greater political power and presence in higher level policy settings as a means by which to improve the effectiveness of policy decisions. In answer to a question about who to trust and who to talk to when making policy decisions, he commented that:

The more people we get (in our sector) from minority groups who move progressively up the totem pole the more you get individuals whose skills base is excellent – here we have a good Head of Indigenous policy I can talk to honestly – because she has many years' experience and we can have a good robust debate.[IJ]

Respondents did point out that at different periods in history governments had established structures with the expressed intention of ensuring that Indigenous cultural values and policy

ideas are represented to governments, directly. In the example below, the respondent comments on the influence of changes in government and consequentially, in policy paradigms on policy decisions.

The extent of community engagement (in the policy cycle) varies, and it's cyclic too. It depends on the ideologies of the governments of the day and the choices they make. With the abolition of ATSIC that was the Howard ideology and they didn't want that process or mechanism there to inform their policy directions. That makes it very difficult when you don't have a mechanism because then what you've done is dismantle a mechanism even if it's difficult – that tries to bring a voice into the political process.[EF]

### **Recognition without representation**

Six of the eight respondents in the study identified actions that they or their institution had taken specifically to increase the effectiveness of policy outcomes for the Indigenous population. Not all the actions had succeeded. The respondent below recognised that new policy ideas were needed to achieve more effective policy outcomes and reflected on the norm of public policy decisions being made in the absence of Indigenous representation.

I think we've replaced doing things with engagement - and often we don't do things because we don't know what to do and we don't have the intervention tools, and we've found it easier to engage than to do - we've engaged but not done – gone overboard on engagement ... I think the historical way we've engaged – we've gone to the community about everything. We don't do that with 'whites' so much – we just go and do things.[IJ]

The institutional norm reflecting the lack of Indigenous representation within policy making was illustrated by an example given by one respondent who commented that:

There are still meetings out here where, apart from my very senior Indigenous colleague, there can be 25 whites sitting around discussing Indigenous issues.[IJ]

### **Worldviews of policy actors**

The Indigenous respondents' own life experiences, professional and personal cognitive beliefs and worldviews, and work with and for Indigenous communities meant that they recognised the influence of the institutional arrangements, and the values, rules, and norms of the institutions on their policy actions. The section below describes their experiences.

One spoke of the dissonance between the needs and priorities expressed by Indigenous communities and the policy priorities that had been imposed by the institution. There is, she said:

always a tension about where priorities come from. How to be trustworthy from the communities' end – it's hard to match responses to their needs and priorities.[EF]

She described a recent example of the mismatch that had resulted in the erosion of Aboriginal communities' trust in her own organisation and in her, as an Indigenous representative within that organisation.

The timeframe set by COAG didn't allow us to do a local engagement process and in one breath they're saying consult with stakeholders and with the other, these are the timeframes [EF].

Representing a minority population with diverse, urgent needs, competing for space in a crowded public policy agenda, and with limited time in which to develop culturally defined

policy solutions, places Indigenous policy actors in mainstream institutions into demanding, transactional roles.

The other Indigenous respondent reflected the tension arising from the competing goals of politicians, the non-Indigenous population, and policy actors within his institution.

But obviously the politics of it all is that there is a different set of arrangements and that's between politicians and the public. For the bureaucracy there is a great deal of frustration and I get the sense that people (that is, policy actors within the bureaucracy) are questioning (whether they are getting the right outcomes) but we don't have the answers about what's a better approach... I think my job and commitment from an Indigenous perspective has been to find answers to these difficult questions.[MN]

The values, ideologies, and problems that are priorities for this Indigenous policy actor's constituent communities are different from those of the institution for which she worked. The political imperatives being described indicated that institution had given space on its policy agenda to include consideration of Indigenous policy ideas. However, the clash described below is between the processes used by Indigenous communities and the social institution to make policy decisions.

[As a manager] my job is to manage the political imperatives – so I do struggle sometimes because my values around inclusion, engagement, and negotiation with the community clashes with government values.[EF]

The patterns of subordination of the value of Indigenous cultures and peoples within the standard operating procedures of institutions are clearly visible to Indigenous policy actors. One Indigenous respondent described the meaning of the subordination of Indigenous



cultures for her, in her day-to-day work as a senior manager within a mainstream institution. When asked what is needed to improve the capacity of her institution to contribute to improving Indigenous health equity, she replied:

That's easy – BE BLACK. Because I don't know whether too many people do this – I'm Aboriginal, come from an Aboriginal background, have experienced lots of things. And because of that, but when you work in this system it's very white, white thinking, white dialogue, and the biggest challenge and frustration for me as an individual is that I'm constantly bombarded by the whiteness that's there and it's a challenge to advocate and negotiate things because particularly if dealing with white people they're looking at things from a white frame of reference. ...So I work in two cultures – in the Aboriginal and non-Aboriginal world.[EF]

The challenge of working in two cultures was echoed by the other Indigenous respondent who explained that from his perspective there was an ongoing mis-match between the worldviews reflected in current policy and the worldviews of Indigenous peoples.

We're trying to deal with communities that have fourth world development issues and we're trying to respond with a conventional first world service delivery model that has no foundation in capacity development.[MN]

However, in the absence of respect for the actor's expertise, and without Indigenous people's direct representation in the process the policy instrument being selected by current policy actors cannot eliminate the problem.

The same respondent pointed out that seeking greater access to equal health care (or material resources) alone:

... is not what Indigenous aspiration is all about. This is still our land. We know we have to share it, we have inherent rights, we have unique cultural values (not saying that non-Indigenous Australia doesn't have them) but ours are what we have and we want access to our own land [MN].

Both the Indigenous respondents had positions of power within their institutions, one as a member of the Senior Executive of the organisation; the other with direct access to the Minister.

The challenge for me is to be skilled enough to get these sorts of initiatives into the federal policy framework – I'm more confident now than I've ever been because of my relationship with the Ministers' office and with senior Aboriginal and Torres Strait Islander people across the nation – have to line up a whole range of factors and use every ounce of energy – feeling more confident but gee it's a long way to go – beyond my life time [MN].

However, even having a powerful role was insufficient to ensure action. One of the Indigenous respondents spoke of the challenge of facing systemic, institutionalised racism and the demands of needing to respond to the denial of co-workers of their part in it, the colonial amnesia spoken of by Sherwood (2009). One was using the position to instigate positive reform of institutional arrangements and to begin challenging and changing the cognitive beliefs of her non-Indigenous colleagues.

When we talk about systemic, institutionalised racism – they say, we're not racist. (We have to find) other ways of doing it without using the terminology – have to be cautious and subtle. Trying to break down the systems and processes that disadvantage communities, particularly our people. In one program it's been possible

to challenge and bring about culture change and changing practice – a complementary Indigenous model of providing services to Aboriginal people [EF].

A non-Indigenous respondent who had taken steps to reform the standard operating procedures of his large institution, had had some successes in bringing about changes in the cognitive beliefs and in the practices of colleagues. As a non-Indigenous representative of a large, mainstream institution, he reflected on the reason it had been necessary to take time to form relationships with communities:

The first effect is trust. If the community tell us ‘you’re alright’ that’s step one – that’s probably the most important outcome [GH].

He went on to describe how he had needed to undertake deep reflection on his own cognitive beliefs and about the ways in which these had contributed to the unequal social treatment of Indigenous communities and colleagues. He had begun to confront historical injustices and to revise his own cognitive beliefs to include the equal valuing of Indigenous cultural values and standards. He had also moved to embed the new way of thinking in organisational practice.

... we have to go by Indigenous standards not our standards, so there are standards or qualities of partnership that I didn’t fully grasp – that I’ve actually engaged in, I’ve transgressed and I’ve had to do a fairly heavy bit of self-reflection because I didn’t understand [how] I had transgressed so then I had a reaction to this happening [GH].

### **Structures and mechanisms for change**

In all the analysis reported to this point respondents had reported on existing institutional rules and norms that had influenced their policy decisions. However, several respondents reported on ways in which they had been able to initiate changes in institutional rules and norms to reduce misrecognition and increase representation in one case or to change

institutional arrangements in another. The mechanisms through which injustices were being reproduced could become mechanisms through which injustice could be, at least, challenged and, albeit over time, overcome.

### **Changes in standard operating procedures**

There were examples of institutions reforming their internal standard operating procedures to enhance recognition and to increase representation within organisations. One Indigenous respondent was able to report on positive changes (in policy and in structures) that had occurred over 5 years within the institution. The changes included increased numbers of Indigenous staff, an increased budget for the Indigenous policy area, and appointment to the Senior Executive Group [EF]. The other Indigenous respondent had achieved a more powerful position within the institution and had used the power to obtain funding to invest in a capacity-building initiative to create opportunities for more Indigenous professionals to take up employment [MN].

Another respondent described an example of intentional change initiated by policy actors from within the institution (in partnership with external, Indigenous communities). It had been possible to expose the harms to health in the local Indigenous community arising from the patterns of cultural value embedded in the institution's standard operating procedures and in the cognitive beliefs of policy actors. Under the leadership of an Indigenous Elder:

... Indigenous staff formed an Indigenous Advisory Group – one member of which them is on the Executive Board of the organisation – with direct voice to management. And whenever we (management) make decisions, we can refer back to the group for advice [GH].

Over 3 years, that same institution set in place an institutional redesign process to change the norms and rules and to make it a culturally safe place to work and from which to receive services. The institution developed a new policy paradigm, outlined in a strategic plan:

We've got a strategic plan – includes a thing called a score card – what's the best picture of our organisation – that's our strategic plan so then it's got a dozen objectives which describes the goals, processes, and resources and people in the institution and in all those dimensions of the institution we've gone in and changed. We've changed our objectives, our internal processes, our resource allocation, we've changed people [GH].

The same institution, in response to long-standing inequalities in health between Indigenous and non-Indigenous children in the area, implemented a restorative justice funding model to allocate funds for a new program. The allocation of three times more funding for the elements of a program being delivered to Indigenous children than for the elements of the same program being delivered to non-Indigenous children was an example of equitable funding – allocating resources equal to need.

There were other examples of social institutions taking action to change their rules and norms to increase their capacity to develop policies that would lead to reductions in the inequalities in the distribution of social resources. Seeking to increase the representation of disadvantaged communities in the structures and processes responsible for developing policy paradigms, one respondent described actions taken by his department:

In the last 5 years, the Department has moved its policy and practice beyond consultation to acceptance of the ILAP2's definition of engagement. We have been pushing the boundaries to encourage the Department to accept shared decision making with communities [CD].

This was an example of a change in standard operating procedures initiated by policy actors to broaden the criteria governing eligibility for membership of policy-making structures. Another described an innovative mechanism through which an institution had increased a non-Indigenous, but socioeconomically and culturally marginalised community's inclusion in shaping public policy. His institution had invested funding to enable a marginalised community to employ its own expert to assist in making policy decisions. The person employed was someone whom residents and the Department knew well and who was selected by both as their trusted expert. It strengthened community members' capacity to participate as peers in the policy process, an example of institutional reform in response to policy actors' ideas.

Community engagement in decision-making is vital but not simple. My group decided to use [time before policy implementation occurred] for community capacity building to educate people about making plans, about the principles of best practice, and the processes used to make decisions about these [CD].

The benefits of shared communication were clearly visible to the respondent.

Through this, we got a rich picture of the needs of the different cultural groups. Although it was not possible to give the groups everything that's demanded, the Department always looked for what can we give them – and found it was possible to adapt policy in response to communities' preferences. That was a win for all [CD].

The institution and its policy actors had each taken purposeful action to change operating procedures to mandate the representation of marginalised communities in policy making. The institution had invested in the community's capacity to gather its own evidence. That increased the legitimacy of the evidence from both the community's perspective and the

perspective of the policy actors involved. This was an example of the interdependence of structure and agency being activated positively.

I concluded the analysis with a table illustrating how I had interpreted the data to decide which of the candidate mechanisms was being activated. See Table 7, below.

Table 7. Candidate mechanisms observed in the data

<b>Candidate mechanisms</b>	<b>Observed examples</b>
Structures	<ul style="list-style-type: none"> <li>• Institutions with policy influence</li> </ul>
Structural influences on policy decisions	<ul style="list-style-type: none"> <li>• Government and institutional policy</li> <li>• Performance measures</li> <li>• Institutional timelines</li> <li>• Selection of policy instruments</li> </ul>
Institutional arrangements influence on policy decisions	<ul style="list-style-type: none"> <li>• Position in organisation</li> <li>• Access to power</li> <li>• Frustration within bureaucracy</li> <li>• Limited presence of Indigenous policy actors within the policy spaces</li> </ul>
Worldviews or cognitive beliefs	<ul style="list-style-type: none"> <li>• Reflection on own beliefs or perspectives</li> <li>• Cultural differences in world view</li> </ul>

Reflexivity	<ul style="list-style-type: none"> <li>• Actors initiating change in structures and paradigms</li> <li>• Institution-driven change in structures and paradigms</li> </ul>
Decisions re distribution	<ul style="list-style-type: none"> <li>• Equal inputs or equal outcomes – what constitutes equity?</li> <li>• How to decide?</li> <li>• Compensatory funding</li> </ul>
Decisions re recognition	<ul style="list-style-type: none"> <li>• Racism – subordinate cultural value – reflected within respondents’ own policy spaces</li> <li>• Time and skill necessary to enable meaningful negotiation with communities</li> <li>• Identification of need for Indigenous actors – or, alternatively, no mention of need</li> </ul>
Decisions re representation	<ul style="list-style-type: none"> <li>• Indigenous people represented (or not represented) in policy settings</li> <li>• Racism - misrepresentation</li> </ul>
Dimensions of power	<ul style="list-style-type: none"> <li>• Influence on policy agenda</li> <li>• Networks and influence on framing policy</li> <li>• Capacity to develop policy independently of dominant culture or power</li> </ul>

## Conclusions

The abductive analysis of the theories identified in the abstract literature search had resulted in the selection of new institutionalism, Fraser’s theory of social justice (including structural racism and colonialism) and Lukes’ three dimensions of power as the normative theories to include in an integrated organising framework that would assist in understanding the events in



more depth. Through the retroductive step I abstracted candidate mechanisms in the real domain through which institutions and policy actors exercise influence on public policies that, in turn, contribute to explanations of the outcomes reported in the empirical domain. The purpose of the interview study was to assess whether:

1. respondents describe the influence of characteristics of structures on their policy decisions?
2. respondents reflect on their own (and others) cognitive beliefs and their roles in shaping public policy?
3. it is possible to identify underlying generative mechanisms that could, plausibly explain the relationship between the events in the actual domain and outcomes in the empirical domain?

Looking beneath the surface of policy actors' self-reported descriptions of the influences on their policy decisions it was possible to identify examples of misrecognition and misrepresentation that were accepted as normal by respondents. The examples of misrecognition and misrepresentation described by the non-Indigenous respondents outweighed examples of transformative actions that they had taken in response to concern about pre-existing policy decisions. The Indigenous respondents, by contrast, expressed strong concern at what they described as racism (in one case), and the lack of direct Indigenous representation in the policy space (and consequent policy failure) in the other case. Only one of the non-Indigenous respondents had identified racism (institutional and interpersonal) as an underlying mechanism influencing policy decisions.

The study did confirm that each of the social institutions represented by these policy actors had expressed formal commitment to improving their responses to Indigenous needs.

However, only one respondent reported specific actions taken to translate the commitment

into policy action. That action was based on the adoption of a view of social justice that recognises that to achieve equal outcomes it is sometimes necessary to deliver unequal inputs, and as a consequence, in this case, that view saw the institution adopt a new funding model for the delivery of a program that, based on the concept of restorative justice, committed a greater proportion of funding (to enable greater program intensity and reach) to the Indigenous rather than the non-Indigenous population.

Respondents reported on multiple actions their institutions and they, as individual policy actors, had taken to increase the responsiveness of their policy decisions to the needs of Indigenous communities and peoples. The appointment of Indigenous professionals into senior managerial roles, the introduction of a structure and process to facilitate respectful communication between communities with divergent cultures and perspectives, and the introduction of a process to build knowledge and trust between a social institution and marginalised communities, were all examples of actions intended to overcome (or contribute to reducing) misrecognition or mis-representation of Indigenous cultures and peoples within policy spaces.

However, the Indigenous respondents, in particular, although powerful within their respective institutions, reflected upon the impact of the ongoing misrecognition of Indigenous cultures and the consequent undervaluing of their policy priorities and ideas on the capacity of their institutions to make effective policy decisions. That only one of the non-Indigenous respondents expressed concern at the absence of Indigenous direct representation in policy making within their institutions confirmed that view.

The analysis revealed that it is common for non-Indigenous policy actors to formulate policies that have an impact on the health and lives of Indigenous constituents in spaces in which there are no Indigenous representatives. At the time of the interviews I failed to

recognise the silence of most respondents about this, and did not probe to understand further. I, too, was carrying worldviews that accepted as normal such existing patterns of practice. That respondents did not raise the need for Indigenous representation in policy-making shows that non-Indigenous actors, even if personally committed to improving the access of Indigenous peoples and communities to social resources, they do not regard it as a necessity to have Indigenous policy actors engaged, formally, in the structures and processes of policy formulation. The Indigenous respondents view this as a central concern recognising it as both a manifestation of the subordinate value ascribed to their contributions to public policy, and as a limit on the power of Indigenous communities and peoples to shape public policies to ensure the equitable distribution of social resources and opportunities. One respondent described, eloquently, how distributive decisions are made without an Indigenous presence as policy actors, reflecting alternative policy options that had been generated through empirical research and the results of community consultations. The options were genuine and a decision between them required judgements about what would be delivered and to whom. Without the active, formal presence of Indigenous policy actors with power and authority in the policy-making process the distributive decisions and their legitimacy (from community perspectives) are questionable.

Among the worldviews expressed by respondents was the preference given to utilitarianism as the ideology underpinning the overarching policy paradigm of government. That respondent reflected on the power of that paradigm in shaping socially-just policy decisions based on the priority given to efficiency (and not equality) as a defining value.

That governmental policy paradigms are based on a theory of social justice that gives priority to utilitarian ideology and efficiency is unsurprising, serving, as it does, the needs and preferences of the majority of citizens. However, it exposes the role of Lukes' dimensions of

power and of cultural injustice in perpetuating the injustices of the past. Cultural injustice (including racism and colonialism) has resulted in Indigenous nations and peoples being excluded from policy spaces, resulting in significant limitations on access to Lukes' first and second dimensions of power. That, in turn, results in distributive injustice. The social resources and opportunities needed by contemporary Indigenous communities and peoples are, as a consequence, different than those required by non-Indigenous Australians. In order to have needs met they are forced to build public support from an, at best, resistant majority. The hegemony of the dominant culture is maintained not only by its having colonised the institutions and cognitive beliefs of those responsible for governance; it is maintained by its being a huge majority whose needs and aspirations are being served.

Misrecognition did appear to be an underlying generative mechanism that exerts influence on contemporary policy decisions through inherited institutional structures, and standard operating procedures, and the rules and norms to which they have given rise. The respondents reported ways in which their decisions were determined by their institutions' structures, rules and norms. The non-Indigenous policy actors' responses revealed acceptance (however unconscious) of the subordination of the value of Indigenous cultures by their institutions.

Misrepresentation was being reproduced – both in the lack of systematic, routine Indigenous inclusion in policy-making, and in developing policies without the knowledge, experience and aspirations of Indigenous people being represented directly. Indigenous policy actors are acutely aware of manifestations of cultural injustice (racism and colonialism) in the policy spaces in their institutions and spoke of the need for transformative actions such as increasing representation on one hand, and decolonisation of the institutions and non-Indigenous policy actors' worldviews on the other. However, there was limited reflection on the part of non-Indigenous policy actors about their own and their institutions' roles in

perpetuating injustice, and only one was taking active, positive steps to remedy both cultural and distributive injustices. Even he, however, had not consciously taken steps to remedy representative injustice although he understood it when it was pointed out.

The candidate mechanisms drawn from the integrative conceptual framework comprised of the institutional arrangements and operating procedures, three types of justice (or injustice) and the three dimensions of power could be observed as influences on the policy decisions of contemporary policy actors. However, it is necessary to set the conceptual framework within the context of Australia's colonial history and the racism and colonialism that underlie cultural injustices. The interpretation of what constitutes cultural injustice is situation dependent. In a colonised nation such as Australia, the historical context within which contemporary policy formulation is occurring plays a vital, although rarely transparent, role in shaping the structures and the worldviews of policy actors, and of Indigenous peoples. That history has created one nation and two societies, one of which continues to seek authentic, respectful, meaningful inclusion in the creation of the public policies through which the nation governs.

In conclusion, the interview study confirmed that it was possible to verify the generative candidate mechanisms being activated in contemporary policy spaces. Respondents did describe the influence of the structural and cultural contexts of their institutions on their policy decisions, and did describe the influence of their own normative beliefs in shaping their public policy decisions. It would therefore, be possible to validate the explanatory power of these candidate generative mechanisms in subsequent studies to contribute to explanations of the relationship between events (public policies) in the actual domain and the observable outcomes in the empirical domain.

## **Chapter Twelve. Reproducing injustice? A critical realist analysis of the roles of social structures and policy actors in the persistence of inequality in the average life expectancy of Indigenous Australians in the 21<sup>st</sup> century**

A significant difference between the average life expectancy at birth of Aboriginal and Torres Strait Islander (hereafter referred in this chapter to as Indigenous) Australians and the average life expectancy at birth of the Australian population as a whole has persisted into the 21<sup>st</sup> century (B. Phillips et al., 2017) . The inequality persists despite continuous improvements in the average life expectancy of the whole population of Australia over the 19<sup>th</sup> and 20<sup>th</sup> centuries. It persists despite strong empirical evidence of the phenomenon, and despite Indigenous explanations of the causes of the inequalities and proposed remedies.

Life expectancy is not the only marker of a good life and the inequality is not the only trigger for moral concern about unjust, unequal social treatment experienced by Indigenous Australians. But it is an observable indicator of the serious consequence of unjust social treatment – it kills.

There have been some positive changes in the life expectancy of Indigenous Australians (adults and children) in recent years, and the same period has seen a growing number achieve greater socioeconomic security, social status and access to power to influence public policies. Initiatives taken by Indigenous peoples themselves and non-Indigenous supporters have seen the achievement of constitutional and legal reforms, and challenges to political and social norms (Attwood, 2003; Bennett, 1991; Perkins, 1975; Rowse, 2010; Wenitong,

Mokak, Councillor, Delaney Thiele, & Calma, 2007). Indigenous controlled organisations deliver services and generate policy ideas and, in myriad large and small ways, are creating and using platforms for change from within social institutions including Parliaments, universities, schools, and health services, sports and arts organisations and the media. Some Indigenous people view the changes so far as having been positive (Enoch, 2016; Grant, 2016b).

All are impatient for change. The gap in life expectancy in the 21<sup>st</sup> century continues as a reminder that much more is required to achieve justice and equality. The levers of power to take action, however, lie within the social institutions and in the control of policy actors whose worldviews are those of a dominant cultural group. Many Indigenous people and communities express despair at the ‘lack of movement on unmet fundamental issues – inequality, discrimination, unfairness and isolation – denial, ignorance and enmity’ (Dodson, 2016; Langton, 2016; Lucashenko, 2015; Wright, 2016). The themes of inequality, discrimination, unfairness and isolation have resonated across the whole of postinvasion history. And there have been hard, ongoing challenges in maintaining culture through this history, including the right to tell their own histories and stories (Wright, 2016, p. 68). The evidence shows that

holistic approaches (to improving Aboriginal health) rich in evidence-based thinking, with emphasis on community control of health services, intersectoral collaboration and improved monitoring and accountability that have been repeated over almost a quarter of a century’ (Houston, 2016, p. 17) are not leading to even a closing of the gap in average life expectancy for Indigenous Australians. The indicators point to the need for changes in approaches to developing and implementing public policy and not simply more of the same (Houston, 2016, p. 17).

## **Research question**

What structures, powers, and underlying mechanisms could contribute to the persistence of the inequality in average life expectancy at birth between the Aboriginal and Torres Strait Islander and non-Indigenous populations of Australia in the 21<sup>st</sup> century?

## **The method**

Critical realism provided the metatheory for the thesis, assuming that there is a real world independent of our knowledge of it, and that reality is stratified in three domains – the real, the actual and the empirical. Critical realism, in accepting that structures (institutions) exist only through human activity, and are not reducible to such activity and social structure that exists independently of current human activity. History matters. Critical realism uses a pluralist, interpretivist epistemological approach to identifying mechanisms in the real domain, drawing on multiple theoretical, disciplinary and cultural perspectives from which to see generative structures that explain a phenomenon (R. Bhaskar, 1998a). Put another way, my thesis was intended to look beneath the course of events to the mechanisms that generate them (Collier, 1994, p. 50). Using a stepwise framework with six parts devised by Bygstad and Munkvold (2011, p. 5), the method begins with a description of observable social phenomena in the empirical domain and redescribes the phenomenon of concern as the persistent, systematic patterns of inequalities experienced by Indigenous Australians.

Through an abstract theoretical analysis of transdisciplinary literature, I describe events in the actual domain and select key components of these that are generalisable across all events.

The key components are the social institutions and the policy actors, and, in a further refinement, the mechanisms through which they influence events.

I explore transdisciplinary literature using an emergent process to identify theories and ideas from different disciplinary, philosophical and cultural perspectives that inform the normative



beliefs of policy actors and that influence their decisions about the determinants of inequalities in health and about appropriate social remedies. I analyse the impacts of these as generative mechanisms in the critical realist real domain that could explain the relationship between events (in this case, public policies) and the persistence of the systematic patterns of inequalities experienced by Indigenous Australians in the 21<sup>st</sup> centuries, with the serious inequality in average life expectancy at birth as a consequence.

An abductive process is used to review and integrate the theoretical perspectives into a theoretical framework that could provide deeper understanding of the causes of the phenomenon of concern. An interview study is then conducted to assess whether it is possible to observe candidate mechanisms from the real domain being activated in contemporary policy spaces and if so, to determine whether the candidate mechanisms are practically adequate indicators that could be validated in subsequent research. The final step is an iteration between the findings of the theoretical analysis of the literature and the results of the interview study.

The theoretical analysis of the literature explains that structures ‘are political institutions within which values are contested and decisions made about the inclusion or exclusion of actors, and within which the merits of different policy instruments are debated’ (Lowndes, 2002, p. 100). New institutionalism explains that the powers of social institutions are observable in their institutional arrangements, standard operating procedures, and although not directly in the assumptions, principles and values about the nature of reality, social justice and the appropriate role of the state, expressed in policy paradigms. The roles of agents (policy actors) in policy making were also explained by new institutionalism. Through tacit knowledge and cognitive beliefs, policy actors’ ideas about the nature of reality, social

justice, colonisation, racism and the appropriate role of the state are expressed through paradigms that influence their policy decisions.

Historical injustices (embedded in institutional policies and practices), and in the cognitive beliefs and worldviews of policy actors arising from these sources become institutionalised in what Fraser termed patterns of cultural value (Fraser, 2000, p. 114), both within the cognitive beliefs of individuals and in the policy paradigms of institutions. Embedded as cognitive beliefs the patterns can continue across generations, interpreted as universal, normative beliefs unrecognised or unquestioned by dominant cultural policy actors, and while hidden, cannot be confronted (Haugaard, 2003, p. 102). Only when transparent can they be challenged.

One manifestation of the dominance of cultural beliefs was evidence in contemporary population health literature explaining the determinants of inequalities in health. The determinants identified have been primarily from the domains of the empirical and actual layers of reality, without reference to structures, powers and underlying generative mechanisms that could be causing inequalities to arise. The political philosophy, political science, sociology, psychology, and postcolonial and anthropological literatures offered additional theoretical perspectives through which to identify potential underlying generative mechanisms. The Eurocentric population-health literature has given precedence to the maldistribution of material resources and opportunities as the principal cause of inequalities in health. The United States of America has given precedence to race (and more recently to racism) and associated inequalities in access to material resources and opportunities as the principal cause of inequalities in health. The Australian literature reflects a mixture of both these orientations. Only recently in Australia has the population health literature begun to include a focus on colonialism (including racism) as a significant cause of inequalities in the

health of Indigenous people. And only recently, too, has the literature begun to include investigations of the causes of the causes - the toxic mix of poor social policies, unfair economic arrangements and bad politics identified by the Commission on the Social Determinants of Health (World Health Organization, 2008).

Other theoretical perspectives revealed the influence of differences in theories of social justice, of equality and equity, of preferred ideologies, of priority social values, of causality and of the obligations of the state carried through the normative beliefs of individual policy actors and institutionalised in the standard operating procedures and policy paradigms of social institutions. Still other theoretical perspectives on racism differentiated between interpersonal and structural forms of racism, while colonialism drew together the sum of historical influences on the worldviews and cognitive frameworks of contemporary policy actors reflecting the role of institutions in transmitting values, norms and practices across generations.

The gaze in this thesis is on the institutions and people responsible for governance, on their characteristics and on their roles, and the mechanisms they activate to influence public policies. The theoretical framework I constructed to integrate the theoretical perspectives from the literature includes several dimensions: institutions responsible for governance and their characteristics; Fraser's theory of social justice (and the three forms of justice or injustice she articulated, including racism and colonialism); and Lukes' three dimensions of power. From each of these I identified candidate mechanisms that are potentially generative that could explain the relationship between the events and outcomes in the actual and real domains. The interview study confirmed that the concepts (candidate mechanisms) could be practically adequate indicators of mechanisms being activated in contemporary policy spaces and practice.

The interview study confirmed that it is possible to identify the influence of institutions on actors' policy decisions. They described institutional arrangements, norms and rules, and policy paradigms that shaped their policy decisions. Taken together, it was possible to identify a combination of the characteristics of structures and of mechanisms that could be described as patterns of cultural value that influenced the decisions of social institutions and policy actors about the distribution of social resources.

The study showed that underlying mechanisms, conceptualised as candidate mechanisms, could be seen to be being activated through contemporary policy actors' descriptions of influences on their own and their social institutions' roles in making public policies. Patterns of cultural value that subordinate Indigenous cultures and people to those of western cultures were still discernible in the institutional arrangements, the institutional rules and norms, and the cognitive beliefs of these policy actors in the 21<sup>st</sup> century. The study also revealed examples of mechanisms that reflected western liberal worldviews – perspectives on social justice, ideological preferences and on methods used to decide between preferences – in institutional standard operating procedures and policy paradigms, and in the personal preferences of policy actors. For example, the influence on policy decisions of utilitarian ideology and of efficiency (in the distribution of social resources) as a priority social value was identified in the study.

In summary, it was possible to identify examples of the structures, powers and generative mechanisms being activated in contemporary policy spaces, and to confirm that they could be practically adequate indicators that plausibly contribute to explanations of the relationship between events and the persistence of the inequality in average life expectancy at birth between the Indigenous and non-Indigenous Australians in the 21<sup>st</sup> century.

## **The logic of the conclusions**

Institutions decide who is eligible for inclusion in policy formulation, whose policy ideas are accepted for inclusion on the agenda, the processes by which policy options are considered and who is eligible to decide on the preferred option. Policy actors bring normative beliefs based on culturally shaped worldviews, and cognitive frameworks to the policy process, and are influenced, too, by their institution's operating procedures, rules and norms.

In Australia the normative beliefs of the colonisers formed the justification for colonisation itself. These beliefs included concepts of what counts as human, the assignment of subordinate value to the original owners of the land and their cultures, the taking of the land, and deconstruction of Indigenous cultures and communities. With complete confidence in the superiority of their culturally defined beliefs, the colonisers classified Indigenous peoples as being less than human, and codified their views in the laws, rules, social mores and norms of the institutions they established through which to govern. Racism, colonialism and western liberal philosophical and theoretical perspectives on social justice and equality were written and absorbed into the dominant culture's narrative about the birth of the nation and its subsequent history.

Indigenous peoples in the same historical period have acted powerfully to retain their cultural integrity and to build institutions with the authority and capacity from which to assert their rights and claims to lands, cultural continuity, to intellectual traditions and to resources to meet their self-determined social and economic aspirations. And there have been large and small successes in changing public policies and increasing access to the resources they require for health and wellbeing.

Throughout postinvasion history there are also many instances of individual settlers, organisations and governments acting with the intention of improving the lives, life

expectancy and health of Indigenous peoples. Reflecting broad shifts in worldview, the goals of successive policy paradigms evolved from dispossession through protectionism, assimilation, self-determination and recognition. Access to material resources and opportunities has been increasing, and there are growing efforts to identify and modify or reverse historical and institutional factors that have contributed to the continuing subjugation of Indigenous knowledges and methodologies (Cunneen & Rowe, 2014, p. 49). Nonetheless, even recent experiences have exposed the fact that the construction of normative beliefs upon which the nation was founded have been maintained (even if by a reducing proportion of the population). These beliefs are self-sustaining and self-renewing (Grant, 2016a; Guba & Lincoln, 1989, p. 145)

For Indigenous Australians the progress is too slow and too hard won, and has not been sufficient to achieve participatory parity or the recognition that will be necessary to co-create the policy table. In contemporary Australia, ‘the struggles and achievements of Aboriginal and Torres Strait Islander peoples in our pursuit of equality and justice continue to be fought over two basic issues: the right to be equal Australian citizens and the right to assert our special status as the original owners of this land’ (Casey, 2016, p. 189). The evidence suggests that the patterns of cultural value that have prevented these aims from being achieved are still at work. And at the end of the second decade of the 21<sup>st</sup> century, the systematic patterns of inequality had persisted and the difference in average life expectancy at birth was still significant.

The theoretical analysis of transdisciplinary literature identified multiple theories that have been developed by different disciplines and from both Indigenous and non-Indigenous perspectives to explain the root causes of the inequities in the distribution of social resources essential to health (Hofrichter & Bhatia, 2010).

There are differences in theoretical perspectives within disciplines (e.g. population health or political philosophy), between disciplines (e.g. between sociological and psychological theories of race and racism), and between cultural groups (e.g. between Eurocentric and indigenous minority groups in colonised nations).

From the perspectives of Indigenous researchers (and peoples) the difference in perspectives is obvious. From their perspective the core source of injustice is cultural and is manifested through everyday and structural racism and colonialism being reproduced by institutions and policy actors from the dominant cultural group that has inherited powers and privileges from its forebears and that resists challenges to these powers and privileges.

Fraser's theory proposes that social injustice arises from three distinct forms of injustice: distributive, cultural and political, each of which is a mechanism that could explain the relationship between events and persistent, systematic patterns of inequalities affecting the life expectancy of Indigenous Australians in the 21<sup>st</sup> century. Fraser distinguishes between distributive injustice, cultural injustice (including racism and colonialism), and political and representative injustice, and Lukes' analysis of power explains the relationship between each form of injustice and the capacity of Indigenous peoples to formulate public policies that could result in the elimination of the inequality in average life expectancy at birth between Indigenous Australians and the Australian population as a whole. Critical to Fraser's theory is that social justice is irreducible – cannot be reduced to a single form of injustice - all are equally vital. They arise from different sources and require different remedies. Each form of injustice plays a role in determining access to the political and social power and authority necessary to transform policy spaces, the worldviews and cognitive frameworks of policy actors, the policy formulation process and policy outcomes. The empirical study confirmed that it is

possible to observe each form of injustice and the limitations of Indigenous people's access to one or more dimensions of power being perpetuated in contemporary public policy spaces.

### **Implications for action: looking for and seeing generative mechanisms in the real domain**

Using each of the critical realist ontological layers to investigate causes of a significant social problem provided a means of exposing to the institutions and actors responsible for public policies, mechanisms through which they are generating and perpetuating 'the toxic mix of poor social policies, unfair economic arrangements and bad politics' (World Health Organization, 2008), that, in turn, result in systematic inequalities in health. And that in a colonialist state have an exaggerated impact on one cultural group above all others. The critical realist, pluralist, interpretive epistemology points to the necessity to look beyond the boundaries of a single discipline, a single philosophical perspective or a single cultural perspective to identify causes of complex, large-scale social phenomena. Using the integrative framework devised from Fraser's theory and Lukes' dimensions of power, it becomes possible to look for and see the contributions of institutional arrangements and practices devised by a dominant cultural group, and of the normative beliefs of policy actors from a dominant cultural group (and from different disciplines) to distributive injustice, of cultural injustice, and representative and political injustice.

Understanding the irreducible relationship between each of the forms of injustice described by Fraser is critical to identifying underlying determinants of inequalities (and of their persistence) – and hence, to identifying effective remedies. For example, the relationship between cultural injustice and representative and political injustice: each plays a role in the other, but each, on its own, requires separate action in order to remedy the injustice. Or, for example, the relationship between distributive injustice and representative and political



injustice highlights the need for material resources (distributive justice) in order to achieve participatory parity (representative justice). Finally, the cultural dominance of the institutions (and the power and authority invested in them) is the mechanism through which public policy decisions (as distinct from normative beliefs) are transmitted across generations. The institutional arrangements that determine who is eligible for inclusion, that set the rules and norms governing the selection of policy ideas, the framing and debate of policy options, and the formulation of public policies are open to analysis using Lukes' dimensions of power and, in particular, to analysis of their contributions to cultural and representative injustices. Their power to influence inequalities in health does not rest alone within the distributive impact of the policies they produce.

### **Implications for action: remedies for injustice**

#### **Decolonising institutions and policy actors: cultural justice (recognition)**

The constructs upon which the colonisation of Australia was based set in motion the pattern of the dominance of one cultural group and the exclusion of the other from political and social spaces and has continued into the 21<sup>st</sup> century. Sherwood (2006) explains the need for and pathway to decolonisation of institutions and actors (and the wider citizenry), to overcome the current paradigm of Western dominance and cultural amnesia that constructs and maintains the systematic patterns of inequality that results in the significant difference in average life expectancy at birth.

The implications of the findings of this research are that, within the worldviews of the dominant cultural group (and codified within the institutions its actors created and control), are three sources of social injustice that are irreducibly linked in creating social injustice, but that require separate remedies to ensure that Indigenous Australians determine what

constitutes social justice and have power to claim the rights, resources and opportunities they determine are necessary to achieve it.

It is well documented that cultural injustice and the racism and colonialism upon which it based are a source of social injustice (with its consequent impact on wellbeing and life expectancy). However, it is, arguably, the form of injustice that meets with most resistance from the dominant cultural group who, having established one nation and two societies based on racial prejudice, now argue that we are all one, and that the constitutional changes, treaties and voice being sought by Indigenous peoples are divisive. Challenges to the subordinate valuing of Indigenous histories and cultures and intellectual, spiritual, and social traditions has long been undertaken by Indigenous peoples, professionals, researchers and institutions working through an increasing range of avenues in all sectors (Bamblett et al., 2019; Behrendt, 2012). But acceptance of these by dominant cultural institutions and peoples has been slow.

Initiatives are becoming increasingly comprehensive and, within some institutions at least, intensive. Arguably, at the structural level there is positive change occurring – a growing number of organisations adopting Reconciliation Action Plans being one manifestation of this, an increase in the number of Indigenous representatives elected to Federal Parliament; and the actions being taken by the Australian Football League (AFL), for example, to eliminate racism from the sport. At the interpersonal level, actions are being taken to decolonise the worldviews of individual professionals (including, for example, health professionals and bureaucrats), with questions being asked and reflective practice being initiated (Downing, Kowal, & Paradies, 2011; Durey & Thompson, 2012; Lea, 2008; McDonald, Bailie, & Michel, 2013).

The advocacy for and leadership of such initiatives continues, though, to lie primarily with Indigenous people and institutions. There is little sign of institutions and their leaders or of non-Indigenous policy actors and citizens expressing urgent, authentic commitment to the inclusion of and respect for Indigenous worldviews, cognitive frameworks, power and experience as major contributions to the future of their own institutions and the nation. The thinking, seems to reflect a view that “We are prepared to support you in the implementation of our organisation’s Reconciliation Action Plan (because we are concerned about the inequalities). However, unspoken is the view that ‘we do not recognise the need to transform our own thinking and practice in order to contribute positively to the achievement of cultural justice’.

Cultural justice, termed by Fraser as recognition, does mean recognition of Indigenous people and the creation of spaces within and beyond existing social institutions that recognise (and celebrate) expressions of Indigenous cultures, knowledges, experiences and aspirations. It does mean recognising the difference in cultural, historical and lived experiences and it does mean recognising Indigenous people as colleagues and peers. Indigenous peoples have long, clearly and poignantly, pointed out the crippling impact of cultural injustice on their lives and health and have long proposed remedies. These remedies, however, do not lie within their control; the responsibility for transformative action lies with the institutions and actors with power and authority. And there is rightful caution being expressed by Indigenous people about the value of such recognition (Balaton-Chrimes & Stead, 2017).

For the non-Indigenous population it means deep reflection within to recognise the worldviews and cognitive beliefs that prevent us from looking for and seeing ways in which our own ideas and actions contribute to the genesis and persistence of cultural injustice. It means recognising changes needed to recognise not only Indigenous people but also their

cultures as being different to our own but having equal value as ways of being in the world. It means not only recognising the differences but also understanding and negotiating with goodwill to transform policy paradigms, institutional arrangements, theories of social justice and processes for policy formulation. It means recognising that power and privilege must be shared.

Recognition, as cultural justice, makes significant demands of non-Indigenous policy actors and citizens whose worldviews and cognitive frameworks are often not transparent to themselves. It is, however, vital.

### **Remedies to confirm power and authority: expanding and formalising representation: representative and political justice**

Representative justice is critical to health both as an indirect and as a direct social determinant of health. It is an independent marker of social respect and equivalent cultural valuing, and it is a necessary platform from which to participate directly in formulating policies that deliver fair, just distributions of social resources, services and opportunities that are essential to life and health. There is debate about what is considered to be representative justice.

For some, the equitable representation of Indigenous peoples as policy actors within the institutions of the state, participating with the dignity and respect and power and authority associated with formal office in the processes of democratic deliberation and policy formulation is a preferred option to achieve not only representative, but also cultural and distributive justice. The implication is that, representation (presence and participation) is a means by which to influence the transformation of institutions from within and to influence public policies to achieve distributive justice. However, others argue that representative and participatory parity can be achieved by Indigenous peoples in colonised states through

refusal to participate within the institutions of the state and the creation of alternative, Indigenous sovereignty that is independent of the institutions of the state.

Misrepresentation is not simply the lack of presence but also the repetition of a pattern in forums about Indigenous people ‘where those most spoken about are never heard’ (Wright, 2016, p. 62). It is also possible to recognise the rights of Indigenous people to participate in policy making without recognising their policy priorities, including both urgent social and health problems, and a treaty and sovereignty.

Representative and political justice for Indigenous Australians can only be achieved if there is transformation of the institutions of the state as they are currently constituted (and of their policy actors). The cultural dominance of western liberalism and its theories of social justice and hierarchies of cultural valuing, cannot continue unchallenged by and unaccepting of Indigenous worldviews, histories and traditions of governance if we are to achieve social justice and eliminate the systematic inequalities that have resulted in the significant difference in life expectancy at birth in the 21<sup>st</sup> century. The remedy for cultural dominance (and the cultural injustices to which it has given rise) cannot be only representative justice.

Responsibility for initiating the transformation rests with institutional policy actors, recognising that both cultural and representative injustices must be overcome. That responsibility, to ensure that the criteria for eligibility and the rules governing the processes of selecting, framing and debating policy options, and for deciding on preferred instruments, is clear. However, the transformative impact of such decisions can be achieved only in concert with recognition and with cultural justice.

## **Redistribution of resources and opportunities: distributive justice**

The irreducible relationship between the three forms of injustice is illustrated here, too.

Representative and political justice is required as a platform from which to participate in the formulation of public policies that distribute material resources and opportunities equitably, fairly and justly, commensurate with need. Representative and political justice is, as well, recognition of the equal valuing of Indigenous cultures, intellectual traditions and forms of governance, a manifestation of social respect and esteem. However, distributive justice is also a function of philosophical beliefs about what constitutes social justice (procedural or substantive outcomes), and of the priority given to equality, fairness and justice as social values (as distinct from individual liberty), safety and efficiency. In other words, the source of distributive injustice is not only cultural injustice, but also independent beliefs about social justice and the ways to achieve it. Cultural justice is essential if distributive justice is to contribute to the elimination of inequalities arising from racism and colonialism – freedom from everyday racism on one level, and freedom from structural racism and colonialism on another. But distributive justice will also require shifts in the normative beliefs of dominant cultural groups about what constitutes a socially just society and the limits of the obligations of governments to its achievement. Again, the transformation can occur only when the actions are undertaken in concert with those to achieve cultural justice.

## **Transforming institutions**

There are signs of some Australian institutions taking some steps to reverse the injustices, creating spaces for routine, systematic Indigenous representation and influence within policy settings. There are some (although smaller in number) that are doing this with the conscious purpose of eliminating misrecognition. Some examples of new ways of working are slowly emerging

(Hill et al., 2012; K. Taylor, Bessarab, Hunter, & Thompson, 2013). Through recognition spaces (Habibis et al., 2013, p. 25), networks (Lock, Thomas, Anderson, & Pattison, 2011) , through self-reflection on the part of non- Indigenous health professionals (Wilson, Magarey, Jones, O'Donnell, & Kelly, 2015, p. 2) and through the implementation of institution-wide change (Behrendt, 2012) there are growing opportunities and capacity to build a future based on institutional arrangements and policy paradigms that have been co-designed (G. Phillips, 2016). Investigation of legal frameworks governing the provision of health care and public health is being investigated to determine organisations' commitment to Indigenous representation and advancement (Howse & Dwyer, 2016).

For Indigenous peoples each of the sources of injustice and the need for institutional transformation is all too clear, and when having access to power, they have taken the lead in transforming institutional arrangements and in challenging the worldviews and cognitive frameworks of policy actors and fellow citizens. They have succeeded in achieving significant shifts in policy and practice. The challenge continues, however, for all social institutions and policy actors who have power and authority to take up their roles in initiating and leading transformative action from within. Recent experiences in Australia have been a powerful reminder that the decolonising transformation that is needed is challenging the structures and people who have power in their institutions and communities in 2019 and who are responsible for the distribution of money, power and resources in society (Grant, 2016a; Pearson, 2011).

Recognition, representation and participation, alone, without the power and authority that arises from reciprocal recognition of cultural value, cannot overcome the institutionalised patterns that have led to social institutions and non-Indigenous policy actors believing they know in advance what solutions there might be or what claims Indigenous groups might bring

to be negotiated (Prokhovnik, 2015, p. 427). Indigenous Australians require the power and authority ‘to freely determine their own political affairs, and to pursue their own economic, social, and cultural development’ (Davis, 2016b, p. 10). Transformative action will require a sharing of power that not only requires Indigenous and non-Indigenous Australians to work together around the policy table across cultural, organisational and interpersonal boundaries. The transformation will require us to ‘co-create the table’(G. Phillips, 2016).

## **Conclusion**

For more than 200 years, Indigenous and non-Indigenous people have lived in the same country under the same governments. But they have not lived in the same society, and have not received the same social treatment from the institutions responsible for governance, or from fellow citizens. As a direct consequence, in 2019 Indigenous Australians can expect, on average, to live almost ten fewer years than the wider Australian population.

This thesis describes a pathway beginning with the assumption that social institutions and policy actors, through their power to shape public policies, are responsible for the distribution of the social resources to the Australian population, including the Indigenous population. The selection of critical realism and its ontological and epistemological positions guided, then, the theoretical analysis of the literature to identify structures, powers and underlying mechanisms that could (potentially at least) explain the persistence of the unequal average life expectancy of the Indigenous population in the 21<sup>st</sup> century. The theoretical analysis of the literature pointed to characteristics and powers of social institutions and of their policy actors, and underlying mechanisms through which they shape public policies.

The contest of ideas about what constitutes the fair, just distribution of social resources in any society is conducted within institutions and by policy actors whose decisions are based on historical paradigms and contemporary worldviews. The systematic, routine and persistence



of the unequal distribution of social resources to the Indigenous population reflect institutionalised patterns of cultural value operating within structures and within their agents. The pattern includes, on one hand, the historical and contemporary subordination of the value of Indigenous cultures and people to that of those of the dominant culture. On the other hand, the pattern also includes western liberal democratic ideas about social justice, ideology, the appropriate role of the state and public intervention, and about preferred policy goals and instruments for their achievement. These are underlying mechanisms that also shape distributional decisions, including decisions about whether it is socially just to single out a group of citizens on the grounds of race or culture for particular social treatment.

The mechanisms through which worldviews and cognitive beliefs translate into policies and practices that result in distributive injustices, cultural injustices and representative injustices are exposed. The link between justice and the power to act is also exposed.

It becomes possible to see how the perspectives of a dominant culture are translated into privilege and, in Australia, into colonialism which is a way of thinking about the past and the pathways by which some (but not all) contemporary Australians are among the wealthiest, longest-lived people in the world and that perpetuates inequality across generations.

Indigenous peoples are seeking to 'live lives free from assumptions of others about what is best for us. It requires recognition of our values, culture, and traditions so that they can co-exist with those of mainstream society. It also requires respecting our difference and celebrating it within the diversity of the nation' (Australian Human Rights Commission, 2003). 'The right to a distinct status and culture, the right to self-determination, and the right to land' are not optional social determinants of Indigenous health and longevity, they are essential. 'The right to write our own histories and stories' (Wright, 2016) too, is integral to a socially just future.

The differences in policy ideas generated by Indigenous Australians arise from unique group experiences that have not been shared by other Australians. Direct representation from within the group is, then, essential. When questions of meaningful citizenship rights and welfare entitlements, demands for protection of identity through culture, language and attachment to place, and when legal redress for injustices arise (Prokhovnik, 2015, p. 420) then recognition becomes essential to a representative deliberative process (O'Sullivan, 2011, p. 89). It means change that includes the development of new knowledge but that also puts into practice that what is already known is needed (Houston, 2016, p. 17). The call for action outlined in the Redfern Statement re-stated the urgent need for action in 2016 (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2016, pp. 26-33). These are not new ideas; they have been expressed by generations of Indigenous people.

Many contemporary policy actors express positive commitment to developing public policies to increase Indigenous people's access to social resources. However the patterns of cultural value that shape their policy decisions, including who is in the room when the decisions are being made, and how Indigenous ideas are accepted and heard (or not), are not necessarily visible to them. Their inherited and learned cognitive biases, unreflected upon, mean that they may not see the mechanisms through which the institutional arrangements and rules that they regard as the norm maintain and reproduce injustice.

Decolonisation of the cognitive beliefs of all Australians, and of policy actors in particular, is the foundation for new patterns of cultural value, for the elimination of social boundaries, and for the elimination of institutional and cultural racism (Bryson & Davis, 2010). They are the means by which contemporary policy actors from the dominant culture and their institutions recognise and create spaces in which real representation is routine, and in which recognition

includes commitment to re-valuing and sharing power with Indigenous agents and communities.

Only by decolonising our own beliefs, by examining, exposing and challenging the blindness to the ways in which whiteness, privilege and negative views of the other can we eliminate the subordination of cultural value from policy decisions (and personal and professional interactions) and, as well, make changes in the internal, institutional arrangements, in the rules and norms, policy paradigms of social institutions and in the cognitive beliefs of peers and colleagues.

Responsibility for change lies with the institutions and people who carry the patterns of institutionalised cultural value and who transform what they look for and what they see. The transformation will require deep reflection, review and evaluation of worldviews and cognitive beliefs about Indigenous peoples, and the negotiation of conflict as cognitive beliefs, rules, norms and policy paradigms are challenged, and as the competition between divergent needs becomes more complex.

Indigenous peoples and communities are seeking the rights, resources and opportunities to make their own choices that are different choices, and with different levels of engagement in the Australian social and economic landscape.

From one Indigenous perspective, ‘they talk about closing the gap. Nice words. But the real gap isn’t in health, education, or in housing. The real gap is in the aspirations of mainstream society for us and the aspirations of Aboriginal people to be left [] alone to manage our own lives in ways that work in the twenty-first century’. John Moriarty, a Yanyuwa businessman, quoted in (Lucashenko, 2015, p. 12). From other Indigenous perspectives, working with and within social institutions in wider society is the option of choice. From another, Indigenous people are ‘seeking engagement from a position of strength and choice, with the freedom to

determine our priorities, to shift our democracy to encompass an acknowledgement of the sovereignty of first peoples, and to negotiate a treaty' (Grant, 2016b, p. 54).

Australia's own modern history demonstrates that when social institutions and policy actors choose to activate their powers to benefit the lives and health of citizens they can do so. The same social institutions and policy actors have, however, also activated their powers to institute public policies that have resulted in the creation and persistence of unequal outcomes for the Indigenous population. The structures, powers and the worldviews of social agents can be transformed but only through the adoption of new ways of seeing. John Berger in his work 'Ways of Seeing' observed that 'the way we see things is affected by what we know or what we believe. We can only see what we look at. To look is an act of choice' (Berger, 1972, pp. 8-9). The transformation of the social institutions through which public policies are formulated and of the worldviews and cognitive beliefs of policy actors can be achieved only with the representation of Indigenous policy actors in all policy spaces and only with recognition of and respect for the equal value of Indigenous cultures and aspirations.

Equally, the transformation can occur only when the policy actors from the dominant cultural group recognise their own worldviews about social justice, about equality, about Indigenous cultures and peoples, about Australia's history and the colonialisation of its present and (unless challenged and changed) its future, and about the possibilities for and means to effect change, to arrive at the shared future at a co-created table.

In 1968 WEH Stanner in a Boyer lecture, spoke of The Great Australian Silence in which he noted the absence of Indigenous peoples from histories and commentaries. He wrote:

... inattention on such a scale cannot possibly be explained by absent-mindedness. It is a structural matter, a view from a window which has been carefully placed to exclude a whole quadrant of the landscape. What may well have begun as a simple forgetting

of other possible views turned into habit and over time into something like a cult of forgetfulness practised on a national scale. We have been able for so long to disremember the Aborigine that we are now hard put to keep them in mind even when we most want to do so (Stanner, 2010, p. 297).

Mokak posed the question ‘What price for that silence, for that inattention, that forgetting, that disremembering?’ (Mokak, 2016).

This thesis began as a choice on the part of a non-Indigenous social agent to try to see, to pay attention, to remember and to not forget. It was a choice to look at the ways in which Australia’s social institutions and their policy actors reproduce injustice even when committed to positive change. The research calls attention to the deep, sustained, authentic effort that will be needed by all Australia’s social institutions and their actors to develop new ways of seeing and acting and of working together with Indigenous Australians to co-create the policy table.

In the Uluru Statement from the Heart (Referendum Council, 2017b) Aboriginal and Torres Strait Islander Australians have created a pathway that will re-set the relationship between our two worlds. ‘We invite you to walk with us in a movement of the Australian people for a better future’.

Voice, Treaty, Truth.

## Chapter Thirteen. Original contributions to new knowledge

*I happen to believe myself that we're all explorers in our way. But exploration is much more than naming and describing. An explorer's task is to postulate the existence of a land beyond the known land (Murnane, 2012, p. 69).*

Scientific research is 'a systematic exercise in categorising the world to advance knowledge of it' (P. Harris, 2013, p. 41). I argue that several original contributions to new knowledge arise from the research reported in this thesis.

In seeking to investigate what could be determinants of the persistence of the systematic inequalities in life expectancy or health experienced by Aboriginal and Torres Strait Islander (hereafter referred to as Indigenous) Australians in the 21<sup>st</sup> century it was necessary to go beyond existing empirical descriptions and theoretical explanations of the determinants of inequalities in life expectancy and health. The focus was on identifying why and how people and structures responsible for the distribution of social resources and opportunities are making policy decisions that result in the persistent, systematic inequalities that are experienced by Indigenous Australians. It was necessary to go beyond the evaluation of particular policy initiatives and the application of a particular disciplinary or theoretical approach.

The critical realist ontological approach is based on the view that scientific work 'is to investigate and identify relationships (and non-relationships) between what we experience, what actually happens, and the underlying mechanisms that produce the events in the world'

(Danermark et al., 2002, p. 21). The selection of critical realism as a metatheory enabled me to ‘pay attention to what produces events – seeking depth – looking beneath the course of events to mechanisms that generate them’ (P. Harris, 2013, p. 43).

‘Instead of aiming to generalise at the level of events, critical realist methodology rests on abstract research, which aims at a theoretical description of mechanisms and structures’, in order to hypothesise how observed events can be explained (Bygstad & Munkvold, 2011, p. 3). The method includes empiricism as one domain of reality but adds that a complete understanding of reality includes, as well, actual and real domains.

The critical realist method is based on the identification, capture and expanded understanding of the interaction of largely existing philosophical ideas and scientific research (P. Harris, 2013, p. 41). Critical realism as a method, uses a process of abstraction to re-think or re-order existing knowledge essentially, re-focusing and re-organising what is there (in the world), identifying the limits and biases of traditional understanding, and aiming for a more accurate (or at least enriched) representation of reality (Ollman, 2001, p. 285). It is the iteration between theoretical abstraction and empirical observation that adds rigour to critical realist research by ‘making each result the next matter for investigation via empirically justifiable content to the non-empirical part of causal chains’ (Collier, 1994, p. 10).

The research adds to existing theoretical explanations of the genesis and persistence of the systematic inequalities in life expectancy and health experienced by Indigenous Australians by identifying underlying mechanisms through which the inequalities are socially produced and perpetuated in a colonised nation state. The abstraction from the empirical observation of the inequalities to the identification of public policies as events that determine the distribution of the social resources and opportunities necessary for health is a first step. That, then, required a further abstraction to identify structures and people responsible for formulating the

public policies. That results in the identification of social institutions and policy actors as both the carriers of public policy decisions within and between generations and as the architects of contemporary public policies. Injustices initiated in Australia at the time of invasion and colonisation have been normalised.

The critical realist methodology not only opens the way but encourages researchers to go beyond their own disciplinary and institutional boundaries, and to challenge their own worldviews and cognitive beliefs. In the field of population health multiple theories have been developed to explain inequalities in health – and their determinants. But the search for philosophical and theoretical ideas from a wider range of disciplines and the abstractive process and the critical reflection to which the search gives rise makes it clear that it is vital to investigate and understand Australia's history, both pre and post invasion, in order to identify underlying mechanisms that are determining the persistence of inequalities in life expectancy. Archer argues that both structural and cultural contexts play crucial roles in determining public policy decisions and that the actions taken by policy actors at any given point in history always take place within pre-existing sets of cultural and structural conditions (McAnulla, 2002, pp. 286-288). The experience of being a colonial state is not particular to Australia – however, it was invaded and colonised and settled in particular ways that included the unjust social treatment of Australia's Indigenous peoples and nations. And that means that the cultural and structural contexts within which policy decisions are being made today are particular to Australia. In addition, researchers developing theories explaining inequalities in health in the populations of states that have not been colonised are in danger of missing the powerful roles of cultural and representative injustice as determinants.



It is for that reason that this thesis is an original contribution to understanding how cultural dominance masks essential differences between and indeed, within populations in the items needed for optimum health and life expectancy.

Fraser's dimensions of justice explain the different sources of the inequalities that are a constant affecting the lives, wellbeing and longevity of Indigenous Australians – including racism and colonialism. Lukes describes the critical role of power and authority in shaping public policies. New institutionalism describes the powers used by institutions to decide who is represented (and how), in policy spaces, as well as the power to frame policy ideas and determine policy instruments, and to reproduce rules and norms across generations. The imprint of history is carried forward.

The original contributions to new knowledge are twofold. From this research, the social determinants of the persistence of the inequalities have been identified as the worldviews and cognitive beliefs of policy actors and the institutions they established to govern the postinvasion state, codified over time in social structures, processes, rules and paradigms and normalised in the worldviews of the citizenry as ways of seeing that are assumed to be reality. The purpose was to identify and understand determinants of a complex social phenomenon – to move beyond a description of the phenomenon to develop a deeper understanding of its determinants. The use of critical realist metatheory and methodology resulted in the identification of generative mechanisms that could be activated by policy actors and institutions and, through their influence on public policies, determine the outcomes observed in the empirical domain. From that flowed the emergence of the ideas that mechanisms would be ways of thinking and seeing on the part of policy actors and characteristics of social institutions through which these ways of thinking and seeing are operationalised. That these were identified as key components does not constitute new

knowledge on its own. However, the investigation of the worldviews and cognitive beliefs of policy actors (what could they be thinking about), the identification of the ways in which institutions influence the decisions of their actors and the links between them are a contribution to new knowledge. The control of institutions by the dominant cultural group, and the influence of the worldviews of policy actors and the explanations of the routes by which they shape public policies in ways that impact between generations are (when linked) additional explanations of the relationship between history, the present, and, unless challenged and transformed, the future. The transformation in the worldviews (including the elimination of racism and decolonisation) will not, alone, be enough. The transformation of institutions will not, either, be sufficient on its own, to break the systematic patterns of inequality. The transformation must include a shift in power – Constitutional change and the expansion of Aboriginal and Torres Strait Islander peoples' access to socially mandated power and authority to influence public policy at each step in the policy cycle.

In what follows I have re-described the logic of the thesis and its findings beginning with the acknowledgment that the distribution of health and its social determinants within and between populations is a function of the worldviews and cognitive beliefs of policy actors about what constitutes social justice and about the limits of the obligation of the state and society to create socially just conditions for citizens.

The research reported in this thesis arrived at the following conclusions:

- That the distribution of health and its social determinants within the Australian population is a function of the worldviews and cognitive beliefs of policy actors about Aboriginal and Torres Strait Islander peoples, and that racism and colonialism are normalised.

- That Indigenous worldviews and cognitive beliefs about a good life, about social justice, and about the obligations of the state and society to create socially just conditions for citizens have been subordinated to the views and beliefs of the dominant cultural group.
- That socially constructed institutions and their agents (policy actors) with responsibility for governance determine who has power and authority to formulate public policies, to shape policy ideas, to influence policy debate and to determine the policy instruments used to distribute social resources and opportunities.
- That the processes of invasion, colonisation, settlement and colonialisation of what became the Australian nation state (and the institutions, processes and policy actors) responsible for governance resulted in the establishment of one nation and two societies. The clash of worldviews and cognitive beliefs between the First Peoples and the colonists was translated into institutions and public policies that subordinated the one to the other, and that excluded Indigenous peoples as individuals and as a whole population, from the formation of the state's institutions, from roles as policy actors, from the formulation of the nation's constitution and from all parts of social, economic and political life for generations.
- That the subordination of Indigenous peoples, the denigration and denial of cultures and the associated intellectual, social and economic traditions, is institutionalised and normalised in patterns of cultural value. The patterns are being challenged in a variety of ways, but recent examples illustrate the continuing presence of the patterns of thought and behaviour on the part of the dominant group.
- That colonialism and racism (manifestations of the subordination of Indigenous peoples and cultures to the western liberal cultural view) are being transmitted between generations through the institutions responsible for governance, through their

power to control who is included in policy spaces, to determine the public policy agenda, to frame policy problems and solutions, to debate and negotiate policy options, and to decide on policy instruments. Social institutions (structures) through seemingly neutral rules and structures actually embody values and power relationships inherited from earlier generations (March & Olsen, 1989) that shape public policy decisions of their agents.

The systematic patterns of inequality experienced by Indigenous Australians are an outcome of structures, agents, the worldviews and cognitive beliefs of policy actors, and the interaction between them in the unique cultural context that has evolved since the first actions taken to establish the postinvasion Australian state.

I propose that the contributions of this research to new knowledge are in:

- identifying underlying generative mechanisms that contribute to explanations of the relationship between the events and empirical outcome that was the focus of the inquiry – the persistence of systematic patterns of inequality in life expectancy, health, and in the distribution of their social determinants;
- confirming that it is possible to look for and to see mechanisms in the real domain being activated by the institutions and policy actors responsible for formulating public policies in contemporary policy spaces;
- integrating theoretical perspectives on what constitutes a good life, social justice and injustice, on racism, colonialism, and political power and authority to identify a linked set of mechanisms and powers available to structures and actors through which they shape public policies;

- recognising separate generative mechanisms and recognising their irreducibility in explaining determinants of systematic inequalities in life expectancy, health, and access to its social determinants – and in developing remedies;
- from the perspective of the institutions and actors who have power and authority to govern, and whose worldviews and cognitive beliefs shape the public policies they implement.

## **We see what we are looking for**

Much of the research conducted to identify actions needed to reduce the inequality in average life expectancy between Indigenous and non-Indigenous Australians is undertaken to describe and explain the problem in the population, in the place, and at the time it is occurring. Such research is then received, interpreted and formed into policy ideas by policy actors working in institutions that are dominated by western liberal worldviews.

A recent example of this was the commissioning by the Northern Territory Government of what became the Ampe Akelyernemane Meke Mekarle *Little Children are Sacred* Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse (Wild & Anderson, 2007). Within weeks of the report being finalised after extensive, deep consultations with Indigenous communities, researchers and organisations, the then Federal Government had over-ridden the findings of the inquiry and had implemented comprehensive legislation to ‘set aside a provision of the Federal Racial Discrimination Act’ and to implement a range of policy initiatives in proscribed Indigenous communities under the leadership of the Australian Army! . The health outcomes of the large intervention have been equivocal at best and harmful at worst (Australian Indigenous Doctors' Association & Centre for Health Equity Training Research and Evaluation, 2010; Bray, Gray, Hand, & Katz, 2014; National Aboriginal Community Controlled Health

Organisation, 2017). The goals of achieving more equitable distributive outcomes (participation in education; access to housing, employment and health care) have not been achieved fully (although there has been some progress over more than a decade). But the initiative perpetuated cultural injustice and undermined representative justice in its implementation. The harms are blindingly clear to the communities (P. Gibson, 2017a; P. Gibson, 2017b).

This research is an effort to identify generative mechanisms that are within the control of contemporary institutions responsible for governance and their agents (policy actors) that are being activated to perpetuate policy decisions that are resulting in the persistent, systematic, group-structured patterns of inequalities experienced by Indigenous Australians. The intent is to prevent the phenomenon from occurring at source – or, at least, to reduce the probability of its occurrence.

In taking this approach the research draws attention to ‘who are we’? In a colonised nation such as Australia, with its unique colonial history and the creation of, essentially, one nation but two societies, the answer to the question ‘who are we’ assumes critical significance.

This research confirms that it is possible to look for and to see mechanisms and powers being activated by contemporary policy actors and institutions in contemporary policy spaces.

Having confirmed that it is possible to see underlying generative mechanisms (if we choose to look), further empirical work can be undertaken to describe and explain the powerful influences of institutions and the worldviews of policy actors on the perpetuation of the injustices that are resulting in the persistence of the inequality in average life expectancy at birth between the Indigenous and non-Indigenous populations of Australia.

The same mechanisms can be activated to reverse the injustice, pointing to actions to work authentically with Indigenous peoples to shift power and authority to govern, to achieve

representative justice in all policy spaces, to actively decolonise worldviews and to co-create the policy table. The judgment as to what constitutes the socially just outcomes resulting from such transformative changes can be made only by Indigenous peoples themselves after having defined, for themselves, what constitutes a good life that they have reason to value.

## **Chapter Fourteen. Strengths and limitations of the research**

Critical realism as a metatheory is based on an ontological position that there is a real, natural world that exists ‘that is not contingent on human perception’ (McEvoy & Richards, 2003, p. 412). However, critical realists also accept that human’s knowledge of that world is (and can only be) socially produced and that it is reflexive (Gorski, 2013, p. 664); so that all knowledge of the world is a construction from observers’ perspectives and standpoints, and there can be valid, alternative accounts of any phenomenon (Maxwell, 2012, p. 5).

A strength of the research is, first, its focus on the challenge of seeking to understand determinants of a complex, deeply challenging and persistent population health (and wider) social phenomenon in Australia. There is a significant body of evidence (from a range of researchers and a variety of cultural and theoretical perspectives) describing the problem of inequalities in health and life expectancy (and its determinants) as it is being experienced by Aboriginal and Torres Strait Islander (hereafter referred to as Indigenous in this chapter) peoples and nations. There is also a significant body of evidence describing what works among the actions taken by governments, the private and NGO sectors, by communities and by health and other professionals to achieve positive change. However, there is limited research seeking to identify and understand reasons that all the actions (taken together) have failed to eliminate the inequalities.

The research is a necessary precursor to identifying effective remedies. A further strength is the use of critical realism as a metatheory based on a structured critical realist methodology



that assumes that, beneath empirical and actual levels of reality, lies a further, deep level of reality within which mechanisms that have roles in generating outcomes at the other levels, are being activated. It is possible to identify the mechanisms only if we choose to look and to see. The critical realist metatheory also assumes that a pluralist, interpretive epistemological approach is a way to move beyond the constraints of single disciplinary and theoretical perspectives.

That leads to the conduct of abstract research and critical review of transdisciplinary literature to identify normative theories that could add explanatory power to existing descriptions of the phenomenon. This thesis exposes the value in moving beyond existing theories developed by even the multiple disciplines contributing to population health research.

The role of historical decisions, the contributions of worldviews and cognitive beliefs, the characteristics of institutions through which decisions of the past are carried across generations as accepted norms, and the role of power and authority in determining policy decisions are all introduced through the abstract review of literature, the focus of each part of which is guided by emergent questions. The conclusion of the substantive review of the literature and the formulation of an integrative framework of normative theories from which to identify candidate mechanisms that, if observable in contemporary policy spaces, could, then become indicators for use in subsequent research is a further strength of the research.

A further strength is the inclusion of an interview study that is intentionally focused on assessing whether, if we look, it is possible to see candidate mechanisms in the real domain, being activated by policy actors in their contemporary policy spaces. Only if they could be seen would it be feasible to generate hypotheses for future research to, first, validate their role

in shaping public policies, and, second, to propose and evaluate the impact and outcomes of new remedies to address the problem.

I selected critical realism as a metatheory for the thesis. Its layered ontological perspective and its pluralist epistemological perspective were necessary to enable a search for deeper understanding of generative mechanisms that could add to existing theoretical explanations of inequalities in health. That meant seeking to go beyond existing explanations of individual determinants contributing to the social phenomenon that was the subject of the thesis in order to seek underlying, generalisable mechanisms that, as concepts, link existing theories in an integrative framework.

The critical realist structured methodology then requires abstract research and critical review of existing theories from across disciplines that, in the course of developing this thesis, led to the emergence of understanding ways in which ways of thinking – worldviews – determine what humans do. And that from such differences, enormous differences in life chances arise – with power and authority becoming a central moderator of ‘who gets what’ – including who gets to determine what is considered to be ‘a good life’ and what resources are necessary to lead such a life. The strength of the critical realist metatheory (and its understanding that new knowledge can emerge from philosophical ideas as well as empirical evidence) is a strength in this research.

The thesis is an attempt to reflect a cultural perspective as a member of the dominant culture in order to understand in greater depth, what could be underlying mechanisms through which non-Indigenous Australians are perpetuating historical injustices that continue to influence the life expectancy of contemporary Aboriginal and Torres Strait Islander peoples.

The integrative framework I developed as the penultimate step in the analysis of the literature is a response to the lack of a pre-existing theory, providing broad guidance for subsequent

researchers and practitioners to use to understand underlying mechanisms that may be being activated in order to explain more fully, the determinants of a health problem and to guide the development of effective strategies for intervention in response.

However, the lack of a single disciplinary base or of single theoretical framework, and the limited contribution (to this study) of empirical evidence are all weaknesses – albeit, if being judged against the standards of empirical research. Working across disciplines as a population health researcher from a health promotion perspective presented significant challenges. Using this method, it is impossible for a single researcher to acquire the deep knowledge of the theoretical perspectives, empirical evidence and philosophical and methodological differences and debates within each of the fields. The knowledge I draw from and critically review from the literature in disciplines outside my own is broad, not deep; thin, not thick.

Another limitation of the research is its broad focus on all public policies (events) through which Australia has been governed over the 240 years of postinvasion history. Taking such an approach leaves no room for nuance, for investigation of factors leading to the success of some policy initiatives and the failure of others (in particular). It leaves little room for explanation of the reality of the structural and cultural contexts within which negotiations between Indigenous Australians and social institutions (and actors) responsible for the governance of the state take place.

A final limitation of the research is the lack of empirical confirmation of the validity of the theory that has been proposed. The research develops a theoretical description of generative mechanisms and structures in the real domain and confirms that it is possible to verify their being activated in contemporary policy spaces to shape public policy decisions. However, it does not include an empirical component that validates the relationship between the

generative mechanisms in the real domain, the events, and the observed outcomes reported in the empirical domain. That is its weakness.

The research does, though, provide a theoretical base from which to generate and test hypotheses explaining the relationship between generative mechanisms, observed events (public policies in this case), and outcomes reported in the empirical domain. That is its strength.

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# Appendix 1

## Letter of Invitation

### **An invitation to participate in a study entitled: Increasing the power of minority populations to engage in setting public policy agendas, in framing problems and solutions, and in adopting public policy**

Dear

I am a PhD candidate under the supervision of Associate Professor Lyn Carson (Department of Government and International Relations at the University of Sydney). I am conducting a study to identify actions that can be taken by public policy makers to increase the power of minority populations to engage in setting public policy agendas, to frame problems and solutions, and to adopt public policy.

I am writing to ask if you would be willing to participate in an interview about your organisation's experience in developing population-health relevant public policy, and about your own experiences in this.

If you are willing to participate in the study I would conduct a semi-structured interview (see attached schedule) that will take less than one hour of your time. With your consent I would like to record our conversation, transcribe it, and if you would like to receive a copy of the transcription, I would return it to you to review, clarify, amend or withdraw. All the information will be confidential and reporting will ensure that the respondents remain anonymous.

Would you please let me know by 2<sup>nd</sup> October 2009 whether or not you are willing to participate. If you do agree to participate I will contact you to discuss any questions or points of clarification, and to make an appointment for an interview at a time and place convenient to you.

If you have any questions please don't hesitate to ring me on (02) 9612 0654 or 0409 606 817 or my supervisor, Professor Lyn Carson on (02) 9772 6650.

Thank you very much indeed for considering this request. I look forward to speaking with you in the near future.

Yours sincerely,

Associate Professor Marilyn Wise

PhD candidate

and


Manager, Healthy Public Policy Program

Centre for Primary Health Care and Equity

University of New South Wales, Australia

## Appendix 2

### Participant Information Statement



The University of Sydney

School of Public Health  
Faculty of Medicine

NSW 2006 AUSTRALIA  
Marilyn Wise  
Associate Professor

Your Building A27  
Telephone +61 2 9351 5122  
Facsimile +61 2 9351 5205  
email marilynw@health.usyd.edu.au

**PARTICIPANT INFORMATION STATEMENT**

**Title:** Increasing the power of minority populations to engage in setting public policy agendas, in framing problems and solutions, and in adopting policy

**(1) What is the study about?**  
This study is intended to identify structures and processes that do (or would) increase the power of minority populations to engage in the development and implementation of population health policy, and hence, to contribute to reducing the unjust inequalities in health outcomes that have persisted in Australia for generations.

**(2) Who is carrying out the study?**  
The study is being conducted by Associate Professor Marilyn Wise and will form the basis for the degree of PhD at The University of Sydney under the supervision of Associate Professor Lyn Carson, Academic Program Director, The US Studies Centre, University of Sydney.

**(3) What does the study involve?**  
The study will involve you in two ways. You will be asked to agree to participate in an interview about your organisation's experience in developing population health-relevant public policy, and about your own experience in this. The interview will be conducted by the researcher. With your permission, the researcher will audio-tape the interview.

**(4) How much time will the study take?**  
You will be asked to participate in a semi-structured interview that will require up to 90 minutes of your time. You may be asked to agree to a follow up interview of no more than 15 minutes to clarify responses in the initial interview.

**(5) Can I withdraw from the study?**  
Participating in this study is completely voluntary - you are not under any obligation to consent and - if you do consent - you can withdraw at any time without prejudice or penalty.  
  
You may stop the interview at any time if you do not wish to continue. Any information you may have given to the interviewer up to that point will be destroyed.

**(6) Will anyone else know the results?**  
All aspects of the study, including results, will be strictly confidential and only the researchers will have access to information on participants. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

Page 1 of 2

Blaming the victim or addressing the causes: increasing the power of minority populations to engage in setting public policy agendas, in framing problems and solutions, and in adopting policy

**(7) Will the study benefit me?**

The study may benefit you in the future, although it is likely that it will take some time for any of its findings to be translated into organisational policies and practices. It is intended to increase the extent to which minority population groups that are currently experiencing much poorer health than the mainstream population (on average) are able to participate in public policy decision-making, and hence, to ensure that their communities have access to the material and social resources needed to improve and maintain their health and to close the gap.

**(8) Can I tell other people about the study?**

Yes, you may tell other people about the study.

**(9) What if I require further information?**

When you have read this information, Associate Professor Marilyn Wise will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact Associate Professor Lyn Carson, 9351 3089.


**(10) What if I have a complaint or concerns?**

**Any person with concerns or complaints about the conduct of a research study can contact the Senior Ethics Officer, Ethics Administration, University of Sydney on (02) 9351 4811 (Telephone); (02) 9351 6706 (Facsimile) or [gbriody@usyd.edu.au](mailto:gbriody@usyd.edu.au) (Email).**

**This information sheet is for you to keep**

# Appendix 3

## Participant consent form

 **The University of Sydney** School of Public Health

Faculty of Medicine

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NSW 2006 AUSTRALIA  
Marilyn Wise  
Associate Professor

Building A27  
Telephone +61 2 9351 5122  
Facsimile +61 2 9351 5205  
email marilynw@health.usyd.edu.au

**PARTICIPANT CONSENT FORM**

I, ..... give consent to my participation in the research project  
Name (please print)

**TITLE: Increasing the power of minority populations to engage in setting public policy agendas, in framing problems and solutions, and in adopting policy**

In giving my consent I acknowledge that:

1. The procedures required for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction.
2. I have read the Participant Information Statement and have been given the opportunity to discuss the information and my involvement in the project with the researcher/s.
3. I understand that I can withdraw from the study at any time, without affecting my relationship with the researcher now or in the future.
4. I understand that my involvement is strictly confidential and no information about me will be used in any way that reveals my identity.
5. I understand that being in this study is completely voluntary – I am not under any obligation to consent.

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**Increasing the power of minority populations to engage in setting public policy agendas, in framing problems and solutions, and in adopting policy**

**Version 1**

6. I understand that I can stop the interview at any time if I do not wish to continue, the audio recording will be erased and the information provided will not be included in the study.

7. I consent to:

i) Audio-taping \_\_\_\_\_ YES  \_\_\_\_\_ NO

ii) Receiving Feedback \_\_\_\_\_ YES  \_\_\_\_\_ NO

If you answered YES to the "Receiving Feedback Question (7. ii)", please provide your details i.e. mailing address, email address.

Feedback Option

Address: \_\_\_\_\_

\_\_\_\_\_

Email: \_\_\_\_\_

Signed:

Name: .....

Date: .....



## **Appendix 4**

### **Script of Telephone Invitation to Participate in an Interview Study**

Script of telephone invitation to participate in study entitled: Increasing the power of minority populations to engage in setting public policy agendas, in framing problems and solutions, and in adopting public policy.

Good morning/afternoon

My name is Marilyn Wise. I am ringing to follow up the letter of invitation I sent recently to invite your participation in my research to identify actions that can be taken by public policy makers to increase the power of minority populations to engage in setting public policy agendas, to frame problems and solutions, and to adopt public policy.

First, could I confirm that you received the letter of invitation to contribute to the study? Do you have any questions about the study question, methods, or potential findings?

Second, are you willing to take part in the study? As I mentioned in the letter, I would like to record our conversation, transcribe it, and if you would like to receive a copy of the transcription, I would return it to you to review, clarify, amend or withdraw. All the information will be confidential and reporting will ensure that the respondents remain anonymous.

Third, if you are willing to take part in the study I would like to set a date, time and location for the interview, please.

Finally, if you have any questions at all about this, please don't hesitate to ring me on (02) 9612 0654 or 0409 606 817 or my supervisor, Professor Lyn Carson on (02) 9772 6650.

Thank you very much indeed for considering this request. I look forward to speaking with you in the near future.

## Appendix 5

### Interview Schedule

#### **Increasing the power of minority populations to engage in setting public policy agendas, in framing problems and solutions, and in adopting policy**

1. What is your organisation's core business?
2. What structures and processes does the organisation use to engage the population it serves in setting the policy agenda and in developing, adopting and implementing policy? In what ways does the organisation engage minority population groups in these steps?
3. When your organisation develops health/housing policy how is the policy agenda established? What issues are given priority on the agenda? How are these brought to your attention? By whom or by which organisations and people?
4. What has been your personal experience in establishing health/housing policy? What structures and processes are available to ensure that priorities of groups making up the population are identified, and that their understanding of the causes of problems and potential solutions are considered actively in the deliberation on policy options and solutions? prompts:
  - is it important or not important (inherently or as a matter of principle) in your view to seek the equal participation from minority citizen groups?
  - do you consider it to be easy or difficult to ensure equal, active participation of minority citizen groups?

- do you consider it to be useful or not useful to have equitable participation - that is, in your view, to what extent does equitable participation lead to more effective, efficient policy outcomes?
5. What sources of information about the needs/problems experienced by minority citizen groups and about policy solutions do you trust and why?
  6. How do you feel about the extent to which minority citizen groups' policy priorities, problem framing and solutions influence policy development and adoption by your organisation?
  7. If you think it should be changed, how could it be changed to be as you think it should be?
  8. What actions would be necessary for your organization to bring about change in the extent and depth of participation of minority citizen groups in policy the policy process? What actions you need to take to bring about change in the extent and depth of participation of minority citizen groups in the policy process?
  9. What would be the effect of making these changes?
  10. What support would you need to work for this change?
  11. What would it take for you to participate in this change?

Based on: (McClain, 1993; Peavey, 1997)