

The politicisation of disease and the disease of politicisation: causal theories and the Indigenous health differential

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My subject here is the negative effects of over-politicising Indigenous health issues. Such issues are always partly political, but it is a question of balance. Of course there remain socio-economic inequalities, inadequate cross-cultural skills in service delivery, racial stereotyping (on both sides), limitations on access to services and other elements in the Indigenous health picture which have a distinctively political cast. Again, certain current differences between Indigenous and non-Indigenous health have come about through Australia's political history of colonisation, with all its depopulation, violence, demoralisation, deportation, residential concentration, discrimination and dispossession of Indigenous peoples in the past. But these same catastrophic events have been endured by others, and in more recent times and on a larger scale, as in the European Holocaust of the 1940s, yet without anything like the same health outcomes for the survivors and the following generations of their descendants. So history of itself is not enough to explain the Indigenous/non-Indigenous health differential in Australia. Fourth World health profiles, even where very similar historical processes were at work over the same period, also vary considerably and do not reflect a single uniform reaction to colonisation. One key factor causing these differences is the differences between the cultures people bring to their disasters.

In particular, every human community which is relatively homogeneous culturally has what might be called a 'health culture'. In the Australian Aboriginal case the communities have a range of variable health cultures, many of which are clearly an amalgam of old, classical traditions and other, newer patterns of health-related practices that have grown up since conquest. Where old elements in a health culture come into collision with new environmental factors, the clash can be very deleterious. For example, people whose sanitation and hygiene practices derive significantly from the period when their ancestors were semi-nomadic, usually naked and living mostly in the open, but who themselves now live in fixed dwellings and use clothing, sheets and blankets, face dangerous biological conditions that were not a problem, or not so great a problem, for their forebears. Combined with large household sizes, these and similar elements in the health culture of many communities help underpin the high levels of a range of different diseases, some of them life-threatening.

It seems to me, as an outsider to the medical field looking in, that the failure of the health system to focus more on behavioural change through child socialisation — something that is needed if the Indigenous health differential is to be tackled head-on — is due significantly to an illness of another kind: the disease of politicisation.

THE DISEASE OF POLITICISATION

A recent issue of the prestigious international medical journal, *The Lancet*, contained a paper by Ian Anderson, an academic physician of Aboriginal identity, and Bebe Loff, a legally trained medical ethicist, entitled “Voices lost: Indigenous health and human rights in Australia”.¹ It began by referring to the now well known statistic that Aboriginal people’s life expectancy is about 20 years less than that of Australians as a whole (men: 56 years versus 77, women: 63 years versus 82), and that Indigenous morbidity is also greater. It also mentioned that more money is spent per capita on Indigenous health than on non-Indigenous health per annum, but not enough to cope with the greater needs of Indigenous people.

Their discussion then suddenly turned to the federal government’s recent abolition of ATSIC, the Aboriginal and Torres Strait Islander Commission, which had since 1989 been an elected Indigenous body responsible for allocation of various resources, policy development, and oversight of federal government Indigenous programs. This was a body which, by 2004, had lost credibility and support very widely, not only among many Indigenous people but also on a bipartisan basis in federal politics. One of the chief reasons for this loss of credibility was the ATSIC’s leadership’s obsessive concern with what is known in Australia as ‘the rights agenda’, and especially with heavily symbolic political issues such as the treaty proposal, a government apology for past mistreatment, and native title. Together with its neglect of some very pressing on-the-ground issues such as violence, especially by men against women, sexual abuse of minors, and child neglect, this reduction of the major issues to largely political ones undermined ATSIC’s standing badly. Given this, and the fact that ATSIC had long been relieved of the Indigenous health budget (since 1995), it was not clear why its demise was relevant other than as evidence of a hostile polity.

Anderson and Loff then said, and many would agree, that increasing primary health care services to Indigenous people – part of what they called “the practical agenda” – was unlikely of itself to yield substantial improvement in people’s health. But this was then followed, not by any mention of encouraging a shift in health-related cultural practices, but by the claim that:

If Aboriginal people have no voice, if there is no capacity for self-government, if there is no means for coming together to identify and address problems, there cannot be any hope of progress in addressing the appalling disparities between the health of Indigenous and non-Indigenous Australians. A so-called practical agenda will come to nought. It is remarkable that this simple fact continues to be ignored.²

Here we have the reduction of a serious medical, social, and cultural issue to the politics of ‘voice’. Such statements always carry with them an underlying message about cause and effect. What this statement tells the world is that the Aboriginal health differential is primarily caused by insufficient political representation. There is typically no room in such arguments for tackling the role of culturally embedded behaviours which have a direct impact on health. These include very basic things such as domestic sanitation and personal hygiene, housing density, diet, the care of children and the elderly, gender relationships, alcohol and drug use, conflict resolution, the social acceptability of violence, cultural norms to do with expression of the emotions, the relative value placed on physical well-being, attitudes to learning new information, and attitudes to making changes in behaviour. If the answer to this criticism is that Indigenous self-government will deliver improvements in all these areas, there is an obvious reply: conditions in remote Aboriginal communities, especially, but also in urban ghettos like Redfern in Sydney, have generally become worse, not better, since the transfer of

¹ Anderson and Loff (2004).

² Anderson and Loff (2004:1281).

local power from church and government to locally elected bodies in the 1970s. There is no empirical evidence for irredentist politics as a cure for extreme rates of renal failure, ischaemic heart disease, infant mortality and domestic homicide.

There is, however, a more solid argument that relates the governmental order to Indigenous health, namely Stephen Kunitz's work on the provision of special health service entitlements to Indigenous people as against universal entitlements.³ In 1987 American Indians without health insurance were covered by the Indian Health Service, while 22% of African Americans were without insurance. In the same year, maternal mortality was 7.1 per 1000 000 live births for Indians and Alaska natives, 6.6 for all races, but 12.0 for all races other than white. Infant mortality was similar: 9.3 per 1 000 live births for Indians, 14.6 among Alaska natives, 10.1 among all races, 15.4 for all non-whites, and 17.9 for African Americans.

But what Kunitz draws from such figures is not some kind of magical relationship between political devolution and health, but between targeted funding and the health of populations with special needs.⁴ In a number of cases the Indians had secured a 'medicine chest' provision in treaties agreed with the colonists, as well as reservations of land. Indeed in all his fourth world case studies (USA, Canada, New Zealand, Australia) there was only one country where treaties were not made, and that was Australia.⁵ Kunitz regards the fact that Aboriginal people are at the bottom of the life expectancy table when compared with American Indians (and Alaska natives), Canadian Indians, and New Zealand Maori, as being a consequence of this absence of treaties.⁶

That there is a correlation that leads him to this view I do not doubt. But I think one has to consider the possibility that both parts of the correlation arise from a third factor or group of factors, particularly the nature of the pre-existing social and economic organisation of the peoples concerned. Australia was the only sample made up entirely of recent ex-hunter-gatherers. Comparisons with settled village peoples who lived in stratified societies and had quite highly formalised arrangements for suppressing internal conflict and conducting warfare during external conflict are comparisons between very different kinds of social and cultural worlds. The selection of 'Fourth World' peoples is not one based closely on historical and cultural commonalities so much as on a common postcolonial political condition. It seems pretty clear that recent ex-hunter-gatherers within the English-speaking New World nation states have generally fared worse than agricultural and other settled peoples.

Kunitz himself argues that cultural differences, such as those between Navajo and Hopi Native Americans, basically account for health differences between peoples who have been subject to the same historical, environmental and governmental conditions.⁷ The Navajo were semi-sedentary pastoralists and the Hopi were sedentary agriculturalists living in socially stratified villages.⁸ It has been the Navajo who have enjoyed greater freedom from epidemics and endemic infectious disease and whose population has survived colonisation more robustly, in the numerical sense, than any other US tribe.⁹ 'Different living conditions' accounted for mortality differences, with the Navajo moving seasonally, being sparsely distributed, and living away from water sources so that the latter remained uncontaminated. Although they defecated not far from their houses, their mobility and sparseness reduced the health dangers of doing so. Hopi, by contrast, lived permanently in crowded quarters and excreta were often

³ Kunitz (1994:181).

⁴ Kunitz (1994:182).

⁵ Kunitz (1994:25).

⁶ Kunitz (1994:26-27).

⁷ Kunitz (1994:129-132).

⁸ Kunitz (1994:121,124).

⁹ Kunitz (1994:134,142).

deposited in narrow streets and passages between houses.¹⁰ In general, however, Kunitz did not foreground pre-existing health-related cultural practices as a major factor in how colonisation events were experienced differently by Indigenous peoples, although he now agrees he could well have done so.¹¹

Kunitz's book ends with a discussion of causality. Science, he says, can be said to transcend culture in the sense that smallpox vaccine is effective regardless of how a society is organised.¹² Science is democratic, in the sense that antibiotics can cure serious diseases regardless of the social standing or skin colour of the patient.¹³ But there are also many health problems which are not susceptible to explanations based on the idea of necessary cause. (Necessary cause is something whose absence always ensures the absence of the particular medical condition.) Many illnesses are

still best explained by multiple weakly sufficient causes, and may always be, and understanding their incidence, prevalence and distribution, as well as their prevention and treatment, may require intimate understanding of particular people and settings.¹⁴

This means, he argues, that the biomedical model of understanding causation, and the anthropological approach, ideally should cross-fertilise each other. But because they belong to different professional interest-groups, they are more likely to be used as "ideological weapons with which different groups may bash one another in a fight over whose way of knowing is most 'fundamental'". Morbidity and mortality, he says, are products not only of "pathophysiological processes and the life cycles of parasites but also [of] the many ways in which human beings live on the land and with each other. That is what is fundamental".¹⁵

MODELLING CAUSATION IN POST-COLONIAL CONTEXTS

The simple and often vague attribution of the cause of Fourth World health and other problems to colonisation and subsequent 'disadvantage' stands in striking contrast to more fact-based and therefore more complex models of the process, of the kind put forward by Alan Cass and others for end-stage renal disease among Indigenous Australians, or Ernest Hunter's schema for relating precursors and consequences of Aboriginal alcohol misuse.¹⁶ It is incumbent on those who put forward historical causal explanations of Indigenous health problems to show us the mechanics of the chain of events. This is not just for the sake of historical accuracy, because the past can teach us a lot about what is going on in the present. But one problem here is that the pre-contact health baseline for Indigenous Australians is not plentifully described.¹⁷

¹⁰ Kunitz (1994:133, 134). So where should the anthropologist's focus of attention be here - *a propos* of the questions of 'voice' raised by people like Anderson and Loff (2004), or Gillian Cowlshaw (2003)? Only or mainly on getting to understand Hopi 'discourse' about the 'meanings' of defecating in the nearest laneway? Or on understanding how this customary practice is learned by children, reproduced through life, has whatever meanings are attributed to it, and interacts with the life cycle of micro-organisms to produce suffering and death?

¹¹ Kunitz (pers. comm. 2004).

¹² Kunitz (1994:187,188).

¹³ Kunitz (1994:188).

¹⁴ Kunitz (1994:188).

¹⁵ Kunitz (1994:188).

¹⁶ Cass *et al* (2004); Hunter (1993:197).

¹⁷ The most positive scientific assessment of pre-colonial Aboriginal general health which I have come across is Stephen Webb's, namely that it was "very good anywhere on the continent" (1995:293), although he also said it varied regionally and lacked effective means of treatment for many diseases (1995:293-294). But his preferred yardstick was mainly the health of the first European settlers in 1788. A comparison with modern post-industrial Westerner health would be far starker.

Stephen Kunitz has presented one of the more complex general models of colonial impacts on Indigenous health, and it is noticeable that many of its elements continue to be active causes of problems. He isolates the following basic elements:

- *disease ecology*:¹⁸ Major parts of the Old World, especially the warm tropics, had their own diseases to which European would-be colonisers had little immunity, whereas in most of the New World the situation was reversed.¹⁹ It follows that colonisers in the Australian case met little real challenge in the way of disease ecology upon their arrival.
- *biological background of population*:²⁰ Immunological status was a vital factor in creating differences between the colonisation experiences of the Indigenous peoples of large parts of Eurasia and parts of Africa as against those of the peoples of the New World. Smallpox, measles and other diseases to which New World populations had no history of exposure were demographically devastating, wrecking subsistence production²¹ and causing demoralisation and 'social collapse'.²²
- *physical conflict*: This includes warfare but also small scale conflicts.²³
- *mode of economic colonisation*: where labour and land were both wanted, as in the case of the Hawaiians, the people were integrated into capitalist society; where only land was wanted, as with most Aborigines and American Indians, isolation and encapsulation on reservations and missions occurred (the dispossession factor); where labour was wanted but not land, as in Samoa, there evolved a planter class with the Indigenous people continuing to live and work in their villages.²⁴
- *political and institutional factors*: policy-related causes of both failure and success,²⁵ including whether or not central government as opposed to regional or state government has taken responsibility for Indigenous health, and whether or not treaties were signed between Indigenous peoples and colonisers.²⁶
- *harder to define*: "epidemic-induced panic, social disorganization, and demoralization".²⁷
- *pre-existing social organisation and culture*: for example, sedentary agricultural people such as the Pueblo Indians had institutionalised mechanisms for socialising children in ways that reduced resorting to violence during conflict, whereas hunter-gatherers traditionally make more use of dispersal. Hunter-gatherers also place more emphasis on personal autonomy so that others are less willing to intervene to stop abusive drinking or violence than in the case of other societies.²⁸

¹⁸ Kunitz (1994:6).

¹⁹ Kunitz (1994:11).

²⁰ Kunitz (1994:7).

²¹ Kunitz (1994:8).

²² Kunitz (1994:9).

²³ Kunitz (1994:12).

²⁴ Kunitz (1994:5).

²⁵ Kunitz (1994:5).

²⁶ Kunitz (1994:6).

²⁷ Kunitz (1994:12).

²⁸ Kunitz (1994:186).

A number of these immediate consequences in turn also themselves became drivers of change:

- *demographic collapse*: This seems to vary very widely, ranging apparently from 53 per cent to 95 per cent in the Americas.²⁹
- *economic collapse*: E.g. where the healthy population fell below that adequate to feed everyone.³⁰
- *ideological collapse*: Religious colonisation could also lead to demoralisation because the religion of the invaders was often thought by both Europeans and natives to be the more powerful.³¹

When it comes to examining the role of pre-existing cultural factors it is important to recognise that, after colonisation, they were no longer operating in the same environmental and cultural context, and they became applied to new substances, new diseases, and new relationships. In that sense, they were no longer 'pre-existing cultural factors' in quite the same sense.

Just to cite one example, the camping patterns of semi-nomadic Aboriginal residential groups of the past are quite well documented in the ethnographic literature. Camps of 20 to 50 people were not uncommon.³² Two of the functional reasons for camps being of such a size are economic – having sufficient able bodied people of sufficient skill to supply the needs of the camp members – and defensive – having sufficient people to keep watch and to defend the members of the group against revenge-attack or wife-raiding parties, for example. Translated in a modified way into modern settlement house occupation, co-residence of ten or twenty relatives is likely to be officially described as 'crowding', whether it is the residents' preference or not. Overcrowded and unhygienic sleeping arrangements are associated with scabies, one of the most important skin infections in central and northern Australia and one which leads to streptococcal infections which are statistically associated with end stage renal disease.³³

There are some ethnographically fine-grained explorations of the role of cultural factors in the generation of Indigenous health problems. Maggie Brady's work on alcohol use and petrol sniffing are well known examples.³⁴ Another good example is Jon Willis's account of barriers to men's use of safe sex technologies in a particular region of Central Australia.³⁵ Of thirteen such barriers which he identifies, most are based on cultural values and psychological reactions which are traditional or at least conventional in the region. Given similarly conventional attitudes to having multiple sexual partners in the same region, these barriers to protection are a key element in the prevalence rates for major STIs. The prevalence rates for gonorrhoea, chlamydia and syphilis in the relevant nearby Nganampa Health Service survey region in 1996 were 841, 157 and 106 times the national notification rates respectively.³⁶

²⁹ For example, Kunitz (1994:13, 129).

³⁰ Kunitz (1994:12).

³¹ Kunitz (1994:9).

³² Peterson and Long (1986).

³³ Cass et al (2004). On the similar experience of Inuit, who have moved "from the clean, open spaces of the tundra to squalid prefabricated villages", see Shephard and Rode (1996:257).

³⁴ E.g. Brady (1992, 2004), Brady and Palmer (1984).

³⁵ Willis (2003).

³⁶ Willis (2003:210)

IS RECOGNISING CULTURAL CAUSATION 'BLAMING THE VICTIM'?

The central area of disagreement over the causes of the Indigenous/non-Indigenous health differential in Australia seems to be between what Emma Kowal and Yin Paradies have called 'structural' explanations and those that stress 'agency'. In their study of participants in a public health practitioner workshop they found that there was a clear tendency towards structural attributions of cause grouped under the *health system, historical context, culture, financial situation, and residential remoteness*. They found participants indicating discomfort at explanations that stressed agency – that is, effects attributable to acts by the Indigenous people themselves. Nearly all the causal factors the participants identified as 'politically incorrect' were within the individual behaviour category.³⁷ "That is, participants were more likely to blame the system, and were reluctant to nominate Indigenous people's choices or actions as a cause of their ill-health ... This ethos of political-correctness is clearly a response to *victim-blaming*, a term given to expressions of Indigenous agency that are generally seen as racist (for instance, blaming Indigenous ill-health on their cultural practices)".³⁸ They concluded that the culture of the Indigenous public health industry in Australia had resulted in an overstructuration of Indigenous ill-health and a de-emphasising of Indigenous agency.

It is important, however, to make a distinction, albeit a problematical one, between individual voluntary and conscious agency and what are often called culturally embedded practices. The scope and the efficacy of individual decision making, in any society, are always constrained by the cultural and social contexts people live in. An apparently rational personal choice based on health outcomes can often be blocked, for example, by a need to enjoy solidarity with others, or to follow traditional practices as defined by figures of authority, or to avoid ostracism arising from appearing to be different or from appearing to be like a member of an out-group (hence the 'coconut' accusation). Even the existence of choice itself, including the conceivability of choosing to do otherwise than what is usually done, or the acceptability of being open to learning new health-related information and new practices, can be denied to individuals, to varying extents, in particular cultural contexts.³⁹

There is widespread agreement on the fact that many Indigenous problems stem ultimately from colonisation, but no agreement at all that this has been the only cause.⁴⁰ When people say that attributing causes of ill health to cultural practices, or even to personal choices, is 'blaming the victim,' they are suggesting that an attribution of this kind is making some kind of statement about moral culpability. This is usually quite untrue. What interests me about the accusation is why some people should feel so instantly attracted by it. One of its attractions may be that it interrupts the scientific discussion of causality and turns it into a moral contest in which the author of this moral politicisation can leap to take the high ground. To that extent it is an exercise in domination. When enough people of a similar political persuasion take the same leap they often make it pretty clear that they are also defending the solidarity of their

³⁷ Kowal and Paradies (2005:1351–2).

³⁸ Kowal and Paradies (2005:1352). Kunitz also noted in relation to trauma: "... to suggest that ... traditional modes of socialization and social control may contribute to the contemporary problem of violence is to risk being accused of blaming the victims and excusing their oppressors" (1994:187).

³⁹ It is not a rare observation that in Aboriginal classical practice, the asking of questions about serious matters is discouraged among the young, information is often given to them only in piecemeal and fragmentary ways, innovation is denigrated as contrary to the Law, and the Law (ideally at least) never changes, whether to accommodate new circumstances or for any other reason. On the discouragement of rapid or comprehensive factual learning by young people and the cryptic imparting of knowledge to them by elders, see e.g. Strehlow (1947:5–6,110 (note 32)), Strehlow 1971:70, 197–198 (note 37)); Hale (1984:258–259); Keen (1994:244–249); Sutton (1998:365).

⁴⁰ I have received widespread support for the view put in Sutton (2002:140, 141, 148–9) that the causal factors are a mix of colonial aftermath and continuations of past practices under changed and now often inappropriate conditions. I reject monolithic causal accounts typified by that in Mathews (1996).

group and its comforting assurance of correct thinking. Such a group is identified by Kowal and Paradies as “the mainstream left/progressives/liberals” who are threatened by the possibility that they do not, in fact, share similar health aspirations with Indigenous people.⁴¹

To observe that this is a rather dominant set of attitudes in the helping professions is not to ignore the many exceptions to it. There are people who have been saying that culturally transmitted behaviours and attitudes lie at the centre of the huge differences between Indigenous and non-Indigenous health outcomes, and here I include both classical patterns that pre-date colonisation, and the many patterns of behaviour which have emerged since then. The critical point in all this is child socialisation.

For example, Gary Robinson wrote in 1996:

... reduction in mortality requires the transmission of improvements in key indicators over generations; these improvements cannot solely be produced by direct medical intervention, but may only be sustained on the basis of significantly changed environments, patterns of activity and consumption and household patterns which influence childcare and development. Even in the short term, the capacity of individuals and their families to alter aspects of ‘lifestyle’ may be decisive in achieving any degree of effect in treatment. These patterns are deeply sedimented aspects of local cultures and environments, including patterns of household, family and community life, with their systems of exchange, obligation and dependence. These the individual cannot ‘rationally’ influence in the interests of his or her own health, and they are not directly amenable to medical or public health interventions without assaults on culture, tradition and lifestyle which would be ineffectual or incur strong resistance.⁴²

Robinson ended that paper on what sounded like a note of resignation, saying that “the researcher’s consciousness of certain lines of causation and of the effects of social change on health and illness does not provide a recipe for change in the interests of better health”,⁴³ because social change was unpredictable and could not simply be engineered, and because to raise the need for social change was also to suggest removal of power from Indigenous people, and a decline in their autonomy and self-determination.

I think there is another way to look at those last points. For a start, major social change of a predictable kind was in fact generated by the creation of holding and training institutions for Indigenous people under mission and government policies of the colonial era and afterwards. That was social engineering on a grand scale and in addition to its harmful effects it had clearly visible positive effects on things like the protection of inmates from frontier ruffians and their drugs and diseases; on the suppression of warfare; on the monitoring, isolation and treatment of infectious disease cases; on the administration of hookworm inoculations; on the use of violence between family members; and so on. But it was also a major suppression of people’s autonomy. While people will say, and so will I, that it is unthinkable to argue for that kind of social engineering and intervention any more, it is arguable that the maintenance of racially separate communities via state funding does constitute a massive continuation of that intervention, and one that results, in many cases, in rapid cultural change, not entirely towards non-Indigenous culture, but so often towards the culture of welfare and the culture of the ghetto.

The cultural assimilation that has wiped out so many languages and art forms and ceremonies is something about which there is a lot of anger and regret. And yet there are also positive forms of assimilation that deserve respect. If people don’t *assimilate* themselves to certain blanket-washing and other relevant practices then their children are more likely to get scabies, and hence more likely to suffer kidney disease. Another way of putting this is that unless there

⁴¹ Kowal and Paradies (2005:1351, 1354).

⁴² Robinson (1996:3).

⁴³ Robinson (1996:7).

is cultural adaptation to the biological features of fixed housing and repeatedly used and shared bedding, the perpetuation of cultural practices and beliefs appropriate to the old semi-nomadic camping style, but now mixed up with fabrics and buildings, will continue to great harm to people's kidneys.

If people want a typically modern health profile they need to adopt a typically modern set of health practices, whether as an augmentation to their existing health culture or in replacement of it. Health service providers should be encouraging this kind of cultural augmentation and change if they want to see improved outcomes as defined in their own terms. Hospitals which employ Aboriginal traditional doctors are encouraging the perpetuation of traditional aetiologies of disease and the use of mystification in producing alleged cures. This places the medical service providers in an impossibly self-contradictory position if they are serious about behavioural change as preventative medicine. If they are serious, then use of traditional doctors should not be official hospital business, but should be left to private arrangements between patients and their communities.⁴⁴

One of the more powerful traditional factors in preventing adaptation to contemporary conditions is the instilling in many Aboriginal people, from an early age, of a causal theory in which most serious illnesses and most deaths are due to the ill-will and sorcery of other people.⁴⁵ This itself is the very profound politicisation of disease and death. Systems of sorcery beliefs and practices are found widely around the world in traditional societies, and even in some not so traditional ones.⁴⁶

Such systems are primarily oriented to blame rather than to objective causation. Blaming makes sense in its own way, as it rationalises what has happened, and externalises causes in a way that is not easily challengeable on the grounds of scientific evidence. Sorcery beliefs have great durability in Aboriginal societies. The evidence is heavily against the rose-coloured expectation that Aboriginal people will simply adopt foreign causal theories, living conditions and health practices with alacrity and on the basis that they are good for their health.

It is not realistic to assume that the kind of cultural change I refer to here is going to occur quickly and simply as a result of education or persuasion of adults. The cycle of childhood socialisation probably needs to be interrupted if specific behaviours to do with hygiene and sanitation and the legitimisation of violence, for example, and the degree of priority placed on physical well-being itself, are to change quickly.⁴⁷ As a voluntary system, Noel Pearson's⁴⁸ suggestion of providing greater opportunities for giving children education and training away from their home communities and in urban areas strikes me as something with strong possibilities, but the main practical difficulty with it would be the problem of scale, should thousands of families take up this option. On the other hand, perhaps the main difficulty with it would prove to be the politicisation of the issue itself, building upon the emotive symbolism of an incomplete analogy with the Stolen Generations rather than upon actual outcomes. I hope not.

⁴⁴ See e.g. Tonkinson (1982), Reid (1983:57-91) and Hunter (1993:54-57) on Aboriginal doctors in remote Australia.

⁴⁵ See e.g. Tonkinson (1982:237), Reid (1983:35-44), Devitt and McMasters (1998:92).

⁴⁶ On the latter, I am thinking of examples such as Malicious Animal Magnetism in Christian Science.

⁴⁷ On Aboriginal child socialisation in this context, see e.g. Berndt and Berndt (1972), Hamilton (1981,1982), Hernandez (1941).

⁴⁸ Pearson (2004).

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REFERENCES

- Anderson, Ian, and Bebe Loff 2004. Voices lost: Indigenous health and human rights in Australia. *The Lancet* 364:1281-1282.
- Berndt, C.H. and R.M. Berndt, 1972. Aborigines. In F.J. Hunt (ed), *Socialization in Australia*, Sydney: Angus & Robertson, pp115-140.
- Brady, Maggie 1992. *Heavy Metal. The Social Meaning of Petrol Sniffing in Australia*. Canberra: Aboriginal Studies Press.
- Brady, Maggie 2004. *Indigenous Australia and Alcohol Policy: Meeting Difference with Indifference*. Sydney: University of New South Wales Press.
- Brady, Maggie, and Kingsley Palmer 1984. *Alcohol in the Outback. Two Studies of Drinking*. Darwin: North Australia Research Unit Monograph
- Cass A., Cunningham J., Snelling P., Wang Z. and Hoy W. 2004. Exploring the pathways leading from disadvantage to end-stage renal disease for Indigenous Australians. *Social Science and Medicine* 58(4):767-785.
- Cowlishaw, Gillian 2003. Euphemism, banality, propaganda: anthropology, public debate and Indigenous communities. *Australian Aboriginal Studies* 2003/1:2-18.
- Devitt, Jeannie and Anthony McMasters. 1998. *Living on Medicine : a Cultural study of End-stage Renal Disease among Aboriginal People*. Alice Springs: IAD Press.
- Hale, Ken 1984. Remarks on creativity in Aboriginal verse. In J.C. Kessler and J. Stubington (eds.), *Problems and Solutions: Occasional Essays in Musicology Presented to Alice M. Moyle*, pp254-62. Sydney: Hale & Iremonger.
- Hamilton, Annette 1981. *Nature and Nurture: Aboriginal Child-Rearing in North-Central Arnhem Land*. Canberra: Australian Institute of Aboriginal Studies.
- Hamilton, Annette 1982. Child health and child care in a desert community, 1970-1971. In J. Reid (ed.) *Body, Land and Spirit. Health and Healing in Aboriginal Society*. St Lucia: University of Queensland Press, pp49-71.
- Hernandez, T. 1941. Children among the Drysdale River tribes. *Oceania* 12:122-133.
- Hunter, Ernest 1993. *Aboriginal Health and History. Power and Prejudice in Remote Australia*. Cambridge: Cambridge University Press.
- Keen, Ian 1994. *Knowledge and Secrecy in an Aboriginal Religion*. Oxford: Clarendon Press.
- Kowal, Emma, and Yin Paradies 2005. Ambivalent helpers and unhealthy choices: public health practitioners' narratives of Indigenous ill-health. *Social Science & Medicine* 60:1347-1357.
- Kunitz, Stephen J. 1994. *Disease and Social Diversity. The European Impact on the Health of non-Europeans*. New York, Oxford: Oxford University Press.
- Loff, Bebe, and Ian Anderson 2000. Aboriginal reconciliation still a long way to go. *The Lancet* 355 (no.9219) 3 June.

- Mathews, John D. 1996. Aboriginal health: historical, social and cultural influences. In Gary Robinson (ed), *Aboriginal Health: Social and Cultural Transitions*. Proceedings of a Conference at the Northern Territory University, Darwin, 29–31 September, 1995; pp29–38.
- Pearson, Noel 2004. Australia needs you. *The Weekend Australian* 10 April 2004.
- Peterson, Nicolas, with Jeremy Long 1986. *Australian Territorial Organization: a Band Perspective*. Sydney: Oceania.
- Reid, J. 1983. *Sorcerers and Healing spirits. Continuity and Change in an Aboriginal Medical System*. Canberra: Australian National University Press.
- Robinson, Gary 1996. Aboriginal health: social and cultural transitions: Introduction. In Gary Robinson (ed), *Aboriginal Health: Social and Cultural Transitions*. Proceedings of a Conference at the Northern Territory University, Darwin, 29–31 September, 1995; pp1–9. Darwin: NTU Press.
- Shephard, Roy J., and Andris Rode 1996. *The Health Consequences of 'Modernization': Evidence from Circumpolar Peoples*. Cambridge: Cambridge University Press.
- Strehlow, T.G.H. 1947. *Aranda Traditions*. Melbourne: Melbourne University Press
- Strehlow, T.G.H. 1971. *Songs of Central Australia*. Sydney: Angus & Robertson.
- Sutton Peter 1998. Icons of country: topographic representations in classical Aboriginal traditions. In D. Woodward and M. Lewis (eds), *The History of Cartography, Vol. 2.3: Cartography in the Traditional African, American, Arctic, Australian, and Pacific Societies*, pp351–386. Chicago: Chicago University Press.
- Sutton, Peter 2001. The politics of suffering: indigenous policy in Australia since the 1970s. *Anthropological Forum* 11:125–173.
- Tonkinson, Myrna 1982. The *mabarn* and the hospital: the selection of treatment in a remote Aboriginal community. In J. Reid (ed.) *Body, Land and Spirit. Health and Healing in Aboriginal Society*. St Lucia: University of Queensland Press, pp225–241.
- Webb, Stephen 1995. *Palaeopathology of Aboriginal Australians: Health and Disease across a Hunter-gatherer Continent*. Cambridge: Cambridge University Press.
- Willis, Jon 2003. Condoms are for whitefellas: barriers to Pitjantjatjara men's use of safe sex technologies. *Culture, Health & Sexuality* 5:203–217.