# Theorising Indigenous health: a political economy of health and substance misuse


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**Abstract**

*For more than two decades we have been engaged in a program of research which examines the health of Indigenous people. More recently this work has focused on ways in which substance misuse affects communities, and their responses to it. Our work is framed by understandings derived from political economy, which directs attention to the web of political and economic relations surrounding individuals and social groups. We have stressed that this framework should not be interpreted in a crudely deterministic fashion, which neglects the nuances of the social determinants of health, or individual and community agency. Much of our recent work documents such agency in community-based actions throughout Australia. In this paper we examine Indigenous drinking and its consequences, outline a political economy approach to drinking, and discuss how this has informed our work. We conclude with a discussion of some criticisms of this approach and our responses.*



***Key words**: Political economy of alcohol, Indigenous drinking*


### Introduction

Although our work exploring Indigenous issues goes back more than two decades, since 1991 we have published a range of material which explicitly attempts to explain why, in spite of more than three decades of concerted intervention, Indigenous health remains stubbornly poorer than that of other Australians (Saggers and Gray 1991; Gray and Saggers 2001). Alcohol misuse is acknowledged as a factor contributing to Indigenous health inequality and our work in recent years has focused on this (Gray and Saggers 1994; Saggers and Gray 1997; Saggers and Gray 1998a; 1998b). Although our theoretical orientations are not identical, our joint publications are framed within a political economy approach—that is, one which seeks explanations for social phenomena primarily at the level of the web of political and economic relations in which individuals and groups are enmeshed. In this paper we: illustrate the political and economic determinants of Indigenous alcohol misuse, the contribution of such misuse to poor health and other negative social outcomes; outline the theoretical foundations of our work; and present some examples of our approach. We finish with a brief discussion on the tensions between competing explanations for poor Indigenous health.

### Indigenous Australian drinking and its consequences

The research we have embarked upon over the past decade has focused on explaining—and dealing with—*excessive* alcohol consumption. We are not concerned with explaining drinking in general. In most societies, most people who consume alcohol do so with clearly beneficial consequences for their health and social well being. However, within those societies in which drinking is acceptable there are some people who drink excessively, leading to harm to themselves and others.

Contrary to some romantic notions, the problematic nature of some Indigenous drinking is not a European construction—the consequence of an ethnocentrically distorted perspective. In the National Aboriginal and Torres Strait Islander Survey (Australian Bureau of

Statistics 1995), when asked what they perceived to be health problems in their local area, almost 60 per cent of respondents identified alcohol. When asked specifically about substance use problems, 76 per cent identified alcohol-related problems. Such concerns have been raised in other contexts—most notably by the Royal Commission into Aboriginal Deaths in Custody. An Aboriginal person in Alice Springs told those who prepared the report *Too much sorry business:*

> Couldn't sleep last night after listening yesterday. Thinking about how grog is killing people, family problems, culture dying, lost respect. Grog is a form of poison, can make a good man or woman go mad, kill, forget their kids. Grog is tearing Aboriginal people apart (Brother of one of those who died in custody in South Australia, speaking at Central Australian Aboriginal Congress—Langton 1991: 3).

To put these concerns into some context it is necessary to know something about patterns of Indigenous drinking. There are a number of published reports on patterns of alcohol consumption among Indigenous Australians, dating from the 1970s, relating to rural (Kamien 1975; Harris *et al* 1987) and urban (Perkins *et al* 1994) New South Wales, the Northern Territory (Watson *et al* 1988), and the Kimberley region of Western Australia (Hunter, Hall and Spargo 1992; Hunter 1993). While they show some regional variation, generally the results accord with the results of the Australian Bureau of Statistics' National Aboriginal and Torres Strait Islander survey, conducted in 1994 (ABS 1995). That survey found that the proportion of current drinkers in the Indigenous population was less than that in the non-Indigenous population. This was mainly due to the number of people who used to, but no longer, drink. Maggie Brady's book *Giving away the grog* (1995a) presents some of the eloquent case studies behind these statistics. The survey also found that Indigenous people drink less often than the general population. About half of those surveyed reported drinking less than once a week, compared to only about 40 per cent of non-Indigenous people who drank so infrequently.

However, it is when reported *levels* of alcohol consumption are examined that the problematic nature of some Indigenous drinking becomes clearer. We need to bear in mind that the household survey relied on self-reports so is likely to under-report levels of consumption. Although there are fewer Indigenous drinkers and they drink less often than drinkers in the general population, overall 79 per cent of Indigenous drinkers—compared to only about 12 per cent of non-Indigenous drinkers—reported consuming alcohol in amounts that the National Health &Medical Research Council has identified as being harmful to health: that is $\geq 41$ grams for women and $\geq 61$ grams for men (ABS 1995).

Not surprisingly, drinking at these levels has serious health and social consequences. Indigenous people are more likely to become sick and also more likely to die of alcohol-related causes than the general population. These epidemiologic consequences are now widely known (Saggers and Gray 1998a). Less well known outside of areas with significant Indigenous populations is the human face of sickness and premature death commonly associated with drinking. In all Indigenous communities people have either experienced these losses within their own families, or have witnessed the effects among others close to them (Brady 1995a; Gray and Saggers 2001).

Anyone who has worked or lived in an Indigenous community will be aware of the direct and indirect social consequences of excessive drinking—violence, disruption of family relationships, school absenteeism, un- and under-employment, food shortages and neglect

of children and older people. These are only some of the traumatic pressures excessive drinking wreaks on Indigenous communities (Saggers and Gray 1998a; 1998b).

### A political economy of health and substance misuse

A political economy perspective is one which examines human social and cultural behaviour in the context of the '...circumstances associated with getting a living and the structures of power that shape and constrain activity' (Roseberry 1988: 179). This is not to say that biology, psychology, social or cultural factors do not influence what people say and do, but that these factors are expressed within a context in which political and economic factors play a broadly determinative role. While such structural, so-called modernist, approaches to the analysis of social phenomena were common in sociology and anthropology in the 1960s and 70s, they have largely been replaced by a range of theoretical perspectives, notably postmodernism with its 'vigorous denunciation of abstract reason and a deep aversion to any project that sought universal human emancipation through mobilisation of the powers of technology, science and reason' (Harvey 1989: 41). The commonalities in postmodern approaches are their eschewal of meta-narratives of human history, and so-called deterministic theories of behaviour. They are suspicious of structural explanations and stress the multitudinous ways in which individual and group agency resist and circumvent monolithic structures and regulation. With few exceptions, explicit political economy approaches in sociology and anthropology are now most likely to be seen in publications outside the mainstream social science disciplines. However, while rarely cited at a macro-theoretical level, political economy approaches to health are still apparent in the range of explanations given for a variety of health behaviours. Our analysis of the origins and maintenance of poor Indigenous health (Saggers and Gray 1991) drew upon a body of literature which reported on the associations between socio-economic factors and ill health. In recent years this work is identified under the banner of the social determinants of health (Marmot and Wilkinson 1999).

A political economy of health which locates sickness and risky behaviours such as excessive drinking, in a context of unequal access to power and economic resources, has a history dating back at least to Engels' *The condition of the working class in England* [1854](1969). The insight Engels contributed to a political economy of alcohol have been summarised by Singer (1986):

- excessive drinking is not simply a health problem, it also has deleterious social consequences;
- drinking is influenced by people's social situations;
- social drinking may symbolise class solidarity;
- levels of drinking and related harms are associated with the availability of alcohol;
- the state plays a prominent role in facilitating and sometimes promoting alcohol availability;
- alcohol producers, as producers elsewhere, want to expand their markets in order to increase profits.

In the last couple of decades these understandings have been complemented by detailed research among non-Indigenous populations into the supply and promotion of alcohol, and attempts at regulating its availability (Single, Morgan and Delint 1981; Plant, Single and Stockwell 1997). Again, however, this literature is not

frequently cited in sociological or anthropological literature. It is also rarely cited in analyses of Indigenous alcohol use, which are more likely to call upon an eclectic mix of social, cultural and psychological theories to explain destructive drinking patterns (Collmann 1979; Brady 1986; 1988; 1991; 2000; Hunter 1993).

A contemporary political economy of alcohol use should, according to Singer, examine:

> ... the larger structures, patterns and processes that create the settings, bring into being social groups, produce and promote the intoxicants, and generate the motivations for prodigious consumption (1986: 116).

In our first book (*Aboriginal health and society* 1991) we tried to show the way in which the process of colonialism and attendant dispossession of Indigenous people, created disparate groups of marginalised people who were not expected to play other than menial roles in the developing political economy of Australia. This consigning of Indigenous people to the lowest socio-economic strata in society ensured their continuing poor health and provided the circumstances in which hazardous drinking thrives. We have provided an analysis of the way these processes impacted on drinking patterns among the Indigenous peoples of Australia, Canada and New Zealand (*Dealing with alcohol: Indigenous usage in Australia, New Zealand and Canada* 1998a). In the following section we provide brief summaries of some of the particular Australian research which forms the foundation of our theoretical approach.

## Australian case studies

The research projects discussed tackle alcohol issues on levels ranging from the state to the local community and involve a range of methodologies from the 'hard' quantitative end of the spectrum to more qualitative analyses involving in-depth interviews and observations in particular rural and regional communities. The work attempts to bring together health and social science perspectives and has been published in a variety of sources in these various disciplines.

### *State-based supply reduction*

There is a demonstrable relationship between the availability of alcohol and its consumption. With greater availability more alcohol is consumed (Stockwell 1995). The price of alcohol also has a significant impact on consumption levels, with consumption falling as prices rise (Edwards, Anderson, Babor *et al* 1994; Godfrey 1997). While it is in the best commercial interests of alcohol producers and distributors to have low alcohol prices, this is not in the health interests of citizens. The taxation of alcohol, therefore, can play an important role in regulating the supply of alcohol and controlling the extent of alcohol-related harm. However, all governments have to balance their role in supporting powerful commercial interests between their desire to raise revenue and the need to minimise the health and social consequences of excessive consumption (Saggers and Gray 1998a). In the case below, we have an illustration of the way in which state intervention through alcohol policy can play both positive and negative roles at the State/ Territory and Commonwealth levels.

Prior to the introduction of the Goods and Services Tax by the Liberal-National Coalition Government, alcoholic beverages were taxed under an *ad hoc* system of excise duties, liquor licensing fees and sales taxes. This system contained significant anomalies. Thus, for example, the 'total tax payable per standard drink' (that is, one containing 10 g of alcohol) was approximately $0.28 on regular strength beer, $0.38 on light beer,

$0.40 on bottled wine, and $0.08 on cask wine. Cask wine enjoyed a significant price advantage under this regime—not only was it cheap to produce and distribute but because of this it incurred only a low level of taxation.

Due to its low unit cost, cask wine is disproportionately associated with high levels of individual consumption, and areas in which it is consumed in higher quantities have been shown to have higher levels of alcohol-related harm (Stockwell, Midford, Masters *et al* 1998). In particular, high levels of consumption of cask wine has long been implicated in high levels of alcohol-related harm by Indigenous community organisations and public health practitioners. Our own research and that of our colleagues— conducted in association with Indigenous community organisations—have provided evidence for this (Saggers and Gray 1998a; Gray and Chikritzhs 2000).

As a result of concern over the harm caused by high levels of cask wine consumption, in 1995 the Northern Territory Country-Liberal Government undertook a significant public health initiative by introducing a $0.35 per litre levy on the sale of cask wine. This levy was in addition to existing liquor licensing fees and a levy on the sale of all alcoholic beverages used to fund the NT's 'Living with Alcohol' program. The explicit aim of the wine cask levy was to reduce consumption of that beverage and to raise revenue to cover the costs of the harm associated with its excessive consumption.

In August 1997, the High Court of Australia struck down all states/territories liquor licensing fees and levies as unconstitutional—ruling that they were *de facto* excise duties (duties which can only be imposed by the Commonwealth Government). In the case of wine, the Commonwealth Government introduced an additional Wholesale Sales Tax (WST)—the proceeds of which were returned to the states/territories to compensate them for the loss of revenue. However, this effectively removed the cask wine levy as the WST did not compensate the NT for this unique impost.

This series of events provided an opportunity to examine the effect of the application, and removal, of the levy on cask wine consumption (Gray, Chikritzhs and Stockwell 1999). Using data on licensee purchases of alcoholic beverages and Australian Bureau of Statistics (ABS) population data, estimates were made of per capita consumption of pure alcohol by beverage type. Time series variables were analysed using multiple linear regression analysis.

Analysis showed that prior to the introduction of the levy, quarterly per capita consumption of cask wine among people aged ≥ 15 years was 0.73 litres. This fell to 0.49 litres during the levy period, and rose again to 0.58 litres when the levy was removed. Consumption of other beverages appeared to be unaffected by the imposition of the levy. These results demonstrate the impact of state interventions such as alcohol taxation policy on public health. On the basis of this research, Gray and colleagues argued for the need to move towards a tiered volumetric system of alcohol taxation. This would have removed anomalies in the system, and taxed beverages on the basis of their contribution to harm, while promoting the consumption of lower-alcohol content drinks through lower rates on these products (Gray, Chikritzhs and Stockwell 1999).

In 1999 the Australian Senate passed the Wine Equalisation Tax Bill, as part of a series of bills paving the way for the introduction of the Goods and Services Tax (GST). The aim of this bill was to maintain then current levels of revenue raised from the taxation of wine—levels which would have fallen if wine was taxed only under the 10 per cent GST. The Government had

the choice of two methods of taxing wine: an *ad valorum* method, which is simply another sales tax based on price; or a 'volumetric' method based upon the amount of alcohol in a particular beverage. As indicated above, the volumetric approach would have raised the floor price of cheap bulk and fortified wine products which were greatly advantaged by the then current system of taxation. Various groups with a public health interest—including the National Indigenous Substance Misuse Council, Australian Medical Association, and the Anglican Church of Australia—used the research cited above to lobby the Commonwealth Government to adopt the volumetric approach. However, unlike the Northern Territory government, in large part due to lobbying by the Winemakers Federation of Australia, the Government adopted the *ad valorum* method. This case illustrates both the importance of a political economy approach to research and the role of political and economic factors in determining the outcomes of important public health issues.

*Supply and promotion of alcohol at the local level*

The supply and promotion of alcohol does not occur only at the level of the state. In large and small communities across Australia alcohol plays a role in the local level political economy. With local Indigenous community organisations we investigated the way in which alcohol is supplied and promoted to Indigenous people in two rural Western Australian towns (Saggers and Gray 1997; Saggers and Gray 1998a). To do this we collected statistical data on alcohol consumption and related harm, and interviewed Indigenous community members, licensees and managers of liquor outlets, and representatives from government agencies. We also made direct observations of alcohol sales and drinking in liquor outlets.

While we found no strategies specifically targeted at the Indigenous populations of these towns, the general promotion of alcohol affected Indigenous people disproportionately, because of their particular drinking patterns. Rather than attempting to attract Indigenous people to licensed premises, as we had anticipated, licensees sometimes actively discouraged Indigenous patrons through measures such as dress standards, levels of security and trading hours. This meant that much Indigenous drinking took place in public spaces or in domestic settings, both of which were associated with unregulated and often hazardous behaviours for drinkers and those around them. It was also much more likely to attract the attention of the police.

While these strategies meant fewer Indigenous people drank on licensed premises, licensees promoted their product to Indigenous people through the competitive pricing of alcohol. The cheaper prices for alcohol, particularly cask wine, at hotel bottle-shops and off-license premises were a powerful incentive for Indigenous drinkers, who were happy not to have to confront the unwelcoming attitudes of licensees and some patrons. At the time this research was conducted, in both towns, the price of a middy of beer (one standard drink) in a hotel bar was $2.20. However, the price of a standard drink from a four litre cask purchased from a hotel bottle-shop was $0.27 and from a liquor store was $0.25 in one town and in the other town the respective prices were $0.31 and $0.24.

Competition for drinkers by liquor outlets has intensified in rural Australia because of the decline of local and regional economies. In one of our study sites it was clear that there were too many liquor licenses, and the oversupply encouraged licensees to aggressively promote alcohol sales to fewer customers. In these circumstances, we suggested there is a case to reduce

the number of licenses in the interests of public health and safety.

In these and many other towns alcohol is central to local level economies, and its supply and promotion is enmeshed within complex relationships between licensees, other business proprietors (such as taxi drivers who provide much of the transport to and from outlets), the police, and Indigenous drinkers and their communities. Our research and that of others supports the anonymous claim that 'behind every blackfella getting drunk, there's a whitefella getting rich', but with a rider. Now that Indigenous people are also becoming licensees in some 'wet' communities, the political economy of alcohol is even more contentious. Money from canteens is being used to develop and maintain basic community infrastructure and provide for health interventions. Contestation over alcohol availability within some of these communities has led to bitter disputes (d'Abbs 1998; d'Abbs and Togni 2000).

*Community-based supply reduction*

Having documented how the political economy of alcohol operates in local communities, and the ways in which this works against the interests of Indigenous people, we also wanted to work with those communities which are trying to do something about it. For many years now Indigenous communities around Australia have initiated attempts to limit the sale and consumption of alcohol—from declaring their communities 'dry' (alcohol-free) to instituting restrictions on alcohol availability (d'Abbs 1990a; Saggers and Gray 1998a). In 1998 we were asked to evaluate the impact of a number of restrictions to the sale of alcohol in Tennant Creek, Northern Territory, which were introduced in 1995. The restrictions included a ban on alcohol sales from takeaway outlets and liquor stores, and the closure of hotel front bars on Thursdays (the so-called 'thirsty Thursday', initially chosen as many social security cheques were received on that day); prohibition of the sales of all wine casks over 2 litres in volume; and a range of other limits to alcohol sales and promotion. An initial evaluation of the restrictions in 1996 had found evidence of 'improvement in the area of police incidents, public order, health and welfare' (d'Abbs, Togni and Crundall 1996). Two years later the Northern Territory Liquor Commission agreed to a second review because of renewed assertions that the restrictions were not working.

We were commissioned to conduct the review by the 'Beat the grog' sub-committee in Tennant Creek, which consisted of a broad range of Indigenous and non-Indigenous people—some of whom had been working for more than a decade on alcohol-related issues in the town (Gray, Saggers, Atkinson *et al* 2000). Our methods included statistical analysis of: alcohol consumption, admissions data from the local hospital, women's refuge and sobering up shelter; police data on detentions in custody and common offences; for the 12 months prior and two years subsequent to the introduction of the restrictions. In addition, we surveyed a random sample of residents to ascertain their attitudes towards the restrictions, and conducted in-depth interviews with key stakeholders in the town.

We found that over the two years following the restrictions there was a 19.4 per cent reduction in annual per capita consumption of pure alcohol in the Tennant Creek area. As well, there were demonstrated declines in hospital admissions for acute alcohol-related conditions, and in the number of people taken into police custody and reported offences on Thursdays. Surprisingly for us, given the very negative publicity surrounding the restrictions at the time of our review, a majority of people—both Indigenous and non-

Indigenous—that we interviewed in the household survey was in favour of the restrictions. More than half of those surveyed also supported further restrictions.

On the basis of the results of our review, the Liquor Commission supported the continuation of the restrictions in Tennant Creek, in spite of vehement opposition from a number of prominent business people in the town. This has provided important encouragement to Indigenous and non-Indigenous people working to improve the health and community well-being of all of Tennant Creek's citizens. It has also been symbolically significant, as communities elsewhere in Australia are seeking solutions to alcohol problems.

*Evaluating what works*

While our research in Tennant Creek demonstrated that restrictions on the availability of alcohol did have a positive impact on health and social indicators, we have also been interested in the broader question of 'what works' (Gray, Saggers, Sputoré *et al* 2000) in terms of alcohol interventions. We reviewed literature dealing with alcohol and evaluation identified from the comprehensive electronic data base on Indigenous alcohol and other drug issues, maintained by the National Drug Research Institute (Morfitt-Sputoré *et al* 1997; National Drug Research Institute 2000), and selected those dealing specifically with the evaluation of alcohol interventions in Australia. These were grouped under the broad categories of treatment, health promotion education, acute interventions and supply reduction. We found that a broad range of intervention strategies had been employed in different parts of Australia but that very few had been subject to rigorous evaluation. In many cases the methodologies used were insufficiently robust to allow generalisation. However, slight as the evidence is, it is not particularly promising.

For almost three decades treatment has been the primary focus of Indigenous substance misuse approaches, and throughout Australia, communities without residential treatment programs, in particular, have agitated for their establishment (Saggers, Gray and Catalano 2001). This form of treatment is the most expensive to provide but its effect on participants is still unclear. Three evaluations covering some 18 treatment programs were inconclusive or showed only modest gains (O'Connor and Associates 1988; d'Abbs 1990b; Miller and Rowse 1995), although residential programs provided at least some 'time out' for drinkers and their families. There are many possible reasons for the limited success of such programs, including staffing and resourcing issues. The narrow range of treatment models (with most abstinence based) has also been suggested as one limiting factor in the success of these programs (d'Abbs 1990b; Brady 1995b).

The results of health promotion programs among Indigenous Australians are equally equivocal. Similar results have been found among the general population, where health promotion programs have had limited efficacy among those populations specifically targeted, such as the poor and Indigenous people (Edwards *et al* 1994). There is stronger evidence that acute interventions, such as sobering up shelters, provide a cost effective means of diverting intoxicated Indigenous people from police lock-ups (Daly and Gvozdenovic 1994), and they are regarded positively by both Indigenous community members and police.

Of all the interventions evaluated, measures to restrict the supply of alcohol have produced the most significant results. Those involved in such evaluations qualify their findings by stressing that control policies may not provide long term solutions to drinking problems, and that such policies should form part of a more broad

alcohol strategy which includes attention to the demand for alcohol by particular groups of people (d'Abbs, Togni and Crundall 1996; Gray, Saggers, Atkinson *et al* 2000). However, restrictions such as those on the sale of cask wine in the Northern Territory, have played a significant role in the reduction of alcohol consumption, and related health and social harms (Gray, Chikritzs and Stockwell 1999).

Our research supports that reported elsewhere. A comprehensive review of Canadian evaluation studies found that among alcohol interventions, alcohol control policies produced the 'strongest and most consistent evidence of program effectiveness' (Eliany and Rush 1992: 77). These policies included increasing the minimum drinking age; restrictions on the sale of alcohol, especially off-premises; increasing the price of alcohol through taxation; and server intervention programs. In combination, alcohol control policies of these types are more effective than single adjustments, such as simply increasing the price of alcohol, for example. Although health education programs about alcohol and other drugs are more popular with both the public and education, health and welfare practitioners, their effectiveness is at best equivocal, with '...scant evidence of enduring behaviour change' (Eliany and Rush 1992: 78). We think this body of research supports our view that safer drinking, and better health, is associated with interventions directed at the political economy of alcohol, at state and local level.

### Political economy and the critics

Our attempts to explain excessive Indigenous drinking have attracted different responses. While there has been a largely positive reaction to much of our work, it is the political economy approach which has received most attention. Whether addressing the impact of state level taxation on the supply and consumption of alcohol, examining the ways in which licensees promote alcohol at the local level, evaluating community attempts to reduce alcohol availability, or assessing the effectiveness of substance misuse interventions, we have started with an analysis of the unequal access of Indigenous people in Australia to the country's political and economic resources, and the intimate way in which alcohol, in particular, is linked to structural and situational disadvantage. Those writing from anthropological, sociological and psychiatry backgrounds have claimed that our explanations are too structural, dismissive of culture and individual agency, and therefore provide insufficient detail of the 'more modest but practical ways' (Syme 1997: 9) Indigenous communities can change their worlds (Hunter 1998; Brady 1999; Giesbrecht 1999).[1]

In part, the criticisms reflect widespread distrust of meta-narratives of human social action, whether because of prevailing theoretical orthodoxy, or other reasons. It is as if, because we use a macro-theoretical analysis, all of our explanations and suggested solutions are concerned only with that level; or, that such approaches are mutually exclusive of all other theoretical orientations at different levels of analysis. Brady's review of our recent book (Saggers and Gray 1998a), for instance, claims we have dismissed individual agency, and argues instead for a 'syncretic approach which integrates structural (ie. historical and political) and sociocultural levels of explanation and looks for policy implications of this approach' (Brady 1999: 203). However, in the book Brady was reviewing and in our work discussed above, we detail a number of the community-based alcohol initiatives which Brady sees as illustrative of community agency, and we point out how these are linked to broader attempts at the level of the state to reduce the supply of alcohol. Brady's own work, in recent years, has tended to focus on structural,

rather than cultural, approaches to alcohol problems (Brady 1994; 1995b; 2000).

However, we do think this type of criticism indicates that, at a theoretical and practical level, we have to do more to show how political and economic factors, and their enmeshing in the broader social and cultural canvas of Indigenous life, influence the ability of individuals and communities to act in their own best health and social interests. This leads to another criticism, that what is missing from our work is reference to '...the Aboriginal-generated material that is hard to package, elusive to evaluate, possibly non-compliant and possibly redolent with the eccentricities of "bush mechanics"' (San Roche 2000: 89). We know that across Australia Indigenous people are working in innovative ways on health issues, but that few are aware of these efforts because details of them rarely appear outside of alternative media. More needs to be done to bridge the gap between the academic literature and these activities. Then we might approach a political economy of health that addresses all levels of human social and cultural action.

**Notes**

[1] However, for one practitioner working with Indigenous people, our analysis obscured 'the state's role in the continued domination of indigenous communities' (Edney 1999: 50)!

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