Class and colonisation

One of the things that surprised me most when I came to Australia was the similarities in the problems I saw in a very different context here and in the UK.

I had come from a family with a working-class background, and learned my general practice in a small city only just recovering from the effect of closing coal mines and steelworks. The health problems I saw were those caused by poor choices in lifestyle, such as smoking and chips. Except people had no choices, because choices required money to be able to afford something more expensive, and a belief that one had a future that was different. People would get their small pleasures with small amounts of money without waiting for a mythical future. So when I arrived in Australia, I recognised the social conditions, lack of control, and lack of opportunities that led to the health conditions I was seeing. I read the GPs at the Deep End articles[1] and recognised my own work in Australia. To my surprise, though, in Australia, deprivation or vulnerability wasn't seen as a problem of class differences or poverty. The language of class that was understood in the UK was mostly meaningless. Difficulties in life were seen as being a problem of living in geographically isolated areas.

As I worked as a GP for the original inhabitants of the country we now call Australia, I thought this omission, the lack of a description of class or economic inequality, was surprising. It was the main cause of the causes of ill health I was seeing.

However, as I heard more from my patients, and understood more, I realised I had not seen the causes of the causes of the causes. People had lived here for 60 000 years or so before Europeans planted a flag, intimately connected with multiple countries across this enormous landmass. For the comparatively tiny length of time — just over 200 years — these Aboriginal people, as the Europeans called them (as well as the Torres Strait Islanders, original inhabitants of multiple small islands off the north east coast), watched half their friends and family die of an unknown disease called smallpox. They were poisoned and shot when they fought back. They were removed from their lands and put on missions. They had their children removed.

It should not be surprising, then, if non-Indigenous people and institutions aren't trusted by Aboriginal and Torres Strait Islander Australians, without having to demonstrate that trust from scratch.

But I have also learnt solutions here. The service I work in is owned and run by my local Aboriginal community, and I am a salaried employee (much rarer here than in the UK). The model comes closest to a cooperative, with the GP's responsibility being mostly clinical, rather than owner, principal, or manager. This model of care, providing longer consultations, more multidisciplinary care, and more patient control, has proven successful in a group of people that the rest of the health system says is hard to reach, despite never being funded adequately according to need.

As it happens, my English class-based lens would recognise this as Tudor Hart's co-production of health between GPs and patients.[2] This model is what the GPs at the Deep End say is required to provide care in deprived Scottish communities.

Looking at health in vulnerable communities through the lens of class or colonisation reaches the same conclusions, because fundamentally they are about giving human beings control over their lives.

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Tim Senior,
GP, Tharawal Aboriginal Corporation, Airds.

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ADDRESS FOR CORRESPONDENCE

Tim Senior
Tharawal Aboriginal Corporation, Airds,
PO Box 290, 187 Riverside Drive, Airds, NSW 2560,
Australia.

Email: drtimsenior@tacams.com.au
@timsenior

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