

The role of the architect in building Indigenous health equality

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While compiling this presentation I was pondering the meaning of equality. There are many grandiose and lofty meanings floating around but to me this unassuming anonymous quote—“When the sun rises, it rises for everyone”—was very succinct and apt when it came to question of Australian Indigenous equality.

Similarly what is architecture? It also has many and varied meanings, goals and aspirations. A quote from Spiro Kostaf—“Architecture is a social act and the material theatre of human activity”—reflects a long steeped culture within Suters Architects that architecture is the embodiment of society and a tool for improvement in our community.

We believe architecture CAN provide the physical framework for better services, better awareness, better interaction and ultimately better equality for all in our modern society.

This ideal of architecture needs to be embedded in the heart of a practice. Suters celebrated 50 years last year and was formed by Brian Suters in 1958 in Newcastle regional NSW instilling a distinctive “grass roots” attitude in the practice. Brian Suters was honoured in the Australia Day Honours List this year by being appointed as a Member of the Order of Australia (AM). This is a wonderful achievement for Brian and reflects his dedication and commitment not just to architecture, but to serving the community throughout his life. It is this dedication and passion that has been instilled throughout the generations within Suters architects and has given us the community awareness and a culture of social passion to strive to deliver health architecture that will tilt the balance towards Indigenous Health equality.

This inherent cultural drive has lead Suters to undertaking numerous remote and regional projects.

But today I wanted to go through the process on two projects we are currently undertaking in the Northern Territory. This will reinforce our small but vital contribution to the improvement of Indigenous health services.

The first is new emergency department at Alice Springs and the other is a renal dialysis unit in the very remote township of Kintore.

“The Alice” is nearly equidistant from Adelaide and Darwin and is the second largest city in the Northern Territory. Alice Springs has a population of around 28,000 people which makes up 12% of the territory’s population. The aboriginal community make up approximately 17% of the population of Alice Springs.

The emergency department has over 30,000 annual patient attendances. Approximately 80% of the patients attending the department are Indigenous and there are over 22 dialects spoken within the region.

We started the project in late 2007 and completed the scheme design in 2008. With recent funding announcements the project has now gained new momentum and will hopefully see the building come to fruition in 2010. As with any project site analysis is the first step in the process. A key factor of getting the whole project right!

Here Option 1 is the site analysis of the brief's proposed site. It had poor visibility, poor access, poor functional relationships with other departments and the remove of some significant trees on the site. Other options were pursued.

Option 2 shows the selected final location at the front of the hospital, creating new identity and being the obvious first port of call as an emergency department should be. It also provided a new entry forecourt and better long term functional relationships.

One of the key benefits, especially for the Indigenous population, with this new building placement was for the entry and the adjacent forecourt to become welcoming and open environment not as restrictive and foreboding as the original brief.

The key to the new entry was about creating a sense of arrival. Currently this is purely functional, a drop off dominated by cars. The Indigenous population try and gather around sparse trees and landscaping in a sea of carparking. We needed to redress this by providing a "gathering" space at the entry that would be up lifting, open and clearly people orientated. We need to welcome everybody and entice them to feel comfortable about using this health service.

The planning has evolved over a series of consultative meetings with staff and some representatives of the Indigenous community. The key to a facility's success is it's level of acceptance and usability.

The entry forecourt leads into a more fluid shaped waiting area. This area is seen as a transition space "a verandah space". It helps with the transition from the open outside area into the more fixed clinic areas. It is purposely oversized, both in floor area and volume to comfortably accommodate large numbers. We intend the space to have mixed mode air conditioning (that is mainly natural ventilation) to again enhance the idea of a more comfortable transition into the clinical space which can be a harrowing experience for the Indigenous user.

As we get into the clinical space, the traditional barn emergency department layout with cubicles all focused around a central staff station wasn't going to work. There were issues with the openness, lack of gender and tribal separation, visual separation, noise.

At first it seemed like the clinical need could not meet the ingenious patient needs. But by thinking outside the square, literally, we came up with a planning concept of a series of "pods" that were splayed in plan to avoid direct visual overlooking. The pods were in smaller groups of 4 beds to reduce noise, aid with a more intimate feeling and assist with gender and tribal separation. These pods also had the opportunity for external views wherever possible to enhance the connection with the outside. The pods are clustered around a staff station to ensure nursing observation and clinical response can be maintained. To date this has struck a balance or equality between the cultural needs and the clinical needs.

To further aid the acceptance of the project within the Indigenous community we have engrained much symbolism in the early design framework. Although it is not blatant we hope this will also subconsciously promote a strong comfort level and increased usability of the health facility, with forms and shapes reflecting the environment

The second project I wanted to present to day is at Kintore. Kintore is located 530km west of Alice Springs nestled at the base of culturally important hills. The population is around 450, 96% of which are aboriginal and Torres Strait Islander people. The community has a school, women's centre, medical clinic, store, an art centre, council office and an airstrip.

Suters' involvement on the Blue House project, as is so often the case with pro bono projects, came about through a chance meeting. Three junior members of staff in our Newcastle office approached the CEO about wanting to do some kind of volunteer work.

Initial inquiries via architects without borders had indicated that all the projects they could assist were overseas, but these members of staff wanted to work on something within Australia and contribute locally.

When the Alice Springs ED project first started up in 2007, our CEO, Robert Macindoe travelled to Alice as part of the project team. While in town he purchased a painting by an artist named Sarah Brown from one of the local galleries. In discussions around the art Sarah mentioned to Robert that she ran the Purple House Dialysis Centre in Alice, and the discussed the then stalled Kintore project. Robert put two and two together, asked the junior members of staff if they were interested in a helping out and the rest is history, as they say.

The project involves the adaptive reuse of an existing building which you can see here. It was previously used as an aged care facility. The building will be redesigned to house a dialysis unit with the capacity to dialyse up to 8 patients a day. In addition to this the clinic will provide an accommodation unit to lodge out of town patients and health educators. The education is extremely important for the locals to learn about their bodies and their health in culturally appropriate ways.

Kintore already has a dialysis chair in the existing health centre but because of limited space it can't meet demand and so numerous locals still have to go to Alice Springs for treatment. This can mean Kintore people effectively ending up in Alice, away from their community, living on the fringes of town and not faring too well. So equality of access to health care was split—the most chronic patients got access in Kintore, but less chronic community members are forced to go to Alice were they are away from their community. Anyone who is distanced from family and friends while undergoing medical treatment is going to struggle.

The money for the original dialysis chair was raised when a number of Pupunya artists painted 4 big collaborative paintings (2 of which are pictured here). Then other art dealers and collectors around Australia donated works with the intention of selling them. An auction was held at the Art Gallery of NSW in 2000 and raised \$1.1m. Since then further international exhibitions in London and Paris has also raised \$100,000. This was an important step in equality for the community; to raise some of the money themselves meant they could do things their way instead of how uninformed authorities may dictate. There has also been some government support from the Commonwealth and Territory Governments.

The Woden Rotary Club has been a major partner in the delivery of the Blue House Project giving building advice, engineering advice, cash donation and other "in kind" support. What appealed to Rotary about Kintore was that it was basically an initiative of the local aboriginal community. The community were saying "We don't want you to do it for us, we want you to help us do it ourselves."

So the Kintore community wanted to expand services to treat more locals with kidney disease, by having a purpose built dialysis facility which also provides space for a community kitchen and education space. That is, the project would be not just being a place for dialysis but a centre of well-being for the community.

In the words of Sarah Brown, communities need places where the emphasis isn't just on the treatment or feeling crook. It becomes a gathering place, a place of support and acceptance. It becomes a real community asset rather than just a couple of dialysis chairs. The Blue House is a symbol that the

people are able to come up to their own solutions to a health problem. They feel like they have control in their lives about their own health outcomes.

So this slide shows is the existing building's floor plan and as you can see a fairly standard aged care layout

This slide shows you the new drawings of the building adapted for dialysis purposes, and also where the Blue House is in relation to the adjacent clinic.

And this is a close up of the proposed Blue House layout. Our aim was to provide a usable, affordable plan for Rotary to fundraise against. Project value is around \$250-\$300K, which will go mostly on materials rather than labour. There are obviously some specialised electrical and plumbing elements to incorporate.

Once again the process was as collaborative as possible. But because of project's physical limitation not all culture concerns could be met in built form like the provision of separate entry for men and women but this can be managed with timetabling which illustrates the team approach.

In November 2008 Rotary first visited the site and began cleaning up the existing building. In 40 degree heat and with the help of 4 locals, rooms were cleaned and all perimeter walls, windows and doors made secure. Internal blockwork walls were demolished, where nominated to prepare for the next stage of the internal fitout.

Rotary intends to visit the site again this year and in the meantime has been organising materials and supplies for transportation to Kintore, and getting prefabricated joinery completed. They have also had a container load of furniture donated by a medical school in Perth.

The challenges for Rotary have included the obvious isolation of the place. The cost of getting people and materials to and from the site is high. Another major hurdle has been trying to source local tradesmen from Alice Springs. To do the project we need to have Nth Territory registered plumbers and electrician, and in travel time and petrol it would cost them about \$2000 to visit the site to do a quote! Therefore this has been very problematic, has slowed the process but is gradually overcome.

From the architect's perspective the challenges of this pro bono project were:

- Time: All the work was done out of office hours—that is after the architects had finished a full day's work in a very busy period at the beginning of 2008 when there was still a boom! Everyone else involved in the project, including Sarah Brown and the Rotary people involved, were also working out of hours so that meant to responses to requests for information or clarification often took days, and blew out the time frame.
- Distance: Not being able to see the site is usually a big issue for any architect, but really, we knew what the site was—flat, red dirt, and very hot. So in that sense distance wasn't a problem. But of course not being able to talk directly one on one to the user groups was a major challenge. In fact we had to go through reverse brief process to work out exactly what it was we had put our hands up for.

The role of the architect in building Indigenous health equality isn't easy but it is very rewarding. There is plenty of short term pain for significant long term gain. The architect is an integral member of a much larger collaborative effort between governments, service providers, wider community and the Indigenous population themselves, to bring about this equality.

We don't profess to knowing all there is about Indigenous culture but we are keen to understand, promote and integrate. As architects we need to Look, Listen and Learn. We can't have preconceived ideas or dictate a "standard solution" for the sake of expediency or cost as shown with the outcome for Alice Springs ED. Once we commit a long held dream can become reality as with the Blue House at Kintore.

Only through engagement and understanding can the cultural awareness begin to infuse the physical design solution. Hopefully this will set the framework for equality in the provision of Indigenous health services.

Presenter

Ken Dyer has been with Sutera for over ten years and was made a principal in 2007. He is the National Health Team Leader and has been the senior project architect responsible for a diverse range of health care projects for both the public and private sectors over the past twelve years. Although based in Sydney, he is particularly familiar with regional projects and understands the right approach to delivering solutions that incorporate good design, meet budget requirements and reflect the needs of the users.