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ABORIGINAL HEALTH

House of Representatives
Standing Committee on Aboriginal Affairs

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FOREWORD

The standard of health of Aboriginals is far lower than that of the majority of Australians and would not be tolerated if it existed in the Australian community as a whole.

When innumerable reports on the poor state of Aboriginal health are released there are expressions of shock or surpirse and outraged cries for immediate action. However, the reports appear to have no real impact and the appalling state of Aboriginal health is soon forgotten until another report is released.

The Committee found that the low standard of health apparent in the majority of Aboriginal communities can be largely attributed to the unsatisfactory environmental conditions in which Aboriginals live, to their low socio-economic status in the Australian community, and to the failure of health authorities to give sufficient attention to the special health needs of Aboriginals and to take proper account of their social and cultural beliefs and practices.

The Committee believes that if the Commonwealth and State Governments had recognised the importance of these factors and had accepted their full responsibilities the disastrous Aboriginal health situation would not exist.

The level of Aboriginal ill health will only be reduced if there are dramatic improvements in the physical environment, if there is maximum participation by Aboriginals in all stages of the planning and delivery of health care,

and if Aboriginals, like all Australians, are given the opportunity to choose the type of health care they consider best suits their needs.

Many different types of health care programs that have been established to provide a service to Aboriginals were examined by the Committee. These can be broadly divided into those provided by Aboriginal organisations, and those provided by government and private agencies. The Committee recognises the advantages of both and believes there is a place for each in the delivery of preventive and curative medicine to Aboriginals.

Members of the Committee

Chairman	..	Mr P.M. Ruddock M.P.
Deputy Chairman	..	Mr A.C. Holding M.P.
Members	..	Mr S.E. Calder D.F.C., M.P.
		Mr J.S. Dawkins M.P.
		The Hon. D.N. Everingham M.P.
		Mr P.D. Falconer M.P.
		Mr J.R. Johnston M.P.
		The Hon. R.C. Katter M.P.*
Clerk to the Committee	..	Mr C.S. Boorman
Specialist Advisers	..	Professor M. Kamien
		Dr J.C. Reid

*The Hon. R.C. Katter M.P. was appointed on 10 October 1978 in place of Mr D.S. Thomson, M.C., M.P.

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APPENDICES (CONTD.)

RECOMMENDATIONS

The Committee recommends that :

on the physical environment -

1 the highest priority be given and immediate action taken to provide clean and adequate water supplies to all Aboriginal communities.

(paragraph 138)

2 a determined effort be undertaken to eliminate as soon as possible the unhygienic sanitary pan system in Aboriginal communities.

(paragraph 139)

3 an advisory group within the Department of Aboriginal Affairs comprising experts in middle level technology be established, and in consultation with relevant departments and the Australian Institute of Aboriginal Studies to: research various options for the provision of community and household facilities; consult with Aboriginal communities to assess their needs; advise them on the most appropriate facilities that best suits their needs; monitor implementation of its advice to communities; facilitate employment of technical advisers by Aboriginal communities; and report to the Minister for Aboriginal Affairs.

(paragraph 141)

4 priority for Aboriginals living in towns and moving into towns away from the fringes, be given to the provision of funds for meeting and upgrading their housing needs.

(paragraph 142)

5 the Department of Aboriginal Affairs consult relevant Commonwealth and State departments, local authorities and Aboriginal communities and organisations to define the responsibility for safe water, public hygiene services, housing standards and inspection of premises in Aboriginal settlements and communities, particularly fringe camps.

(paragraph 143)

<u>on cultural factors</u> -

6 Aboriginal cultural beliefs and practices which affect their health and their use of health services such as their fear of hospitalisation, their attitudes to pain and surgery, the role of traditional healers and the differing needs and roles of Aboriginal men and women, be fully taken into account in the design and implementation of health care programs.

(paragraph 193)

on health care programs -

7 savings to the State funded health services which result from the Commonwealth funded State Aboriginal preventive health programs be directed to the further development of preventive programs.

(paragraph 209)

8 an independent evaluation team responsible to the Minister for Aboriginal Affairs be established to evaluate the effectiveness of all Aboriginal health care services and programs in accordance with the World Health Organisation's definition of health and the principles of self-determination, and to establish suitable criteria so that standardised information can be collated and that funds be provided for this purpose where programs are funded by the Government.

(paragraph 297)

9 the full range of choice of the various types of programs delivering health care to Aboriginals be maintained and, where appropriate, support increased.

(paragraph 298)

on self-determination -

10 Aboriginal communities be given the opportunity to determine the type of health service that will best suit their needs and available resources and that a Task Force be established to place the full range of alternative health care services before them.

(paragraph 314)

on community development -

11 an inquiry be held into the implementation of the policy of self-determination as it affects community development.

(paragraph 324)

on Aboriginal involvement -

12 Aboriginals be involved to the fullest possible extent in all stages of the provision of health care services and that the Minister for Aboriginal Affairs assess the number of Aboriginals required, the time it will take to train them to assume responsibility for the health of their own people and, to this end, develop, in consultation with relevant Ministers, suitable training programs.

(paragraph 351)

on employment of non-Aboriginals -

13 training hospitals for nurses, university medical faculties and other tertiary institutions introduce into their curricula, both at undergraduate and graduate level, a component which deals with Aboriginal health.

(paragraph 358)

14 comprehensive orientation courses be conducted for all non-Aboriginal staff recruited to serve in Aboriginal communities before commencing duty, that they receive regular in-service training, and that a formal diploma or certificate be provided by a tertiary institution for professionals actively involved in providing health care to Aboriginals.

(paragraph 362)

15 governments introduce special allowances and entitlements which recognise the unusual working conditions and the geographical, social and professional isolation experienced by personnel working in predominantly Aboriginal communities in remote areas.

(paragraph 368)

SUGGESTIONS

In addition to the recommendations listed on pages xv-xix, the Committee has made a number of suggestions on matters that it considers require attention.

Many of these suggestions have a direct bearing on the recommendations and should be read in conjunction with the recommendations and have not been included in the list below.

Other important suggestions which are not related to recommendations are :

<u>on the physical environment</u> -

1 authorities supplying electricity accept greater responsibility for the adequate provision of electricity to Aboriginal communities.

(paragraph 119)

2 Aboriginals undergoing transition to town life receive assistance through the use of 'homemaker services' such as presently provided in Western Australia.

(paragraph 127)

<u>on social factors</u> -

3 full support be given to outstations to prevent a movement back to settlements where services are available but where health is worse.

(paragraph 159)

on cultural factors -

4 live-in facilities for patients and kin (particularly for mothers and babies) be provided in hospitals.

(paragraph 171)

5 limited inpatient facilities be provided in large settlements so that only serious cases be evacuated to distant hospitals.

(paragraph 171)

6 The practice of evacuating pregnant women before the birth of their babies, beyond the reach of daily family visits, be abandoned except where actively sought by the patient or where complications are anticipated.

(paragraph 172)

7 at best one midwifery sister be appointed to each isolated community or health centre, Aboriginal health workers be given training in midwifery and the services of traditional midwives be utilised wherever possible.

(paragraph 172)

8 every effort be made never to separate an infant or child from its mother.

(paragraph 173)

9 there is an urgent need for State health authorities to establish a procedure by which the bodies of patients who have died in hospital can be returned immediately to their families.

(paragraph 176)

on health care programs -

10 a cautious approach be adopted when consideration is being given to requests to support task forces.

(paragraph 287)

on self-determination -

11 State and Northern Territory Governments and their agencies offer partial or full control of existing or expanded health services to Aboriginal communities.

(paragraph 311)

12 all support be readily available to help communities which have chosen to control their own medical service and not be withdrawn simply because of a downturn in expectations.

(paragraph 315)

13 there is a need for an exchange of views and information between all types of medical services meeting the needs of Aboriginals and that these matters be considered at sponsored conferences organised at local, State and/or national levels.

(paragraph 316)

on Aboriginal involvement -

14 Aboriginal communities contribute significantly to decisions about the appointment of non-Aboriginal health personnel to their communities.

(paragraph 327)

15 every effort be made to give Aboriginal patients (those, for instance, in hospitals) access to Aboriginal healers if they so request.

(paragraph 330)

16 Aboriginals selected for training courses be given every support.

(paragraph 334)

17 any regulations which stand in the way of greater access of Aboriginals to vocational training in the health professions be reviewed immediately.

(paragraph 335)

18 the Aboriginal Health Worker Training Program developed in the Northern Territory be the model upon which State training programs be based.

(paragraph 338)

19 there be a rapid increase in the number of Aboriginal health workers in training so that each community, regardless of size, has at least one person in training.

(paragraph 340)

20 Aboriginality be an important qualification for employment in hospitals.

(paragraph 346)

21 hospitals at communities like Cherbourg and Palm Island have their own hospital board.

(paragraph 350)

<u>on integration and co-operation between existing services</u> -

22 there be full integration of all the activities of the Department of Health in each Aboriginal community.

(paragraph 353)

23 patient records be amalgamated or, where appropriate, duplicated provided that confidentiality and privacy are maintained.

(paragraph 354)

24 there be greater consultation between the Department of Aboriginal Affairs and the States with respect to programs financed by the Department of Aboriginal Affairs such as Aboriginal medical services and alcohol rehabilitation programs.

(paragraph 355)

1 INTRODUCTION

The Committee

1 The Committee was appointed in the 31st Parliament by resolution of the House of Representatives on 2 March 1978[1] with the following terms of reference :

> (1) That a Standing Committee be appointed to inquire into, take evidence and report on :
>
> (a) the present circumstances of Aboriginal and Torres Strait Island people and the effect of policies and programs on them, and
>
> (b) such other matters relating to the Aboriginal and Torres Strait Island people as are referred to it by -
>
> (i) resolution of the House, or
>
> (ii) the Minister for Aboriginal Affairs.

2 A similar Committee was originally appointed in the 28th[2] Parliament and reappointed during the 29th[3] and 30th[4] Parliaments.

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[1] Votes and Proceedings, No.6, 2 March 1978.

[2] Votes and Proceedings, No.26, 16 May 1973.

[3] Votes and Proceedings, No.6, 18 July 1974.

[4] Votes and Proceedings, No.11, 17 March 1976.

The Reference

3 On 1 December 1976[5] and on 10 March 1977[6] the Committee received a reference on Aboriginal health from the House of Representatives.

4 On 16 March 1978 the Committee, pursuant to Clause (1)(b)(ii) of the Committee's resolution of appointment, received a reference on Aboriginal Health from the Minister for Aboriginal Affairs. The terms of the reference are identical to those previously given by the House of Representatives and are as follows :

(1) The health problems of Aboriginals with particular attention to -

(a) the prevalence of different types of disease suffered by Aboriginals and Aboriginal communities;

(b) the relationship between Aboriginal health and environmental, social and cultural factors;

(c) the effectiveness of existing health care programs for Aboriginals generally, and the adequacy of Western European-type health services to cope with the health problems of Aboriginals; and

(d) alternative methods of health care delivery that take account of Aboriginals' life styles, including camp situations.

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[5] Votes and Proceedings, No.73, 1 December 1976.

[6] Votes and Proceedings, No.3, 10 March 1977.

(2) That the Committee consider ways and means by which -

(a) persons with appropriate qualifications can be encouraged to assist Aboriginals achieve a better standard of health, and

(b) Aboriginals including traditional healers can participate in the development and delivery of health care services to their own communities, and in any modification of existing services.

(3) That the Committee recommend possible courses of action.

Activities of the Committee

5 Advertisements were placed in metropolitan newspapers in all States and the Territories in December 1976 and October 1977, inviting submissions to the Inquiry. Interested persons and organisations were also invited to present submissions.

6 The co-operation of the State Premiers was obtained and the Committee records its appreciation of the assistance given to the Inquiry by State officials.

7 One hundred and thirty-six submissions were received, and 26 days of public hearings were held in all mainland States, the Northern Territory and Canberra.

8 During the Inquiry 136 witnesses appeared before the Committee. A list of witnesses is given in Appendix 1. Evidence taken at public hearings is available for inspection at the Committee Office of the House of Representatives, the National Library of Australia and the Australian Archives. Copies are also held by the Commonwealth Parliamentary Library.

9 As the Committee considered it essential to see at first-hand the conditions which affect Aboriginal health it visited communities throughout Australia and held informal discussions with many Aboriginal people and persons concerned with the delivery of health care to Aboriginals. A list of the communities visited is given in Appendix 2.

Specialist Advisers

10 The Committee acknowledges the assistance given by its specialist advisers, Professor Max Kamien, Unit of General Practice, Department of Medicine, University of Western Australia, Perth, and Dr Janice Reid, Medical Anthropologist, Cumberland College of Health Sciences, Sydney.

PART 'A'

PREVALENCE OF DISEASE SUFFERED BY ABORIGINALS

In its terms of reference the Committee was requested to report on :

> the prevalence of different types of disease suffered by Aboriginals and Aboriginal communities.

2 INTRODUCTORY REMARKS

Historical Aspects

11 There is considerable evidence to indicate that, prior to European settlement of Australia, Aboriginals were generally in good health and that most of the disorders which commonly affect them today were non-existent in Australia. The records of early European explorers, the findings among Aboriginals pursuing a semi-nomadic life style away from settlements and towns, and studies of disease patterns and health status among other isolated hunting and gathering groups elsewhere in the world strongly support this assumption. There is, however, conjecture as to whether high mortality among infants, the aged and infirm was a result of natural selection in pre-contact times.

12 Contact with non-Aboriginal visitors to the Australian shores (from perhaps the 17th century onwards) and with European settlers (from the 18th century onwards) resulted in the introduction and rapid transmission of diseases exotic to Australia. A variety of infectious diseases (such as measles, smallpox, tuberculosis, influenza and venereal disease) and parasitic diseases (such as hookworm) were responsible for death, recurrent disease and debilitation among Aboriginals, e.g. smallpox was claimed by Sturt in his early exploration to have wiped out most Aboriginals in communities he visited.

13 Susceptibility to these diseases was increased by the establishment of missions and settlements and the introduction of grazing and other activities which resulted in the breakdown in the traditional Aboriginal culture and caused a dramatic ecological change in living conditions. The transition from a

semi-nomadic to a settled existence with associated over-crowding, poor hygiene and sanitary facilities, dietary changes and other stressors, combined to bring about the highly unsatisfactory health status of Aboriginals which prevails today.

14 In recent times Aboriginals have succumbed to degenerative diseases which afflict the wider community. Diabetes and high blood pressure predispose to heart attacks which in some areas account for over 70% of all deaths in Aboriginal adults with many of these deaths being in those below the age of 50 years.

15 There is some similarity between the present health profile of Aboriginals and that of Australians at the turn of the 20th century. This similarity is illustrated in a graph of infant mortality rates for Aboriginals in Queensland and the Northern Territory in recent years, and for Australians since 1901. (See Appendix 3.)

16 Improvements in European health since the turn of the century accompanied not only advances in medical technology but improvements in water supplies, sewerage, housing, nutrition and other aspects of the social and physical environment. Factors which influence the level of Aboriginal health are discussed later in this report.

17 With the advent of European colonisation the Aboriginal population of Australia suffered a dramatic decline in numbers which lasted about 150 years. The best estimate of pre-European population is approximately 300,000 which declined to approximately 67,000 in the 1930s. The population of those who identified as Aboriginal at the 1976 Census was about 161,000.

The State distribution at the time of the Census together with current departmental estimates is shown below :

	1976 Census	Estimates
N.S.W.	40,450	30-35,000*
QLD	41,345	55,000
W.A.	26,126	34,500
S.A.	10,714	9,000
N.T.	23,751	27,500
TAS.	2,942	5,000
VIC.	14,768	8-15,000
A.C.T.	828	*
Totals	160,924	169-181,000

*A.C.T. figures included in N.S.W.

The Committee notes that estimates made by some authorities put the Aboriginal population higher than recorded at the Census.

18 There is no reliable information on the number of traditionally oriented, fringe dwelling and urban Aboriginals.

Measurement of Health

19 The World Health Organisation defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity." The Committee accepts the World Health Organisation's definition but recognises that as soon as attempts are made to measure health, problems arise in relation to lack of information and cultural, social and subjective interpretations. The Committee has based

its assessment of physical ill health on available conventional indices and has relied on anecdotal evidence with respect to mental and social wellbeing.

20 The Committee has been requested to report on the prevalence (number of cases) of disease suffered by Aboriginals. However, throughout this Part reference will also be made, where appropriate, to the incidence (rate of occurrence of new cases) of disease. The Committee recognises that the available statistics often understate the actual situation. This is so for both Aboriginals and non-Aboriginals because many cases are not reported. The Committee believes that proportionately more Aboriginal than non-Aboriginal cases are unreported. This is because, as indicated later, many Aboriginals are reluctant to present themselves to conventional curative services.

21 As part of its approach, the Committee decided to rely on available evidence of disease patterns rather than commission its own surveys.

22 There is still a conspicuous lack of data on a regional scale on a national basis with which to measure Aboriginal health. This problem is discussed in Chapter 4.

3 MORTALITY AND MORBIDITY

Demographic Vital Statistics

23 For the first time, available statistics on Aboriginal births and deaths have been assembled and included in the 1977-78 Annual Report of the Director-General of Health. These statistics, together with corresponding rates for Australia as a whole, are shown in Appendix 4.

24 Infant mortality rates, which are the number of deaths of live born children within one year of birth per 1000 live births, are widely used as an index of community health. While some of these rates with respect to Aboriginals in Queensland and the Northern Territory and Australia as a whole are shown in Appendix 4, Appendix 5 provides information over a longer time span. The figures in Appendix 5 show that infant mortality rates for Aboriginals in Queensland decreased by 51% from 110 to 54 between 1973 and 1977. The rates for Aboriginals in the Northern Territory decreased by 65% from 143 to 50 between 1965 and 1975, but increased by 50% from 50 to 75 between 1975 and 1977.

25 Despite an overall improvement in Queensland and the Northern Territory, the Aboriginal infant mortality rate remains at an unacceptable three to four times higher than that for Australia as a whole (13.8 in 1976).

Life Expectancy

26 The first report of the National Population Inquiry calculates life expectancy of Aboriginals at birth to be 50 years. This compares with figures for Australia as a whole of 69.3 years for males and 76.3 years for females as at 1976.

Hospitalisation

27 Western Australia and the Northern Territory are the only regions which compile comprehensive statistical data on the hospitalisation of Aboriginals, namely numbers treated in hospital and length of stay in hospital. Information on Aboriginals treated in some hospitals is available for New South Wales and Queensland. The problem of the scarcity of statistical data on all aspects of Aboriginal health is discussed in Chapter 4.

Numbers Treated in Hospital

28 Appendices 6 and 7 give the total of Aboriginals and non-Aboriginals treated in Western Australian hospitals, as measured by discharges from hospital, between 1971 and 1976, while Appendices 8 and 9 convert these totals to a rate per 1000 population for comparison purposes and show that the rate for Aboriginals in 1976 was 663 and for non-Aboriginals 213, i.e. on a pro rata basis about three Aboriginals are treated in hospital for every non-Aboriginal.

29 Similar information in respect to the Northern Territory between 1974 and 1976 is shown in Appendices 10 and 11. This shows that the rates per 1000 population in 1976 were 205 for Aboriginals and 204 for non-Aboriginals. A factor which has influenced hospital statistics in recent years in the Northern Territory is the expressed policy that Aboriginal patients wherever possible are now treated in the home environment or clinic rather than evacuated to hospital.

Length of Stay

30 Figures from Western Australian hospitals indicate that the average length of stay has remained fairly constant for Aboriginals at around 9.5 days since 1971, whereas it has been

reduced for non-Aboriginals over the same period from 8.6 in 1971 to 7.6 days in 1976. (See Appendix 12.)

31 Figures provided for all hospitals in the Northern Territory show that the average length of stay has declined for Aboriginals from 19.7 days in 1966-67 to 11.7 days in 1977-78. Over the same period the length of stay for non-Aboriginals showed a smaller rate of decrease from 8 days to 6 days. Ten years ago Aboriginals' stay in hospital was about 2½ times longer than non-Aboriginals, while today it is about twice as long. (See Appendix 13.)

Morbidity

32 The principal diagnosis for hospital inpatients and rates per 1000 population are detailed for Western Australia and the Northern Territory in Appendices 6 to 11. Available data from Queensland and New South Wales is set out in Appendices 14 and 15.

33 The following table compares Aboriginal and non-Aboriginal rates per 1000 population (extracted from Appendices 8, 9 and 11) of the most common conditions treated in Western Australia and the Northern Territory hospitals in 1976.

MOST COMMON CONDITIONS TREATED IN HOSPITAL FOR ABORIGINALS AND NON-ABORIGINALS - RATES PER 1000 - 1976

	Aboriginal	Non-Aboriginal	Ratio
Conditions mainly related to the physical environment			
Infective and Parasitic			
W.A.	95	8	12 : 1
N.T.	18	4	4½ : 1
Respiratory System			
W.A.	137	22	6 : 1
N.T.	30	17	2 : 1
Skin and Subcutaneous Tissue			
W.A.	38	6	6 : 1
N.T.	n.a.	n.a.	n.a.
Total			
W.A.	270	36	8 : 1
N.T. (incomplete)	48	21	2 : 1
Other Conditions			
Nervous System and Sense Organs			
W.A.	51	10	5 : 1
N.T.	3	1	3 : 1
Pregnancy and Childbirth			
W.A.	50	23	2 : 1
N.T.	25	35	1 : 1½
Accidents, Poisoning, Violence			
W.A.	97	25	4 : 1
N.T.	32	32	1 : 1
TOTAL			
W.A.	663	213	3 : 1
N.T.	205	204	1 : 1

34 The above table shows that the rates of conditions mainly related to the physical environment when totalled for Aboriginals are 40% of the total Western Australian admissions compared with the next largest category (accidents, poisoning, violence) of 15 per cent. A similar comparison in the Northern Territory is 23% (incomplete figures) and 16 per cent. Appendices 14 and 15 show a similar situation in Queensland and New South Wales.

35 The table also shows that the ratio of the rates of the conditions mainly related to the physical environment is many times greater for Aboriginals than non-Aboriginals in Western Australia and the Northern Territory.

36 While the above figures relate to treatment of diseases in hospital, it is recognised that not all treatments of diseases are carried out in hospital but in clinics and the home environment. To this extent the hospital figures understate the actual state of ill health. Further, as indicated in paragraph 20, the Aboriginal position is more likely to be understated than the non-Aboriginal due to more cases being untreated.

Principal Morbidity Conditions

37 The principal morbidity conditions amongst Aboriginals are discussed below.

Diseases Related to the Physical Environment

38 Not only are these diseases the most significant group of diseases among Aboriginals but a major characteristic is the extremely high rate of recurrence, particularly among babies and children. The Committee was repeatedly informed of cases where patients having been successfully treated in hospital and

returned to their home environment, would within a short period be re-admitted to hospital with the same complaint.

39 The major causes of diseases related to the physical environment are the highly unsatisfactory environmental conditions in which many Aboriginals live. These diseases are described below and the environmental conditions which affect them are described in Chapter 6.

Intestinal Infections

40 The major disease in this category is gastroenteritis. Aboriginals are particularly susceptible to this disease because of contaminated water supplies, inadequate hygiene standards and overcrowding. Malnutrition and previous attacks are factors in impairing absorption of essential food elements.

Intestinal Parasites

41 Common bowel infestations, particularly among children, include protozoal parasites, hookworms, roundworms and threadworms. Prevalence varies according to environmental conditions and the nutritional status of the individual, and hookworms particularly are a significant cause of anaemia.

Respiratory Infections

42 These include upper and lower respiratory tract infections, chest infections and airway diseases, and occur as a result of low standards of personal hygiene, malnutrition, overcrowding, excessively smoky atmosphere, and lack of water. As these infections recur they lead to conditions such as chronic bronchitis, middle ear catarrh and drum perforations. For example, the National Trachoma and Eye Health Program (see below) also screened for disease of the ear and found that the

prevalence of middle ear infection was 15.7 times higher for Aboriginals than non-Aboriginals.

Trachoma

43 This condition is very prevalent among Aboriginals and is aggravated in hot, dry and dusty environments where secondary infection occurs due to unsatisfactory hygiene practices, the use of unwashed clothing and blankets, and flies.

44 In an effort to combat this problem in the remote rural areas of Australia, the Royal Australian College of Ophthalmologists commenced the National Trachoma and Eye Health Program in 1975. The Program is being funded mainly by the Commonwealth Department of Health through a Health Program grant of $1,964,000.

45 Over 70 Ophthalmologists have given their time voluntarily working in the field with the full-time staff of the Program.

46 The major aim of the Program is to improve the prospects of those already suffering from trachoma and free future generations of Australians from it. The initial screening and survey phase of the Program has been completed.

47 The total number of persons examined under the Program was approximately 100,000, of whom 61,700 were Aboriginal. Of the Aboriginals examined, trachoma was present in 23,600 (38.3%). The prevalence of trachoma related to all age groups and increased progressively from 25% in the under two years age group to 69% in the 60 years and over age group. The worst area was in Central Australia where the Trachoma Team found that of 8,000 Aboriginals examined, 6,150 (77%) had trachoma. The

prevalence of trachoma among Aboriginals in Central Australia is twice that for all Aboriginals examined.

48 Severe cicatricial trachoma (blinding or potentially blinding lesions) was present in 2,240 (3.6%) Aboriginals. Again, prevalence related to all age groups and increased progressively from 0.4% in the under two years age group to 27.8% in the 60 years and over age group.

49 Of the Aboriginals examined by the Program, 1.4% were blind in both eyes. An additional 0.6% had such poor vision that they were entitled to a pension for blindness. A further 2.3% were blind in one eye. The position is far worse in the 60 years and over age group where 15.6% were blind in both eyes, and the vision of an additional 5.8% was so bad that they were entitled to a pension for blindness.

50 While 38,450 non-Aboriginals were examined by the Trachoma Team, it is not realistic to compare the results of the examination of Aboriginals and non-Aboriginals. This is mainly because every effort was made to ensure that the Team examined as many Aboriginals as possible, whereas the same intensive campaign was not carried out for non-Aboriginals.

51 Of the non-Aboriginals examined, only 1.3% were found to have trachoma.

52 Of the total number of patients examined, approximately 25,000 required treatment and approximately 1,400 patients required eye surgery. Approximately 60% of the cases requiring surgery have been completed. Approximately 7,000 people have been prescribed spectacles through the activities of the Program.

Diseases of the Skin

53 These diseases common among Aboriginals include ringworm, scabies, head lice, infected insect bites, impetigo, eczema or dermatitis and chronic ulceration. While there is no comprehensive information available on the prevalence of these diseases, they rarely have direct significance for major morbidity. They are most prevalent amongst children. Being visible and irritable afflications they are prime examples of diseases which have severe psychological and social consequences. While most skin diseases are not serious, they may still require treatment which often takes up a great deal of the nursing sisters' available time. They interfere with school attendance and can cause considerable loss of sleep, energy and concentration.

Malnutrition

54 The diet of Aboriginals before European settlement was high in protein, roughage and vitamins and low in fats and carbohydrates. Hunting, gathering and dietary patterns were highly adapted to their way of life and sharing practices ensured that all obtained adequate food.

55 On European contact Aboriginal dietary habits and patterns deteriorated. There are many reasons for this, the major one being the transition from a nomadic to a sedentary life style by the establishment of settlements and missions and grazing and other activities. Settlement life militates against the maintenance of a nutritious diet as does the ecological effects of the pastoral industry. Hunted and gathered foods are no longer readily available. The Committee noted that the choice, quality and price of food provided at community stores varied considerably. This was due to a number of factors including remoteness from major wholesale food

outlets, transportation problems and management. Stores were often stocked with highly priced 'junk' foods rich in refined carbohydrates or fats, and the choice of nutritious fresh foods was often limited. Mothers especially are often not fully aware that a diet consisting primarily of sugary or fatty ready prepared foods is nutritionally damaging.

56 Aboriginals greatly prefer fresh foods rich in minerals, vitamins and high in protein (such as bush and sea foods) but these are either hard to obtain, out of season or made scarce by the effects of non-Aboriginal settlement, or are simply too expensive when large low income families must be kept fed. The resultant diet which is high in carbohydrates and low in protein, vitamins and minerals not only causes sub or malnutrition but interacts with repeated or cyclical infections to debilitate both children and adults.

57 Malnutrition covers a wide range of nutritional abnormalities ranging from starvation and degrees of dietary deficiency and imbalance to minor deficiencies of specific nutrients. It contributes to obesity due to excessive calorie intake, diabetes, cardiovascular disease, dental caries and poor resistence to infection. A survey conducted by a study group between 1969 and 1974 in South Australian Aboriginal communities showed that the prevalence of these diseases is greater among Aboriginals than non-Aboriginals. For example, diabetes was found to be 20 times greater in the 20-39 year age group and 10 times in the 40-59 year age group, obesity was found to be twice as common and cardiovascular disease was found to be two to five times more prevalent.

58 Faulty nutrition is a contributing factor in the general state of Aboriginal ill health. However, because of the complex, inter-relationships between socio-economic,

environmental and cultural factors it is difficult to assess accurately the impact of malnutrition on specific morbidity. Malnutrition may contribute to a variety of pre- and post-natal retardations, including delayed brain development and intellectual impairment.

59 The Western Australian Department of Public Health in their annual nutritional and anthropometry surveys found that in 1975 and 1976, approximately 20% of Aboriginal children up to five years of age were below the internationally accepted standards for height and weight which have been derived from the 'Harvard Standards'. In some Aboriginal communities in the Northern Territory approximately 20% of Aboriginal children weighed less than 80% of the standard weight for age. While Aboriginal weight relative to height may be below the 'Harvard Standards', this does not necessarily mean that Aboriginals are nutritionally disadvantaged. However, Aboriginal growth parameters seem to confirm that Aboriginals are nutritionally disadvantaged compared to non-Aboriginals.

Anaemia

60 The anaemia that is common amongst Aboriginals can be regarded as a nutritional disorder, although it is not necessarily due to a dietary deficiency; failure to absorb or utilise specific anti-anaemia factors in the diet such as iron, protein or folic acid, or abnormal iron and protein losses such as may occur in heavy hookworm infestations are alternative or concurrent causes of deficiency.

61 From the figures available, anaemia in Aboriginals, children and adults, is from 10 to 20 times more common than it is for non-Aboriginals and is often more severe. In addition, lower mean blood and tissue values for Aboriginals imply that

their iron, vitamin and haemoglobin 'reserves' against added nutritional or infectious stress are lower than for non-Aboriginals as a whole when they need to be higher for better resistence. The impact of widespread anaemia on general health, levels of physical activity and school performance, and capacity to survive serious infections in childhood, is highly significant. Although the relative causal importance of dietary deficiency, malabsorption and associated biochemical derangements is conjectural, all appear to play mutually reinforcing roles. Like other specific deficiency diseases, 'iron-deficiency' anaemia is only a part of the pattern of malnutrition and symptomatic of underlying socio-economic stress.

Leprosy

62 In the Northern Territory there were 710 Aboriginals, 40 non-Aboriginals and 67 unreviewed cases on the Leprosy Register in 1976. Of these cases, 14 Aboriginals and 4 non-Aboriginals had active infections. Aboriginal notifications declined from 41 in 1967 to 14 in 1977, and non-Aboriginals from 5 to 2. Three factors have contributed to this decline; namely the use of long acting, injectable, anti-leprosy preparations; the early diagnosis by health centre staff, and the establishment at the East Arm hospital of a rehabilitation service.

63 In Queensland in 1977 there were four new cases notified.

Tuberculosis

64 Tuberculosis in the Northern Territory while rapidly declining in incidence is still chronic among older people. Aboriginal notifications declined from 28 in 1967 to 11 in

1977, and for non-Aboriginals from 17 to 9. Several factors are responsible for this decline; namely the improved health and resistence of Aboriginal people, the sustained B.C.G. immunisation program, intermittent mass radiographic screening programs, and early diagnosis and domiciliary treatment.

65 In Western Australia, the incidence of tuberculosis in 1976 among Aboriginals was half what it was five years ago. It is approximately three times the overall incidence in Western Australia. The number of Aboriginal notifications between 1971 and 1976 was fifty-one.

Sexually Transmitted Diseases

66 There is little statistical evidence on the prevalence of sexually transmitted diseases in Australia. Professional opinions, however, suggest that there is a very high occurrence of syphilis and gonorrhoea among Aboriginals throughout Australia. There is no section of the Australian population routinely screened for these diseases except for ante-natal tests for syphilis and the Western Australian Aboriginal medical audits.

67 Gonorrhoea figures in the Northern Territory indicate that the notified incidence has remained reasonably constant over the past few years. Non-Aboriginal notifications increased from 325 to 389 between 1971 and 1977 and Aboriginal notifications from 87 to 171.

68 Syphilis figures in the Northern Territory are of considerably more concern. Non-Aboriginal notifications increased from 18 in 1971 to 164 in 1977, and for Aboriginals from 2 to 703. Translated to rates per 1000 population, the increase for non-Aboriginals is from 0.3 to 2.1, and for

Aboriginals from 0.1 to 27.1. Although there was a particularly rigorous case finding exercise in 1976, the incidence of syphilis appears to be increasing.

Alcoholism

69 During its Inquiry into Aboriginal Health the Committee did not specifically examine the effect of alcohol on Aboriginal health because its predecessor had reported on the matter. However, Aboriginals themselves consistently raised alcoholism as a major factor contributing to their ill health during the Inquiry into Aboriginal Health.

70 The previous Committee tabled two reports on alcohol in the House of Representatives, an interim report on "Northern Territory Aspects" on 7 October 1976, and a final report "Alcohol Problems of Aboriginals" on 1 November 1978. In its interim report the Committee stated "Alcohol is the greatest present threat to the Aboriginals of the Northern Territory and unless strong immediate action is taken they could destroy themselves.", and in its final report observed that alcohol abuse is just as devastating in some areas of the mainland States as in parts of the Northern Territory. Of particular concern to the previous Committee was the devastation in some traditional communities where the whole population was at risk.

71 In view of the strong statements made by the previous Committee and as it is 16 months since its final report was tabled, the Committee regrets that, although the reaction of the previous Minister for Aboriginal Affairs on the report was made known to the Committee, the attitude of the Government has not been reported to the Parliament as required by the Government's directive of May 1978.

72 There have, however, been three major developments that have come to the attention of the Committee. The first of these is that there was a substantial increase of approximately $1m allocated in 1978-79 to mainly Aboriginal organisations to help combat alcohol problems. In its final report on alcohol the Committee identified 18 projects which were receiving Government support and although the total allocation of funds was unknown, it appeared that the total expenditure in 1976-77 was in excess of $600,000. In 1978-79, thirty-five organisations received funds (including seven WOMA committees in South Australia as compared to one in 1976-77), a total of approximately $1,750,000.

73 The second development was the assenting to of the Northern Territory Liquor Act 1978 on 22 January 1979. The Committee believes that the provisions of this Act go a long way to satisfying the recommendations of the report "Alcohol Problems of Aboriginals".

74 The third development is that the Commonwealth Government provided funds to the Oenpelli Council in the Northern Territory in early 1978 to purchase and manage the 'Border Store'. This store, which is just outside the boundary of the Arnhem Land Reserve, had a liquor licence and the unrestricted sale of liquor has had a devastating effect on the Oenpelli community.

75 The Committee commends these developments.

Mental Health

76 Evidence was received that the levels of major psychiatric morbidity in Aboriginal communities are about as high as those of non-Aboriginal populations. Some studies have

shown minor psychiatric morbidity quantifiably different to that of non-Aboriginals. It was not entirely clear whether Western diagnostic categories are appropriate for Aboriginal patients or whether attempts are being made in many areas to study and learn Aboriginal concepts of emotional illness or to utilise Aboriginal expertise. There are difficulties and dangers in using psychotropic drugs on remote settlements under poor supervision as a means of coping with psychiatric illness. Nevertheless, with major psychiatric illness this may be necessary. Other approaches to minor or traditionally related psychiatric illness should include the training of Aboriginal behavioural health workers as at Townsville, and referral to Aboriginal traditional healers.

77 While symptomatic relief of the emotionally disturbed may be necessary in the short term, mental ill health is predominantly the result of extreme stress. Stress-related conditions such as alcohol abuse, depression, hypertension, aggressive outbursts and other traumas result from chronic physical ill health, the breakdown of traditional and social authority structures, the loss of purpose and self-esteem, a perception that social and personal crises are beyond one's ability to change or control, suppressed fear and anger and discrimination. Further causes of stress include lack of assets, refusal to grant authority to Aboriginals which will enable them to develop viable communities, and lack of recognition by non-Aboriginals of the right of Aboriginals to retain with pride an Aboriginal identity and culture.

Dental Diseases

78 Evidence received by the Committee indicates that Aboriginal dental health was excellent prior to European contact. Natural foods not only encouraged the development of characteristically strong jaws and well-spaced even teeth but

discouraged dental caries and the early onset of gum infections and resulting dental degeneration. As nomadic Aboriginals adopted a 'civilised' diet of flour, sugar and tea with beef or mutton where these were available, Aboriginal dental health suffered to a standard which today is generally very bad.

79 The low standard of Aboriginal dental health today is a consequence of numerous factors including a lack of understanding of the relationship between diet and dental health, lack of water for dental hygiene and lack of motivation for maintaining regular brushing and tooth care.

80 Authorities agree that fluoride in drinking water supplies can reduce dental caries by 60 per cent. At Yuendumu, for example, where the water contains natural fluoride, the dental health of Aboriginals is very good. Details were also provided about the fluoridation of a small domestic water supply to Angurugu Mission, Groote Eylandt, in 1973-74. For a population of 700 persons the cost of the plant, including installation, was $1,500. The additional annual cost is estimated at $700 for maintenance and parts and $450 for a year's supply of sodium fluoride reagent. This is equivalent to a cost of $1.85 per person per year or 0.5 cents per person per day over a period of 10 years.

Conclusion

81 State health authorities and the Northern Territory Department of Health claim that Aboriginal ill health in general has decreased in recent years. In justifying this claim reference is made to the statistical evidence cited earlier in this chapter as well as to subjective observations by health professionals.

82 Infant mortality and hospitalisation figures indicate an improvement in Aboriginal health. However, the Committee was informed that recurrence of the majority of infectious diseases prevalent amongst Aboriginals is common and difficult to prevent because of the poor physical environment in most Aboriginal communities. The Committee received considerable evidence indicating that social and stress-related conditions amongst Aboriginals such as depression, hypertension, alcoholism, diabetes, obesity, and traumatic injuries are increasing and becoming a major health concern.

83 On the basis of infant mortality rates, Aboriginal health is three to four times worse than for non-Aboriginals. Hospitalisation rates show a similar picture with rates for some environmental infectious diseases 12 times higher for Aboriginals than for non-Aboriginals.

84 It is apparent therefore that little progress has been made in raising the overall standard of Aboriginal health.

85 The Committee considers that this is a deplorable situation that would not be tolerated for non-Aboriginals.

4 NEED FOR ABORIGINAL HEALTH STATISTICS

86 The statistics given previously in this Part attempt to measure the ill health of Aboriginals and, where possible, to compare it with non-Aboriginal ill health. Available health data shows that there is a lack of comprehensive mortality and morbidity statistics. The figures shown are not always comparable due to differences in definition and in methods of collection.

87 The lack of data makes it extremely difficult to evaluate the endeavours being undertaken in the management and control of Aboriginal ill health and to assess programs objectively and to identify problem areas. Quantitative measures of health are essential to health evaluation and planning. Such measurements enable the health of communities to be compared and trends studied. Health indices determine priorities for most effective health action and continuous monitoring enables health problems to be evaluated.

88 The lack of data with respect to Aboriginals stems in part from the now repealed Section 127 of the Constitution which had until 1967 excluded Aboriginals from official statistics. In addition, State and Territory legislation does not currently allow for the registration of vital statistics (births, deaths) by race. This situation does not exist in other developed Western countries with indigenous minorities, such as the United States of America and New Zealand, where such statistics have been collected on a routine basis for many years.

89 The first collection of Aboriginal health data on a regular basis began in 1957 when infant mortality figures were provided by the Northern Territory Administration. This was for many years the only published information on the state of Aboriginal health. Since then Western Australia, New South Wales and Queensland have commenced the collection of data and the Northern Territory has expanded its collection.

90 At a meeting in 1973, Commonwealth and State Health Ministers endorsed a policy of collecting national Aboriginal health statistics. Despite this endorsement and reports by the National Health and Medical Research Council, the National Population Inquiry, the Commission of Inquiry into Poverty, the report by the Senate Select Committee on Aborigines and Torres Strait Islanders, the House of Representatives Standing Committee on Aboriginal Affairs, the Workshop on Aboriginal Medical Services held in 1974, the National Aboriginal Consultative Committee in 1973 and 1974, and the National Aboriginal Conference Executive in August 1978, recommending that statistics on Aboriginal health be collected and made routinely available, there is still no single health category where Aboriginal statistics are available nationally.

91 In 1975 Dr L.R. Smith, Research Fellow, Health Research Group, Australian National University, was requested to undertake a thorough investigation and develop a plan for the collection, interpretation and dissemination of Aboriginal health statistics on a national basis.

92 In evidence to the Committee, Dr Smith proposed that a national system of Aboriginal health statistics should be the responsibility of a small section to be created within the Aboriginal Health Branch of the Commonwealth Department of Health.

93 The Department of Health informed the Committee that there has been significant progress made as a result of Dr Smith's work in the area of establishing an ongoing data collection base. As collection procedures are modified and standardised, the Department expects to have a uniform national system for some of the indicators, by the middle of 1979. The Committee welcomes this development.

PART 'B'

ENVIRONMENTAL SOCIAL AND CULTURAL FACTORS

In its terms of reference the Committee was requested to report on :

> the relationship between Aboriginal health and environmental, social and cultural factors.

5 INTRODUCTORY REMARKS

94 The Committee considers there is a direct relationship between environmental, social and cultural factors affecting Aboriginals and their health and that the influence of these factors varies considerably between urban, fringe-dwelling and traditionally oriented Aboriginals.

95 In this Part of the report the Committee will first discuss physical environmental conditions and then social and cultural factors as they affect Aboriginal health.

6 PHYSICAL ENVIRONMENTAL FACTORS

96 It is universally accepted that the attainment of a satisfactory standard of health in any community depends on the provision of certain basic amenities including water supply, sanitation and sewerage facilities, housing and electricity. The high incidence and recurrence of many infectious diseases amongst Aboriginals described in Chapter 3 result largely from their unsatisfactory environmental conditions.

97 The most recent and comprehensive data on the environmental conditions of all non-metropolitan Aboriginal communities is contained in a series of surveys conducted by the Department of Aboriginal Affairs in 1977. This information is contained in the Department of Aboriginal Affairs' Statistical Section Newsletter No.5 and is shown in Appendices 16 to 19. These surveys are referred to throughout this chapter. Where possible, other surveys are also referred to.

98 The Committee did not receive any concrete data on the environmental conditions of Aboriginals living in Sydney, Melbourne, Brisbane, Adelaide, Perth and Hobart, which were excluded from the Department of Aboriginal Affairs' survey. The Committee, however, believes that the physical environment of Aboriginals living in these cities is unsatisfactory, mainly as a result of frequent overcrowding.

99 The Department of Aboriginal Affairs' surveys show information separately for the States and the Northern Territory. This generally confirms observations of the

Committee and evidence received by it that the physical environmental conditions are better in Queensland than elsewhere and worst in the Northern Territory.

100 Although the surveys conducted by the Department of Aboriginal Affairs indicate that most non-metropolitan Aboriginal communities have inadequate water and electricity supplies, unsatisfactory sanitation and sewerage facilities; and inadequate and inappropriate housing, it is difficult to accurately gauge the extent of this problem. However, the Committee considers that on the basis of other surveys, its own observations and evidence received during the Inquiry, the results of the Department of Aboriginal Affairs' surveys understate the true position regarding the environmental deficiencies of non-metropolitan Aboriginal communities.

Water Supply

101 A plentiful, accessible and uncontaminated water supply is internationally recognised as the most important and basic requirement for the attainment of good health. Water must be uncontaminated for human consumption and readily available for personal and domestic hygiene. The Committee considers that until adequate water supplies are provided there will be no significant improvement in the standard of health amongst Aboriginals.

102 The Department of Aboriginal Affairs' survey of 675 communities with a population of 125,097 found that 5% of the population had no piped water supply nor bore water supply; 22% had access to piped water from wells or other sources; 2% had access to water from rain water tanks; and 71% had access to water piped from mains.

103 A survey of 25 larger traditional communities in the Northern Territory conducted by the Northern Territory Division of the Department of Health in 1976, however, revealed a situation different to that suggested by the Department of Aboriginal Affairs' survey, e.g. 57% of the population of these communities did not have an adequate water supply. This survey also found that water was often supplied through a limited number of communal taps (e.g. at Umbakumba, 325 people were serviced by seven communal taps); taps were often malfunctioning (e.g. at Elcho Island, 40 taps in 97 houses were either malfunctioning or not functioning at all); and there was often no available means of heating water (e.g. at Elcho Island, 89 out of 97 houses had no water heating facilities).

104 On the basis of the Committee's experience and evidence received by it, taps were often long distances from living areas (e.g. at Haasts Bluff and Warburton, taps were up to one km from the camps); and pressure was often poor (e.g. at Yirrkala, poor water pressure was reported in most cases).

105 The Committee observed situations, similar to those described above with respect to the Northern Territory, in many Aboriginal communities it visited in the States, e.g. at Cundeelee in Western Australia, the only source of water for Aboriginals was from mobile water tanks, and the water supply was unsatisfactory in all fringe camp situations.

106 The success of the outstation movement is particularly dependent upon the prior provision of an adequate water supply.

Sewerage and Sanitation

107 It is difficult to assess the standard of sewerage and sanitation facilities provied in non-metropolitan communities.

The survey of non-metropolitan Aboriginal communities conducted by the Department of Aboriginal Affairs in 1977 showed that 12% of the surveyed population had no public sewerage, septic tank system or sanitary pan collection; 13% of the population relied on a sanitary pan system; and 74% of the population had access to flushed toilets including septic tank systems. However, during the Inquiry the Committee received evidence that sewerage and sanitation facilities in these areas were less satisfactory than the Department of Aboriginal Affairs' survey indicates.

108 A survey of 25 Aboriginal communities in the Northern Territory conducted by the Northern Territory Division of the Department of Health in 1976, found that 63% of the people did not have access to a functioning lavatory in or near a family dwelling. It was also found that toilets were often mal-functioning, mainly through misuse and lack of maintenance and were left in a state of disrepair for months on end. When the Committee visited Yirrkala, it was informed that 16 of the community's 35 septic tank systems were not functioning.

109 The Committee was informed that in certain cases there has been a tendency in the past for sanitary facilities in rural Aboriginal communities to be unnecessarily sophisticated which often proved to be unsuitable. Suggestions were made to the Committee that simpler approaches to this problem, for example, by the provision of pit latrines, may be more successful, particularly as these facilities tend to be easier to instal, more economical, maintenance free and generally more suitable for communities which are relatively mobile. Where pit latrines are provided it is important that they do not affect the water table.

110 The Committee observed in some areas that spring return taps, fly control, solar water heating and other simple

techniques were working successfully and believes that they could be extended to other areas.

111 Although many Aboriginal people in remote communities accept the use of modern sanitary facilities, few tend to appreciate fully the effects of their improper use or possess the skills to maintain or repair them. It is suggested that when modern sanitary facilities are installed, it is essential that members of the community be given education in their use and training in their proper maintenance and repair.

Housing

112 The housing situation in Aboriginal communities is difficult to assess. Some information is provided in the survey of non-metropolitan communities undertaken by the Department of Aboriginal Affairs in 1977, which showed there were 19,514 private dwellings, of which 73% were classified as a house, flat or unit, 24% were described as improvised dwellings (wiltjas, tents, lean-to's, sheds, shanties, car bodies, etc.), 2% were described as mobile dwellings such as caravans, cars or buses, and 1% were unspecified.

113 The Committee considers that the results of this survey do not accurately reflect the real housing situation in many communities. From the Committee's visits to non-metropolitan Aboriginal communities and the evidence presented to it during the Inquiry it is apparent that many of the houses are in sub-standard condition and in a state of disrepair, many are vacant for a variety of reasons, and those which are occupied are mainly grossly overcrowded.

114 A housing survey carried out by the field staff of the Aboriginal Health Section of the New South Wales Health

Commission in 1976 revealed that more than 2,000 families (50% of the Aboriginal population in New South Wales) lived in housing conditions that were considered detrimental to physical and social health and would be unacceptable by standards normally applied to the white population. Many examples were given, including Wilcannia where 20 families lived in 10 small houses with an average density of 12 persons per house, and Gingie Reserve, Walgett, where 158 people lived in twelve 3-bedroom houses at an average density of 13 persons per house. The New South Wales Health Commission estimates that it will cost $10m per year for the next six to eight years to provide housing of a minimum standard for Aboriginal families in New South Wales.

115 The Western Australian Department of Public Health informed the Committee that current estimates show there is a need to provide housing for 2,700 Aboriginal family units in that State.

Electricity

116 An important factor affecting health is the provision of electricity which allows for the storage of perishable foodstuffs by refrigeration and provides efficient and immediate lighting and heat. Use of electricity also eliminates reliance on fire as the traditional source of heat and light. According to some authorities, smoke from fires in Aboriginal communities can be detrimental to health, particularly where upper respiratory tract infections and eye diseases are prevalent.

117 The Department of Aboriginal Affairs' survey of non-metropolitan Aboriginal communities in 1977, showed that 9% of the population had no electricity supply, 11% had access to locally generated power, and 79% occupied dwellings that were connected to power lines.

118 The Committee believes, however, that the actual availability of electrical power is less than stated above and that while the survey provides reasonably accurate figures relating to connection of power, it does not indicate actual utilisation of power. Many communities had only one source of power. Often power may be connected but is not used or is improperly used due to a lack of knowledge about electrical fittings and appliances with a resultant lack of safety. This situation is compounded by the absence of skilled persons within most communities capable of repairing and maintaining electricity services and appliances.

119 The Committee became aware of a need for authorities supplying electricity to accept greater responsibility for the adequate provision of electricity to Aboriginal communities. They should be sensitive to the special needs of Aboriginals in that they do not await the receipt of a formal application but get out among the Aboriginal communities to assess their needs. This is unlikely to occur unless the Department of Aboriginal Affairs adopts a special role in liaising with authorities in this regard.

Special Needs of Traditionally Oriented Communities

120 The Committee believes that greater attention should be paid to the special environmental circumstances and requirements of traditionally oriented communities. Two areas of particular concern to the Committee are the availability and accessibility of public utilities such as water, electricity, sewerage and sanitation, and the provision of suitable housing.

121 The Committee recognises that some Aboriginal groups and individuals do not, for a variety of reasons, wish to settle permanently in one location. Individuals and families may shift within a settlement because of a death, because of intra or inter-group friction, because of living conditions, because of marriage or change in the composition of the family unit or for a variety of other reasons. Where fixed structures such as houses exist, movement may involve leaving the house for shorter or longer periods of time. For instance, the Committee was told at Warburton that six Aboriginal houses in the community had been vacated and would remain vacant for two years because of the occurrence of a death. People may also move to other communities where ties of family are strong, or leave their home community temporarily or permanently because of familial or personal problems. In the past five years, extended family and clan groups have, in addition, left large settlements to establish outstations some distance away. Under these circumstances the provision of fixed and elaborate public utilities may be inappropriate, for, when people move to unserviced areas they no longer have access to electricity or an adequate water supply. It is important therefore that the provision of essential services be planned in consultation with the community.

122 It is questionable whether conventional European housing and town planning concepts are appropriate for traditionally oriented Aboriginals. Conventional contemporary housing is dependent on services which either do not exist in many remote communities or are unreliable, and presupposes a life style and set of values which many Aboriginals do not share with the wider Australian population. Chronic problems, such as a lack of piped and drinking water or functioning power supply, and the inability of those responsible to repair and modify houses to meet occupants' needs often multiply and

interact to have an adverse effect on Aboriginal health. Further, fixed conventional housing may be inappropriate and even burdensome to those people who have reason to move within or outside the community. The design and siting of housing which does not reflect Aboriginal social and cultural relationships results in increases in stress, frustration, social disintegration, problems of adjustment and therefore in exacerbated ill health. The Committee saw many examples of costly housing built after scant consultation with the client population, often maladapted to their needs and practices and to the climate, and often abandoned, vandalised or uncared for.

123 The Committee considers that, as there is considerable variation in the stated wishes and needs of Aboriginals with respect to housing, ranging from fixed, conventional housing to the less elaborate and perhaps movable shelters favoured on some outstations, the most important requirement for the solution of housing problems is that Aboriginal communities have the opportunity to determine their own priorities and be allowed to make and implement, or have implemented, their own decisions. It is also important that, in deciding what form of housing is most desirable in a given set of circumstances, Aboriginal community members and their councils have access to informed advice about relative costs, designs, and the advantages and disadvantages of various housing options, and that they have ample time to discuss and consider these options before reaching a decision. When decisions are made it is equally important if resources are not to be wasted and frustration ensue, that these decisions, and not the preconceptions of advisers and construction agencies, form the basis for housing programs.

124 Associated with the provision of housing and public health facilities is the issue of community composition and settlement patterns. Settlement patterns are frequently a social map of a community, reflecting family affiliations, traditional alliances and social distance. Traditional groupings were primarily determined by ties of blood and marriage, but they were also the essential units of economic, religious, political and social life and in many respects remain so today. Co-operation and reciprocal obligations exist within local groups and between those groups which, for a variety of reasons, are closely allied. Ceremonial links between groups continue to span loose federations of several thousand people over distances of many hundreds of miles in such areas as central and northern Australia. These large groups still gather for ceremonies and for consultation on matters of mutual significance. On these occasions elaborate organisational arrangements are undertaken by leaders to ensure that plans proceed smoothly and that all the needs of those attending are met. Clearly the establishment of settlements and missions and the relocation of Aboriginals cut across and disrupted traditional affiliations. For instance, members of the Walbiri tribe now live in the widely separate communities of Lajamanu, (Hooker Creek), Willowra, Yuendumu and Warrabri, separated from each other and their traditional lands by decisions taken by non-Aboriginals in past decades. Problems were created by the artificial proximity of unrelated groups, and the associated barriers to communal enterprise. Some of these problems have been resolved using traditional means, others through the creation of councils, the effectiveness of which has varied from community to community. Others still exist. More importantly, services often were and are provided by government agencies without regard to logical traditional or contemporary groupings. For instance, although the Walbiri people of Lajamanu are entirely affiliated with people living to the

south, Lajamanu is included in the northern, Darwin based, not the southern, Alice Springs based, region of the Department of Health. The centrifugal tendencies of the large settlements, the result of the desire of residents to live in uncrowded circumstances and with people they are related to and trust, became apparent when recognition was given to the outstation movement and to rights in land, and groups could, and did, move away from the settlements.

125 Clearly the composition and size of Aboriginal communities is in flux as communities seek to reassert traditional affiliations which have been for many years suppressed, and to find new and acceptable residential arrangements compatible with changing life styles. This fact will need to be borne in mind in the planning of community development, housing and public health programs. To be successful the programs will need to be designed to have the potential of adjusting to organisational changes within Aboriginal communities. If they are to be consistent with present and future cultural and social realities, it is important, as discussed in detail in Chapter 11, that they be developed by the community at the community level and that they be based firmly in a commitment to the policy of self-determination.

Special Needs of Fringe Dwelling Aboriginals

126 The Committee considers that certain problems are inherent in the provision of housing and other amenities for fringe dwelling Aboriginal communities. On the one hand these often severely disadvantaged groups need adequate housing and access to other community services. On the other hand, attempts to upgrade housing and services in impoverished and unsatisfactory physical and social environments may perpetuate

the deprivation and fringe dwelling status of those who would prefer to move into towns and take advantage of the amenities which they offer.

127 The Committee believes that, when Aboriginals choose to live in predominantly non-Aboriginal communities, it is important that they be given every assistance in functioning effectively within those communities. Their needs may include assistance in using and relating to schools, health services, housing and other agencies and the acquisition of skills needed to maintain houses, appliances and other accompaniments of urban and suburban life. Generally speaking, Aboriginals who are undergoing the transition to town life do not receive sufficient assistance and are therefore not afforded the chance to become community members having status and opportunities equal to those of non-Aboriginal community members. One area where such assistance can be provided is through the use of 'homemaker services' such as presently provided in Western Australia. The scope of this service includes general social welfare support. This needs to be done with a great amount of sensitivity and after full discussion with the individuals concerned.

Special Needs of Urban Aboriginals

128 The Committee considers that the environmental circumstances in which many urban Aboriginals live are similar to those of other socially and economically handicapped minority groups in the Australian community. The most important need for this group is housing to alleviate the problem of overcrowding. This problem arises not only from poverty and a lack of adequate housing but also from a variety of socio-cultural factors including the Aboriginal kinship ethic by

which Aboriginals feel obliged to accommodate visiting relatives and members of their former clan or tribal community.

Funding

129 Information on the level and trend of funds made available to improve the physical environment of Aboriginals is not complete. Funds allocated by the Commonwealth Government on Aboriginal affairs are shown in Appendix 20. There is no corresponding information available of the funds made available by State Governments out of their own resources. The expenditure of Commonwealth funds on housing for Aboriginals increased from $2.3m in 1968-69 to a peak of $45.3m in 1975-76. Funds allocated in 1978-79 totalled $40.3m. Other funds allocated for the improvement of the physical environment are included in the category 'town management and public utilities'. This category is included with other categories in 'economic services' in Appendix 20. However, the following figures on expenditure for town management and public utilities are available in recent Annual Reports of the Department of Aboriginal Affairs :

1974-75	$24.8m
1975-76	$26.1m
1976-77	$24.2m
1977-78	$25.4m.

Estimated expenditure on town management and public utilities in 1978-79 is $26.1m which includes $4.1m allocated for expenditure on essential services to Aboriginal communities in the Northern Territory. Estimated expenditure on the physical environment for Aboriginals in 1978-79 by the Commonwealth Government is a total of the housing and town management and public utilities categories and totals $66.4m out of a total expenditure of $140.9m.

130 Because existing information on the adequacy of housing and public utilities is not comprehensive it is not possible to accurately estimate the level of expenditure which would be required to raise physical environmental conditions to a standard necessary for the attainment of satisfactory health standards. The Committee considers that the inadequacy of this information has serious implications for governments and administrators who are responsible for determining priorities and allocating funds in this area.

131 However, as specific information on public utilities is not available, and on the basis of evidence received by the Committee on housing needs in Western Australia and New South Wales, a number of broad conclusions can be made on the adequacy of funding.

132 During this financial year the Western Australian Government was allocated $3.95m to complete 30 houses under an Urban Housing Program and a Village Housing Program which aims to provide 130 houses over three years. An additional $1.2m was allocated to 10 Aboriginal Housing Associations for the completion of 52 houses and the commencement of sixteen. At this rate, and ignoring population growth and replacements, it will take at least 30 years to overcome the current Aboriginal housing backlog in Western Australia of 2,700 family units.

133 As stated in paragraph 114, it is estimated that in New South Wales $10m will need to be allocated for the next six to eight years to provide housing of a minimum standard for Aboriginal families. On the basis of expenditure allocated for Aboriginal housing in New South Wales this financial year, that is $6.89m, it is estimated that adequate housing will not be available for Aboriginals in New South Wales for at least another 10 years.

134 From the two examples given, and ignoring population growth and replacement of housing, the Committee believes that if there is no change in the present level of expenditure on housing, it will be several decades before the standard of housing is raised to a satisfactory level.

Role of Local Authorities

135 Under the devolution of responsibility from the Commonwealth and State Governments to local authorities, local government today has prime responsibility for safe water, public hygiene services, housing standards and inspection of premises. Other than power to make special laws for Aboriginals, the Commonwealth has no legislative competence in these areas of local authority responsibility. However, local government generally has no power to enforce housing, hygiene, or other standards on land owned by the Commonwealth or State Governments. This arguably includes land under the control of Aboriginal Land Trusts.

136 There is an urgent need for the three levels of government and Aboriginal communities to consult on ways of maintaining the physical environment of Aboriginal communities. A number of matters require immediate attention, namely the formulation of appropriate housing, water and hygiene regulations for Aboriginal fringe dwellers who cannot be housed properly in the towns, and the solution to delays which result from Commonwealth and State departments and local authorities not having accepted individual responsibility for making decisions concerning Aboriginal communities.

137 It may well be necessary for the Commonwealth to fund local authorities through grants to the States with specific conditions to ensure that adequate and proper standards are applied to Aboriginal communities generally ignored by local

authorities because they are not rate-paying or are regarded as being outside local authority regulatory power. In other cases, it may be more appropriate to fund directly Aboriginal communities or organisations for town management purposes.

Conclusion

138 The Committee believes that the provision of clean and adequate water supplies is the most important environmental factor in improving the health of Aboriginals. This is particularly important in the arid areas of Australia and to the success of the outstation movement. It therefore recommends that the highest priority be given and immediate action taken to provide clean and adequate water supplies to all Aboriginal communities.

139 In paragraph 107, reference was made to the fact that 13% of the Aboriginal population relied on a sanitary pan system. The Committee recommends that a determined effort be undertaken to eliminate as soon as possible the unhygienic sanitary pan system in Aboriginal communities.

140 In paragraph 109, the Committee referred to a tendency to provide over-sophisticated sanitary facilities and suggested that there may be a simpler approach to this problem. In paragraph 122, the Committee also suggested that elaborate houses in traditionally oriented communities may be needlessly costly and still not provide a form of housing which is acceptable. It therefore sees a need for consultation with the Aboriginal people on these matters and in co-operation with them for greater research and experimentation.

141 The Committee therefore recommends that an advisory group within the Department of Aboriginal Affairs comprising experts in middle level technology be established, and in

consultation with relevant departments and the Australian Institute of Aboriginal Studies to: research various options for the provision of community and household facilities; consult with Aboriginal communities to assess their needs; advise them on the most appropriate facilities that best suits their needs; monitor implementation of its advice to communities; facilitate employment of technical advisers by Aboriginal communities; and report to the Minister for Aboriginal Affairs.

142 The provision of housing is the most important environmental factor in the improvement of the health of Aboriginals living in towns. This also applies to Aboriginals moving into towns away from the fringes. The standards of such houses would be the same as for other citizens of the towns and automatically include water, electricity and sewerage or septic systems. It has also been indicated that, at the current rate of expenditure and ignoring population growth and replacement, it will take many decades before the backlog of housing is overcome. For an effective improvement to be made in the standard of Aboriginal health, the Committee recommends that priority for Aboriginals living in towns and moving into towns away from the fringes, be given to the provision of funds for meeting and upgrading their housing needs.

143 In paragraphs 135 to 137, the Committee referred to the responsibility of local authorities for housing and hygiene standards and the urgent need for consultation between the three levels of government. The Committee therefore recommends that the Department of Aboriginal Affairs consult relevant Commonwealth and State departments, local authorities and Aboriginal communities and organisations to define the responsibility for safe water, public hygiene services, housing

standards and inspection of premises in Aboriginal settlements and communities, particularly fringe camps.

7 SOCIAL FACTORS

144 Aboriginal society changed irrevocably following European settlement in Australia. Entire social groups died out as the result of disease, dispossession, conflict and, in some cases, massacre.[7] Large numbers succumbed to introduced illnesses and to the despair which characterises people dominated by a more powerful and alien society. The heritage of these often destructive contacts with European society has been continuing at inordinately high rates of ill health and poverty, and highly inadequate living conditions compounded by limited opportunities for education and employment. Like other minority groups living in depressed socio-economic circumstances, Aboriginals suffer feelings of worthlessness, apathy and hopelessness. They must cope, often daily, with discrimination from members of the dominant society. They are, in addition, doubly burdened by spiritual depletion resulting from dispossession, dispersal and re-settlement and, until recently, denial of rights of ownership of their own land. With the progress of land rights in the Northern Territory and South Australia, some of these problems are being alleviated in those areas.

145 Many social problems experienced by Aboriginal communities have resulted from the impact of Western society on their traditional nomadic existence and the imposition of a predominantly settled life style. Aboriginals who lead a fringe dwelling existence experience other social problems in their efforts to adapt to the white Australian economic system and cultural mores, while retaining an Aboriginal identity

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[7] The Destruction of Aboriginal Society, C.D. Rowley, A.N.U. Press, 1970-71.

and pride. Whatever their situation, most Aboriginal people are attempting to conduct their lives in environments and circumstances which are often unfamiliar and hostile to them.

Poverty

146 Many Aboriginals in remote, rural and urban areas are caught up in a self-perpetuating cycle of poverty. This results not only from loss of the traditional economic base (the land and the resources it contained) but from a lack of access to the economic sector of Western society. In remote areas employment is often unavailable for those who wish to be employed. The ability and willingness of some Aboriginals to enter the workforce is often adversely affected by the failure of non-Aboriginals to accept and respect Aboriginals and Aboriginal culture and by the resultant loss of self-respect and self-reliance by the Aboriginals themselves. Relegated to a socially and geographically marginal life style and without independent resources many subsist on shared social security payments which then are frequently inadequate or mismanaged to meet other than subsistence needs.

Discrimination

147 The effects of discrimination pervade the history and present conditions of Aboriginals. During the Inquiry it became apparent that in some Aboriginal communities some non-Aboriginal staff did not afford Aboriginals the respect and consideration, particularly in health matters, which they would have afforded non-Aboriginals. For example, in one settlement the request of an Aboriginal woman that she consult the doctor in private without staff and patients hearing and seeing the consultation, and be assured that her records would not be freely read by hospital staff, was greeted with both surprise and annoyance by non-Aboriginal staff present.

Land

148 Land is of fundamental importance to Aboriginal people, especially traditionally oriented people who see land as the religious and economic foundation of their society. For some rural and fringe dwelling communities land continues to be an important symbol of their Aboriginality and an important source of the motivation and pride needed for their development. The consequences of their alienation from it are only now being acknowledged. The Committee believes the previous practice of developing reserves and settlements for diverse groups of Aboriginals was deleterious to their welfare. On the other hand, it recognises, especially in Central Australia, that settlements enabled some Aboriginals to survive in situations of harsh climatic conditions such as drought. The artificial creation of settlements, together with attempts at assimilation, adversely affected the basic social structure of Aboriginal communities, including authority structures and social control, kinship obligations, child-rearing and other socio-cultural beliefs and practices.

149 The loss of use and ownership of land with the coming of Europeans had dramatic ramifications for Aboriginal society, depriving Aboriginals of sources of food, spiritual strength and the basis of the corporate identities and functions of local groups. The Committee received evidence that the ownership of land is a necessary (though not sufficient) prerequisite for a healthful life style and for the motivation of Aboriginals to create viable, self-sufficient and healthy communities. It was told by several witnesses that security of tenure of land is essential to the psychological and physical health of Aboriginals, as discussed below.

150 When people feel insecure and have no home which they see as permanent and inalienable, they crowd together in depressed, hopeless, dispirited groups having neither the confidence nor the motivation to create less crowded or more healthful living environments. The settlements on which they live take on the characteristics of institutions and the residents fall into a state of 'learned helplessness'. By contrast, when people have control over their physical environment they feel able to make and implement decisions for their own benefit, knowing that their decisions and actions are an assured investment in the future.

151 An active decentralisation movement leads to assertion of selected traditional values, beliefs and aspects of the religious sytem, which in turn buttresses and validates the indigenous social control system. Secure within the boundaries of their own land, and removed from the pressures of unrelated groups, leaders are more able and willing to exert their authority and control such disruptive behaviour as petrol sniffing and alcoholism. However, an important part of the success of the decentralisation movement depends on ownership of land. Aboriginals know that their livelihood and survival depends in many ways on government and mission staff. Unless explicit recognition of their ownership of land is given under Australian law and their movement to outstations supported, they will not risk moving for fear of being abandoned by those who control vital resources and services.

152 Land rights facilitates the outstation movement and hence access to gathered and hunted food, which is both fresh and highly nutritious.

153 With assurance of continuity and control of their life style community members often budget carefully to obtain material and perishable goods, and may pool their resources to purchase capital items for the benefit of the entire community. The sharing of resources and labour ensures that all community members receive adequate food and support. Such sharing and support is eroded on large settlements.

154 Recognised ownership of land and the freedom of movement and confidence it brings facilitates re-assertion of inter-group affiliations, rights and duties (seen today at ceremonies involving more than 1000 people) and thus promotes cohesion and co-operation at the regional as well as local level. The re-establishment of these inter-group ties provides an organisational infrastructure which could lead to the design and management of new initiatives such as the Aboriginal medical services.

155 Among people who occupy their own lands, traditional educational processes are re-established and these can act not only as vehicles for the continuation of the identity, pride and knowledge of the local group, but as mechanisms for the dissemination of new information considered important for the development of the community.

Outstations

156 The outstation or decentralisation movement in northern and central Australia has resulted from the natural desire of many Aboriginals to move back to their traditional lands and away from the often deleterious effects of settlement life and the proximity to large non-Aboriginal communities. This movement has been facilitated by Land Rights Legislation in the Northern Territory and proposed in South Australia, and

increased availability of funds and support services for outstations. There are, at present, approximately 95 established outstations in the Northern Territory. Other groups have moved back to their lands in Western Australia, South Australia and Queensland but in many cases without assurances of security of tenure in their lands. Some groups live with the anxiety of not knowing how long support for their communities will be forthcoming.

157 There is very little statistical evidence on the effect that outstations have had on Aboriginal health. However, on the basis of observations and the views of Aboriginals themselves and health personnel, the move to outstations has not only increased the confidence and mental health of residents but has led to a reduction in the consumption of alcohol and a decrease in certain diseases, particularly those of infancy and childhood.

158 In some cases isolation incurs greater patient risks when acute illness occurs when health services are not immediately available. On balance, however, there is an overall improvement in health.

159 It became clear to the Committee during the Inquiry that the beneficial effects on health of outstations would be lost if the communities did not have ready access to necessary services and resources. In north-eastern Arnhem Land, where a very active policy of support for outstations has been pursued, and where water and nutritious foods are readily available, the Committee was very impressed by the clean and healthy outstation environments and the industry and enthusiasm of residents. In central Australia it was clear that a great deal more needed to be done in many areas to ensure that outstations have safe water supplies and regular

access to medical, educational and other services. The support given to outstations varies considerably. The Committee believes that if full support is not given there will be a decline in community wellbeing and groups will move back to settlements where services are available but where health is worse.

160 There is a need for governments to be more imaginative in their responses to the requirements of outstations and the Committee believes that the advisory group of middle level technologists, recommended in paragraph 141, should have a major role to play in this regard.

Hygiene

161 The semi-nomadic life style of traditional Aboriginals facilitated the disposal and decay of wastes and ensured that the living environment of Aboriginal groups was clean and healthy. With the establishment of settlements with minimal sewerage, sanitation and water supplies and with very poor shelter Aboriginals were forced to live in conditions which promoted the transmission and prevalence of infectious and parasitic diseases.

162 The Committee believes that it is unrealistic to expect any group to maintain reasonable standards of hygiene in the absence of basic facilities such as clean and adequate water supplies, adequate sanitation and appropriate housing. The involvement of public hygiene officers and Aboriginal health workers is essential to the maintenance of community hygiene standards. A description of the role of these workers is discussed in paragraphs 336 to 344.

Conclusion

163 Evidence therefore indicates that, despite substantial allocation of funds for Aboriginal affairs by the Commonwealth Government including welfare, education and employment (see Appendix 20), there has been no reduction in the incidence of socially related medical disorders such as alcoholism, venereal disease, mental illness, trauma, obesity, addiction to petrol sniffing, chronic anxiety and psychosomatic disorders, in fact these have increased.

8 CULTURAL FACTORS

164 An effective health care program for Aboriginals requires a recognition by non-Aboriginal health personnel of those Aboriginal beliefs and practices which affect health and the use of health services. It is important that the cultural factors which influence Aboriginal attitudes towards health and health care be fully appreciated not only by those directly involved in the delivery of health services, but also by governments in the allocation of funds and determination of priorities, by policy and decision-makers involved in the planning and administration of programs, and by the various learning institutions in the instruction and training of medical personnel. A few hospitals, health centres and staff are already aware of these factors and take them into account in the provision of services. The majority do not.

165 One reason for the emergence of Aboriginal Medical Services is the failure of conventional services to take account of cultural differences and to accept the importance of Aboriginal beliefs and practices. Several cultural factors were identified during the Inquiry which particularly influence the use and acceptability of health services. The influence of these factors varies considerably from community to community.

Aboriginal Attitudes to Health and Illness

166 Aboriginal views of health differ in some respects from those of non-Aboriginals. For instance, the Committee was informed that, while the Pitjantjatjara wish to be healthy and want their children to be strong and happy, they do not view health as one of the inalienable rights of life. While they

feel great sadness and grief at a death and seek to alleviate pain and illness, they view themselves as subject to spiritual forces outside themselves and thus accept illness, deformity and disability more readily than most non-Aboriginals. They do not share the great value placed by Europeans on preserving each human life at all costs. This attitude is often evidenced in a stoicism about traumatic injury and pain. However, internal pain or symptoms (which do not have an immediately evident cause or may be thought due to sorcery) can cause distress and fear out of proportion to a Western medical assessment of the severity of the condition.

167 Attitudes to health and illness have also been affected by the Aboriginal experience of continuing sickness and poor health. People who suffer pain and discomfort more or less continually inevitably cease to complain about conditions which they feel cannot be alleviated and are part of the life experience.

168 In Arnhem Land the decline in health of past decades is clearly recognised by Aboriginals who link their ill health to consumption of alcohol and processed and stale foods, to the stress of life on crowded, heterogeneous settlements and to an unhealthy environment. They explicitly contrast the good health of their children on outstations to the poor child health on settlements. They also maintain that the security of outstation life away from the dangers of sorcery and dangerous spirits is beneficial for health. Good health is seen as resulting from harmonious relationships with the physical, human and supernatural environment. Sickness results from disruption to these relationships.

Hospitalisation of
Aboriginal Patients

169 It became apparent during inspections of hospitals which admit a significant number of Aboriginal patients that they are, in many respects, poorly adapted to Aboriginal needs.

170 Aboriginal patients may abscond from hospitals because of enforced isolation, poor communication by staff, attitudes of medical staff towards Aboriginals, fear of medical procedures, unfamiliarity with the hospital environment, and cultural beliefs such as fear of dying far away from their home or birthplace and fear of spirits of people who have died in hospital away from their traditional lands. The Committee found that the majority of large hospitals were not designed for the special needs of Aboriginals. They are particularly forbidding to Aboriginal patients for whom they are alien and lonely places. While cultural and linguistic barriers are greatest for Aboriginals living in remote areas, Aboriginals living in fringe and urban communities are also often intimidated and anxious when admitted to hospital.

171 There is an urgent need in many areas for live-in facilities for patients and kin (particularly for mothers and babies) in the hospital itself, for greater sensitisation of European staff to Aboriginal needs and fears, and for the employment of Aboriginals as hospital staff in far greater numbers than is presently the case. There is also an urgent need for limited inpatient facilities to be provided in large settlements and staffed preferably by Aboriginal health workers so that only serious cases need be evacuated to distant hospitals.

172 The practice of evacuating pregnant women before the birth of their babies, beyond the reach of daily family visits,

should be abandoned except where actively sought by the patient or where complications are anticipated. At least one midwifery sister should be appointed to each isolated community or health centre, Aboriginal health workers should be given training in midwifery and the services of traditional midwives be utilised wherever possible. Counter arguments are most strongly expressed by professional obstetricians based on perinatal death and morbidity statistics which derive from mainly urbanised communities.

173 Similarly, every effort should be made never to separate an infant or child from its mother, as occurs in some areas, because disruption to the mother-infant bond at birth and during early separations is of serious concern and may cause inadequate mothering and behavioural disorders later on. Other consequences of such separations, such as the interruption or termination of breast feeding and subsequent need for bottle feeding, greatly increase the risk of further infant illness. While it is important to minimise perinatal deaths, it may be far more important to minimise the much higher disparity between Aboriginal and non-Aboriginal mortality and morbidity in later months and years with strong social disintegration a frequent factor.

174 Spiritual ties to the land strongly influence the attitudes of many Aboriginals, particularly those in traditionally oriented areas, towards health and hospitalisation. Infant deaths are doubly traumatic for a mother and family when the child dies away from its home territory, especially if, as in some areas, it is believed that the child's soul remains in its tribal territory to await rebirth at a more propitious time. When a baby dies in a hospital many miles from home its spirit cannot find its way to its homeland and is thus lost to mother and community forever.

175 While the death of a baby in hospital is often a tragedy to its mother, the death of an aged person in hospital can be a severe blow to the whole community, especially if it is a man or woman who has been a respository of tribal law and knowledge which gives meaning to the past, present and future of the community. Such people die 'away from their dreaming' or spiritual continuity. Their life force is then separated from their country and the strength of the 'dreaming' is weakened to the eternal loss of all survivors.

176 The policy which prevails in many parts of Australia of not returning Aboriginal bodies to their home communities after death is deeply distressing to their families and shows a bureaucratic insensitivity to Aboriginal traditions and concerns. The Committee was informed by representatives of some Departments of Health that they do not take responsibility for returning bodies to communities and that community members themselves are expected to make appropriate arrangments and to bear the cost of having the body brought home by road or air. There is an urgent need for State health authorities to establish a procedure by which the bodies of patients who die in hospital can be returned immediately to their families.

Traditional Healing

177 The apparent high rates of utilisation of health services and hospitals attest to the confidence which many Aboriginals have in Western medicine. However, many traditionally oriented Aboriginals may also seek treatment by the Aboriginal practitioner, male or female, (known by such terms as ngangkari, maban and marrnggitj) particularly if an illness is perceived as chronic or serious, or if it does not respond to Western medical treatment. The healer often specialises in treating sicknesses which have resulted from

the actions of sorcerers and spirits. The healer is believed to have the power to remove the cause of illness which has resulted from the actions of sorcerers such as 'pointing the bone', and 'singing' a person or spirits which have travelled from other sick people, from a deceased person's home, from an old camp site or spiritual homeland.

178 The Aboriginal healer may be consulted before, after, or in conjunction with Western medical care. In some cases he alone is consulted. Sometimes both are used in the hope that one or both will prove effective. Treatment by the Aboriginal practitioner usually consists of external massage, the apparent removal of harmful objects or substances from the body, or the use of powerful objects to alleviate the effects of the illness. Ministrations are, however, directed not only towards ameliorating the physical signs of the illness but towards removing its spiritual or other cause. The Aboriginal healer thus promotes healing and has a powerful and usually beneficial, psychological effect on the patient.

179 Treatment involves not only the healer and his patient, but everyone in the patient's immediate family group. When an individual has become ill as a result of falling out of harmony with his spiritual or social environment, the concern and attention which his suffering evokes often overrides intra-community tensions and draws the community together. The healer is a catalyst in this process, using his diagnostic abilities and healing powers to focus attention on the patient and to highlight the great importance of community solidarity and mutual support. Thus the practice of medicine in traditional Aboriginal society is not merely a matter for the sick person and the practitioner, but is the concern of the whole community. It is therefore not surprising that many Aboriginals prefer to be attended by the healer before, or

instead of, attending a clinic or hospital. Nor is it surprising that they are reluctant to be taken out of the community and evacuated to distant hospitals for treatment.

180 Aboriginal women have, particularly as they grow older, significant ritual and healing roles and act as midwives in many traditionally oriented communities. These roles have been eclipsed by non-Aboriginal interest in traditional practitioners and by the activities of Western health services, and are at present under-utilised by Western health services. Their knowledge, authority and experience could profitably be mobilised by involving them in decisions concerning health care and upgrading their existing skills in home treatment and midwifery. In this regard Australia is behind many developing countries in adding to the skills of those who have indigenous health roles and giving them an expanded role in the changing social system. The practice, for instance, in some Asian, African and South American countries of upgrading the skills of traditional midwives (or 'birth attendants') has not yet been adopted in Australia despite a clear endorsement of this strategy by national and international agencies.

181 In general, there is little or no evidence that the activities of traditional healers conflict with those of medical services provided that there is open communication and co-operation. Most of the evidence to the contrary stems from non-Aboriginal professionals who state only what they see as unacceptable practices such as lack of sterility.

182 The involvement of Aboriginal healers in the delivery of health care is further considered in paragraphs 328 to 330.

The Differing Health Needs and Roles of Aboriginal Men and Women

183 In many Aboriginal communities, particularly those traditionally oriented, there is a clear demarcation between 'women's business' and 'men's business' and all gynaecological and obstetric matters are dealt with by women with the greatest privacy and propriety. Many Aboriginal women avoid seeking gynaecological treatment and family planning advice because of their apprehension and embarrassment about approaching an often strange non-Aboriginal male doctor. The Committee was informed that Aboriginal women are rarely treated with the sensitivity, understanding and sympathy which non-Aboriginal women expect when consulting doctors about these matters. There is a great need for Aboriginal female health workers to receive training in the diagnosis of common gynaecological complaints and in family planning techniques and for female doctors to be available to Aboriginal women for consultation on a regular basis.

184 Men are often reluctant to seek medical care from female nursing sisters and Aboriginal health workers, particularly for uro-genital illnesses. Their reluctance is compounded by the fact that settlement health centres are generally patronised by women and children and run by women. Each community should have at least one male Aboriginal health worker and separate visiting times should be made available for male patients, or separate rooms or entrances be provided for males and females.

185 In traditionally oriented Aboriginal communities certain categories of people stand in avoidance relationships to one another. They may not, for instance, mention each other's names, make eye contact, converse or otherwise interact directly with one another. These conventions vary from region

to region. It is common for a brother and sister, and for a mother-in-law and her son-in-law, while having an affection and concern for each other's welfare, to avoid close physical or social contact. Situations can therefore arise in which it is inappropriate for Aboriginal health workers to treat members of the opposite sex. Under these circumstances they must delegate treatment to other health workers who stand in appropriate relationships. A lack of awareness of these conventions among non-Aboriginal health personnel can lead to acutely embarrassing and upsetting situations for Aboriginal health workers and those seeking health care. It is therefore important that non-Aboriginal health personnel be made aware of Aboriginal social conventions relevant to their work, that they are trained in Aboriginal culture, and, most importantly, that Aboriginals hold the responsibility for determining which people may or may not interact in the health care context.

186 It can similarly be inappropriate, in some circumstances, for female Aboriginal health workers to treat elderly or senior men of the community. Such constraints may be overcome by the presence of male health workers or health workers who themselves are senior community members. Again it is only the Aboriginal health personnel, community leaders and patients themselves who possess the knowledge needed to determine which interactions are or are not appropriate.

187 It is therefore important that, as already happens in most areas, training bodies invite and accept the community's choice of health worker trainees whatever their age and whatever their level of literacy since these choices are made taking into account such cultural factors as those described above.

Other

188 There are a number of other cultural factors which influence Aboriginals' perception of health and attitudes towards health care which should be considered in the treatment of illness and the provision of health care. Some of these are described below:

(a) Many Aboriginals consider themselves cured once the pain has gone (the disturbing spirit has left the body) and they therefore do not complete medication which may be necessary for complete cure.

(b) Many Aboriginals avoid pain and distress. This is considered more important than a person's long-term welfare. For example, although a mother is capable of carrying out certain therapeutic functions for minor complaints such as syringing and drying out of ears, she will desist from the practice if a child finds the treatment painful or unpleasant.

(c) Aboriginal explanation of causes of serious illness often involve the malicious actions of sorcerers or spirits. They may therefore reject scientific explanations such as the concept of cross-infection which attributes the blame for a person's illness to a close relative.

(d) Individuals and groups may be hesitant to seek help or may feel that their health care needs are not adequately met because Aboriginal health workers may be members of another family, clan or tribal group. The Committee found that most councils recognise this when selecting trainees and that health workers were generally drawn from several different groups.

(e) Many Aboriginals are strongly opposed to surgery because :

- The sanctity of the body and the importance of maintaining its physical integrity are basic to Aboriginal concepts of treatment of illness. Surgery is believed to 'spoil the body' and 'waste the blood'. Blood is regarded as powerful and, according to the context, a source either of strength or danger.

- Surgery is similar to sorcery where the removal of blood and vital organs is used to harm people.

- There is no corresponding treatment in the traditional medical system.

189 While most of the socio-cultural conventions discussed are strongest in traditionally oriented Aboriginal communities, the Committee received evidence that some conventions persist, often in an attenuated form, in urban, rural and fringe communities.

Conclusion

190 The Committee considers that health problems in all Aboriginal communities are exacerbated by the lack of knowledge among community members of the rationale for Western medical procedures and their lack of involvement in or influence over the health centre and its programs. It believes that this problem would be alleviated were more individuals of standing in the community actively involved in policy and decision-making and in the running of health programs at all levels. Denial of the legitimacy of traditional beliefs and refusal to acknowledge traditional practices will reduce the effectiveness

of any programs designed to improve Aboriginal health. New and existing health care programs should, where possible, be based on existing Aboriginal community structures, and should be consistent with the culturally determined decision-making processes and beliefs and practices of community members.

191 The Committee further believes that it is essential to the success of any health care program that proper care be taken in the selection and training of non-Aboriginal medical personnel so that they are fully cognizant of the medical and social requirements of their position and are sensitised to the needs of the people.

192 While it is highly desirable that the cultural beliefs and practices of Aboriginals be recognised, understood and accepted by non-Aboriginal personnel, the Committee considers that only the Aboriginals themselves have the expertise and background which are the necessary prerequisites for the successful design of culturally congruent health care programs.

193 So that the delivery of health care to Aboriginals can be maximised, the Committee recommends that Aboriginal cultural beliefs and practices which affect their health and their use of health services such as their fear of hospitalisation, their attitudes to pain and surgery, the role of traditional healers and the differing needs and roles of Aboriginal men and women, be fully taken into account in the design and implementation of health care programs.

PART 'C'

DELIVERY OF HEALTH CARE TO ABORIGINALS

In its terms of reference the Committee was requested to report on :

(1)(c) The effectiveness of existing health care programs for Aboriginals generally, and the adequacy of Western European-type health services to cope with the health problems of Aboriginals.

(1)(d) Alternative methods of health care delivery that take account of Aboriginals' life styles, including camp situations.

Ways and means by which -

(2)(b) Aboriginals including traditional healers can participate in the development and delivery of health care services to their own communities, and in any modification of existing services.

These matters are closely related and are therefore considered together in this Part.

9 DESCRIPTION OF EXISTING HEALTH CARE PROGRAMS FOR ABORIGINALS

194 Before reporting on the delivery of health care to Aboriginals it is first necessary to describe the existing health care programs.

Hospitals and General and Specialists' Practices

195 These offer a medical service which is generally curative and available to all people. The onus is on the patient to seek treatment.

Visiting Professionals to Aboriginal Communities

196 Many professionals, such as hospital medical officers, school health and dental teams, hearing conservation teams, T.B. teams, leprosy teams, optometrists, dentists, ear, nose and throat teams, and child welfare teams visit Aboriginal communities.

Royal Flying Doctor Service of Australia

197 This Service provides primary health care and aerial evacuation to hospital for outback people. It is complemented in the Northern Territory by the Northern Territory Aerial Medical Service.

198 Routine clinical visits are made, normally on a basis of not less than fortnightly. In one or two isolated places with small populations, visits may be monthly. There are a number of centres where visits are made up to three and four times a week. About 100,000 patient contacts are made and 6,000 evacuated each year.

199 Aboriginals represent approximately 40% of the doctors' workload. Aboriginal patients usually require two to three times the length of consultation than do non-Aboriginals. Of the 3,000 patients attended on an emergency basis in the 12 months to August 1978, 48% were Aboriginal.

200 The budgeted expenditure in 1978-79 is $5.214m for operational and maintenance purposes other than the acquisition of capital equipment or for replacement or additional facilities. Funding of this $5.214m will be by Commonwealth grant of 33%, grants and subsidies from State Governments of 43%, and the balance of 24% funded internally.

201 Gross expenditure for capital purposes in 1978-79 is estimated to be $2.597m, of which the Commonwealth will contribute $0.877m by way of grants.

Missions

202 The major Christian churches provide curative and, in some cases, preventive health services to many Aboriginal communities throughout Australia, including the staff of hospitals and clinics. The Australian Inland Mission, for example, has worked in Aboriginal communities or areas with significant Aboriginal populations since 1914. The major areas are the Kimberleys, the Cape York Peninsula, the south-west of Queensland, Oodnadatta, Warburton, Finke, and Alice Springs.

203 As a general rule these services are heavily subsidised by governments.

Aboriginal Health Programs Operated by the States

204 The functional and constitutional responsibility for the improvement of the health of all citizens within States

(including Aboriginals) rests primarily with the States. However, in 1946 an amendment to the Constitution (Section 51. (xxiiiA.)) provided that the Commonwealth Parliament have power to make laws for the provision of medical and dental services. The Northern Territory situation is discussed in paragraphs 228 to 236.

205 Before the Commonwealth Office of Aboriginal Affairs was established in 1968, little recognition was given by the States to the special health needs of Aboriginals. In mid-1969 Ministers agreed that State Health Departments should pay special attention to the health of Aboriginals, and each State (with the exception of Tasmania) established an Aboriginal health unit. The date of establishment of each unit is given later.

206 All the funds for these special units have been provided through the Department of Aboriginal Affairs. See Appendix 21 for funding to the States since 1972-73. This table shows that expenditure increased from $2.9m in 1972-73 to a peak of $14.1m in 1975-76. The estimated expenditure in 1978-79 is $12.7m.

207 The Committee notes that while the States accept functional and constitutional responsibility for the health of Aboriginals, and while they claim they have insufficient funds for their special Aboriginal health programs (paragraph 277) they have not seen fit to accept any financial responsibility for recurrent expenditure with respect to these programs. It could be claimed that this illustrates a lack of genuine support for programs designed to improve the health of Aboriginals in their State. Furthermore, the Committee was informed by the State health authorities that the special programs are improving the health of Aboriginals (paragraph 275) and it was also

informed of examples where there was a resultant decline in the number of Aboriginal patients admitted to State hospitals, e.g. in some towns in New South Wales the number of Aboriginal admissions to hospital has halved since the program commenced in 1973. This in turn results in a reduction of expenditure by State Governments on hospital and other curative services. An illustration of what can be achieved as a result of preventive Aboriginal health programs reducing hospital workloads is evidenced in Wilcannia in N.S.W., where hospital staff were able to go into the community and carry out preventive work.

208 The Committee strongly supports the view that the States should accept some financial responsibility for improving the health of Aboriginals as citizens of the State. It notes the statement by the Minister for Aboriginal Affairs when tabling the report by the Department of Aboriginal Affairs in the House of Representatives on 24 November 1978, that :

> The Aboriginal population of the States is included in general revenue reimbursement calculations and the Commonwealth Government expects that the States will provide at least a pro rata share to Aboriginals in their own welfare programs, and in those supported by the Commonwealth, and apply the priority of need principle in respect to Commonwealth funds made available for welfare purposes

209 The Committee recommends that savings to the State funded health services which result from the Commonwealth funded State Aboriginal preventive health programs be directed to the further development of preventive programs.

210 Where this is not done effectively such programs should be directly funded by the Commonwealth and corresponding amounts deducted from untied grants to the States concerned.

211 The programs conducted by the State units emphasise preventive medicine and community health rather than relying on curative services alone. In preventive services health personnel work among the community through clinics and visits to homes rather than the onus being on the patient to seek treatment. There are large educational components in the programs in such matters as facilitating access to normal services and advice in the home on diet, hygiene and home management. The health personnel working among the community can also advise sick people to seek treatment and, if necessary, transport them. Medicines and immunisation can be administered on the spot.

212 All the State Aboriginal health units recognise the important role that Aboriginal health workers play in the delivery of this type of preventive health care.

213 The organisation in each State which administers Aboriginal health is described below. These organisations are additional to normal State curative services such as hospitals and child welfare services.

New South Wales

214 The Aboriginal Health Section has operated since 1973 within the Bureau of Personal Health Services of the Health Commission of New South Wales. In April 1978 it had a staff of 104 comprising 13 in Central Office and 91 regional staff. Five Aboriginals were employed in Central Office and 54 in the regions. The emphasis in the regions has been on the employment

of community health nurses (32) and community health workers (41). In addition, the regional staff comprised alcoholism counsellors (3), mental health counsellors (4), and hospital health workers (3).

215 Training for community health workers and community health nurses is mainly on-the-job and includes two sessions of formal training per year each of a week's duration. The mental health and alcoholism counsellors also receive special training.

Victoria

216 The Special Health Services Section (Aboriginal) operates within the Department of Health and was established in May 1974. In July 1978 the Section employed a staff of 20, including 12 Aboriginals.

217 Teams have been established comprising one nurse and two Aboriginal community health aides to work in the key regions. Training of the Aboriginal health aides initially involved 1½ days in-service every two weeks, then it was two days per month and at present it is one week per month.

Queensland

218 The Aboriginal Health Program was established within the Department of Health in 1973.

219 Total employment at 30 June 1978 was 150 (72 Aboriginal, 78 non-Aboriginal), of whom 123 were field staff. The field staff comprise mainly public health nurses (2 Aboriginal, 26 non-Aboriginal), Aboriginal health sisters (2 Aboriginal, 11 non-Aboriginal), health assistants (45 Aboriginal), health workers (19 Aboriginal). Medical officers numbered three, of

whom two were regional and 15 administrative. Twenty-two field teams have been established, each comprising a sister and Aboriginal assistants.

220 The aim is for nurses to receive an in-service training course of four months, health assistants two months, and field officer (clerical) five weeks. Because of financial uncertainty the last courses were conducted in September 1977.

221 In addition to the work of the Aboriginal Health Program, the Department of Aboriginal and Islander Advancement conducts Health Education Programs, a mobile dental service in the Torres Strait area, a supplementary Food Assistance Program for children and mothers on reserve and a Hearing Conservation Program.

Western Australia

222 The Community and Child Welfare Division of the Department of Public Health was established in 1972 and is responsible for Aboriginal health.

223 The health service in Western Australia is divided into 5 regions. A full-time medical officer is assigned to each region and he is supported by other medical officers, public health field nurses and health assistants. In May 1978 the Service employed 19 doctors, 220 nurses and 100 Aboriginal health assistants. Camp nurses are also employed.

224 Training for Aboriginal health assistants is 'on-the-job' and in May 1978 it was hoped to establish shortly a training scheme based on the scheme operating in the Northern Territory.

South Australia

225 There is an Aboriginal health unit operating within the South Australian Health Commission. It was established in 1973 and as at August 1978 the staff of the unit numbered 70 comprising specialists and administrative staff (10), sisters (20), and Aboriginal health workers (40).

226 The unit provides both a clinical and preventive service in the remote reserves of the State. In other areas where conventional medical services are available a preventive service only is provided. Training of Aboriginal health workers is on-the-job.

Tasmania

227 Health services for Aboriginals are provided within the normal operations of the Department of Health Services. The Department of Aboriginal Affairs provides the salary of a non-Aboriginal nursing sister and operating costs of a Medical Centre at Cape Barren Island.

Aboriginal Health Program in the Northern Territory

228 Before 1973 the responsibility for Aboriginal health in the Northern Territory rested with the Welfare Branch of the Northern Territory Administration, and between early 1973 and 31 December 1978 with the Northern Territory Division of the Department of Health (the Northern Territory Medical Service). The responsibility now rests with the Northern Territory Government.

229 The Northern Territory Medical Service provided both a curative and preventive service in centres of Aboriginal

population, but the emphasis appears to be curative. There are no private medical practitioners working in Aboriginal communities.

230 The Territory is divided into three regions each under the control of a medical officer. There are 37 Rural Health Centres each with a sister in charge, health centres have been established on 13 Missions, 10 pastoral properties have a subsidised sister and nine Stations employ an Aboriginal health worker.

231 The Service employs 13 doctors and 60 nurses. As a general rule the nurses reside at the Aboriginal community and the doctors reside in the major towns and conduct regular periodic clinics in the communities.

232 Since 1972 the Northern Territory Medical Service has undertaken an active program of training of Aboriginal health workers. These workers are being trained in the following areas :

- basic medical and nursing care;
- personal health care;
- community health action, especially in the area of environmental health, alcohol, venereal diseases, etc; and
- health service management.

They are also expected to be fluent in an Aboriginal language, have the full support of the community in which they are going to train and be willing to live and work within that community.

233 The teaching program consists of two levels :

- Basic

  The aim is to develop basic health skills to cope with the most common health problems without the complications of theory, and to be able to refer serious cases to a nurse or doctor.

- Post-Basic

  This is for persons who have completed the basic level and it is expected that graduates will take over the running of the health services in their own communities.

234 In June 1978 there were 200 Aboriginal health workers in training. Eighty-one had completed the basic skills course and 47 of these were proceeding with the post-basic skills course. The aim had been to increase the number of trainees to 300 (1 to 100 Aboriginal population) by the beginning of 1979 but staff ceilings prevented the achievement of this aim. Training is 'in-service' supplemented by courses (mainly in numeracy and literacy) and seminars.

235 The "Policy Statement on Aboriginal Health Worker Training" by the Northern Territory Department of Health is contained in Appendix 23.

236 The direct expenditure on Aboriginal health in the Northern Territory is shown in Appendix 22.

Comparisons

237 From the information available in the above descriptions of the State and Northern Territory Aboriginal health units, the following comparisons are made :

	Aboriginal Population 1976 Census	FUNDS 1978-79	per 1000 Aboriginal Population	STAFF Aboriginal	Non-Aboriginal	Ratio
		$m	$m			
N.S.W.	40,450	1.6	0.4	59	45	4 : 3
VIC.	14,768	0.4	0.3	12	8	3 : 2
QLD	41,345	3.1	0.8	72	78	1 : 1
W.A.	26,126	6.3	2.4	100	239	1 : 2½
S.A.	10,714	1.3	1.3	40	30	4 : 3
N.T.	23,751	4.7	1.9	200	73	2½ : 1

238 The above table shows on an Aboriginal population basis that Western Australia receives considerably more funds for its Aboriginal health program than the other States and the Northern Territory. The table also shows that more Aboriginals than non-Aboriginals are employed in the programs in all regions except Western Australia and Queensland.

Urban Aboriginal-Controlled Medical Services

239 There are 11 urban Aboriginal-controlled medical services in Australia which provide an alternative curative medical service to the service available from general practitioners and others. In some cases they also undertake preventive work.

240 Ten of these services are funded by the Department of Aboriginal Affairs. The total amount of funds provided in 1978-79 is estimated to be $1,863,000. All the services indicated to the Committee that they did not receive sufficient funds to maximise the service to their Aboriginal clients and these problems have often been highlighted publicly. On the other hand the Committee received evidence that the funds provided were often mismanaged.

241 All but two of the 11 services bulk bill the Commonwealth Department of Health.

242 Total employment is approximately 120 Aboriginals (some part-time) and 30 non-Aboriginals. Many of the Aboriginals are health workers. Most of the non-Aboriginals are professionals such as doctors, dentists, nurses and social workers.

243 Financial membership of the Aboriginal-controlled medical services is open to all members of the Aboriginal community. However, as with most community organisations, few join the service or attend meetings. Aboriginals and non-Aboriginals can obtain treatment at the Medical Centres irrespective of membership. In some cases lack of membership does not preclude Aboriginals from speaking or voting at meetings.

244 The Aboriginal medical services that are operating in urban areas are :

Redfern (N.S.W.)

245 The Aboriginal medical service was incorporated and received its first grant from the Department of Aboriginal Affairs in 1973. The service provides primary medical and dental care for Aboriginals living in Sydney and other parts

of New South Wales. A food supplement and nutrition program is also conducted. The Aboriginal population in Sydney varies considerably because of movement into and out of Sydney, and would average about 15 thousand. There are about 200 financial members.

246 Patient records number 25 thousand. Medical clients *number 4,000 per annum and dental clients three thousand.*

247 The Department of Aboriginal Affairs funds allocated for 1978-79 is estimated to be $355,000. Information provided to the Committee by the Department of Aboriginal Affairs indicates that these funds are to provide full-time employment for 17 Aboriginals and 9 non-Aboriginals.

248 The Service claims that it has been actively involved in sponsoring other Aboriginal medical services throughout Australia. This involvement has been an influence in the establishment of medical services at Kempsey, Port Augusta, Perth, Townsville, Gippsland and Melbourne. Other communities have requested assistance to establish their own service, namely Bourke, Wilcannia and the Kimberleys. The Redfern Aboriginal Medical Service also services rural areas by mounting field trips.

Durri, Kempsey (N.S.W.)

249 The Durri Aboriginal Medical Service has been operating on a full-time basis since July 1977. The client population is three thousand. The Department of Aboriginal Affairs allocated funds of $70,000 in 1978-79 on the basis of 4,000 clients per year. One doctor and two Aboriginals are employed.

250 A number of clinics are conducted by the Service in districts in the Kempsey area.

Fitzroy (Victoria)

251 The Victorian Aboriginal Health Service was established in 1974 and provides medical and dental clinics for Aboriginals living in Melbourne, Shepparton and Morwell. Membership of the Service is 150 out of a target population of about eight thousand.

252 Patients number 10,000, of whom over 6,000 are in Melbourne. Over 2,400 dental patients were treated in 1977.

253 The Department of Aboriginal Affairs funds in 1978-79 are estimated to be $273,000 comprising $129,000 for the medical service and $144,000 for the dental service. Employment comprises 12 Aboriginals and 5 non-Aboriginal professionals.

Gippsland (Victoria)

254 An average of 250 patients are seen each month by the Gippsland and East Gippsland Co-operative established at Bairnsdale in 1973. Membership of the Co-operative is thirty-four. A doctor is no longer employed because, as the Service states, it has taught the Aboriginal people to use conventional services. Forty-eight thousand dollars was provided in 1978-79. Five Aboriginal staff are employed.

Shepparton (Victoria)

255 The Shepparton-Goulburn Murray Aboriginal Health Service provides a transport and health referral service. Two Aboriginals are employed. In 1978-79, $14,000 was made available.

Brisbane (Queensland)

256 The Aboriginal and Islander Service, established in 1973, operates medical clinics at South Brisbane, Ipswich, Inala, Wacol, Acacia Ridge and Murgon, and a dental clinic at South Brisbane. Major social and preventive health programs are also undertaken. The population serviced is approximately thirteen thousand. Membership is 400 and 100 attend meetings. Consultations number about 14,500 per year and employment is 27 Aboriginals and 3 non-Aboriginals. The Department of Aboriginal Affairs allocated $363,000 in 1978-79. The Service does not bulk bill the Commonwealth Department of Health.

Townsville (Queensland)

257 The Aboriginal and Islander Community Service operates medical and dental clinics at Townsville. The target population is estimated to be between 6 and 10 thousand. About 7,000 patients are treated each year. Special employment is five behavioural health technicians out of a total of 19 Aboriginals and 3 non-Aboriginals. The Department of Aboriginal Affairs allocated $183,000 in 1978-79.

Port Augusta (South Australia)

258 The Aboriginal Medical Service operates a medical clinic at Davenport Reserve near Port Augusta. The Service commenced in August 1976. The target population is 15 thousand. Patients average about 300 per month. One Aboriginal and two non-Aboriginals are employed. The Department of Aboriginal Affairs allocated $42,000 in 1978-79.

Adelaide (South Australia)

259 The Aboriginal Medical Service operates from the premises of the Aboriginal Community Centre. A part-time

medical service is provided. About 750 patients are treated in one year. Government funds are not provided.

Perth (Western Australia)

260 The Aboriginal Medical Service of Western Australia provides a medical, welfare and field nursing service to about 12,000 persons in Perth and surrounding country areas. The average number of cases treated per month is six hundred and eighty. Full-time employment is seven Aboriginals and two non-Aboriginals. A number of Aboriginals and non-Aboriginals are also employed part-time. The Department of Aboriginal Affairs allocated $215,000 in 1978-79.

Alice Springs (Northern Territory)

261 The Central Australian Aboriginal Congress operates a medical and social welfare service to town residents and Aboriginals from outlying areas. It employs 22 persons on a full-time basis. No information was provided to the Committee about the number of patients treated. The Department of Aboriginal Affairs allocated $300,000 in 1978-79. The Service does not bulk bill the Commonwealth Department of Health.

Aboriginal-Controlled Medical Services in Traditional Areas

262 Three such Services commenced operation in 1977-78. They are, together with funds made available by the Department of Aboriginal Affairs for 1978-79 :

	$ 000s
Lyappa Congress, Papunya	431
Pitjantjatjara Homelands Service	349
Urapuntja, Utopia	202
	982

263 The Lyappa Congress took over the health clinic from the Northern Territory Medical Service in June 1978 and provides the only primary health service to Papunya and out-stations with a total population of about one thousand. The Service caters for four predominantly different tribal groups. It employs a non-Aboriginal doctor, non-Aboriginal nurses and a number of Aboriginals. The total number employed is 7 full-time and 28 part-time staff, which is more than double the staff previously employed by the Northern Territory Medical Service.

264 The Pitjantjatjara Service operates mainly in the north-west of South Australia. It extends into eastern Western Australia and southern Northern Territory. The Service was established because of the movement by Aboriginals out of the larger towns onto their traditional homelands and the resultant difficulty in maintaining health services from the established centres. It excludes the surrounding Aboriginal communities of Docker River, Warburton, Amata, Ernabella and Indulkana. There are about 1,000 Aboriginals in about 20 recognised communities in the area of the Service. Fourteen Aboriginal health workers and three non-Aboriginals are employed.

265 The Urapuntja Service is based on the Utopia cattle station which was purchased by the Government. There are four different tribal groups comprising between 1,000 and 2,000 covered by the Service depending on movement to and from adjacent pastoral properties. It employs two non-Aboriginals and 11 Aboriginals.

266 Aircraft of the Northern Territory Aerial Medial Service are used to evacuate patients from each of the three regions covered by these Aboriginal medical services. A further

common feature of the three Services is that the Northern Territory Department of Health is involved in the training of Aboriginal health workers.

267 The above three Services are pilot projects and are being evaluated by the Commonwealth Government. The Minister for Aboriginal Affairs informed the Committee that evaluation of these Services would not be regarded as an essential prerequisite to consideration of further proposals for the establishment of Aboriginal medical services. The matter of evaluation is discussed in paragraphs 288 to 294.