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Aboriginal and Torres Strait Islander Health — Current Policy Issues

Department of Social Work
The University of Queensland, Brisbane



Introduction

This article addresses Aboriginal and Torres Strait Islander health problems and critically investigates current government policies which are attempting to raise the health standards of these Indigenous people. Particular emphasis will be placed on the Queensland Aboriginal and Torres Strait Islander population, which, according to the Australian Bureau of Statistics census in 1986, stood at just over 61,000 or 2.4 per cent of the State's population.

As the traditional owners of the land, the Aboriginal people had a nomadic lifestyle which suited the harshness of the countryside, and were able not only to survive, but to thrive, as hunters and gatherers. They possessed a broad knowledge of natural medicine and herbal remedies which sustained them for over 40,000 years. Sadly, since colonisation two hundred years ago, the Aboriginal population has been decimated by European diseases, dominated by White society and all but eradicated by numerous acts of genocide.

The sub-standard health of Australia's Indigenous people is recognised and recorded in numerous government statistic reports. Such matters as infant mortality, morbidity, substance abuse, life expectancy and deaths in custody will be dealt with here. Underlying these issues and others like

them, are the major problems of low socio-economic standards, high unemployment, poor housing and inadequate access to health services. I believe that, in order to be efficient and effective, appropriate health services must meet physical and mental needs as well as being culturally sensitive to the Indigenous people and their lifestyles. Shannon (1994: 34) points out that:

In Aboriginal society, women's business and men's business are quite separate, and are governed by strict social rules that can result in punishment if these are breached. Thus, when a patient of the opposite sex is treated by a health practitioner, it can be an experience of great shame, which may lead to complete withdrawal by the patient.

Clearly, the Aboriginal concepts of health and health care are significantly different from those of the wider community, mainly due to social customs and taboos.

For this reason the *Report of the National Health Strategy Working Party* (1989) defined Indigenous health as:

Not just the physical well-being of the individual but the social, emotional, and cultural well-being of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life.

This definition of health contrasts with the view of the general community 'that the health of people is the domain of the agencies established to provide care'. The Health Department, the general practitioner, the specialist and the hospital are expected to do whatever is required to make people healthy (Shannon, 1994: 34).

In my opinion government Aboriginal health initiatives would be more successful if they were applied along the lines of the Indigenous concepts of health care. That is, they must be socially and culturally acceptable as well as universally accessible.

In an attempt to analyse the current health levels of Aboriginals and Torres Strait Islanders accurately, the following key facts from the draft report *Queensland Aboriginal and Torres Strait Islander: Health Policy* (Queensland Health Department, 1994: 8) should be considered.

Aboriginals have the worst health status of any group in Queensland. Moreover, neo-natal mortality rates for Torres Strait Islanders and Aboriginal peoples are four times and three times higher respectively than those of the non-Indigenous population. The report goes on to state that there has been no improvement in Aboriginal and Torres Strait Islander health status in the last 15 years. It lists the illnesses which contribute to hospital admissions and early mortality of Indigenous peoples as circulatory conditions, respiratory conditions, diabetes and injuries.

These facts persist in spite of the Commonwealth Government committing \$1.532 billion nationally over a five-year period from December 1990 (Commonwealth Government, 1992: 3). It is obvious that government funding alone is not enough to ensure improved health standards for Indigenous peoples. The same document concludes that:

In order for Aboriginal health to be improved there is a clear need for Aboriginal involvement/participation and better coordination of service delivery at all levels.

This conclusion is in line with the previously outlined Aboriginal definition of health care. However, it would seem that government health initiatives are primarily concerned with meeting the needs of the general community. In particular, the issues of Aboriginal involvement and participation in the administration of health policies appear to be neglected. This was evidenced in March 1989, when Commonwealth, State and Territory Ministers responsible for Health and Aboriginal Affairs established an Aboriginal Health Group (AHDG) which did not have Aboriginal representation. This necessitated the

establishment of an Aboriginal Health Advisory Group (AHAG) with representatives from Aboriginal Health services to advise AHDG (Commonwealth Government, 1992: 1).

Aboriginal health services are seen by many Aboriginal people as the major providers of primary health care. In situations where there are no Aboriginal health services, Aboriginal people use the general community's health care facilities. However, there are many who do not feel comfortable using such services, because of staff attitudes and lack of appreciation of cultural differences (National Aboriginal Health Strategy Working Party, 1989: 63).

According to Gray and Sagers (1992: 129) Aboriginal units have been established in Victoria, New South Wales and Western Australia to assist in the formulation of health policy. They claim that only the South Australian government has established an Aboriginal Unit to provide health services directly to Aboriginal people. However, I was employed by the Queensland Health Department, as an Aboriginal Health Worker, in a similar unit between 1979 and 1981.

In South Australia, Aboriginal health workers and hospital liaison officers were employed in an attempt to meet the 'involvement and participation' recommendations of the *Working Party Report* (1989). This proved to be only partially successful due to the fact that the workers were constrained by the rules and structures of the organisations by which they were employed. Their ability to respond to Aboriginal people in culturally appropriate ways was limited because they were caught between the demands of their community and the health bureaucracy. This example illustrates the importance of health care programs which recognise the social, emotional and cultural well-being of the Indigenous population being served. It also highlights the difficulties encountered when these recognitions are not built into the programs.

The development and implementation of Aboriginal and Torres Strait Islander health policies and programs in Queensland have been guided by no less than ten principles based on Indigenous concepts and definitions of health. These principles, set out in section 3 of the draft copy of *Queensland Aboriginal and Torres Strait Islander: Health Policy*

(Epidemiology and Health Information Branch, 1994: 1-2) represent a positive approach to future health care programs in Queensland. They recognise that many factors impact on Aboriginal and Torres Strait Islander health, including:

... issues dealing with education and training, economic development, housing and infrastructure, community welfare, culture, sport and recreation, land, justice and law enforcement

...

As these issues are dealt with one by one, the overall health standards of Aboriginals and Torres Strait Islanders are slowly improving. A noticeable area of improvement since the early 1970s has been in the statistics relating to infant mortality.

A report published by the Queensland Health Department (1993) titled *Background Issues Papers — Towards the Development of a Queensland Aboriginal and Torres Strait Islander Health Policy* states that since the early 1970s the infant mortality amongst the Indigenous population in Queensland has been progressively reduced. In the years 1974-75, there were 78.8 infant deaths per 1000 live births. By 1988-90, this figure had dropped to 15.6 infant deaths per 1000 live births. While this represents a dramatic improvement, when compared to the total population the figures are

still at the unacceptably high level of almost two to one. Hogg and Thomson (1992: 21) state that:

The infant mortality rate for the total Australian population is 8.3 per thousand live births. The Aboriginal infant mortality rate in Queensland is almost twice as high at 15.6 per thousand live births.

A second report titled *Goals and Targets — For Australia's Health in the Year 2000 and Beyond* (Nutbeam *et al.*, 1993) also discusses the topic of infant mortality amongst the Indigenous population. It reveals that the Aboriginal infant mortality rate is highest in the more remote areas of Australia. This situation highlights the problems associated with lack of access to health facilities experienced by the traditional Aboriginal population, especially those living a nomadic lifestyle in remote areas.

In an attempt to deal with this problem, some State government authorities have set up birthing centres for Aboriginal and Torres Strait Islanders where babies can be delivered in a healthy environment. The birthing centres are established in cooperation with the local Indigenous community, thereby ensuring that the women attending the centres feel culturally at ease in a non-threatening environment. The Alukura

Call for Submissions

The Editors of *The Australian Journal of Indigenous Education* welcome submissions such as:

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- ◆ research reports
- ◆ news items
- ◆ book reviews
- ◆ notices of forthcoming conferences, seminars, etc.
- ◆ reports on relevant conferences
- ◆ information about resource centres and how to access them
- ◆ resources and materials for teachers and students.

Please see inside back cover of this issue for **Guidelines for Contributors**.

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The Editors
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Aboriginal and Torres Strait Islander Studies Unit
The University of Queensland
Brisbane. Qld. 4072

Birthing Centre in Alice Springs began as a pilot program in 1986 with temporary funding and a lot of controversy, but it has proved itself an indisputable success (Anon., 1991: 15). Since then, other pilot programs have been established in five remote Northern Queensland Indigenous communities (Queensland Health Department, 1993: 18).

Aboriginal and Torres Strait Islanders who live on their traditional land frequently experience poverty, poor housing, lack of sanitation and clean drinking water, along with inadequate nutrition and limited diet. These factors directly contribute not only to infant mortality, but also to high morbidity throughout the Indigenous population.

Health issues of particular concern with regard to morbidity are diabetes, heart and respiratory diseases, sexually transmitted diseases, infections and parasitic conditions, diseases of the nervous system, injuries and poisoning. All of the above are in most cases as high as double the national level, and in some instances six to nine times higher than in the general population. The document 'Enough to make you sick' (1992: 90) states that:

... morbidity and hospital admission rates could be reduced by appropriate environmental, social and behavioural interventions ...

Such interventions are yet to be fully implemented and thus remain a challenge to Federal and State governments. I believe that the continuing high levels of morbidity clearly indicate the failure of current government Aboriginal health policies. The simple expedient of throwing money at the problem has proved to be both ineffective and expensive.

Money certainly has the potential to help reduce morbidity but much of the health funding allocated by governments is consumed by high administrative costs, expensive reports, committees and health research projects. There have been instances when Aboriginal health funds have been applied to road making, port docking facilities and other capital works. Such creative bookkeeping is usually justified by claims that the Aboriginal people benefit; however, morbidity continues at unacceptably high levels as health funds sometimes go astray.

Throughout the world, various dispossessed indigenous populations suffer serious harm related to the abuse of alcohol and other substances. In Australia, substance abuse contributes to Aboriginal ill health, with men, women and children all at risk. According to Dr Michael O'Connor (1994: 43-44) up to 50 per cent of teenagers on some settlements in the 'top end' regularly sniffed petrol. Alcohol and substance abuse has been established by the State Tripartite Forum as a priority issue in Aboriginal and Torres Strait Island ill health (Queensland Health Department, 1993: 18).

The *Queensland Aboriginal and Torres Strait Islander: Health Policy*, draft copy (Epidemiology and Health Information Branch, 1994: 42) also prioritises goals of minimising the level of illness, disease, injury and premature death associated with the use of alcohol, tobacco, pharmaceutical and illicit drugs. Other goals include minimising the level and impact of criminal drug offences and related crimes. Personal and social disruption, loss of quality of life, loss of productivity and other economic costs associated with the use of alcohol and other drugs are all sought to be minimised.

For the Indigenous people of Australia, substance abuse is closely linked to a sense of loss. Chronic unemployment, loss of income, loss of identity and purpose, boredom and depression are all classic symptoms associated with alcoholism and drug abuse. A *National Aboriginal Health Strategy* (AGPS Working Party, 1989: 192) correctly points out that for Aboriginals:

Alcohol abuse is simultaneously a health problem, a cause of other health problems and a symptom of socio-politically related problems.

Dispossession from the land represents the major loss for Aboriginals, a loss so keenly felt that many choose to deaden the pain by resorting to substance abuse. The eventual loss of health and sometimes even death, is the final link in this sad chain.

The Federal government is funding a National Campaign Against Drug Abuse (NCADA) project, which supports Aboriginal community-controlled substance abuse education and prevention projects. This project was allocated \$7.34 million between 1990 and 1995. A further two-stage response, which was a major health recommendation of the

Royal Commission into Aboriginal Deaths in Custody, has seen a total of \$400 million committed to the substance abuse problem. This represented the major expenditure involved in implementing the National Aboriginal Health Strategy (NAHS), which commenced in December 1990 (Aboriginal Co-ordinating Council, 1990).

The first stage of the package, announced on 31 March 1992, allocated \$150 million to address the immediate legal and justice issues and alcohol and substance abuse itself. The \$250 million second stage, announced on 24 June 1992, is focussed on the future and concentrated on reducing dependency, increasing employment and income generation and on young people (Commonwealth Government, 1992: 4).

I believe that substance abuse is currently the most serious health problem affecting Australia's Indigenous population. In particular, alcoholism is a primary contributing factor to the disproportionate life expectancy of Aboriginals and Torres Strait Islanders.

The *Queensland Aboriginal and Torres Strait Islander: Health Policy* (Epidemiology and Health Information Branch, 1994: 26) states that:

Life expectancy rates for Aboriginal and Torres Strait Islanders are up to 20 years less than the non-indigenous population.

These figures are in keeping with those of third world countries and as such, are a damning indictment of Australian health policies. Australian health records reveal that there are three main medical conditions which account for over half the excess deaths in Indigenous adults over forty. These are circulatory conditions, diabetes and respiratory conditions, all of which are linked to poor diet, low nutrition, inadequate housing and lack of sanitation.

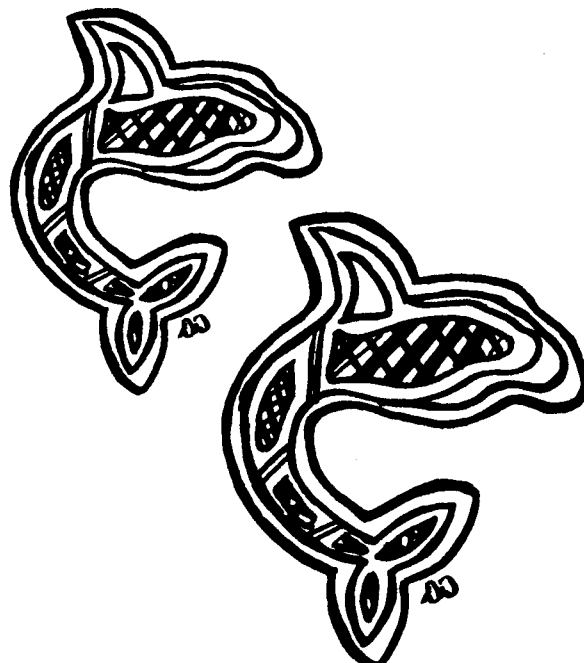
In recent years Australia has achieved very little success in the reduction of our poor record of excess deaths, in contrast with other Western developed countries. The Queensland Health report titled 'Causes of excess deaths in Aboriginal and Torres Strait Islander populations' points out that, in the global context of Indigenous races:

... the lack of progress in mortality rates of indigenous adults in Queensland is also in marked

contrast to the rapid improvements in the health of indigenous people in North America and New Zealand, where life expectation are higher than for indigenous Queenslanders.

The startling facts are that in New Zealand the risk of death is twice as high for Maori men aged 40 years as it is for white 40 year-old males. In contrast, the same comparison in Queensland reveals a death rate ten times higher. This appalling situation cries out for immediate attention, especially in light of the fact that there has been little or no change in the health status of adult Aboriginals in the last 20 years. During this time there has been around a 33 per cent reduction in the mortality of the general adult population. I believe that every Australian should be ashamed of these facts concerning excess mortality. However, a greater national shame is our extremely poor record concerning Aboriginal deaths in custody.

So bad is our record in this area, that a public outcry has resulted in a Royal Commission into Deaths in Custody, which has been described as unique in both the breadth of the issues it covered and the depth of its analysis. The grossly over-represented percentage of Aboriginal and Torres Strait Islander people in custody is directly responsible for the totally unacceptable number of deaths. The Royal Commission describes the disadvantaged and unequal position of Aboriginal and Torres Strait Islander people in our society — socially, economically and culturally — as the most important contributing factor to their over-representation in custody.



Section C — Research

It was set up to examine the deaths of 99 Indigenous people, who died while in custody in prisons or juvenile detention centres.

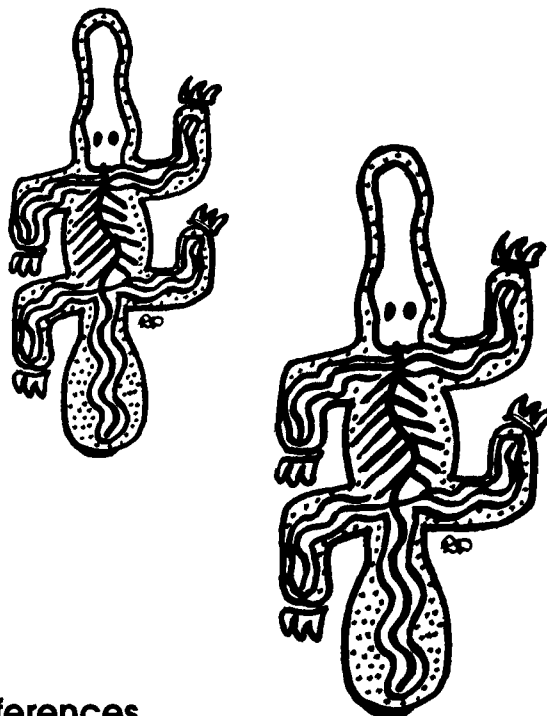
The report, *Aboriginal Deaths in Custody: Overview of the Response by Governments to the Royal Commission* (Commonwealth of Australia, 1992: 5) documents the European impact upon Aboriginal and Torres Strait Islander people and their dispossession and subordination within an often hostile society. It describes the development of racist attitudes, both overt and hidden, and the way in which these attitudes became institutionalised in the practices of legal, educational, welfare and Aboriginal and Torres Strait Islander assistance authorities.

Only time will tell how many of the 339 recommendations of the Royal Commission will be implemented and to what extent. Because of the wide-ranging scope of the recommendations, a 'whole of government' response is essential.

In conclusion, it can be seen that Aboriginal and Torres Strait Islanders experience a health status which is clearly far worse than that of fellow Australians. Disproportionately high levels of infant mortality, morbidity, substance abuse, life-expectancy and deaths in custody are but some of the clearly documented evidence of the poor overall health standards experienced by our Indigenous people. The political and economic responses to their poor health status, while they have been substantial, have not yet been totally successful. The encouraging dramatic reduction in infant mortality rates is but one area where government health initiatives have clearly been effective. However, much remains to be done, and many problems persist. In areas such as substance abuse and deaths in custody, evidence suggests that little progress has been made.

From the point of view of Aborigines, myself included, the struggle is an on-going process. With their efforts to resist colonisation, to cling to their land, their culture and their social identity, Aboriginal and Torres Strait Islander peoples have demonstrated their tenacity and determination to survive. It is my hope that, with the help of the extensive government health strategies outlined herein, and a more culturally sensitive approach to their application, the overall health status of

Indigenous Australians will be greatly improved in the near future.



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