

Original Article

Historical perspectives on indigenous health in Australia

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In spite of much effort over the past 25 years, the life expectancy of the indigenous people remains nearly 20 years behind the non-Aboriginal white population of Australia. These figures compare unfavourably with the improved life expectancy over the past 25 years of other indigenous peoples, such as the New Zealand Maori and the American Indian populations. By 1990–94, the average Australian indigenous all-cause mortality rate was 1.9 times the Maori rate, 2.4 times the US indigenous rate and 3.15 times the all-Australian rate. The persistence of this discrepancy in Australia is obviously a matter of great concern. There is clearly a gap between available knowledge and its application. Some indication of the possibility of reversal of the current situation is given by a recent report of the beneficial impact of the Homelands Movement on Health Outcomes in Central Australian Aborigines. The study compared the prevalence of obesity, hypertension and diabetes in two groups of Aboriginal adults: those living in homelands versus those living in centralized communities in Central Australia. Baseline studies revealed a lower prevalence of diabetes, hypertension and obesity in the homelands group, compared with those living in centralized communities. They were also less likely to die and less likely to be hospitalized for any cause, particularly infections, injury involving alcohol and other injury. Mean age at death was 58 and 48 years for the residents of homelands and centralized communities, respectively. The benefits were most marked in young adults. It is suggested that the homelands communities have a greater degree of control of their own lives than those living in the centralized communities and this may be an important factor in their improved health status. Improvement in indigenous health should be one of the key issues of reconciliation. Priorities include community control of Aboriginal Health Services under the National Aboriginal Community Controlled Health Organisation (NACCHO), throughout Australia, a greater priority for prevention and public health services (housing, water supply and environmental services) education and economic issues, improved training of indigenous health professionals and increased funding. A national professional organization including NACCHO needs to be established to bridge the big gap between available knowledge and its application for the benefit of the indigenous people of Australia.

Key words: Homelands Movement, indigenous mortality, NACCHO, priorities for improvement.

Introduction

The state of the health of our indigenous people is an enormous challenge to the Australian nation. It is a special challenge to all of us in the health field in Australia today. In spite of much effort over the past 25 years, the life expectancy of the Aboriginal people remains nearly 20 years behind the non-Aboriginal white population of Australia.

These figures compare unfavourably with the improved life expectancy over the past 25 years of other indigenous peoples, such as the New Zealand Maori and the American Indian populations.

The persistence of this discrepancy in Australia is obviously a matter of great concern. There is clearly a gap between available knowledge and its application which must be bridged.

In this paper I wish to review the more important aspects of the past and present situation. It is not possible for me to provide a comprehensive discussion but I want to consider elements of a strategy designed to overcome this situation. More detailed information on the Aboriginal health situation is readily available elsewhere¹ and there is an excellent recent comprehensive review by Burden.²

A brief history of the health status of the Aboriginal people

It is useful to consider health status in relation to a series of three ecosystems to which indigenous people have been exposed.³

The first ecosystem is that of the hunter–gatherer — representing a remarkable human adaptation dating from more than 40 000 years ago. Food is secured by hunting and fishing by the men and the gathering of seeds and plants by the women and children. Constant movement from place to place in search of food of uncertain quantity leads to a lifestyle characterized by plenty of exercise, plenty of sleep and careful regulation of population numbers. The adaptation achieved is one of the most remarkable in human history. When first seen by Europeans, the Aborigines impressed them with their athletic stature.³ The hunter–gatherer lifestyle is also characteristic of Inuits, the Kalahari Bushmen

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(the Kung) of South Africa, the Hadza of Tanzania and the South American Indians.

The second ecosystem dates from 1788, when the white man forcibly pushed the Aborigines off their hunting grounds as he developed the country for agricultural purposes. The Aboriginal people, like all hunter-gatherers, are not aggressive — such qualities are associated with agriculture, which the Aborigines have never developed. They were quite unable to effectively resist the white man and so, during the next 100 years, were either killed off or forced into the least productive parts of the country. The story is a tragic one including extermination in Tasmania, murdering (by hunting expeditions as late as 1900), pillage and rape all over the country. The situation is one that can only raise shame and guilt in the more aware and sensitive generations of the second half of the 20th Century in this country.

Something had to be done, so a guilty and desperate Australian government decided on the Reserve to 'protect' Aborigines from the white man. As Professor Elkin pointed out: 'Protection led to the establishment of settlements, institutions and reserves, which were viewed as training grounds in which Aborigines could gain the necessary education and skills to leave their protected environment and move out into competition with the wider community, cleansed from the disadvantages of their origin and straightened from the bias of the past'.

The policy was a complete failure — and the present disastrous state of nutrition and health of the Aboriginal people is a direct result of it. There was no stimulus for initiative, the Aboriginal lost his self-respect associated with his tribal lands, his hunter-gatherer way of life and constant environmental challenge, which had produced a previously successful human adaptation associated with a nomadic, athletic way of life.

A third ecosystem has become evident more recently with the establishment of a mixed sedentary and nomadic way of life on some settlements — for example the Pitjantjatjara in South Australia. Here, an early attempt was made to evolve a compromise between the hunter-gatherer and the sedentary agricultural style of life. From 1970, there has been a widespread scattering or decentralization of the larger Aboriginal communities, such as those at Ernabella and Hermansburg, as well as in Arnhem Land, with return to old tribal areas. This scattering or 'homelands movement' was initially assisted by several years heavy rainfall producing an abundance of plant and animal foods and readily available water supply.³

These groups are able to hunt kangaroos, euros, wallabies and emus, collect vegetables and then supplement them from the shop as needed. Some groups are also growing fruit and vegetables so that their diet has improved and there is a widespread impression that the people are better nourished and healthier (see further below).

The development of community-controlled health services

Since the early 1960s, Aboriginal and Torres Strait Islanders initiated political action which has brought about a situation where today indigenous Australians have a greater degree of control of their lives than at any time since 1788. Starting with the Yirrkala bark petition in 1963, the push for civil rights led onto the Gurindji political action beginning in 1966 with the Walk-off from Wave Hill Cattle Station; the 1967

referendum which gave Aboriginal people citizenship; the 1972 Tent Embassy in Canberra; the 1976 Northern Territory Land Rights Act; the 1981 Pitjantjatjara Land Rights Act; the 1992 High Court Mabo decision which removed the fiction of 'terra nullius' and the 1996 Wik decision. This political action is indicative of the increasing militancy within the Aboriginal and Torres Strait Islander population in the last 35 years and of their unwillingness to continue to accept the role historically cast for them within the wider (white) Australian society.²

The emergence of Aboriginal-controlled health services in the early 1970s was another manifestation of this militancy. Frustrated by the lack of health services that were appropriate to their cultural needs, and imbued with a new sense of autonomy following the 1967 referendum, Aboriginal people took matters into their own hands.

In 1971, the first Aboriginal community-controlled health service was established at Redfern in Sydney. Other communities followed and in the ensuing years set up their own health services — in Fitzroy in 1973, Perth in 1974 and in Alice Springs the Central Australian Aboriginal Congress (CAAC) was established in 1974.

The CAAC Health Service developed following a National Seminar on 'Better Health for Aborigines' at Monash University in May 1972. It was attended by 70 participants, including 20 Aborigines from all over Australia.⁴ The primary conclusions and recommendation from this seminar began as follows: 'Judged by accepted (WHO) criteria, the health of the Aboriginal people in Australia is at a disastrously low level'. The following recommendations were made with a sense of great urgency: they were strongly supported at that time in an editorial in the *Medical Journal of Australia*.⁵

Principles 1. In any program of health care, the integrity of the Aboriginal people is crucial; therefore every attempt must be made to foster a sense of solidarity and dignity, so that Aboriginal identity can be preserved and promoted.

2. Health programs should be planned in consultation with the Aboriginal communities they are designed to serve, over the entire cultural, linguistic and economic range of such communities throughout Australia and carried out through the people themselves and their community leaders.

3. The current disastrous health situation is a by-product of the complexity and diversity of an Aboriginal society under the pressure of an European society. It is a total community problem and not primarily one of individual health. A strategy to meet this problem requires a comprehensive approach aimed at a drastic improvement in education, housing and economic opportunity, as well as health services.

In due course this National Seminar led to the full establishment of the CAAC Health Service when Dr Trevor Cutter was appointed director in 1975 — having been previously a member of my former Monash Department of Social and Preventive Medicine.

Trevor Cutter proceeded with great enthusiasm and commitment to implement the community and holistic concept of health care that had been advocated by the National Seminar. This meant that the CAAC Health Service, in addition to providing medical care, sought to address the political, social, service and environmental factors that underlie so many

Aboriginal health problems. The aim was, as stated by the Monash Seminar, to improve the quality of life at both the individual and community level. Dr Cutter provided inspired leadership over a period of 12 years.

By the end of the 1980s there were more than 60 Aboriginal community-controlled health services in existence with another 91 centres awaiting funding to establish their own health services.

Community control gives Aboriginal people the opportunity to take responsibility for their own health, as was the case in pre-controlled Aboriginal society, where such responsibility was a shared community experience. These services have been staffed predominately by trained Aboriginal health workers. While the doctors and trained nurses working in these services are non-Aboriginal, they are nevertheless accepted because they are perceived as having an empathy with Aboriginal people with a genuine interest in their health and well-being.

Training courses have now developed in each state, which have provided Aboriginal health care workers with the professional development and career structure necessary for them to meet the challenges of their work.

More recent developments now provide a wider range of programs, including mental health and dental services, as well as rehabilitation welfare, public health and substance abuse programs.

The National Aboriginal Health Strategy (NAHS), formulated in 1989, focused in particular on the role of environmental factors in relation to Aboriginal ill health and the need for an Aboriginal definition of health. It also concentrated on a holistic approach to health care and emphasized the importance of community control.

In recommending that all Aboriginal primary health care services be transferred to Aboriginal community control, the NAHS recognized the critical importance of community participation and control, and asserted the right of Aboriginal people to determine their own destiny in this and other aspects of their lives.

The establishment of the Aboriginal Torres Strait Islander Commission (ATSIC) in 1990, under the Hawke government, established a structure to enable broad representation of Aboriginal and Torres Strait Islanders to emerge.

A by-product of the creation of ATSIC has been the formation of NACCHO, the National Aboriginal Community Controlled Health Organization, which took over supervision of the Aboriginal community-controlled health services. This function was too complex to be handled by ATSIC in addition to its other responsibilities. There are now some 100 community-controlled health services represented by NACCHO, which maintains close contact with the Minister of Health through its chairman, Mr Puggy Hunter.

Current status of Aboriginal health

Despite limitations in the data which are likely to result in underestimation of the rates of illness, hospitalization and death, there is strong evidence that indigenous people continue to suffer a much greater burden of ill health than do other Australians.¹

In 1991–96, life expectancy at birth was estimated to be 56.9 years for indigenous males and 61.7 years for indige-

nous females, compared with all-Australian estimates of 75.2 years for males and 81.1 years for females.

Indigenous Australians die at younger ages than do non-indigenous Australians and this is true for almost every type of disease or condition for which information is available. In 1995–97 in Western Australia, South Australia and the Northern Territory combined, over half of the deaths among indigenous males and about four in ten deaths of indigenous females occurred before age 50. The age-specific death rates for indigenous males and females exceeded those of their non-indigenous counterparts in every age group, but the differences were greatest in relative terms among those aged 35–45 years. The death rates in this age group were 6–8 times higher for indigenous males and females, than for their non-indigenous counterparts.

For all causes of death combined in Western Australia, South Australia and the Northern Territory in 1995–97, there were about three times more deaths than would be expected among indigenous males and females, if Australian death rates applied. Circulatory diseases, respiratory disease, injury, endocrine diseases and cancer were responsible for about three out of every four deaths among indigenous people in these jurisdictions.

The health disadvantage of indigenous Australians begins early in life and continues throughout the life cycle. On average, indigenous mothers give birth at a younger age than non-indigenous mothers. In most states and territories, their babies are about twice as likely to be of low birthweight and more than twice as likely to die at birth, than babies born to non-indigenous mothers.

Indigenous people were more likely to be hospitalized than other Australians in 1996–97, but the exact amount of the excess is impossible to determine, due to underidentification of indigenous people in hospital records. Respiratory disease and injury were among the most common causes of hospitalization for both indigenous males and indigenous females, but kidney dialysis accounted for a greater proportion of hospital admissions among people identified as indigenous (22% for dialysis vs. 8–13% for respiratory disease and injury). Almost 40% of all procedures performed in hospital among patients identified as indigenous in 1996–97, were kidney dialysis procedures, compared with less than 10% of procedures among non-indigenous patients.

Although there are difficulties in determining the exact extent of the problems, indigenous people are more likely to be hospitalized for and/or die from conditions that are indicators of mental illness, such as self-harm, substance misuse and suicidal behaviour. They are more likely to be at risk of reduced mental and emotional wellbeing, due to such factors as violence, removal from family, poverty and racism.

Health risk factors

Some of the differences between the health of indigenous and non-indigenous Australians can be attributed to the health risks to which indigenous people are more likely to be exposed. These include poor living conditions, poor nutrition, smoking, consumption of alcohol at hazardous levels, the use of illicit drugs and other harmful substances and exposure to violence.

Indigenous people are more likely than other Australians to live in improvised and/or overcrowded dwellings. Almost

a third of all households living in improvised dwellings in Australia in 1996 were indigenous households and nearly half of all dwellings with 10 or more people living in them were occupied by indigenous households. Almost 7% of indigenous people in Australia lived in dwellings housing 10 or more residents in 1996, which is more than 50 times greater than the proportion of other Australians living in such conditions.

Indigenous adults are more likely to smoke and more likely to be categorized as obese than other Australian adults, but less likely to report drinking alcohol. Those who do drink are more likely than their non-indigenous counterparts to do so at hazardous levels; however, indigenous people are more likely than non-indigenous people to be victims of violence and to suffer intentional injuries (those inflicted on purpose by another person) resulting in hospitalization. Almost half (46%) of all hospital separations among females for intentional injuries in 1996–97 were of women identified as indigenous.¹ Indigenous people are also overrepresented in intimate partner homicides, with 20% of victims and 22% of offenders in 1989–96 identified as indigenous.

Health services: provision, access and use

Based on available data, it is estimated that about 2.2% of total health expenditure in Australia in 1995–96 was spent on health services to indigenous people. The estimated expenditure per person was \$2320 for indigenous people and \$2163 for non-indigenous people. The differential in expenditure is smaller than the differential in various measures of health status, such as those described in the next section. There were differences in the pattern of service use between the indigenous and non-indigenous populations, with the indigenous population having a greater reliance on public hospitals and community health services and less on private hospitals, Medicare, the Pharmaceutical Benefits Scheme (PBS) and nursing homes, than the non-indigenous population. Medicare and the PBS accounted for more than a third (36%) of government expenditure on non-indigenous people, but just 5% of expenditure on indigenous people. The per-person expenditure on Medicare and PBS was only about one-fifth as much for indigenous people as for non-indigenous people.¹

Comparison with other indigenous groups

Since the 1970s, indigenous infant mortality rates have been declining, but life expectancy has not changed because of continued high adult mortality rates, due largely to high death rates from chronic diseases in middle age. This pattern contrasts with that of the indigenous people of Canada, the US and New Zealand, where marked improvements in health have occurred. While the health status of Australians as a whole continues to improve, the all-cause death rate for Aboriginal women is unchanged and the rate among men has decreased only slightly. As a result, the gap between the death rates for the Aboriginal population and the total Australian population has widened. Relatively few causes account for most of the mortality rate difference between indigenous Australians and all Australians.⁶

All-cause mortality rates

Annual all-cause mortality rates and fitted trend lines for Australian indigenous people, Maoris, Native Americans and

all Australians reveal the mortality rate from all causes for indigenous people in WA and the NT fell by 9% between 1985 and 1996. Over the same period, the all-cause rate for all Australians fell by 26%. The indigenous rate was 2.5 times the all-Australian rate in 1985 and three times the rate in 1996.

Death rates for NZ and US indigenous people fell relatively rapidly in the 1970s and more slowly thereafter. Between 1974 and 1984 mortality rates in Maoris fell 32% and a further 19% between 1984 and 1994. Mortality rates in Native Americans fell 17% between 1973 and 1982, from levels some 30% lower than those for Maoris, and a further 11% between 1982 and 1992. Current mortality rates in Australian indigenous people are comparable with rates in Maoris in the early 1970s.

By 1990–94, the average Australian indigenous all-cause mortality rate was 1.9 times the Maori rate, 2.4 times the US indigenous rate and 3.15 times the all-Australian rate.

Main causes of excess mortality in Aboriginals and Torres Strait Islanders

The International Classification of Diseases 9 (ICD-9) coding system groups all causes of death into 17 broad categories. Four groups of conditions accounted for almost 70% of the total excess death in the Aboriginal and Torres Strait Islander population of WA and the NT during the 5-year period 1992–96. Circulatory conditions accounted for more than a quarter (26%) of all excess deaths, with ischaemic heart disease, cerebrovascular disease and hypertension accounting for most of the circulatory disease excess; the injury and poisoning group, principally transport accidents, homicide and suicide, accounted for 15% and respiratory conditions, including chronic obstructive airway disease and pneumonia, accounted for 16%; endocrine conditions, largely diabetes, caused a further 10% excess deaths (Table 1).

Strategies for improvement in indigenous health

There has been a striking improvement in the health status of the white population of Australians since 1970. This is mainly due to the fall in mortality from coronary heart disease, which has fallen by more than 60% since 1968. The major factor in this improvement has been the change in diet — fall in consumption of saturated fat as indicated by the massive switch from butter to margarine consumption in this country. Other lifestyle factors such as fall in smoking and increased physical exercise are also important.⁷

Table 1. Ratios of standardized* mortality rates for Australian indigenous people vs Maoris, Native Americans and all Australians, for selected causes of death, 1990–94⁶

	Indigenous groups		
	NZ	US	Australian
Diseases of the circulatory system	1.5	2.6	2.5
Diseases of the respiratory system	3.1	4.5	6.6
Injury and poisoning	2.8	1.3	4.0
Endocrine diseases and immunity disorders	2.4	3.2	8.5
All causes	1.9	2.4	3.1

*Standardized to the World Standard Population 1960.

Such changes in lifestyle have not occurred in the Aboriginal population with consequent failure of improvement in morbidity and mortality.⁸

There is clearly an urgent need to promote healthy lifestyle education in the Aboriginal community. The complex of obesity, diabetes, coronary heart disease and hypertension now called 'the metabolic syndrome' is a lethal factor in the indigenous community today, as it is in indigenous communities in other parts of the world. However, these conditions can be prevented by appropriate health education measures directed to a healthier lifestyle — reduced fat and high fibre intake and increased exercise.⁸

The occurrence of recurrent childhood infections associated with middle ear disease and deafness, kidney disease and rheumatic heart disease has long since been controlled in the white population, but not in the Aboriginal population. These infections in childhood are now thought to be a factor in the occurrence of diabetes and vascular disease in middle age. They are preventable by good hygiene, vaccination and an adequate diet.⁸

Some indication of the possibility of reversal of the current situation is given by a recent report of the beneficial impact of the Homelands Movement on Health Outcomes in Central Australian Aborigines.⁹

The study compared the prevalence of obesity, hypertension and diabetes in two groups of Aboriginal adults: those living in homelands versus those living in centralized communities in central Australia.

Baseline studies revealed a lower prevalence of diabetes, hypertension and obesity in the homelands group, compared with those living in centralized communities. They were also less likely to die and less likely to be hospitalized for any cause, particularly infections, injury involving alcohol, and other injury. Mean age at death was 58 and 48 years for the residents of homelands and centralized communities, respectively. The benefits were most marked in young adults. Differences are summarized in Table 2.

Table 2. Mortality, age at death and cause of death, homelands and centralized communities, central Australia, 1987–95⁹

	Homelands	Centralized	$P(\chi^2)$
Subjects < 35 years at baseline			
Number	319	196	
Deaths	9	15	
Person-years (py)	2160	1482	
Mortality (deaths per 1000 py)	4.2	10.1	0.003
All subjects			
Number	530	295	
Deaths	39	39	
Person-years	3572	2229	
Mortality (deaths per 1000 py)	10.9	17.5	0.016
Mean age at death (SD)	58 (22)	48 (18)	0.036
Cause of death, <i>n</i>			
Infections	11	8	
All injury	8	11	
Alcohol-related injury	2	10	
Circulatory, renal, endocrine	14	15	
Other	6	4	

It has been hypothesized that the sense of control that people have over their lives and the sense of hope this gives are important determinants of health status.¹⁰

It is suggested that the homelands communities have a greater degree of control of their own lives than those living in the centralized communities, and this may be an important factor in their improved health status.

Another factor could be the special assistance that has been provided by the Centre for Appropriate Technology (CAT) in Alice Springs, concerned with appropriate products for the special needs of the homeland communities, with water supply, sanitation, housing and general hygiene.¹¹

The director of the CAT is Dr Bruce Walker. I was associated with this initiative, which finally emerged from a partnership between the CSIRO Divisions of Human Nutrition and Land Management and the Northern Territory Department and the Department of Aboriginal Affairs.

Working against mainstream perceptions, Dr Walker was eventually able to attract grants, which facilitated research and development of products that were useful to people in remote communities. In 1980 he designed, built and installed the first hand-pump at Kintore close to the Western Australian border. This allowed people who had been brought in from the desert to return to what is now a community of 350 Pintubi people living on their country.

He established an enterprise training workshop, which provided employment for 12 indigenous people manufacturing a range of products specifically designed to respond to local needs. The workshop was self-supporting and turned over three-quarters of a million dollars per year.

He then established a training arm of the CAT, which provides on-the-job technical problem solving skills through the Aboriginal Technical Worker (ATWORK) program. The ATWORK program was developed and accredited nationally. This course is based on the knowledge that the average size of an indigenous community is around 100 people. No community of this size can accommodate the levels of specialization that are expected or provided through mainstream training responses.

Dr Walker was able to bring much of this experience to a head through the Human Rights commission report into *The Provision of Water and Sanitation in Aboriginal and Torres Strait Island Communities*, which was written by him and tabled in the Federal Parliament in May 1994. The report explains some of the technological contradictions that people often raise in relation to the apparent failure of technology in remote communities.

He has transferred the vision established in the mid 70s into a viable organization, which became an incorporated indigenous organization in 1989. The work of the CAT is now controlled by a board of indigenous people, who have grasped the opportunity to develop a service that has national significance for their people.¹¹

A reappraisal of health issues for the new century

As Ring and Elston point out in their recent paper on 'Health, History and Reconciliation': 'If there is a consensus with the non-indigenous population about any aspect of indigenous life, it is the need to radically improve the health of Australia's indigenous population. That is an important reason for making health one of the key issues of reconciliation'.¹²

It is significant that they point out the importance of 'housing, water supply, environmental issues, an expanded political voice in the life of the country and finally enhanced self-esteem through a much wider recognition and confrontation of our history, as it has affected indigenous people'.¹²

Beyond these issues they also distinguish four major specific strategies for the improvement of indigenous health.

Community control of health services. The strength of a relationship between a health service and the community it serves is fundamental. Community control now operates in some 100 Aboriginal Health Services under NACCHO throughout Australia. These are not always adequately funded.

Health services. There is a need for much greater priority to be given to prevention and public health services. New models for health service delivery need to be explained. New Zealand, for example, embeds Maori health service delivery in a wider set of holistic services encompassing health, education, culture, community/social and economic issues.

Training. There is need for a national training program to deal with major deficiencies in the training of indigenous health professionals. A national scheme is required — with specific indigenous recruitment targets for medical, nursing, allied health and Aboriginal and Torres Strait Islander health workers to meet the health service needs for the next 10–15 years.

Funding. There are inadequate funds to address the challenge of indigenous health — the Commonwealth on a per capita basis spends 63 cents on the indigenous population for every \$1 it spends on the non-indigenous population as a whole. This is in spite of the fact that the indigenous population has illness and morbidity levels three times as high as the rest of the Australian population.

The NSW Aboriginal health strategic plan

I am impressed with the Strategic Plan that has been put forward by the 1999 NSW Department of Health with ATSIC and the Aboriginal Health and Medical Research Council of NSW.¹³ This plan follows agreement on policy at the state level. It has had inputs from Aboriginal Health Plans at Area Health Service and local Aboriginal Service levels.

Supportive strategies include: effective partnerships and cultural awareness, improved commonwealth and state co-ordination, support and development of the Aboriginal health workforce, effective monitoring of progress against performance indicators and improved collection of health information and informed decision making supported by a needs-based resource allocation model

The key priorities are: (i) improving access to health services; this includes effective networking within the partnership structure; (ii) addressing identified health issues; these include diabetes and diseases of the circulatory system, eye health, maternal, infant and child health and oral health; (iii) improving social and emotional wellbeing; issues being addressed include stolen generations, prevention of youth suicide, substance abuse and information, local issues and education; and (iv) increasing the effectiveness of health pro-

motion; this will be covered with lifestyle factors, injury prevention and family violence and creating an environment supportive of good health.

Housing, water quality, sewerage and waste disposal systems demand much more attention. There are problems with the multiplicity of agencies involved. Intersectoral collaboration is required. A similar excellent plan for Aborigines in South Australia was issued in 1997.¹⁴

The way forward

It is of interest to contrast the situation of Maoris in New Zealand with the Aborigines in Australia. Maoris have one language — and they had the Treaty of Waitangi. This, although imperfect, gave the Maori people substantial standing and power in the law.

In Australia, Captain Cook put up his flag in the belief there were no custodians. This was reinforced by the concept of 'terra nullius' from 1788 until it was overturned by the High Court of Australia in 1993.

There are 5600 tribal groups in Australia. Most Aborigines have a tribal identity only, so there is a problem with obtaining consensus and with representation.

The Aborigines have a strong culture of sharing, including sharing with Europeans, but sharing implies obligations. There is, however, no concept of ownership in the Aboriginal culture, which is a remarkable but an awkward situation.

Resource allocations among Aborigines, as in the 1997 NSW Partnership Forum, have to be agreed by a process of give and take. Eventually agreement, although difficult, is achieved. The same process of discussion needs to occur at the national level through a mechanism such as a national forum.

It is clear to me that there is a need for a national organization to be formed primarily concerned with indigenous health. This should be recognized as an advocate and educator within the Australian community. There is a need to consolidate professional resources to include not only doctors and nurses, but allied health professionals from both the Aboriginal and white community. In addition professionals from the appropriate technology area are also needed to provide the multidisciplinary input so important to improving the health of our indigenous people.

We know that significant improvement in indigenous health will not occur until the health situation is remedied for the rural, remote and fringe-dwelling groups. The report on the homelands experience⁹ indicates that improvement can occur with a healthier lifestyle and attention to the environment using the appropriate technology developed by the centre in Alice Springs.

However, these and other advances require a national initiative with Aboriginal leadership. There is a need for much more advocacy with the Australian community and the development of an indigenous Health Organization including both Aboriginal and non-Aboriginal professionals.

Such an initiative is required to bridge the great gap between available knowledge and its application for the benefit of the indigenous people of Australia.

The Australian indigenous health situation is an urgent and pressing national issue. A national initiative is called for, as pointed out by the Australian Medical Association expert

group in evidence before the recent House of Representatives inquiry.¹⁵

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