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**UNHEALTHY ENCOUNTERS:  
LEGACIES AND CHALLENGES FOR THE  
HEALTH STATUS OF SETTLER AND  
ABORIGINAL COMMUNITIES**

David Wilkinson

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University of South Australia  
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The Hawke Institute  
University of South Australia  
St Bernards Road  
Magill  
South Australia 5072  
Australia  
[www.hawkecentre.unisa.edu.au/institute/](http://www.hawkecentre.unisa.edu.au/institute/)

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# **UNHEALTHY ENCOUNTERS: LEGACIES AND CHALLENGES FOR THE HEALTH STATUS OF SETTLER AND ABORIGINAL COMMUNITIES**

David Wilkinson\*

In this paper I will outline the differences that exist in the health status of Indigenous and non-Indigenous Australians. While some of the differences that do exist are widely known and recognised, their depth, complexity and magnitude is perhaps less well recognised by many. It seems to me essential that this paper should provide a clear picture of differences in health status now, and over time, and I aim to do that. From there I will present data on use of health services by Aboriginal Australians, showing quite marked differences from use by non-Aboriginal people. I will then go on to make some international comparisons, seeking to determine whether the health status of Indigenous people in places like New Zealand and North America is as bad as it is here. I then want to consider why the health status of Australian Indigenous people is so poor. That is, I want to explore the determinants of health and health status in these communities. From there, I will present some suggestions about what can be done, how we can respond—as a society, as organisations and as individuals—in very practical ways.

This paper expresses a personal view, a view informed by my own experiences, my training and my expert knowledge. Importantly, I am a new Australian. I have been living and working here for three years and have been a citizen for a few months only. I grew up and did my medical training in the UK and then worked in very rural and very black South Africa for the best part of twelve years as a doctor and public health researcher. In my time in South Africa I experienced the very worst of apartheid at first hand, I witnessed Mandela's release from prison and lived through the incredibly stormy transition to democracy and black majority rule. Much of my life has been rooted in cross-cultural experience and this inevitably influences my thinking.

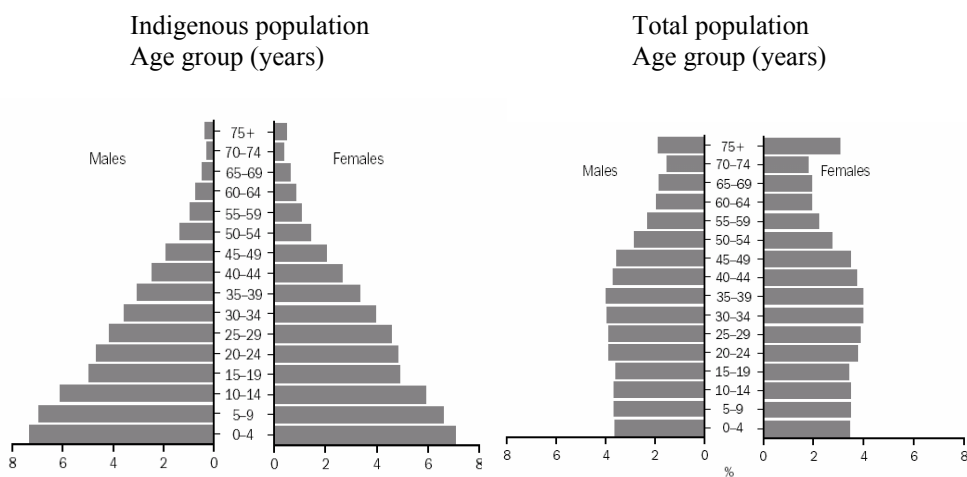
It is only in the last few years that we have even been able to gather data of reasonable quality on Aboriginal health status in Australia: most states haven't even been able to count Aboriginal deaths accurately until recently, and some still

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\* David Wilkinson is Professor of Rural Health, Adelaide University and University of South Australia, and head of the South Australian Centre for Rural and Remote Health. This paper is based on a public lecture David gave as part of the 'Encounters: cultural and scientific legacies and visions' lecture series presented by the Hawke Institute and the Hawke Centre, 13 March 2002, Brookman Hall, City East, University of South Australia.

cannot. It is no surprise then that we have limited data on Indigenous health status and how it has changed over the last 200 years. This in itself indicates the low priority accorded to Aboriginal health. However, historical accounts do indicate that, prior to the arrival of Europeans, Indigenous people were strong and healthy hunters and gatherers with an active lifestyle. Indeed there is little historical evidence of widespread illness or disease among Aboriginal peoples, and it seems reasonable to conclude that the epidemics of obesity, heart disease, renal failure and cancer that they suffer today were largely absent prior to European settlement. Indeed, some historians have suggested that in the late 1770s Indigenous people are likely to have been healthier than European settlers. After all, they had had at least 50 000 years of a strong and intact culture, and successful adaptation to their environment. As has happened elsewhere in the world, and indeed continues today, the arrival of settlers in environments that are home to Indigenous peoples also heralded the introduction of infectious diseases such as measles that wreak havoc in previously unexposed Indigenous populations.

**Figure 1: Indigenous health status demographics**



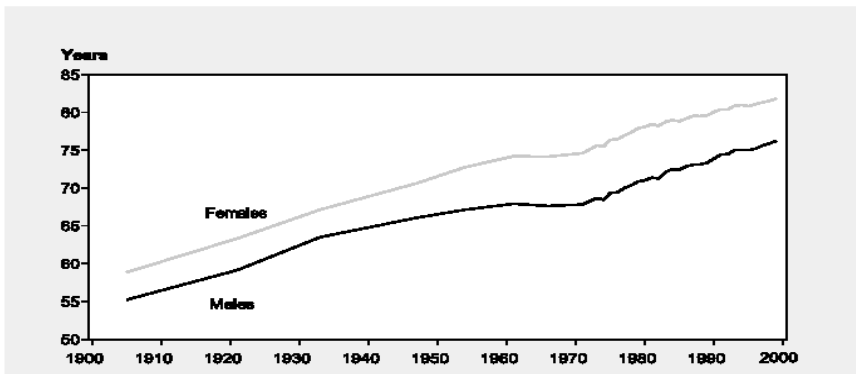
Source: ABS (1998).

So, what of health status now? Well first we must recognise that the Indigenous population is very different from the non-Indigenous population even in terms of its age distribution and location. These population pyramids show that the Indigenous population is overall much younger and has few older people. This is absolutely typical of what is seen in poor, developing countries in Africa with high birthrates, high rates of infectious (and other diseases) killing many young people, and high overall death rates. In contrast the non-Indigenous population has modest

birthrates and low mortality rates among the young, with most people surviving to old age.

Aboriginal people are distributed right across Australia, with important concentrations in urban areas, but it is in remote areas that they make up a large proportion of the population and hence tend to be more 'visible'. It is important to make a number of points. First the basic characteristics of the Australian Indigenous population are different from other Australians, and this must be taken into account when comparisons in health status are made. Second, although the Indigenous population as a whole is dramatically different from the white population in, for example, age structure and geographical distribution, nevertheless, within the Indigenous population there is also substantial variation in characteristics, risk and health status.

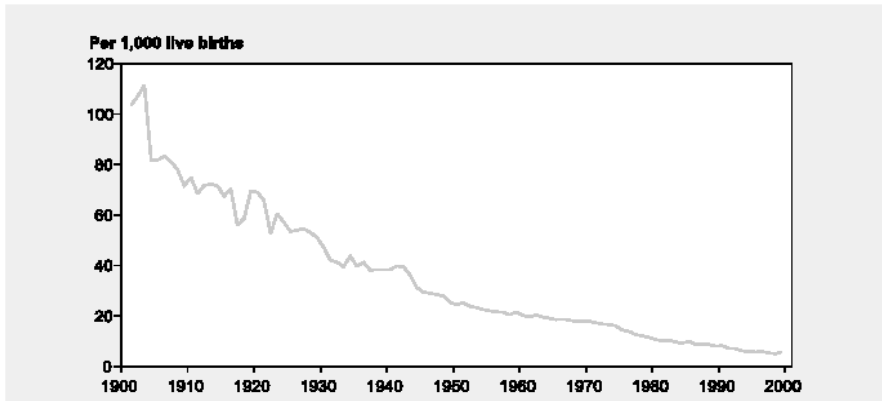
**Figure 2: Trends in life expectancy at birth, 1905 to 1999**



Source: ABS (2000).

In the last 100 years life expectancy has increased by about 20 years for the average Australian, from about 55 to 75 years for males and from about 60 to 80 years for females. These are typical of the gains experienced in other developed countries and are due to increased wealth, improved living conditions and better health services. Much of this gain is actually due to an extraordinary reduction in the infant mortality rate—the probability of death in the first year of life.

**Figure 3: Trends in infant mortality, 1901 to 1999**

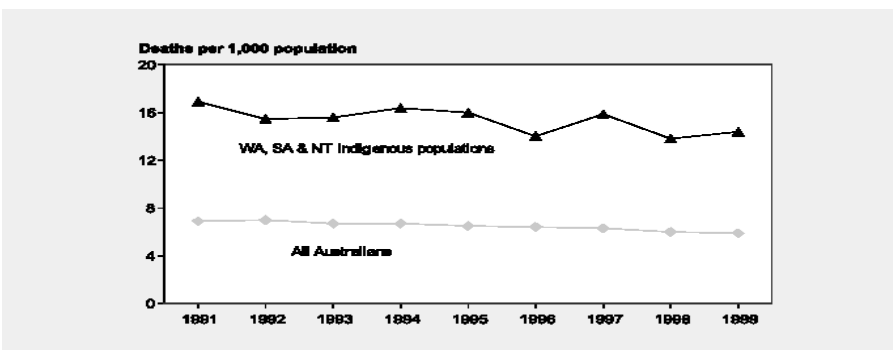


Source: ABS (2000).

Clearly by preventing a very early death, rather than delaying death by a short time in an older person, we can increase the number of years of life dramatically. As most readers will appreciate, these gains have not been shared equally around the globe, with life expectancy in many parts of Africa and Asia much lower than that in the West.

The net effect of all this is that death rates in Australia have continued to decline (with women consistently doing better than men) at levels that match those observed in developed countries across the planet.

**Figure 4: Indigenous mortality rates**



Source: Looper and Bhatia (2001: 23).

The tragedy, however, is that Indigenous Australians suffer much higher death rates than do non-Indigenous Australians. Indeed the death rate for all Australians is now 5.9/1000 per year while that for Indigenous Australians (as estimated from data collected from South Australia, Western Australia and the Northern Territory) is 14.4/1000 per year, more than twice as high. Note that, as for whites, the Indigenous death rate is higher among males than among females.

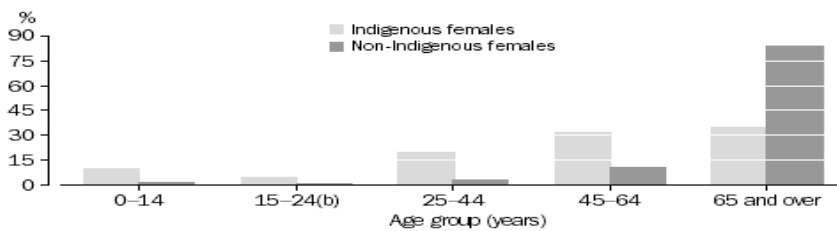
**Figure 5: Age distribution of deaths**

8.2 AGE DISTRIBUTION OF DEATHS(a), Males—1997–99



(a) Data for Queensland, South Australia, Western Australia and Northern Territory combined. Based on year of registration.  
Source: ABS data available on request, Deaths Registration Database.

8.3 AGE DISTRIBUTION OF DEATHS(a), Females—1997–99



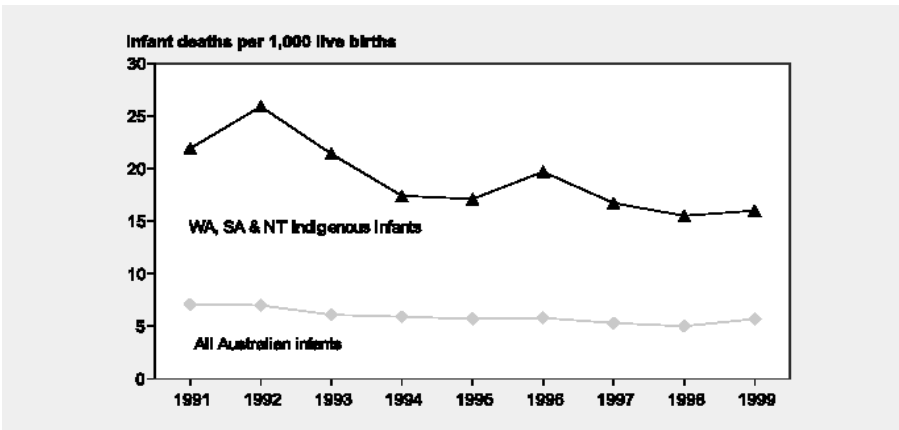
(a) Data for Queensland, South Australia, Western Australia and Northern Territory combined. Based on year of registration.  
(b) Data values for non-Indigenous females are too small to be visible on the graph.  
Source: Data available on request, ABS Deaths Registration Database.

Source: ABS (2001: 113).

These graphs add further, important, information to this sorry tale. The dark bars are the proportion of deaths in a given age group for non-Indigenous people, males at the top and females at the bottom. As you would expect the large majority of non-Indigenous people (75–80%) die over the age of 65 years, and indeed very few die in the very early years of life. In stark contrast the light bars provide data for Indigenous people and you can see that the large majority of Indigenous people actually die before the age of 65 years, with only 25–35% living beyond this age. These differences are clearly very striking and very disturbing as they speak to quite fundamental differences in life experience, risk factors for disease, and mortality experience. Note that the burden of early mortality among Indigenous

people is largely borne by young adults, but also note that the Indigenous infant mortality rate is *three times* that of non-Indigenous infants.

**Figure 6: Infant deaths per 1000 live births**



Source: Looper and Bhatia (2001: 26).

External causes of death include accidents, poisoning, murder, self-harm, suicide and so on. The rates for Indigenous men are up to 4 to 5 times higher than for non-Indigenous men, depending on age group, and the differentials are about the same for women, speaking to quite extraordinary stresses and behaviours in some Indigenous communities.

All this data can be quite overwhelming, and very depressing, so I want to move now to put a human face to these figures. I want to discuss trachoma.

Hugh Taylor, Professor of Ophthalmology in Melbourne, writes 'Trachoma is a disease that has been with us since antiquity' (Taylor 2001: 371). He explains that it is an infection caused by a bacterium called chlamydia and it is spread through overcrowded and unhygienic conditions. Trachoma came to prominence first in the armies of the Napoleonic wars in Europe. The low levels of personal and community hygiene in European urban slums at that time further provided ideal conditions for spread. It seems that trachoma was brought to Australia by early settlers and, with the heat, dirt and flies, trachoma spread rapidly.

As living conditions improved in urban and rural Australia trachoma subsequently started to disappear, as it had in Europe. However, trachoma did not disappear from Indigenous communities in the Northern Territory and central Australia. Indeed, it took Fred Hollows in the 1960s to bring this to widespread attention, and the federally funded trachoma program through the 1970s both defined the extent of the problem and successfully treated large numbers of people. A program review

by Hugh Taylor in 1996 showed that, while much progress had been made, in some areas nothing had changed at all. Indeed, of 54 countries in the world where blinding trachoma still occurs, Australia is the only developed country. This is clearly shameful. Endemic trachoma is simply a reflection of inadequate living conditions. As Hugh Taylor says,

To eliminate trachoma in Australia we need to upgrade the basic services and housing of Indigenous communities in the outback to the same minimal standard that every other Australian enjoys. This is fundamental and can only occur if the Australian community accepts the need and insists that the problem be rectified. ... This would be a good example of 'practical reconciliation'. (Taylor 2001: 372)

The key point about trachoma is that it is symptomatic of fundamental, structural inequities in Australia. But it is also a good example of what can be done to improve the situation when the effort is made.

Summarising the first part of my paper, it is clear that Aboriginal health status is dramatically worse than is the health status of other Australians. Indeed death rates are around three times higher, resulting in much reduced life expectancy. Overall there is more disease, and it occurs earlier. I would stress that, while there are some diseases (such as trachoma and rheumatic fever) that are almost exclusive to Aboriginal people, the real story is that the disease profile in the two populations is similar; there is just more of it and it occurs earlier in Aboriginal people. Many people see this as a shameful, national disgrace. It is, but it is also important to stress that this is a situation that can be changed. It does not have to be this way.

What then of health services and Aboriginal people? Well, firstly, for many Aboriginal people and communities the full range of health services, which the rest of us expect to access readily, is often very far away. Very large numbers of people live more than 100km from a hospital. This obviously reflects the reality that many Indigenous people live in small rural and remote areas that cannot support a hospital, but it also reflects the fundamental challenge of providing reasonable services to the whole population. The large majority of communities do have a community health centre. However smaller groups may live quite some distance even from a health centre, and the services provided through these health centres may be quite limited.

Let's look at staff availability. While most communities do have daily access to Aboriginal health workers and nurses, few have daily access to a doctor. Importantly, most communities have to make do with weekly or fortnightly visiting medical services. Is this enough? I would suggest not. Also, note that quite a few people have no—or very limited—access to any of these services. The picture is even worse for dentists and medical specialists, even those as necessary as obstetricians. No discrete Aboriginal communities have daily access to these. Most

rely on visiting services every three months or less, and several communities have no access at all.

What is at least as disturbing is data recently published in the *Medical Journal of Australia* by Joan Cunningham (2002). The study used routinely collected administrative data from the National Hospital Morbidity Database collected from Australian public and private hospitals between 1997 and 1998. In public hospitals Indigenous people were found to be much less likely than other patients to have a procedure done even after adjusting for various factors that might influence this. This disparity was noted for most diseases. Interestingly, this disparity was not seen in private hospitals. Cunningham concludes that there may be systematic differences in the treatment of Indigenous patients in public hospitals, including often unintentional systematic discrimination.

**Table 1: Patient encounters identified as Indigenous 1998–2000**

	Encounters for patients identified as Indigenous	Encounters for patients identified as Indigenous as a % of all state/territory encounters	Indigenous people as a % of total state/territory population
New South Wales	695	0.7	1.8
Victoria	254	0.4	0.5
Queensland	825	1.6	3.2
South Australia	265	1.1	1.6
Western Australia	509	2.2	3.2
Tasmania	33	0.5	3.4
Northern Territory	183	6.8	28.3
Australian Capital Territory	19	0.4	1.1
Australia	2783	1.0	2.2

Source: ABS (2001: 57).

Further data is presented here that seems to confirm that Indigenous people make less use of some health services. These data refer to rates of attendance at general practices and the middle column provides the proportion of all attendances that are by Indigenous people. When comparing this with the proportion of the population that is made up by Indigenous people in each state and territory you can see that in every one rates of attendance are lower than would be expected on a population basis. Overall, Indigenous people seem to make use of GPs about half as often as would be expected. This seems surprising when, with much higher levels of morbidity or illness, one would actually expect much higher levels of attendance than among the healthier white population. Further research indicates that cultural factors, as well as poor access, affect this.

**Table 2: Estimated health expenditure 1998–99**

	Ratio (a)
Through state programs	2.4
Through Commonwealth programs	
MBS/PBS benefits	0.37
Other Commonwealth programs	0.5
Total Commonwealth (b)	0.74
Through local government programs	1.78
Through non-government programs	0.23
Total recurrent expenditure	1.22

(a) Ratio is equal to Indigenous expenditure per person divided by non-Indigenous expenditure per person.

(b) Excludes grants to states and includes Indigenous-specific programs. Expenditure through government programs includes payments by patients as well as government funding of these programs.

Source: ABS (2001:46).

Table 2 shows that the ratio of health sector spending on non-Indigenous people to Indigenous people is 1.22. This means that if a dollar is spent on a non-Indigenous person, one dollar and twenty-two cents is spent on an Indigenous person. This is only a modest amount extra on a per person basis (22%) and most commentators agree that much more expenditure is needed if we are serious about trying to redress the inequalities that are so well documented. Indeed, very crudely, if mortality rates are 3 times higher among Indigenous people, maybe health spending should be 3 times higher, not 1.22 times higher?

Let us take this further, with a real life story that illustrates many of these issues. I want to read to you excerpts from the Wakely prize essay published in *The Lancet* medical journal and written by Caroline de Costa, an obstetrician in Cairns (de Costa 2001). The essay is titled ‘Flora’s legacy’.

For more than 2 years now, we have been trying to get Flora to come for colposcopy [a special examination of the cervix].

Flora’s problem first became evident when she appeared, late in her third pregnancy, at her local health clinic. She was 17 years of age then. At 14, she had had a miscarriage, and at 16, a stillbirth with no antenatal care. ... [A] Pap smear taken by the clinic nurse showed severe dysplasia [suggesting the possibility of early cancer].

That same nurse, after several attempts, located Flora at a relative’s home, and explained that she should see a doctor ... who visits

regularly from the nearest large town, some 800 km away, that she should undergo an examination of her cervix ... and probably have some simple treatment under local anaesthetic. Flora agreed to think about it. But on the day of her appointment, she failed to turn up, and could not be found by health workers; this happened again at the next visit, and the next.

By then, Flora was pregnant again. Presenting at the clinic late one Sunday evening with some bleeding, and clearly worried about her baby, she consented to another Pap smear. This showed worsening premalignant changes. She was told in no uncertain terms that she must come for treatment after this baby was born. That second child is now 6 months old, and Flora has missed two more colposcopy appointments. (de Costa 2001: 2162)

Flora lives in the vast Cape York Peninsula and, although she has moved around between communities, her medical history is all preserved in a single file. When she miscarried her first pregnancy blood samples taken at the time showed she had syphilis. The results were mailed to the clinic and included in her chart, but she was only located, and treated with penicillin, when she was pregnant again and in fact in labour with her premature stillborn son. Untreated syphilis killing unborn children is the stuff of Africa, not Australia.

Flora's records contain computer printouts of the results of her Pap smears. Indeed all the clinics in the region are now linked by a computer network so that test results are instantly accessible. Flora's need for colposcopy will flash onto the screen of every clinic in the region that she may present to, for herself or with her children. Yet despite this ready availability of technology, the fear is that her severe cervical dysplasia will become invasive cancer—and kill her—before it can be prevented. Caroline de Costa continues:

Although she lives in a remote area, Flora in many ways has been provided with excellent medical services. All the communities she has stayed in have health centres with trained nursing staff and regular visits from doctors of the Royal Flying Doctor Service, who also provide a high-quality emergency service. Specialists of many kinds visit frequently, and for surgery and other procedures, patients are flown to the larger towns. Flora has had her pregnancies assessed in her own community with a portable ultrasound machine, she has been taken by plane thousands of kilometres for the births of her babies, and a mobile colposcope is available for her cervical assessment. However, so far, these services have had almost no impact on her health. The only item that has made a demonstrable difference was the benzathine penicillin that cured her syphilis. She remains unconvinced of her need for colposcopy. ...

It seems that the provision of services, of increasingly complex technology, and of dedicated trained staff, is not in itself enough. There has to be something more. There has to be, at the least, understanding of, and willingness to use, these services.

These are surprisingly difficult concepts for those of us schooled in the 'white, western' model of health care to grasp. I know that it is not simply that Flora does not want to help herself or cannot be bothered. But I do not know what she does feel. Is it that the clinic and hospital are air-conditioned, cold, white, frightening places? That the doctors and nurses change so often? That there are always different faces—white or Asian but never Aboriginal? That they use long words that Flora does not know? That there is pain, and there are needles and other things that poke or prod her whose purpose is uncertain? Is it that she will risk this for her babies, because she can see the results, but that she cannot understand why she should do it otherwise? ... Flora, to make such decisions, must not only be able to comprehend the various options. She must believe she has a future to control. ...

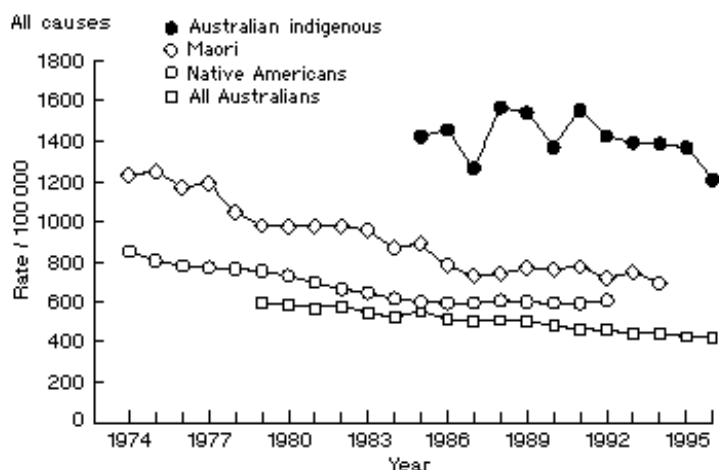
In Flora's story, the inseparable links between health and education can be easily seen. To have good health, knowledge is needed; to acquire that knowledge, one must start with good health. Flora's birth legacy—her legacy of poverty, poor housing, recurrent infection, alcohol and nicotine addiction, teenage pregnancy—has excluded her from good health and good education, and placed her on the margins, both physical and metaphorical, of our society. ...

Flora's story is simple. Deceptively so. ... Flora's experience, not unusual, is not considered the stuff of tragedy, does not have the drama of television news bulletins. Her premature death will go largely unremarked. (de Costa 2001: 2163)

This is our national tragedy.

Now, let's put this in some international context. How do we in Australia compare internationally in terms of Indigenous and non-Indigenous health differentials?

**Figure 7: Trends in directly standardised all-cause mortality rates for indigenous people in Australia, the United States and New Zealand, and for all Australians**



Source: Ring and Firman (1998).

This graph shows trends in all cause mortality in the last 20 years or so for all Australians, Aboriginal Australians, Maori and Native North Americans. As you can see, the lowest rates are enjoyed by white Australians, with Native Americans next, Maori rather worse, and Aboriginal Australians worst off. The rates for Aboriginal Australians are at least 50 per cent worse than for Maoris. Encouragingly, there is some evidence that rates are gradually falling for all these populations, but the gap between them is not closing fast enough.

**Table 3: Ratios of standardised mortality rates for Australian Indigenous people versus Maori, Native Americans and all Australians, for selected causes of death, 1990–94**

	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

Source: Ring and Firman (1998).

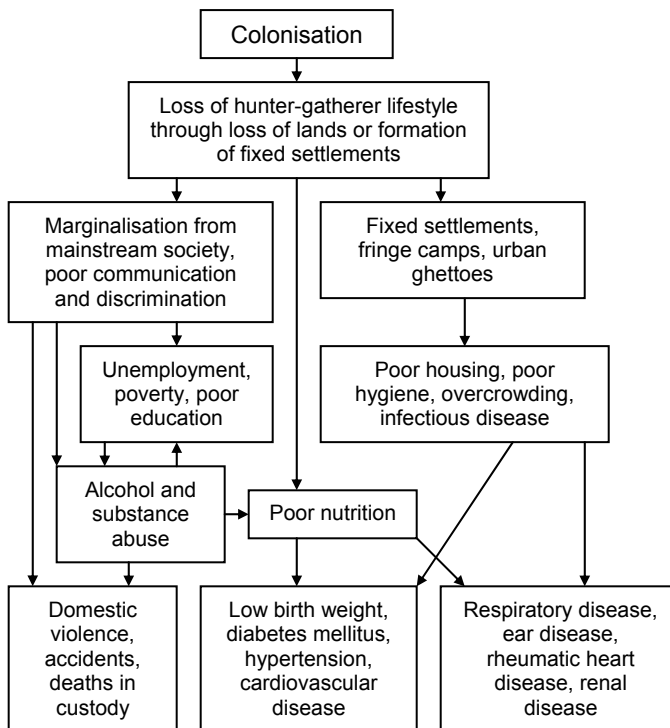
This table shows standardised mortality rates (that is, accounting for different population characteristics such as age) for these three Indigenous populations. In almost every case the rates for Aboriginal Australians are worse than for the other groups, and for some they are much worse.

The four groups of conditions that accounted for 70 per cent of total excess death in Indigenous people in Western Australia and the Northern Territory in 1992–96 were:

- circulatory conditions (including heart attack, stroke and high blood pressure)
- injury and poisoning (accidents, homicide and suicide)
- respiratory conditions (including pneumonia)
- endocrine conditions (mainly diabetes)

In each of these categories, once again Aboriginal Australians are much worse off compared with Maori and Native Americans. Indigenous people living in Australia seem to be much worse off in terms of mortality experience than Indigenous peoples in New Zealand and North America.

**Figure 8: Understanding the links between colonisation and ill-health**



Now, why is this? Why would colonisation lead to poorer health status? We need a model so that we can understand the links, if indeed we are to respond effectively. Figure 8 provides a useful model, I think. Professor John Mathews proposed it when he was at the Menzies School of Health Research in Darwin (Mathews 1998). It suggests that the primary impact of colonisation is the loss of a traditional lifestyle, loss of land, and loss of settlements. This in turn inevitably leads to marginalisation from society and, of course, displacement from traditional settlements leads to the formation of new settlements that are typically very unhealthy. These settlements are typified by overcrowding, poor housing and hygiene, and high levels of infectious diseases. Coupled with the inevitable unemployment that follows marginalisation and discrimination, poor nutrition occurs, alcohol and substance abuse becomes rampant as hope is lost, and a variety of diseases and social ills are the result. I think this is a very helpful model that clearly links colonisation to poorer health and increased mortality. Of course, over the course of a couple of hundred years it is very easy to lose the sense that these events are in fact connected. We tend to focus on what we see here and now, and forget how it has all come about. I think this model is a useful way of reconnecting events.

**Figure 9: A model for improving Aboriginal health status**

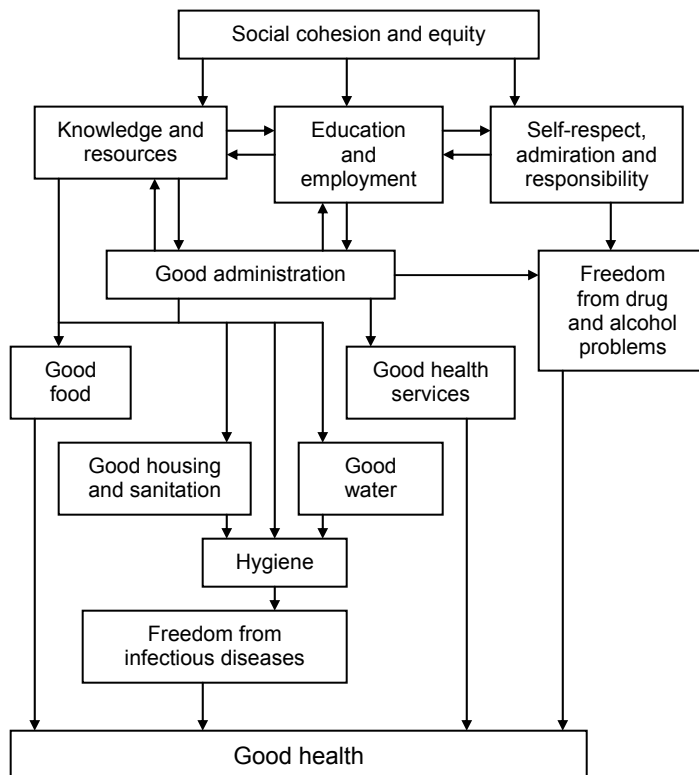


Figure 9 provides a possible model for responding to the determinants of Aboriginal ill health, and is again proposed by John Mathews (1998). The key underpinning, it is suggested, is the need for a return to social cohesion and equity. This in turn will increase education, employment levels, self-respect, responsibility and hope—a stake in the future. From there we can expect a fall in the levels of drug and alcohol abuse and, linked with better housing and sanitation and good health services, health status would improve dramatically and quickly. This model is important because it helps us understand that the responses we make need to take into direct consideration the levels of causation. A focus on one point or one level is simply inadequate—the model is just too complex. Also, by investing at a level that is further away from the root causes, we risk wasting time, money and effort. Pouring money into health services while ignoring good administration or education, or indeed social cohesion, is a recipe for failure. We absolutely must look hard at how social cohesion can be strengthened, and this is all about politics, land, power and responsibility.

I find this statement to be a useful summary of these issues:

Aboriginal health is not just the domain of the health care system. By accepting the need for an approach that is multifaceted and covers all aspects of people's lives, including housing, education, employment and social justice, we can then understand that physical and symptomatic relief of disease will not in itself redress the burden of Aboriginal ill-health. (Jackson and Ward 1999: 440)

Interestingly, the Royal Australian College of Physicians issued their Darwin Declaration in 1997 in which they state:

the health of Aboriginal and Torres Strait Islander Australians is disastrously poor ... the fundamental cause is disempowerment, due to various factors including continued dispossession from the land, cultural dislocation, poverty, poor education and unemployment.

What is so interesting here is that this statement was made five years ago, and it was made by a professional group that inevitably, and rightly, focuses on clinical medicine and health services, rather than issues like poverty and dislocation. For the college to acknowledge the reality of the root causes of Aboriginal health status is an important first step forward to a meaningful response.

In summary then, in my opinion the case for the need for reconciliation, from a health status and a health system perspective, can be summarised as follows:

- The health status of Aboriginal people is cause for national shame.

- This poor health status is rooted in the exclusion of Aboriginal people from society since 1788.
- In order to start to properly address the poor health status there needs to be a fundamental awareness of the links between social and economic status and health status, for all people.
- We also all need to acknowledge that racism, prejudice and marginalisation compound the situation.
- The only effective response will be based upon a commitment by all—including, fundamentally, government—to social, educational and economic equity for all Australians.

It has been suggested by the United Nations High Commission for Refugees, using the Van Boven principles (Van Boven 1996), that reconciliation needs the following key steps:

- First, an acknowledgement of wrongs and then a formal apology;
- Second, formal and legislated guarantees against repetition;
- Thirdly, measures of restitution are important because this acknowledges the seriousness of the wrongs and assigns a value to them. Such restitution would include monetary compensation;
- Fourth, measures of rehabilitation, which means a series of key measures designed to specifically address the imbalances and inequities that have arisen from the original wrongs.

We have yet to get past step one (a formal apology) in Australia.

It is worth recalling that South Africa used these principles in its Truth and Reconciliation Commission post-Apartheid. I was living in South Africa at that time and without doubt the TRC was an incredibly emotional experience. At times overwhelming, it was always very intense and created huge news across the country. Many doubts were expressed over the wisdom of going through that process. However, looking back, it was essential, I think, for any sort of healing to occur. Importantly, the TRC was time-limited, and so it was designed to deal with the wrongs of the past and then to move ahead into the future, without dragging things out and letting them fester unnecessarily. I think a similar sort of process in Australia might be worthy of consideration, so that we can all deal with the wrongs of the past—rather than continuing to debate whether they actually occurred—and then move ahead together in a positive way. It seems to me that, while parts of the

population might be ready for such a process, the current federal government clearly is not.

I would suggest that what we need, ideally, is a national response at three levels. The first is society-wide, government-driven reconciliation. The second is an organisation and institution-level response that deals with equal opportunity and affirmative action, and the third is at a personal level that aims to build bridges between communities, families and people. Of course, much of this sort of thing has been tried or is underway, but it is largely in a patchy way, and I think that unless there is a coordinated and integrated approach we will always be left wanting. Reconciliation, in its broadest sense, needs to be a societal and governmental priority. My deep concern is that for many Australians it just never will be.

I would like to move towards a close now, by once again turning to real life and practical examples, this time of possible solutions.

My own university department of rural health, a joint initiative of the University of South Australia and the University of Adelaide, has made a particular effort to address Aboriginal health issues over the last few years. We have adopted two key principles. The first is that whatever we do we will do in partnership and with the aim of building Indigenous capacity. To this end, we have worked with Pika Wiya Health Services in Port Augusta to employ someone to develop numerous joint projects, we have helped the health service recruit doctors, have developed joint bids for projects and tenders, and are partners in the Unique Centre of Learning that is being developed there. We are currently leading a statewide project that is providing management support to all Indigenous health and social well-being services in South Australia. Here we provide mentoring and management skills development that strengthens the capacity of these organisations to do basic business planning. Finally, cultural awareness training, field trips, and other resources have been developed, and to date several hundred health workers and health science students have undergone formal cultural awareness training.

Our second key principle is to address curative and preventive health issues concurrently. Thus, we have helped establish a dental clinic at Pika Wiya and are helping design a community dental outreach program. In Coober Pedy we have established a new medical service in the Aboriginal health service there and an explicit aspect of that work is developing local capacity with the intent of handing the service over to the local community within three years. The Adelaide University Rural Clinical School will be co-located with Pika Wiya, Coober Pedy and hopefully Ceduna Aboriginal medical services, thereby ensuring that the next generation of Australian doctors trained in this state is very aware of key Aboriginal health issues and is prepared to respond to them.

In summary, then, I have shown that Aboriginal health status is very poor compared with the health status of settlers, and that there has been little relative improvement over time. Furthermore, we compare very badly internationally. We now have a full understanding of the reasons for this inequitable situation and this includes the complex interplay between fundamental issues such as land ownership, equity and education that would traditionally not be seen by some as related to health status, and other more direct factors such as housing and the provision of health services. Although this is understood by some, it is not at all clear that we fully acknowledge it as a society, and we are certainly not responding to it in an appropriate way.

We need, I think, a more structured reconciliation process that is a very high national priority and that is fully integrated vertically and horizontally across society. But where will the drive for this come from? Hopefully, what has been described by some as an emerging black middle class, that is, against all odds, educated, healthy, employed and assertive, will provide at least some of the required drive. Hopefully too, this can help overcome the despair, sense of hopelessness, and lack of initiative evident in some Aboriginal communities.

Northern Territory Minister John Ah Kit articulated this issue so well in his recent ministerial statement. He said:

We cannot—indeed must not—continue to gild the lily about what is happening on our communities. ... Many, many Aboriginal people acknowledge that the rot lies within their own communities. The high rates of sexual assault, domestic and other violence are no more acceptable to Aboriginal people than they are to anyone else. Aboriginal people feel enormous shame at the antisocial behaviour of their countrymen and women; of drunks and beggars in the streets; and of the lack of will from so many Aboriginal people to take charge of their own lives. ... The simple fact is that it is almost impossible to find a functional Aboriginal community anywhere in the Northern Territory. ... We cannot pretend that a community is functional, when half the kids don't go to school because they have been up most of the night coping with drunken parents—or because they themselves have been up all night sniffing petrol. We cannot imagine that a community is functional when less than one in ten people can read or write; or where people are too ill through chronic disease or substance abuse to hold on to a job—let alone receive training. Or where kids are born with illnesses that have largely disappeared from most of the Third World, and those who survive into adulthood can be expected to die two decades earlier than their non-indigenous counterparts. Or where only 14 per cent of our kids reach Year 12—compared to 80 per cent of their non-indigenous brothers and sisters in the cities and major towns. (Ah Kit 2002)

Importantly, Minister Ah Kit then went on to articulate the key elements of the policy he believed could start to address some of these issues. Rooted in social justice, this policy includes the key principles of equity, equality of rights, access to essential services, access to information, and the rights to full participation in social and community decision making. He also listed a comprehensive set of actions that the new Northern Territory government will undertake, building upon the policy principles. It is clearly early days, but it seems to me that, unless Aboriginal people take full, competent control of their affairs, and unless this control consists of a firm policy base upon which practical and effective action is then built, Aboriginal health status will not improve in any meaningful way any time soon.

As the Minister said, ‘In this way, each of us will no longer talk about “them” or “the other”. Instead we will use the phrase “us Mob”—and that will include all of us’ (Ah Kit 2002).

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Hawke Institute Director: Professor Alison Mackinnon

Telephone +61 8 8302 4370

Facsimile +61 8 8302 4776

Email [alison.mackinnon@unisa.edu.au](mailto:alison.mackinnon@unisa.edu.au)

Hawke Centre Director: Ms Elizabeth Ho

Telephone +61 8 8302 0371

Facsimile +61 8 8302 0420

Email [hawke.centre@unisa.edu.au](mailto:hawke.centre@unisa.edu.au)