## 10 EFFECTIVENESS OF EXISTING HEALTH CARE PROGRAMS AND THE ADEQUACY OF WESTERN EUROPEAN-TYPE HEALTH SERVICES

268 In assessing the effectiveness of any health service, it is necessary to consider its acceptability and accessibility, the availability of funds, the environmental conditions in which it operates, and the socio-economic circumstances of its clients.

269 The Committee believes that no matter how much time, money, or well-intentioned effort is put into a health service, it will not be fully effective unless it is readily acceptable and this depends largely on the degree of sympathy and understanding the service offers.

270 The injection of increased funds for Western European-type curative health services for Aboriginals may not necessarily result in a significant improvement in the standard of Aboriginal health. The Committee's attention was drawn to the "Many Farms Project" among a Navajo population in Arizona, United States of America, where, six years after the introduction of a sophisticated Western medical service, few gains in the improvement of health had been made. Specifically, illnesses which were amenable to medication (tuberculosis and otitis media) had decreased in incidence, but the incidence of diseases caused predominantly by poor living conditions such as trachoma, gastroenteritis and pneumonia remained high, particularly among children. The Committee understands that in more recent years the emphasis in the provision of health services to the Navajo nation has been directed towards substantially increasing the participation of the local community in the design and delivery of health services. For instance, the Navajo Health Authority has developed a family

medicine program and is actively involved in training Navajo people as health workers at professional and para professional levels.

271 Health care programs have been particularly effective in reducing the prevalence of diseases such as smallpox, typhoid, diphtheria, whooping cough, malaria, measles, rubella and poliomyelitis which reached epidemic proportions among many Aboriginals in the past. However, they have not been as effective in reducing the prevalence of recurring respiratory and intestinal diseases which constitute a major health problem among Aboriginals, nor the socially related diseases such as alcoholism, trauma and venereal disease which are increasing in incidence.

272 The Committee attributes the lack of success of the present programs not only to their unacceptability to Aboriginals but also to the poor physical environment and socio-economic conditions in which many Aboriginals live. In this regard the Committee believes that the Department of Aboriginal Affairs ignored the importance of non-medical environmental factors when, in evidence to the Committee, it pointed to the ill health of Aboriginals and concluded that "health programs have generally been inadequate and inappropriate for Aboriginals."

Hospitals, General Practitioners and Specialists

273 The Committee believes that these services generally provide an effective and adequate service for those Aboriginals who are integrated into Australian society. For example, in Adelaide, of 450 Aboriginal homes visited by Aboriginal health workers it was established that less than half required assistance to use the general health services.

274 On the other hand, many other urban and traditionally oriented Aboriginals are reluctant to use conventional medical services. Factors involved in this are :

- Aboriginal apprehension of strange surroundings and procedures found in doctors' surgeries and hospitals;
- European professionals' unfamiliarity with and lack of sensitivity to Aboriginal cultural beliefs and practices;
- experience of Aboriginals of being misunderstood and discriminated against; and
- distress arising from Aboriginals' poverty and inability to pay.

The result is that often Aboriginals do not present themselves and their children for treatment and when they do present it is often very late. This strongly suggests that the health service offered is not effective or adequate as far as this group of Aboriginals is concerned.

State and Northern Territory Aboriginal Health Units

275 The State Aboriginal health services and the Northern Territory Medical Service all claim that their programs are effective and adequate where they operate. In general, they claim that their preventive programs, which involve getting out into the community, have prevented minor illnesses from becoming more serious. The following information has been provided to the Committee to support their claim that their preventive programs and curative services have contributed to an improvement in Aboriginal health :

- In New South Wales in some towns the number of Aboriginal admissions to hospital has been halved since the program began in 1973.

- In Queensland

  - the infant mortality rate of 14 Aboriginal communities where the Unit has been active, fell by 41.8% to a rate per 1000 live births of 46 between 1972-74 and 1975-76, whereas it fell in seven Aboriginal communities where there has been no health unit by only 24.6% to a rate per 1000 live births of 76.7 in the same period;

  - perinatal mortality rate per 1000 births, has been reduced from 66 to 51, or where the Aboriginal Health Program has been active there has been a reduction from 65 to 29 while the other areas show an increase from 58 to 62;

  - there is a downward trend in prevalence of discharging ears;

  - incidence of bacterial skin infections, scabies and head lice is falling;

  - severity of malnutrition and its prevalence are decreasing;

  - anaemia amongst children has been reduced in frequency and severity; and

  - hookworm and roundworm have been controlled to levels approaching eradication.

- In South Australia

  - haemoglobin surveys of Aboriginals on remote reserves show no significant anaemia;

  - the average birth weight has increased due to improve antenatal care; and

- infant death rates have shown a definite reduction while the number of births has remained constant.

- In the Northern Territory

  - T.B. and leprosy are but a fraction of the problem they were a generation ago;

  - measles, poliomyelitis and whooping cough do not occur in Aboriginal communities as a result of sustained immunisation programs;

  - V.D. has now become a major problem which can be expected to be brought under control as a result of programs currently under way;

  - as a result of access to surgical services, disease and deformities following injuries are now little more likely than anywhere else in Australia;

  - although mortality of children is still well above Australian levels, it is substantially less than it was a generation ago;

  - severe malnutrition in children is now unusual; and

  - the Aboriginal mother is no more likely to die in childbirth than a non-Aboriginal woman elsewhere in Australia following the introduction of conventional maternal health services.

276 While the Aboriginal Health Units in Western Australia and Victoria claim that there has been an improvement in Aboriginal health, they did not provide supporting data to the Committee.

277 All the State services and the Northern Territory Medical Service claim that their service would be more effective if it were not for :

- The poor physical environment in which Aboriginals live. They point out that they have no functional responsibility to provide the necessary environmental facilities and that their role is advisory only.

- Insufficient funds for the State programs. This, together with uncertainty of the future level of funds, precludes long-term planning. In particular, the Queensland Aboriginal Health Unit could employ an additional 12 health teams which would bring the number of teams to thirty-four. In New South Wales an additional $800,000 per year, an increase of about 50%, was required to maximise the effectiveness of the Service.

- Insufficient funds for and staff ceilings in the Northern Territory Medical Service. This applied to the end of 1978 when the Service was transferred to the Northern Territory Government. The present position regarding funding and staff ceilings is unknown. The constraints as they applied to the end of 1978, had particular implications for the recruitment and training of Aboriginal health workers.

278 The Committee received evidence from other sources that the States and the Northern Territory Medical Services would be more effective if it was not for :

- Public Service procedures which do not allow flexibility in the hiring and firing of staff to maximise the service to Aboriginal communities. There are problems in communication, high staff turnover, and lack of co-ordination, etc.

- Lack of sensitivity to the special problems of Aboriginals by some professional staff.

- Reluctance on the part of some professional staff to recognise the role that Aboriginal traditional healers and health workers can play in the improvement of Aboriginal health.

- Over-professionalisation of medical services that are inappropriate to the basic needs and life styles of Aboriginals.

- Trend towards centralised rather than 'in-the-field' services.

Aboriginal-Controlled Medical Services

279 The Committee was informed that medical services controlled by Aboriginals themselves are more effective than conventional departmental medical services because Aboriginals have confidence in such services, relate to them more easily and use them more frequently than they would use government services. It was argued that services which are controlled by Aboriginals :

(a) employ staff who, having been interviewed by Aboriginals themselves and being answerable to their Aboriginal employers, are likely to be genuinely interested in cross-cultural work, to be dedicated to Aboriginal causes, to have a good rapport with Aboriginal people and to stay longer in employment;

In Central Australia some non-Aboriginal employees of Aboriginal medical services spoke the languages of one or more groups fluently. They were deeply interested in Aboriginal culture, related to Aboriginals personally, worked very long hours without extra pay or concessions, and were, in addition, highly qualified in their professional fields.

(b) provide earlier first contact and so prevent minor illnesses becoming more serious;

(c) heighten the awareness and involvement of Aboriginals in their own health problems and programs as a result in part of 'peer group' pressure and word-of-mouth recommendation. This in turn promotes service utilisation and community preventive health action;

(d) are congruent with the organisational infrastructure of the community and take into account different norms and values and rates and types of change, unlike the State-wide models which are usually applied without modification to all communities regardless of differences between them;

(e) are dynamic and flexible and can be changed and restructured according to community wishes or according to residential or organisational shifts in the community, such as the movement to outstations;

(f) are immediately responsive to socio-structural and other imperatives, unhampered by the delays which often occur when decisions must be taken by a centralised, hierarchical organised body;

(g) are able to deploy European and Aboriginal staff where most needed;

(h) ensure that Aboriginal health workers can and do take an active and responsible part in the running of the health service and advance in skills and responsibility as quickly as possible;

(i) co-operate openly and with ease with the traditional healers and reintroduce indigenous medicines and health practices as an integral part of the health program;

(j) develop to serve a population which defines itself as a logical bounded unit rather than serving a unit which is defined by an outside agency and does not reflect familial, clan or tribal affiliations;

(k) allay the fears of Aboriginal people about approaching conventional health services, as outlined in paragraph 274; and

(l) expand the ambit of their activities to include preventive and educational measures, that is, to promote a life style which is conducive to the control of debilitating, infectious, parasitic and degenerative diseases.

280 The Committee was informed of problems that can arise in the operation of Aboriginal medical services :

In urban areas it was argued by some witnesses that such services may :

(a) encourage Aboriginal dependency on separate services instead of assisting them to utilise existing services, or apprising conventional services of the need to adapt to Aboriginal needs and fears. As Aboriginals become more familiar with community medical services and the latter more actively aware of their Aboriginal clients, there should be a diminishing role for special services;

(b) funds were used for services unecessary in primary health care such as mis-use of patient transport;

(c) 'peer group' pressure may prevent some individuals from making a free choice;

In remote areas it was argued by some witnesses that :

(d) institutions which attempt to bring together different tribes and clans, as at Papunya and Hermannsburg, are likely to fail because of differences between them and because traditional authority rests with each local group. Although, as stated by several witnesses, ceremonies involving large groups of people belonging to a variety of clans or tribes, are frequently held in central and northern Australia, there is no evidence which guarantees that these indigenous organisational and administrative mechanisms will or could be relied on, or allowed to operate on the same scale for an Aboriginal medical service;

(e) in many cases Aboriginals are still not sufficiently familar with, nor do they have the necessary knowledge and understanding of modern medical techniques and systems to make an informed decision on health matters which affect them;

(f) often the only people in a community with the necessary skills and knowledge are non-Aboriginal health professionals. Their advice is normally accepted and in fact control of the service rests with them and not the community;

(g) most of the grass roots health professionals who remain for considerable periods in departmental services, are just as dedicated and qualified as those employed by Aboriginal-controlled medical services, have a good rapport with Aboriginals, are fluent in languages and work long hours;

(h) many of the non-Aboriginal professional staff employed by Aboriginal medical services were not initially interviewed by the Aboriginal community concerned but transferred from another Aboriginal medical service. In addition, some non-Aboriginal staff were interviewed by non-Aboriginals employed by the Aboriginal medical service;

(i) services which are imposed from outside by pressure groups and do not arise from a genuine community need are likely to fail. Evidence was received that the three recently funded Aboriginal-controlled medical services in central Australia may reflect the aspirations and designs of non-Aboriginals or Aboriginals not closely related to the community in question. There are difficulties for non-Aboriginals to determine whether a stated decision or desire by Aboriginals is genuine and informed or whether the Aboriginals are responding favourably to a suggestion made to them. This could be because, according to Aboriginal custom, the Aboriginals are seeking to establish a relationship with the non-Aboriginal designer or decision-seeker - or simply because they have no alternative with which to make comparisons within their experience. In addition, it could be because they agree with a suggestion on the assumption that it then becomes the responsibility of the person making the suggestion to see that it is carried out;

(j) the introduction of essentially curative services which are outside the control of the State or Northern Territory health authorities, result in the fragmentation of the delivery of health care to Aboriginals. For example, in the Northern Territory five independent authorities are now involved in the direct delivery of Aboriginal health care, namely the Northern Territory Government's health service, the Central Australian Aboriginal Congress' medical service, Alice Springs, the Lyappa Congress at Papunya, the Urapuntja Council at Utopia, and the Pitjantjatjara Homelands Service in the southern regions. There are further examples in Western Australia and South Australia; and

(k) there is no comprehensive responsibility for health services in the area.

281 Aboriginal medical services are responsible to the community. All States and Northern Territory health authorities have overall constitutional responsibility for the health and maintenance of health standards in their State or Territory. While it is desirable that the expansion of existing Aboriginal medical services and establishment of future services remain flexible, the traditional constitutional areas of responsibility remain with the State or Territory, namely :

- the maintenance of medical standards;
- the delineation of responsibility for more specialised back-up services; and
- assistance in cases of epidemics or major medical emergencies.

Task Forces

282 Task forces have been used in the past in an attempt to improve the health of Aboriginals.

283 Such programs are most effective in 'one-off' situations such as the eradication or prevention of disease. The Committee was informed that task forces were successful recently in containing the spread of malaria in far north Queensland and in eradicating smallpox in the eastern part of the Northern Territory. Other areas where such an approach would be successful are the mass treatment of yaws where one injection is all that is necessary, prevention of smallpox by vaccination or the control of epidemic diseases.

284 The effectiveness of the task force approach is limited in situations which require on-going health care and an improvement in the physical environment such as respiratory infections, bowel infections and skin diseases. The current National Trachoma and Eye Health Program, described in paragraphs 43 to 52, comes within this category. This program which mass screened and mass treated and which was well received, undoubtedly brought immediate benefits to the people concerned. These benefits, however, will be eroded in the long-term unless there is extensive follow-up treatment and education programs. In any event, trachoma will not be eradicated until the physical environment is satisfactory. This is best illustrated by the fact that the current trachoma program in the Northern Territory is the latest in a series of three for the same condition since the 1950s.

285 The Committee was informed of proposals for task forces in mental health, diabetes, venereal disease and alcoholism. While such task forces would make the health authorities aware of the extent of the problem, their effectiveness is dependent on long-term care programs and a change in life style as much as anything else. For example,

diabetes requires careful management by the individual himself for the rest of his life and would not be improved by a task force approach.

286 There are problems in respect to communities arising from the task force approach. The sudden injection of a large team into a community not only completely disrupts the life of the people but the normal programs. It overtaxes the facilities and usually requires existing staff to make extra-ordinary efforts. The morale of the staff could also be affected as it may seem to them that they have failed in their task.

287 The Committee therefore considers that a cautious approach should be adopted when consideration is being given to requests to support task forces.

Evaluation

288 The Committee believes there is a need for all programs (State/Territory, Aboriginal medical services, Missions) delivering health care to Aboriginals to prove their effectiveness.

289 The House of Representatives Standing Committee on Aboriginal Affairs appointed in the 30th Parliament, was informed by the Department of Aboriginal Affairs in August 1977, that the Department recognises the need for evaluation of projects, including health programs, and it is developing a regular procedure for reviewing the progress made and determining whether such programs differ from the original expectations. It was proposed that teams visit each region at least annually to examine the majority of projects, to test whether ministerial priorities are being adhered to and whether the organisations are effective within reasonable expectations.

Aboriginals' own assessment of programs needs to be taken into account. The Committee was informed of the results of reviews of Aboriginal medical services conducted at Brisbane in 1977 and Gippsland in 1978. These reviews were more of a subjective description rather than an indepth evaluation.

290 As mentioned in paragraph 267, the three newly established Aboriginal medical services in Central Australia are being evaluated. The evaluation is in two parts with the Department of Health responsible for evaluation of the delivery of professional services, and the Department of Aboriginal Affairs responsible for evaluation of its impact upon the Aboriginal communities and its compatibility with the Government's policies of enhancing Aboriginal self-management and maintaining traditional culture to the extent sought by Aboriginal communities and individuals.

291 The Department of Health appointed an evaluation team and in November 1978 the guidelines for the evaluation were discussed by the team with the three medical services. The Department of Aboriginal Affairs had not commenced its part of the evaluation by late 1978 and it may now be difficult to carry out a satisfactory evaluation.

292 The Committee is concerned that the evaluation is being conducted by two independent organisations. It believes that there should only be one study which takes account of the requirements of the World Health Organisation's definition of health. (See paragraph 19.)

293 The Committee fully supports the evaluation of all programs as it is only by this means that the effectiveness of each can be assessed and comparisons made between the various types of programs.

294 The Committee believes that an evaluation team, which should include professionals in evaluation, health and anthropology, should be appointed to develop evaluation criteria and standardise procedures within each program so that their effectiveness can be compared.

Conclusion

295 In the absence of definitive information the Committee has not been able to make a judgment on the effectiveness of any of the various health programs discussed in this report.

296 However, the Committee believes there are advantages in both the major types of health services delivering health care to Aboriginals. The State and Northern Territory health units provide a necessary service in the provision of preventive medicine and health education. The Aboriginal-controlled medical services provide a valuable service in facilitating access to curative services, mainly because of their acceptability to the client population.

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

298 The Committee further recommends that the full range of choice of the various types of programs delivering health care to Aboriginals be maintained and, where appropriate, support increased.

# 11 ABORIGINAL SELF-DETERMINATION IN HEALTH CARE

299 Recommendations are made in this chapter for increasing Aboriginal decision-making and involvement in health care, and for planning health services to fit more closely with community health needs and the wishes of community members. The Committee believes that such changes would promote self-determination and community pride, and reduce the burden of ill health which presently besets most Aboriginal communities.

300 The recommendations are based on the Committee's belief that Aboriginals should have the fundamental right to retain their Aboriginal identity and traditionally oriented aspects of their life style, or, where they desire, to devise or adapt to new life styles. They should also have the right to determine their own future and establish their own priorities over a time span of their own choice. Aboriginal communities have the right to determine the type of health care service they require and to be involved at all levels in the design and management of curative and preventive community health programs.

## International Health Care Policy

301 The Committee's position, as outlined in the following pages, accords with contemporary directions in health care in the developing countries and among minority groups in the developed countries. A great deal of literature is now available on the potentials and pitfalls of various organisational arrangements and philosophies in health care delivery. Two themes recur in recent literature. One is that communities should, to the greatest extent possible, be responsible for their own health care. The second is that health care should be integrated with the planning and growth of related community

services and projects. The first of these themes is dealt with here. The second is discussed later in this chapter under 'Community Development'.

302 The 1977 Report of the UNICEF-WHO Joint Committee on Health Policy notes the world-wide shift which has been occurring this decade from the techno-economic 'growth-oriented' model of community development, which prevailed throughout the 1950s and 1960s, to a 'people-oriented' model, in which community members are the key resource in development. It affirms that "the group of people that make up a community have the innate collective capacity to make decisions, commit resources, and take responsibility for the conduct of activities carried out by the group". The degree to which this capacity is exercised can vary. Ideally, a community should participate "actively and meaningfully" in its own development. When the purpose and content of development originates with the people a unified sense of belonging and dignity develops. This ideal is not, however, necessarily realised. Some communities participate in development only in the sense that they are 'passive recipients' of benefits. In between these two extremes are those which "share to a limited degree in decision-making and have marginal physical interaction with the decision-makers". The report concludes that, in the area of health care delivery, the basis for the design and implementation of any primary health care activity should be the aim of meeting the community's needs. Success in this aim "calls for the involvement of community members in all stages of planning and implementation of such activities". The satisfaction of those needs, "promotes the confidence of the community for further involvement in developmental activities".

303 The Committee accepts that the approach of the UNICEF-WHO Joint Committee on Health Policy is relevant to Australia as a developed country with an Aboriginal minority requiring special needs.

304 The conclusions of the Report of the UNICEF-WHO Joint Committee on Health Policy are echoed in the recommendations of the 1978 International Conference on Primary Health Care organised by WHO and UNICEF and held in Alma-Ata, U.S.S.R. The Declaration of Alma-Ata (Appendix 24) endorsed by delegations from 134 governments, representatives of 67 United Nations organisations, and others states that "the people have the right and duty to participate individually and collectively in the planning and implementation of their health care", and that effective primary health care "requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care, making fullest use of local, national and other available resources".

305 Evidence given during this Inquiry and the visits of the Committee to Aboriginal communities, settlements and health services shows clearly that the focus of responsibility and decision-making in Aboriginal health care still lies outside most communities. The major health care networks for Aboriginal communities are designed and directed by centralised administrations which are often physically, culturally and philosophically distant from their clients. The developmental ethos of the 1950s and 1960s which included reliance on outsiders to educate and change communities and which involved the client group only as 'passive recipients' still prevails in most areas of Australia. The Aboriginals' perception that most health programs do not belong to their community and are only marginally susceptible to community influence, causes a variety

of problems from low rates of utilisation or non-compliance to distress and embarrassment, and, less commonly, aggression towards European health personnel. No program can succeed in its goals unless those goals are understood, shared and valued by its clients. Aboriginal clients are unlikely to have any real commitment to community health programs unless they have had the opportunity to define health problems, setting goals and priorities, and directing the resultant health-related activities.

306 The Committee considers that a significant change in Aboriginal health and in the suitability of health services will involve a reorientation of policy and practice such that the impetus and direction for community development can come from the inside, not the outside, of the community.

Health Services

307 Self-determination implies that Aboriginals should be given the opportunity to choose or design a health service which best suits their particular needs and available resources. These needs vary according to the size and tribal composition of communities, cultural factors, proximity to urban areas, acceptance of Western values and concepts, degree of socio-economic development and particular health problems. As described earlier in this report, there are presently a number of options available, including existing curative and preventive services offered by the States and the Northern Territory and by missions and Aboriginal-controlled medical services.

308 The Committee considers it fundamental that Aboriginal communities have access to information concerning the full range of health care options from which they might choose. This information should be clear, objective and detailed.

Thus a community may, upon considering its needs, choose to retain its present service, ask for modifications, opt for a different but existing model, or design an innovative service. Depending on the nature of the Aboriginal community and its own objectives, the community's health service model would be likely to be the composite result of a series of individual decisions about such factors as: resident doctor/no resident doctor, resident sister(s)/no resident sister(s), centralised service (at settlement)/decentralised service (settlement and outstations), mainly curative/mainly preventive/both, responsible for public health programs/not responsible for public health programs, and so forth.

309 The Committee believes that detailed information about the various options, their benefits, costs, and the means of implementing them should be provided to communities by members of an independent Task Force responsible directly to the Minister for Aboriginal Affairs. The Task Force should be small in number and consist of Aboriginal members and of non-Aboriginal members who have appropriate professional expertise and qualifications. These members would be independent of any existing services providing health care to Aboriginals. The Task Force would require sufficient administrative support to maintain a data bank of resource people and organisations (technical, medical, anthropological and other) to whom it could turn or guide Aboriginal communities for assistance in the design and implementation of community health programs. Its budget should be adequate to ensure that it could retain these people (or organisations) as consultants on behalf of the communities seeking help.

310 The Task Force should, in its operations, ensure that a community is fully informed and understands all the options open to it and that its request for a particular health service

genuinely constitutes a considered, community based decision. The costs of alternatives should be presented so communities can design the optimum service within the constraints of available funds. In traditionally oriented communities it is essential that leaders understand all the alternatives and have the opportunity to discuss their implications, and adequate time for thought and discussion is given to ensure that any decision reflects the consensus of the community.

311 The Committee recognises that this proposal requires the co-operation of the State and Northern Territory governments. To enable the Task Force to provide a full range of options it is necessary that State and Northern Territory governments and their agencies offer partial or full control of existing or expanded health services to Aboriginal communities. This would avoid any duplication arising in the provision of health services.

312 Venturing into new terrain involves many risks for those currently in positions of responsibility and few immediate rewards. However, the Committee believes risks must be taken if change is to occur and that the co-operation of relevant governments and departments is vital. Without it the number of options which a task force can offer to communities will be severely limited.

313 Under this proposal the role which existing departments would play in primary health care would vary from place to place. Where communities choose to have an independent, community based service, State and Northern Territory departments of health may continue to train Aboriginal health personnel, to maintain hospital and transport services, to undertake screening and treatment programs in consultation with communities and to

render assistance in emergencies, such as during epidemics, and supervise medical and professional standards as they do in the wider community. They would also constitute a source of advice, technical information and manpower should communities wish to consult departments, to retain, or to contract their services. They may also maintain a pool of non-Aboriginal staff who could either be employed directly by the departments or be seconded to communities. Ultimately the role of existing departments in primary health care must be worked out by each community. Some may choose to 'go it alone', others to retain services as presently offered and others to request a combination of both. For example, no community should feel constrained to seek an Aboriginal-controlled medical service as the only basis for obtaining an acceptable medical practitioner.

314 For the attainment of self-determination, the Committee recommends that Aboriginal communities be given the opportunity to determine the type of health service that will best suit their needs and available resources and that a Task Force be established to place the full range of alternative health care services before them.

315 The Committee was informed that in attaining self-determination communities will make mistakes. However, the process of learning to take charge of an entire community and its needs, is for any human group, fraught with the probability of mistakes. Learning cannot take place without these pitfalls. The Committee believes that the activities of the Task Force and implementation of its proposals for built-in evaluative procedures in all health services will minimise such mistakes. Nevertheless it emphasises the need for tolerance and assistance to Aboriginal communities which have chosen to control their own services and considers that, should problems occur, the unsought intervention of health authorities should be seen only as a

last resort. Instead all support should be readily available to help communities to surmount any problems and should not be withdrawn simply because of a downturn in expectations.

316 Evidence was presented to the Committee that there is a need to co-ordinate all current and future Aboriginal-controlled medical services. It was suggested that the Central Australian Aboriginal Congress might co-ordinate those in central Australia, that co-ordination in all areas might be the responsibility of the National Aboriginal Conference, that each National Aboriginal Conference area might have its own medical service, and that a separate Aboriginal Health Commission might be established. The Committee believes that it is inappropriate to make recommendations on these proposals because of the number of alternatives available to Aboriginal communities and the likelihood that different communities will opt for different alternatives. There is, however, a need for an exchange of views and information, and for discussion of related organisational questions. These are matters that should be considered at sponsored conferences organised at local, State and/or national levels for medical services of all types meeting the needs of Aboriginals.

Community Development

317 As stated earlier in this report, the provision of health services alone, whatever their form of organisation, will not be sufficient to have a marked effect on Aboriginal health. Any new Aboriginal health initiative must be based on a clear recognition that health and ill health are multi-factorial and are the result of the interaction of such factors as lack of water, poor housing, an unhygienic environment, insecure tenure in land whether for physical or spiritual

sustenance, domicile or economic self-sufficiency, personal stress, cultural and social disintegration, malnutrition, institutionalisation, and so on.

318 As stated in the Declaration made by the International Conference on Primary Health Care held in Alma-Ata in 1978 (Appendix 24), a national health strategy must involve co-ordinated efforts in all sectors relating to health and community development such as food, education, employment, housing, public works, and communications. At present the approach to many of the factors which influence health is piecemeal. Multiple departments and agencies, even those solely within the health care arena, are responsible for overlapping medical, social and environmental services and development. Even at the community level fragmentation of services exists. In many Aboriginal communities several organisations have been established to manage different functions, e.g. at Papunya in 1978-79, $258,000 was provided to the housing association, $431,000 for a medical service, and $689,000 for town management and public utilities. Much greater economy and effectiveness would be attained through co-ordination of all services. Comprehensive health care for Aboriginals requires a broad, integrated approach.

319 In the past many attempts to promote co-ordination have proved neither efficient nor effective. Aboriginals must appeal to a variety of departments for a variety of services, with some assistance in co-ordinating these by the Department of Aboriginal Affairs. They complain of delays, frustrations, and inaction in their attempts to elicit responses and action from large centralised organisations.

320 The problems of co-ordination are apparent to all administrators and are not likely to be ameliorated by further exhortations to departments to work together more closely and efficiently. In order to circumvent problems of co-ordination and in keeping with the policy of self-determination, the Committee suggests promoting co-ordination not at a national or State level but at the level of each community. With appropriate advice and technical expertise it would be relatively simple for a community to devise and experiment with integrated developmental programs tailored to the needs and stated priorities of each community and designed to tackle a variety of community problems in a logical manner. Such programs would have the additional advantage if arising from within communities, rather than being offered from without, of being congruent with cultural beliefs and practices and with organisation or residential constraints not readily apparent to non-Aboriginals.

321 Although it is clear that Aboriginal health cannot improve dramatically without co-ordinated action on several fronts, it is considered most practicable to promote a program of community development which is spear-headed by a 'health service' and associated public health program (water, housing, sewerage, hygiene, health education). 'Health' is a logical cornerstone for the progressive realisation of effective community self-determination for two reasons. Firstly, it is an area in which, as shown earlier in this report, there is a profound and disturbing discrepancy between Aboriginals and non-Aboriginals. Secondly, the effects of ill health resonate throughout all other areas of life, affecting the ability of the individual to learn, to work, to maintain important ceremonies and simply to mould a life style which is felt to be satisfying and meaningful. It is reasonable to expect that the process of taking control of even some domains of life will

result in greater self-confidence and self-respect which will inevitably and positively affect others, such as alcoholism and petrol sniffing. In addition, as experience in health programs in other countries has demonstrated, control of a health service is likely to heighten the awareness of Aboriginals of the precursors of community problems and to provide a collective momentum which will facilitate action on other issues.

322 Ideally, the development of a community should be under the control and management of one representative organisation. The Aboriginal Councils and Associations Act 1976 was enacted for this purpose. The Committee recognises, though, that some communities may not choose to integrate all functions under a single body and that, since the same influential individuals are likely to serve on different formal organisations, this would probably not be a problem. Communities would receive funding directly, on a community rather than sector basis, to enable them to budget, to establish priorities and then to contract the services they deem necessary either from government departments or from the private sector. In this way communities would be able to act quickly and with flexibility in taking decisions and acting on them, and their dependence on external authorities would be attenuated. Ideally, funding should be provided on an assured and long-term basis. Uncertainty in funding from year to year not only frustrates programs, but severely discourages Aboriginals from taking initiatives. Some communities will have access to independent funds, such as royalties, but for those which are entirely or partially dependent on the government purse, arrangements should be made at first instance to guarantee a specified level of recurrent funding over a period of years (e.g. a triennium), later to be developed to include capital funding.

323 Under these circumstances, while the primary aim of the Task Force would be to provide information concerning health care delivery and the merits of the various possible approaches, its role could be expanded to assist communities in identifying the major influences on health and ill health and in planning and implementing preventive and environmental programs to tackle the basic causes of physical ill health. The division which exists between curative, preventive and environmental services, all of which directly affect health, is an artificial one which results from the division of community life into functional categories (housing, water, etc.) for purposes of public administration. Communities will need help in tackling these not as discrete but as inter-related needs. It is encouraging to note the statements of the non-Aboriginal employees of the Urapuntja Health Service, who indicated to the Committee that they and their Aboriginal employers see their role as assisting in the provision of both medical and environmental requirements.

324 In view of the complexity of the issues associated with self-determination in Aboriginal health care and in wider aspects of community development, the Committee sees merit in a study into how the policy of self-determination can best be applied and realised at the community level. The Committee recommends that an inquiry be held into the implementation of the policy of self-determination as it affects community development.

# 12 ABORIGINAL INVOLVEMENT IN THE DELIVERY OF HEALTH CARE

325 The Committee found a consensus among representatives of health authorities throughout Australia that Aboriginals should participate to the greatest extent possible in their own health care programs and be consulted on all matter concerning their health. In practice, the level of such involvement is generally low. This is due in part to the lack of training programs, in part to the fact that programs, such as those for Aboriginal health workers, are limited by staff ceilings and restrictions on funds, and in part to the reluctance of health personnel, both in the field and in administrative positions, to confer greater responsibility on Aboriginals.

326 Three general categories of persons were considered in attempting to assess the degree of involvement of Aboriginals in health care; non-specialist Aboriginal community members, indigenous Aboriginal practitioners, and Western trained Aboriginal health personnel.

## Aboriginal Community Members

327 The Committee considers that Aboriginal community members (as individuals or through their representatives - leaders and council members) should be fully consulted and involved in decisions which affect their health and health care. They should, for instance, contribute significantly to decisions about the appointment of non-Aboriginal health personnel to their communities. Frequently Aboriginals have little or no say in the staffing and organisation of their services and must accept the choice of staff made by departmental officers who

are stationed elsewhere and unaware of their wishes. Aboriginals rarely feel able to request that unsatisfactory staff be transferred. It is also clear that programs and facilities are designed according to standard specifications within each State, not according to the particular needs of each community. The consultation which takes place is often rushed and does not allow Aboriginals sufficient time to consider, discuss and reach a consensus.

## Aboriginal Traditional Healers and Therapists

328 The traditional roles of Aboriginal healers and therapists (men and women)were discussed in paragraphs 177-182. Aboriginal healers provide crucial services to their communities and should therefore be recognised in their own right. The role of the healer is an amalgam of the roles of doctor, spiritual adviser and psychiatrist in Western society.

329 There should be full co-operation between them and non-Aboriginal professionals. The Committee is of the opinion that they should not be trained as health workers unless they and their communities so choose. They should not have subordinate roles in health centres or hospitals. However, should a healer ask to receive training in Western methods of treatment, health authorities should respond to this request.

330 Every effort should be made to give Aboriginal patients (those, for instance, in hospitals) access to Aboriginal healers if they so request. The Committee also considers that medical staff could be assisted in their work with Aboriginals by consulting with and learning from these individuals.

## Western Trained Aboriginal Health Personnel

### Aboriginal Health Professionals

331 There are no Aboriginal doctors, few nurses and nurse trainees, and a limited number of nurse aides. One important way of improving Aboriginal health is to have Aboriginals themselves filling these positions. It is therefore necessary that as many Aboriginals as possible be trained in these professions in the shortest time possible.

332 By comparison with developing countries and with minority groups in Western countries, such as indigenous Americans, Australian Aboriginals are grossly under-represented in the ranks of health professionals and para-professionals. The will and commitment to train indigenous people which was evidenced by the Australian Administration in Papua New Guinea prior to Independence, does not seem to have been transferred to Aboriginal Australia. Papua New Guinean doctors and health extension officers were being trained in their own country from 1960 onwards, nurses from 1958, and hospital orderlies, aid post orderlies and other health auxiliaries as early as World War II. They now constitute the core of the health manpower resources of Papua New Guinea. In Australia until recently, by contrast, there have been very few special efforts to recruit, train and assist Aboriginals to staff services to Aboriginal communities - services which have long been staffed by non-Aboriginals.

333 The training of Aboriginals as health personnel will require the complete support of training institutions and every assistance for the trainee. The Committee understands that the University of N.S.W. admits students, including Aboriginals, to its medical faculty without the normal academic entry requirements and that in special cases extra tuition is provided to

ensure that candidates succeed. While the position in the other universities is not known, the Committee believes that the assistance and support given by the University of N.S.W. is commendable. The Committee received evidence of Aboriginals who began training courses in nursing but failed to complete them. The reasons for this are many and include loneliness, lack of emotional support from their communities, lack of adequate financial support, discrimination, problems associated with visiting their home communities, and the fact that unless they are fortunate enough to train under exceptionally understanding and dedicated hospital staff, they do not receive the extra tutoring which would enable them to complete their courses.

334 The Committee believes that if Aboriginals are to be trained in these areas, recognition needs to be given to the special needs of Aboriginals and that those selected for training courses must be given every support.

335 The Committee was informed that Nhulunbuy and Katherine Hospitals had not established nurse aide training schools because they had fewer than 50 beds. The Committee considers that any regulations which stand in the way of greater access of Aboriginals to vocational training in the health professions should be reviewed immediately.

Aboriginal Health Workers

336 While some training of Aboriginal people in health care delivery commenced some 30 years ago in Missions and some government settlements, it is only in recent years that governments have taken the initiative and developed health worker training programs.

337 The training of Aboriginal health workers is being conducted by the State and Northern Territory Aboriginal health units (with about 500 in training) and by the Aboriginal medical services (about 80 in training). Training is both through formal tuition and in-service training under the supervision of non-Aboriginal staff.

338 The Committee considers that the Aboriginal Health Worker Training Program developed in the Northern Territory, should be the model upon which the State training programs are based.

339 The main features of any training program should be that :

(a) communities select their own trainees and support them. Consideration might be given within each community to the establishment of a committee which would be responsible for the interviewing and selection of trainees and for liaison with the health authority;

(b) at least one male and one female, regardless of age, be trained in each community;

(c) female health workers be given special training in obstetrics and gynaecology; and

(d) as experience is gained, greater responsibility be placed on the Aboriginal health workers with non-Aboriginals having a diminishing role. All first contact by Aboriginal health workers be achieved as soon as possible with the Sister's main responsibility being teaching and support. This change should be reflected in commensurate financial rewards for the Aboriginal health worker. Consideration should also be given to recruiting nursing sisters with the aim of preparing the Aboriginal health workers to take over the running of the health centre. In some cases this could be achieved within one or two years. Again, their financial rewards should be commensurate with 'working themselves out of a job'.

340 The Committee sees a need for a rapid increase in the number of Aboriginal health workers in training so that each community, regardless of size, has at least one person in training.

341 It is particularly important, however, especially in isolated communities, that Aboriginal health workers have access to rapid communication (air, road and radio) to seek advice and, if necessary, order evacuation.

Aboriginal Public Hygiene Officers

342 As illustrated in paragraph 161, the general standard of public health in most Aboriginal communities is unsatisfactory. Until Aboriginals themselves are given urgent training in the management, installation and maintenance of hygiene facilities and services (water supply, sewerage and sanitation and garbage disposal) and are employed expressly for this purpose, it will be difficult for communities to take responsibility for the upgrading and maintenance of environmental services and standards.

343 It is also important that training promotes the ability of public hygiene officers, in conjunction with Aboriginal health workers, to lead and educate other community members in hygiene practices and that they be given the necessary authority by their communities to enable them to carry out their duties.

344 The Committee was impressed by the role of hygiene officers in Aboriginal communities in Queensland.

### Aboriginals Employed in Hospitals

345 The number of Aboriginals employed in hospitals is very small. For example, the Committee was informed that at Nhulunbuy hospital where 60% of the patients are Aboriginal, not one Aboriginal was employed in any capacity. When Aboriginals are employed it is mainly in unskilled areas. For example, the Alice Springs hospital employs 39 Aboriginals and of these 35 are industrial staff.

346 The Committee considers that greater efforts should be made to increase the number of Aboriginals employed in hospitals. In this regard, Aboriginality should be regarded as an important qualification for employment. This is particularly the case in the support roles of interpreter (to translate and explain medical procedures and hospital routines), receptionist, social worker, nurses, nurse aides and orderlies, to ease stress experienced by Aboriginals who often find hospitals forbidding and alien places.

### Aboriginals in Planning and Administration

347 There is a great need for an increased number of Aboriginals in health planning and administration at all levels of the health care system. While Aboriginal communities may be consulted on matters that affect them, they are rarely seen as equals, let alone involved as the primary planners and managers. The reasons often given for such lack of Aboriginal involvement in planning and administration is that they lack the necessary experience and skills. The only way that experience can be obtained is through participation and the Committee believes that Aboriginals should be given every opportunity to obtain skills in management and administration.

348 The Committee considers that appropriate training in management and administration should be available throughout Australia and, in this context, welcomes the recent establishment of the Aboriginal Training and Cultural Foundation Ltd in Sydney for the training of Aboriginal community leaders.

349 One important area in which Aboriginals could be immediately involved is in policy making and the running of hospitals as members of hospital boards. This is particularly relevant where the hospital serves a population which includes Aboriginals. The Committee sees merit in a board membership of Aboriginals proportionate to the size of the Aboriginal segment of the population which the hospital serves. The Committee was told of only one Aboriginal serving on a hospital board and of one being contemplated for appointment.

350 During its visit to Queensland, the Committee was informed that the hospital at Cherbourg was under the control of the Kingaroy Hospital Board, and the hospital at Palm Island was under the control of the Townsville Hospital Board. At the time it visited these communities, the Committee was informed that there were no Aboriginals on either Board but that the appointment of one was contemplated to the Kingaroy Board. The Committee questions the effectiveness of such Boards and their ability to consider effectively and provide for the special needs and problems of the Aboriginal patients and believes that the hospitals at communities like Cherbourg and Palm Island should have their own board.

Conclusion

351 In this chapter the Committee has suggested ways and means by which Aboriginals can be involved in the delivery of health care to their people. It is only by this means that the

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

## 13 INTEGRATION OF AND CO-OPERATION BETWEEN EXISTING SERVICES

352 The Committee received considerable evidence that the effectiveness of the existing health services for Aboriginals could be improved by integration of, and greater co-operation between the services. Aspects of particular concern to the Committee are discussed below.

353 In some States there is only vertical integration within different branches of each State Department of Health. The Committee was made aware of many cases where there was no integration between various branches of the one department operating in an Aboriginal community and that each branch was responsible to its own branch head in the department's central office. In Wiluna (W.A.), for example, officers of the Medical Department and Community and Child Health Services represented different areas of responsibility of the Public Health Department, while in Cherbourg (Qld) the hospital, Aboriginal Health Program team and the Child Welfare Unit all operated independently. A different kind of example was found at Hopevale (Qld) where the operation of the Aboriginal Health Program depends on it providing its own premises while the hospital is greatly under-utilised. While it is recognised that functions vary and that there is usually co-operation on the ground between the different branches, the Committee sees advantages in the full integration of all the activities of the Department of Health in each Aboriginal community.

354 Each of the many health services operating in an Aboriginal community maintains its own patient records. The Committee sees merit in the amalgamation of these records

or, where appropriate, duplication of them provided that confidentiality and privacy are maintained.

355 While there is some consultation between the Department of Aboriginal Affairs and the States with respect to programs financed by the Department of Aboriginal Affairs such as Aboriginal medical services and alcohol rehabilitation programs, the effectiveness of these programs could be enhanced by greater consultation between the parties concerned.

## PART 'D'

## EMPLOYMENT OF PERSONNEL CONCERNED WITH ABORIGINAL HEALTH

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

Ways and means by which -

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

## 14 EMPLOYMENT OF PERSONNEL CONCERNED WITH ABORIGINAL HEALTH

356 Part 'D' of the report deals primarily with the employment of non-Aboriginal personnel by Federal, State and Territory health authorities and other non-Aboriginal organisations in the field of Aboriginal health. The employment of Aboriginal personnel in health services is discussed in Chapter 12. It is stressed that the Committee regards the employment of Aboriginals as essential to the successful design, administration and delivery of health care programs and considers that major efforts should be made towards providing them with expertise in all fields of health so that they can assume greater responsibility in this area.

357 The Committee considers there are a number of way and means by which non-Aboriginal personnel with appropriate qualifications can be encouraged to assist Aboriginals in achieving a better standard of health. It has become apparent to the Committee that, until Aboriginals can assume greater responsibility for their own health care, as discussed in Chapter 12, there is an urgent need to attract suitably motivated medical and nursing personnel to the field of Aboriginal health through the introduction and development of undergraduate and graduate courses in Aboriginal health by universities, hospitals and health authorities. The special health needs of Aboriginals should be emphasised in such programs. The Committee also considers that comprehensive orientation and in-service training programs are an essential requirement for personnel taking up appointments in Aboriginal communities, particularly in remote areas. Finally, the Committee sees a need to further compensate employees working in Aboriginal communities for the hardships they may suffer

as a result of their physical, social and cultural isolation and to provide additional incentives for personnel engaged in this specialised field of health.

Need for Special Courses on Aboriginal Health

358 Staffing problems, and particularly the initial selection of suitable personnel, arise partly from the fact that few medical personnel have more than a very basic knowledge of the special health needs of Aboriginals. From evidence received by the Committee, it is apparent that there is a need to introduce into undergraduate and graduate medical and nursing courses a component which deals with all aspects of Aboriginal health including relevant socio-cultural factors. For these courses to be realistic field work must be an integral part of the training of undergraduates. The Committee believes that funds for this purpose should be earmarked by the Tertiary Education Commission. At the present time, very few courses on Aboriginal health of suitable content or length are provided by training hospitals for nurses, or by university medical faculties and other tertiary institutions. The Committee believes it is important that adequate information on Aboriginal health be made available to various health professionals during and after their training so that those with the necessary motivation for and commitment to this field of health are better prepared to work with Aboriginals. The Committee recommends that training hospitals for nurses, university medical faculties and other tertiary institutions introduce into their curricula, both at undergraduate and graduate level, a component which deals with Aboriginal health.

Orientation and In-Service Training

359 The Committee considers it is necessary to provide comprehensive orientation and in-service training courses for

all staff taking up health appointments in Aboriginal communities, particularly in isolated areas. Such courses should aim to deal not only with the diagnosis and treatment of diseases common among Aboriginals, but also with socio-cultural aspects of the Aboriginal way of life including Aboriginal concepts of health, disease, death and the nature and history of Aboriginal/non-Aboriginal relationships. The significance of these factors to Aboriginals is discussed in Chapter 8. Programs should also aim to reduce the initial 'cultural' shock experienced by medical personnel taking up appointments, help them to understand and behave in ways acceptable to Aboriginals, and prepare them to provide health care and assistance which will also be acceptable to the Aboriginal people. Basic training in an Aboriginal language is also considered desirable and proficiency in a language should be encouraged at all levels.

360 The Committee sees considerable merit in the use of in-service training. This training takes place to a limited extent in the Northern Territory where each region has the responsibility for organising suitable programs for field staff. Medical personnel also undertake courses conducted by institutions such as the Darwin Community College and the Institute for Aboriginal Development. The courses are generally of one week's duration and are held two to three times a year. Topics covered include professional methods and techniques, cross-cultural studies and languages. The Committee believes that orientation and in-service training courses should be increased in length, scope and frequency.

361 The Committee considers that there is a need for a formal qualfication, such as a diploma or certificate, in Aboriginal health care. This could be provided by a tertiary institution such as a university or a college of advanced

education. The qualification would be open to medical, nursing and other health staff actively involved in providing health care to Aboriginals. It could be offered either at the institution, as a correspondence course, or both and would involve course work, field work and formal assessment. Such a qualification should constitute a basis for professional advancement.

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

## Remuneration, Special Allowances and Incentives

363 Benefits available to medical personnel working in remote areas include special rates of remuneration and incentives such as zone and travel allowances and special leave entitlements. The Committee has received evidence that although medical staff receive some compensation for working in remote Aboriginal communities, isolation remains the most important factor affecting the recruitment and retention of medical personnel. Medical personnel employed in traditional communities often work under difficult conditions and endure not only geographical isolation but also social and cultural isolation. They must contend not only with living in a harsh and uncomfortable physical environment and working long and irregular hours, but most overcome language barriers and cope with unfamiliar customs, beliefs and ways of life. In their attempts to provide medical care to the client population, they must be prepared to cope with a variety of emergency

situations due both to medical problems and accidents occurring as a result of fighting and excessive drinking among some Aboriginals. The equipment and assistance available to staff is often inadequate, particularly when emergencies occur and working in isolated areas often precludes discussion with medical colleagues of diagnoses and/or treatment techniques.

364 Allowances and other entitlements set by the employing agency, generally State, Northern Territory and Commonwealth Public Service Boards, which are available to medical personnel working in isolated and predominantly Aboriginal communities, are comparable to those available to employees working in isolated but essentially non-Aboriginal communities. The Committee considers that the socio-cultural isolation and difficult working conditions often experienced by medical personnel employed in remote Aboriginal communities and the adjustments demanded of them warrant increased compensation either in the determination of salaries, in the granting of special allowances and benefits such as extra leave, study or travel, or in opportunities for promotion. The Committee further considers that compensation should be provided for nursing staff who take up appointments in traditionally oriented communities on the understanding that the aim of their job is to effectively 'work themselves out of the position' by training Aboriginals to assume full responsibility for the running of health centres. These should be recognised as special categories and should not be used as a basis for arguing for extended benefits for those working in isolated areas which are predominantly non-Aboriginal.

365 In some areas nurses are entitled to special awards. For example, several years ago nursing staff employed in rural areas of the Northern Territory were promoted to the position

of Senior Sister although their seniority and experience were equivalent to the position of Sister in hospitals in larger centres. However, this promotion incentive is counteracted to some extent by the fact that Sisters employed in isolated areas are not entitled to the penalty rates available to hospital staff.

366 The Committee sees a need to develop a new approach to the employment of health personnel in remote Aboriginal communities whereby a condition of employment would be continual appraisal by the community itself, through its Council, of the employees. Ideally, this condition should ensure that only those persons prepared to relate effectively to the client population would be attracted to the appointments.

367 The Committee further believes that medical personnel employed in Aboriginal communities should be rewarded at the conclusion of their term of employment in that area for special efforts made in the performance of their duties and for maintaining a successful working relationship with the Aboriginal community. The introduction of this type of incentive should also help to overcome the problem apparent to the Committee during its visits to many communities that too often employees whose work performance and relationship with an Aboriginal community were unsatisfactory, were transferred or promoted to other positions so that poor performance in an appointment could in fact achieve the desired result for the appointee at no cost to himself but at considerable cost to the Aboriginal community concerned.

368 The Committee recommends that governments introduce special allowances and entitlements which recognise the unusual working conditions and the geographical, social and professional

isolation experienced by personnel working in predominantly Aboriginal communities in remote areas.

Staff Selection Criteria

369 Many factors affect the selection of Aboriginal health personnel including the duties of the position and characteristics of the client population. Formal academic qualifications may not be sufficient. The nature of the work, particularly in isolated communities, demands special personal attributes such as motivation, independence and self-sufficiency, the ability to adjust to a remote and unfamiliar community and the ability to understand and accept other standards and attitudes. The success of many health care programs depends largely on the capacity of personnel to respond to and work successfully with Aboriginal health workers at all levels. It is also important that they be prepared to develop a satisfactory working relationship with traditional Aboriginal practitioners based on mutural respect.

370 Personnel need to be acquainted with socio-cultural factors peculiar to Aboriginals and particulaly those which contribute to socially related illness. The training of medical personnel as community health educators is also considered necessary.

371 The high rate of staff turnover in isolated Aboriginal communities results from unsatisfactory selection procedures, pay and allowances and other conditions of employment. The continual changes in staff, staff shortages and relocation of personnel places greater strain on the remaining staff and increases their disillusionment with what they regard as management's failure to recognise the difficulties they

encounter and the importance of the services they are expected to deliver. This leads to a diminution in the effectiveness of health services and a reduction in the confidence of Aboriginals in identifying with and utilising the service.

P.M. RUDDOCK
Chairman

(Date)

APPENDIX 1

## LIST OF WITNESSES

| | |
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| ALBRECHT, Pastor P.G.E. | Private Citizen, Alice Springs, N.T. |
| AUSTIN, Mr J.R. | Director, Aboriginal Community Centre, Aboriginal Medical Service, Adelaide, S.A. |
| BAIN, Miss M.S. O.B.E. | Private Citizen, Mornington, Vic. |
| BAKER, Mr I. | Training Officer, Pitjantjatjara Traditional Homelands Health Service, Pipalyatjara, Via Alice Springs, N.T. |
| BECKETT, Dr J.R. | Anthropologist, Sydney, N.S.W. |
| BELL, Dr C.O. | Medical Officer, Special Health Services Division (Aboriginal), State Health Department, Melbourne, Vic. |
| BOURKE, Mr C.J. | Director, Centre for Research into Aboriginal Affairs, Monash University, Clayton, Vic. |
| BRANDL, Dr M.M. | Anthropologist, O'Connor, A.C.T. |
| BRISCOE, Mr G. | Acting Director, Central Australian Aboriginal Congress, Alice Springs, N.T. |
| BROWN, Professor T. | Private Citizen, Beaumont, S.A. |
| CAMPBELL, Dr C.H. | Physician-Superintendent, Alice Springs Hospital, Alice Springs, N.T. |

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| CAWTE, Professor J.E. | Fellow and International Officer, Royal Australian and New Zealand College of Psychiatrists, Sydney, N.S.W. |
| CHAPPLE, Mr A. | Assistant Commissioner, Departmental Structures Division, Public Service Board, Canberra, A.C.T. |
| CHEEK, Professor D.B. | Director, Royal Children's Hospital, Research Foundation, Melbourne, Vic. |
| COLE, Mr E.R. | Acting Assistant Commissioner, Pay Policy Branch, Public Service Board, Canberra, A.C.T. |
| COULSON, Mr C.J. | Regional Nursing Sister, Northern Territory Division, Department of Health, Alice Springs, N.T. |
| COULTHARD, Ms J. | Receptionist, Aboriginal Medical Service, Port Augusta, S.A. |
| COWLISHAW, Ms G. | Anthropologist, Darlinghurst, N.S.W. |
| CUTTER, Dr T.N. | Senior Medical Officer, Central Australian Aboriginal Medical Service, Alice Springs, N.T. |
| DAVISON, Dr R. | Medical Officer, Outside Clinics, Aboriginal and Islander Community Health Service Brisbane Ltd, South Brisbane, Qld. |
| DEVANESEN, Dr D.M. | District Medical Officer, Co-ordinator, Aboriginal Health Worker Training Program, Northern Territory Division, Department of Health, Alice Springs, N.T. |
| DICKIE, Mr L. | Field Worker, Aboriginal Medical Service, Perth, W.A. |

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| DINNELL, Sister G.P. | Private Citizen, Henley South, S.A. |
| DOBBIN, Dr M.D.H. | Co-Medical Director, Victorian Aboriginal Health Service Co-operative Ltd, Fitzroy, Vic. |
| DOWNING, Rev. J.H. | Director, Institute for Aboriginal Development, Alice Springs, N.T. |
| DUGDALE, Dr A.E. | Reader in Child Health, University Paediatric Unit, Mater Children's Hospital, Brisbane, Qld. |
| EASTWELL, Dr H.W. | Representative, Royal Australian and New Zealand College of Psychiatrists, St Lucia, Qld. |
| EDWARDS, Mr E. | Field Worker, Victorian Aboriginal Health Service Co-operative Ltd, Fitzroy, Vic. |
| ELLIOTT, Mr J.F. | Optometrist, Brisbane, Qld. |
| ESLAKE, Mr E.J. | Director, N.S.W. Section, Royal Flying Doctor Service of Australia, Sydney, N.S.W. |
| FITZGERALD, Dr R.R. | Medical Officer, Aboriginal Medical Service, Adelaide, S.A. |
| FORRESTER, Mr V.C. | Senior Vice President, Central Australian Aboriginal Congress, Alice Springs, N.T. |
| GALLACHER, Mr J.D. M.B.E. | Assistant Secretary, Northern Territory Division, Department of Education, Darwin, N.T. |
| GRAY, Mr D.A. | Anthropologist, Community and Child Health Services, Department of Public Health, Perth, W.A. |

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| GREEN, Dr A.C. | Australasian College of Dermatologists, Adelaide, S.A. |
| GRIFFITHS, Rev. M.J. | General Secretary, Australian Inland Mission, Uniting Church of Australia, Sydney, N.S.W. |
| GRUNSEIT, Dr F. | Paediatrician, Prince of Wales Children's Hospital, Randwick, N.S.W. |
| GURD, Dr C.H. | Director, Northern Territory Division, Department of Health, Darwin, N.T. |
| HAMILTON, Ms A. | Anthropologist, Department of Behavioural Sciences, Macquarie University, North Ryde, N.S.W. |
| HANLEY, Ms S. | Secretary, Koloured Kids Kompany, Eagle Heights, Qld. |
| HARRIS, Mr W.S. | Private Citizen, Aranda, A.C.T. |
| HARRISON, Sister M. | Senior Sister, Special Health Services Division (Aboriginal), State Health Department, Melbourne, Vic. |
| HAUSFELD, Dr R.G. | Medical Anthropologist, School of Public Health and Tropical Medicine, University of Sydney, N.S.W. |
| HERRIOTT, Dr B.A. | Chairman, Medical Committee, N.S.W. Section, Royal Flying Doctor Service of Australia, Sydney, N.S.W. |
| HICKS, Dr D.G. | Chairman, Medical Sub-committee, Aboriginal Medical Service, Perth, W.A. |
| HOLLIS, Mr K.J. | Assistant Commissioner, Staffing Branch, Public Service Board, Canberra, A.C.T. |

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| HOLLOWS, Associate Professor F.C. | Director, National Trachoma and Eye Health Program, Sydney, N.S.W. |
| HOLMAN, Dr L.J. | Director-General and Deputy Commissioner, Department of Public Health, Perth, W.A. |
| ISAACS, Mr R.F. | President, Aboriginal Medical Service, Perth, W.A. |
| JONES, Dr I.H. | Department of Psychiatry, University of Melbourne and St Vincent's Hospital, Melbourne, Vic. |
| JORGENSEN, Dr D.M. | Consultant Venereologist, Institute of Medical and Veterinary Science, Adelaide, S.A. |
| JOSE, Dr D.G. | Private Citizen, North Balwyn, Vic. |
| KAILIS, Professor D.G. | Private Citizen, Perth, W.A. |
| KALOKERINOS, Dr A. | Medical Officer, Aboriginal Medical Service, Redfern, N.S.W. |
| KARTINYERI, Mrs P. | Chairperson, Aboriginal Medical Service, Port Augusta, S.A. |
| KELLY, Dr K. | Medical Officer, Townsville Aboriginal and Islanders Communith Health Service, Townsville, Qld. |
| KENNEDY, Ms E. | Administrator, Townsville Aboriginal and Islanders Community Health Service, Townsville, Qld. |
| KETTLE, Matron E.S. M.B.E. | Private Citizen, Nhulunbuy, N.T. |

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| KICKETT, Mrs M. | Aboriginal Medical Worker, Aboriginal Medical Service, Perth, W.A. |
| KIRKE, Dr D.K. | Acting Assistant Director, Southern Region, Northern Territory Division, Department of Health, Alice Springs, N.T. |
| KNIGHT, Mr K.G. | Federal Secretary, Royal Flying Doctor Service of Australia, Sydney, N.S.W. |
| KOCKEN, Mr K.A.F. | Acting Assistant Secretary, Research and Overview Branch, Department of Aboriginal Affairs, Canberra, A.C.T. |
| LANGSFORD, Dr W.A. | First Assistant Director-General, Public Health Division, Department of Health, Canberra, A.C.T. |
| LAVER, Mr R.W. | Director Administration (Health Services), South Australian Health Commission, Adelaide, S.A. |
| LEWIS, Dr R.B. | Associate Executive, Synod of the Southwest, the United Presbyterian Church, United State of America. |
| LIDDLE, Mr R. | Director, Central Australian Aboriginal Congress, Alice Springs, N.T. |
| LIMMER, Dr A.N. | President, South Australian and Northern Territory Section, Royal Flying Doctor Service of Australia Inc., Adelaide, S.A. |
| MAM, Mrs P. | Administrator, Aboriginal and Islander Community Health Service Brisbane, Ltd, South Brisbane, Qld. |

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| MAM, Mr S. | Programming Officer, Aboriginal and Islander Community Health Service Brisbane Ltd, South Brisbane, Qld. |
| MARAR, Dr S. | Medical Officer, Aboriginal Medical Service, Port Augusta, S.A. |
| MAULE, Mrs L. | Registered Nurse, Aboriginal Medical Service, Port Augusta, S.A. |
| MAYERS, Mrs N.R. | Administrator, Aboriginal Medical Service, Redfern, N.S.W. |
| MITCHELL, Dr J.D. | Paediatric Gastroenterologist, Prince of Wales Children's Hospital, Randwick, N.S.W. |
| MONKS, Mrs R.L. | Social Worker, Alice Springs Hospital, Alice Springs, N.T. |
| MOODIE, Professor P.M. | Lecturer, School of Public Health and Tropical Medicine, University of Sydney, N.S.W. |
| MORICE, Dr R.D. | Department of Psychiatry, Flinders Medical Centre Bedford Park, S.A. |
| MORLAND, Mr R.F. | Senior Lecturer, Department of Social Work, Western Australian Institute of Technology, Perth, W.A. |
| MUSGRAVE, Dr I.A. | Health Officer (Aboriginal Health), Department of Health, Brisbane, Qld. |
| NAYDA, Mr L. | Chairman, Aboriginal Advancement Committee, Adelaide, S.A. |
| NGALA, Mrs G. | Aboriginal Health Worker, Angarapa Health Service, Utopia Station, Via Alice Springs, N.T. |

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| NGWARAI, Mr M. | Councillor, Angarapa Health Service, Utopia Station, Via Alice Springs, N.T. |
| PACKER, Dr A.D. | Senior Medical Officer, Aboriginal Health Unit, South Australian Health Commission, Adelaide, S.A. |
| PERKINS, Mr C.N. | First Assistant Secretary, Policy II Division, Department of Aboriginal Affairs, Canberra, A.C.T. |
| QUADROS, Dr C.F. da P. | Deputy Director, Community and Child Health Services, Department of Public Health, Perth, W.A. |
| REES, Mr A.S. | Assistant Director, Special Projects Sub-section, Department of Aboriginal Affairs, Canberra, A.C.T. |
| REFSHAUGE, Dr A. | Medical Officer, Aboriginal Medical Service, Redfern, N.S.W. |
| REID, Dr B.D. | Senior Assistant Director, Northern Territory Division, Department of Health, Darwin, N.T. |
| REID, Dr J.C. | Medical Anthropologist, Redfern, N.S.W. |
| RESER, Dr J.P. | Environmental Psychologist, Hughes, A.C.T. |
| RIOLI, Mr M. | Director, Aboriginal Medical Service, Perth, W.A. |
| ROBERTS, Dr R.W. | Director, Community and Child Health Services, Department of Public Health, Perth, W.A. |

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| ROBINSON, Mr M.V. | Co-ordinator, Special Project on Homelessness, Department for Community Welfare, Perth, W.A. |
| ROWLEY, Professor C.D. | Private Citizen, Hawker, A.C.T. |
| RUSSELL, Dr D.P. | Acting Director, Aboriginal Health and Health Centre Co-ordination, South Australian Health Commission, Adelaide, S.A. |
| SAMISONI, Dr J. | President, Aboriginal and Islander Community Health Service Brisbane Ltd, South Brisbane, Qld. |
| SAMISONI, Sister M. | Sister in Charge, Maternity and Child Health and Family Planning, Aboriginal and Islander Community Health Service Brisbane Ltd, South Brisbane, Qld. |
| SAWENKO, Mr A. | Administrative Officer/Health Educator, Angarapa Health Service, Utopia Station, Via Alice Springs, N.T. |
| SCRAGG, Dr R.F.R. | Private Citizen, Unley Park, S.A. |
| SCRIMGEOUR, Dr D.J. | Medical Officer, Pitjantjatjara Traditional Homelands Service, Pipalyatjara, Via Alice Springs, N.T. |
| SEMPLE, Mr D.L. | Senior Social Worker, Supervisor - Social, Department for Community Welfare, Perth, W.A. |
| SKUTA, Mrs N.M. | President, Gippsland and East Gippsland Aboriginal Co-operative Ltd, and Executive Member, National Aboriginal Conference, Bairnsdale, Vic. |

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| SMITH, Mr D.R. | Field Officer, Aboriginal Dental Service, Victorian Aboriginal Health Service Co-operative Ltd, Fitzroy, Vic. |
| SMITH, Mr J. | Executive Director, Eastern Goldfields Section Inc., Royal Flying Doctor Service of Australia, Kalgoorlie, W.A. |
| SMITH, Dr L.R. | Health Research Group, Australian National University, Canberra, A.C.T. |
| SMITS, Mrs M.L. | Private Citizen, Elizabeth Downs, S.A. |
| SOMERS, Ms A. | Assistant Secretary, Policy Branch, Department of Aboriginal Affairs, Canberra, A.C.T. |
| STACY, Miss S.J.G. | Private Citizen, St Kilda, Vic. |
| STOLL, Mr G. | Superintendent, Hermannsburg Mission, Via Alice Springs, N.T. |
| TAYLOR, Mr J.C. | Acting Lecturer, Department of Behavioural Sciences, James Cook University of North Queensland, Townsville, Qld. |
| THORPE, Ms M. | Office Manager, Victorian Aboriginal Health Service Co-operative Ltd, Fitzroy, Vic. |
| TOM, Dr H. | Medical Officer, Angarapa Health Service, Utopia Station, Via Alice Springs, N.T. |
| TONKINSON, Dr M.E. | Anthropologist, Garran, A.C.T. |
| TONKINSON, Dr R. | Anthropologist, Garran, A.C.T. |

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|---|---|
| TREGENZA, Mr J.D. | Administrative Officer, Pitjantjatjara Traditional Homelands Health Service, Pipalyatjara, Via Alice Springs, N.T. |
| TURNER, Dr G. | Medical Officer, Aboriginal and Islander Community Health Service Brisbane Ltd, South Brisbane, Qld. |
| UDECHUKU, Dr J. | Acting Regional Medical Officer, Eastern Goldfields Region, Community and Child Health Services, Department of Public Health, Boulder, W.A. |
| VANTHOFF, Mr G.N. | First Assistant Commissioner, Pay and Conditions Division, Public Service Board, Canberra, A.C.T. |
| VINER, The Hon. R.I. M.P. | Minister for Aboriginal Affairs, Parliament House, Canberra, A.C.T. |
| WAIT, Mrs M. | Private Citizen, Alice Springs, N.T. |
| WALKER, Mr D.B. | Chairman, Koloured Kids Kompany, Eagle Heights, Qld. |
| WALLACE, Mr C. | Senior Tutor, Social Work Department, University of Queensland, St Lucia, Qld. |
| WALTON, Mr R.G. | Assistant Director-General, Aboriginal Health Branch, Department of Health, Canberra, A.C.T. |
| WANGANEEN, Mr S.M. | Senior Field Officer, Aboriginal Community Centre, Aboriginal Medical Service, Adelaide, S.A. |

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| WARD, Dr J.A. | Senior Medical Officer, Aboriginal Health Section, Health Commission of New South Wales, Sydney, N.S.W. |
| WARD, Mrs R.M. | Secretary, Gippsland and East Gippsland Aboriginal Co-operative Ltd, Bairnsdale, Vic. |
| WATSON, Mr S. Jnr | Research and Programming Officer, Alcoholic Rehabilitation Program, Aboriginal and Islander Community Health Service Brisbane Ltd, South Brisbane, Qld. |
| WEBBER, Mr D.L. | Senior Psychologist, Woden, A.C.T. |
| WHITE, Mr N.G. | Lecturer, Department of Genetics and Human Variation, La Trobe University, La Trobe, Vic. |
| WHOP, Mr J. | Senior Behavioural Health Technician, Townsville Aboriginal and Islanders Community Health Service, Townsville, Qld. |
| WILLIAMS, Dr P.C. | Aboriginal Medical Service, Perth, W.A. |
| WILSON, Mr W.T. | Senior Project Officer (Alcohol), Research and Overview Branch, Division I, Department of Aboriginal Affairs, Canberra, A.C.T. |
| WINCH, Mrs M.J. | Private Citizen, Coolbellup, W.A. |
| WISDOM, Mr S.K. | Director, Social Policy Section, Department of Aboriginal Affairs, Canberra, A.C.T. |
| WISE, Professor P.H. | Department of Medicine, Flinders Medical Centre, Bedford Park, S.A. |

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| YARRAN, Miss L.N. | Private Citizen, Maylands, W.A. |
| YOUNG, Miss P.C. | Community Nurse Practitioner, Aboriginal Medical Service, Perth, W.A. |

APPENDIX 2

## COMMUNITIES VISITED BY THE COMMITTEE

### New South Wales

Bourke
Brewarrina

### Northern Territory

Gangan
Hermannsburg
Hooker Creek
Papunya
Port Keats
Wandawuy
Yirrkala
Yuendumu

### Queensland

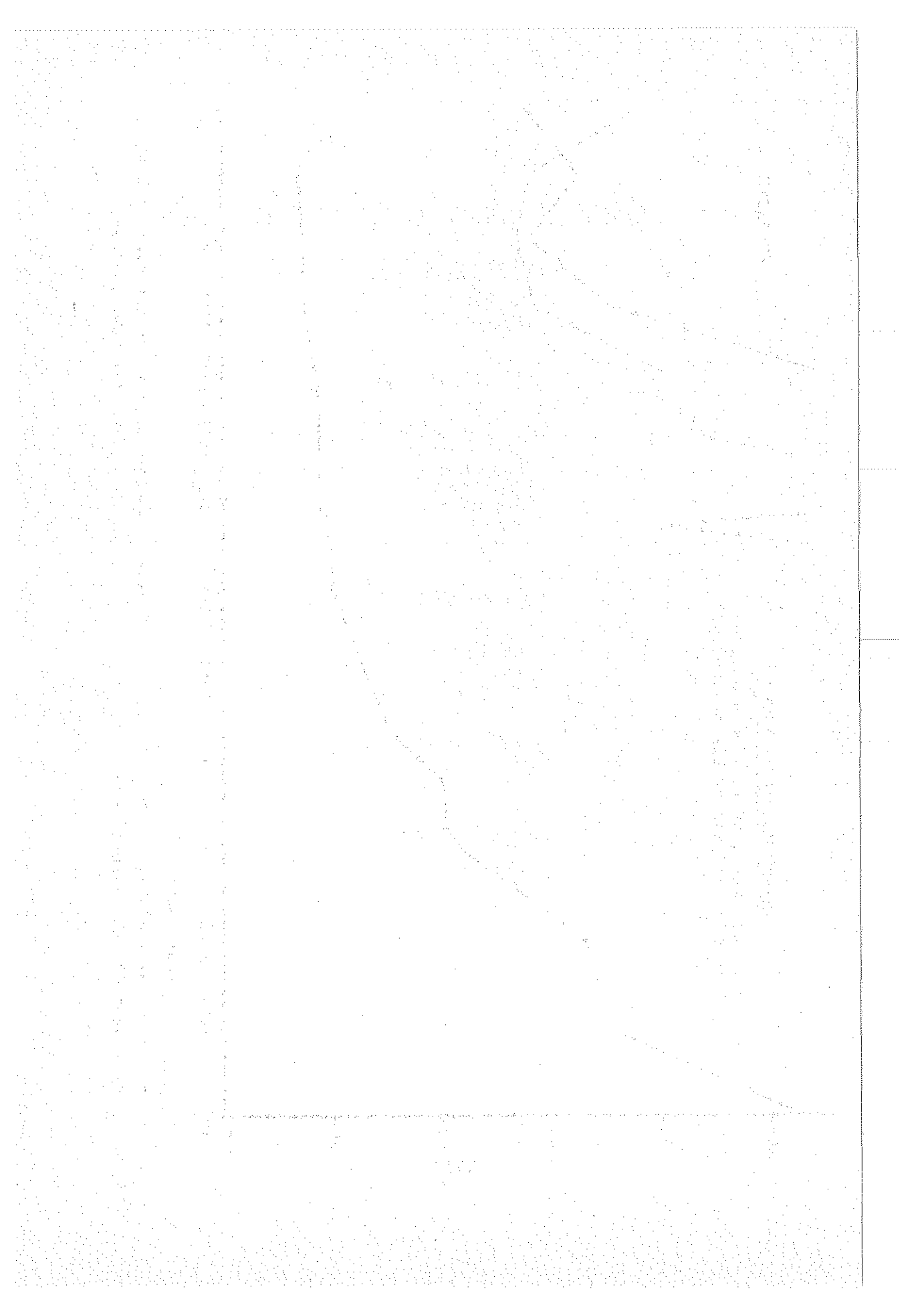
Aurukun
Cherbourg
Hopevale
Palm Island

### South Australia

Pipalyatjara

### Western Australia

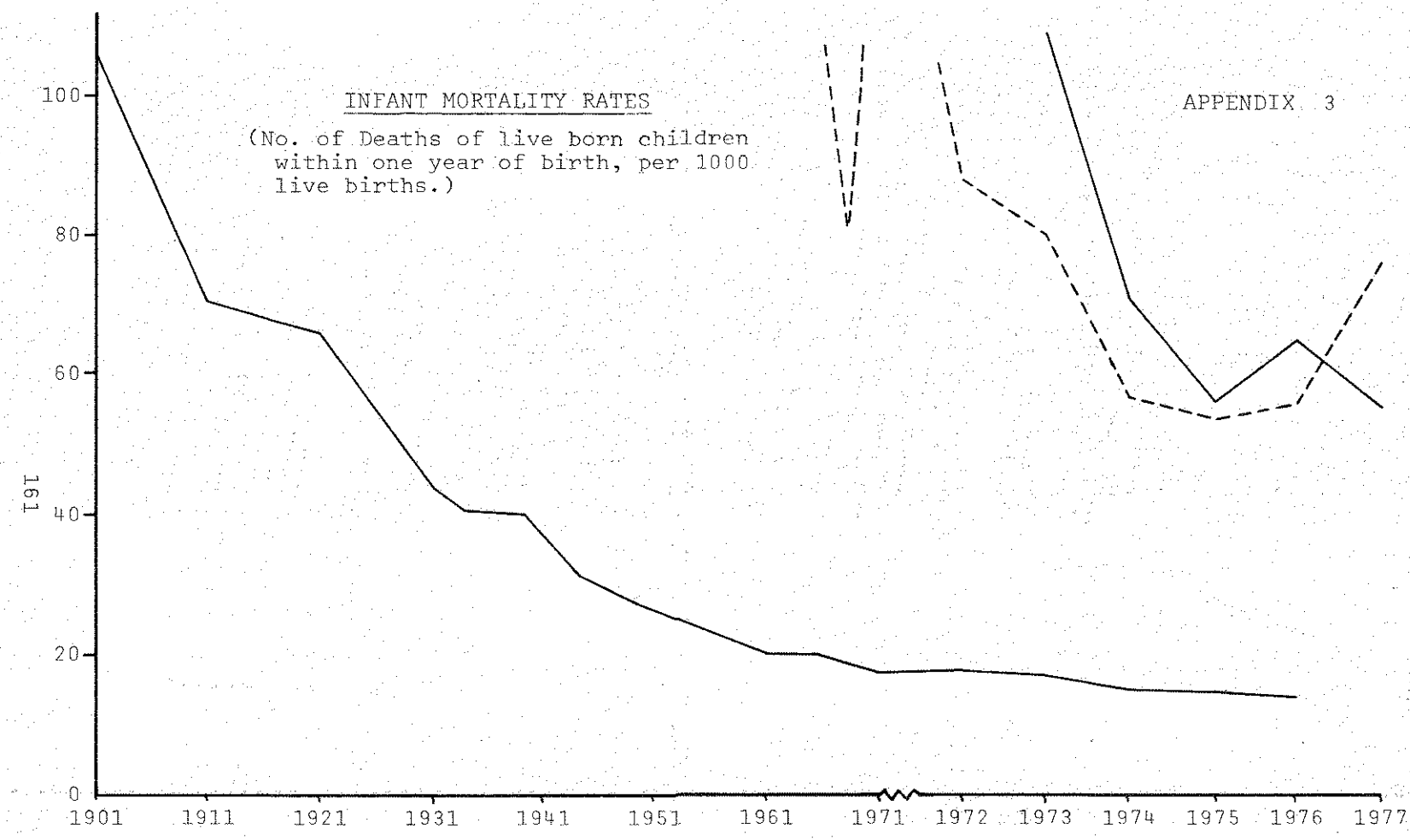
Cundeelee
Fitzroy Crossing
Kalgoorlie
Warburton
Wiluna



APPENDIX 3

# INFANT MORTALITY RATES

(No. of Deaths of live born children within one year of birth, per 1000 live births.)

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Aust. Rate

- - - - - N.T. Aboriginal rate

========= Qld Aboriginal rate

Source - Annual Reports of Director-General of Health 1974-75 - 1977-78.

APPENDIX 4

ABORIGINAL BIRTH RATES AND DEATH RATES - QUEENSLAND (a), WESTERN AUSTRALIA AND NORTHERN TERRITORY - 1973 TO 1977, TOGETHER WITH CORRESPONDING RATES FOR THE AUSTRALIAN POPULATION AS A WHOLE

Data have been drawn from a number of sources which may not be totally comparable between States, and the figures may be subject to revision.

| | 1973 | 1974 | 1975 | 1976 | 1977 |
|---|---|---|---|---|---|
| Crude birth rate(b)- | | | | | |
| Qld. .. .. .. | 37.8 | 34.5 | 32.6 | 32.3 | 29.2 |
| W.A. .. .. .. | 32.5 | 32.1 | 31.5 | 26.8 | n.a. |
| N.T. .. .. .. | 35.9 | 34.4 | 36.0 | 32.8 | 32.6 |
| Average rate(c) | 34.6 | 33.3 | 33.4 | 29.8 | 31.6 |
| Australia .. .. | 18.8 | 18.3 | 17.2 | 16.4 | |
| Crude death rate(d)- | | | | | |
| Qld. .. .. .. | 14.6 | 13.2 | 9.6 | 11.7 | 9.7 |
| N.T. .. .. .. | 12.2 | 12.1 | 13.9 | 15.8 | 13.3 |
| Average rate(c) | 12.9 | 12.4 | 12.7 | 14.6 | 12.2 |
| Australia .. .. | 8.4 | 8.7 | 8.1 | 8.1 | |
| Stillbirth rate(e)- | | | | | |
| Qld. .. .. .. | 21.5 | 42.1 | 20.6 | 25.4 | 39.8 |
| W.A. .. .. .. | n.a. | n.a. | 17.0 | 20.2 | n.a. |
| N.T. .. .. .. | 20.4 | 34.3 | 18.6 | 34.7 | 36.5 |
| Average rate(c) | 20.7 | 36.6 | 18.2 | 26.9 | 38.8 |
| Australia .. .. | 11.7 | 11.8 | 10.3 | 10.4 | |
| Neonatal mortality rate(f)- | | | | | |
| Qld. .. .. .. | 38.5 | 46.9 | 21.1 | 37.7 | 12.7 |
| N.T. .. .. .. | 31.2 | 34.3 | 23.4 | 24.0 | 42.6 |
| Average rate(c) | 33.3 | 37.9 | 22.7 | 28.0 | 34.5 |
| Australia .. .. | 11.8 | 11.6 | 10.0 | 9.9 | |
| Perinatal death rate(g)- | | | | | |
| Qld. .. .. .. | 59.1 | 87.1 | 41.3 | 62.1 | 52.0 |
| N.T. .. .. .. | 50.9 | 67.4 | 41.5 | 57.9 | 77.5 |
| Average rate(c) | 53.3 | 73.1 | 41.4 | 59.1 | 70.6 |
| Australia .. .. | n.a. | 23.3 | 20.2 | 20.2 | |
| Infant mortality rate(h)- | | | | | |
| Qld. .. .. .. | 109.9 | 70.4 | 54.2 | 66.7 | 54.1 |
| N.T. .. .. .. | 79.7 | 55.6 | 50.1 | 52.8 | 74.6 |
| Average rate(c) | 88.6 | 59.9 | 51.2 | 56.8 | 69.0 |
| Australia .. .. | 16.5 | 16.1 | 14.3 | 13.8 | |

Source : Annual Reports of the Director-General of Health 1973-78.

(a) The Queensland rates are for the following 14 communities: Aurukun, Bamaga, Bloomfield river, Cherbourg, Doomadgee, Edward river, Hopevale, Kowanyama, Lockhart river, Morington island, Palm island, Weipa south, Woorabinda and Yarrabah.

(b) The number of live born Aboriginal children per 1000 mean Aboriginal population.

(c) Average of the separate rates, weighted for the different numbers in each State or Territory.

(d) The number of Aboriginal deaths per 1000 mean Aboriginal population.

(e) The number of Aboriginal stillbirths per 1000 of all Aboriginal births, live and stillborn.

(f) The number of deaths of live born Aboriginal children within 28 days of birth, per 1000 Aboriginal live births.

(g) The number of stillbirths and neonatal deaths of Aboriginal children per 1000 total Aboriginal births.

(h) The number of deaths of live born Aboriginal children within one year of birth, per 1000 Aboriginal live births.

## INFANT MORTALITY RATE*

| | QLD** (Aboriginal) | N.T. (Aboriginal) | Australia (Total) |
|---|---|---|---|
| 1965 | | 142.7 | 18.5 |
| 1966 | | 147.3 | 18.7 |
| 1967 | | 100.0 | 18.3 |
| 1968 | | 80.9 | 17.8 |
| 1969 | | 94.8 | 17.9 |
| 1970 | | 115.1 | 17.9 |
| 1971 | | 142.9 | 17.3 |
| 1972 | | 87.0 | 16.7 |
| 1973 | 109.9 | 79.7 | 16.5 |
| 1974 | 70.4 | 55.6 | 16.1 |
| 1975 | 54.2 | 50.1 | 14.3 |
| 1976 | 66.7 | 52.8 | 13.8 |
| 1977 | 54.1 | 74.8 | |

* Number of deaths of live born children within one year of birth, per 1000 live births.

** For 14 Aboriginal communities. (See Appendix 4.)

Source : Evidence, p.1332, and Annual Reports of the Director-General of Health 1974 to 1978.

APPENDICES 6 - 11

HOSPITAL MORBIDITY, PRINCIPAL CONDITION

WESTERN AUSTRALIA AND NORTHERN TERRITORY

ABORIGINALS AND NON-ABORIGINALS

Source : Department of Aboriginal Affairs' Statistical Section Newsletter No.6.

APPENDIX 6

Hospital morbidity, principal condition, Western Australia 1971 to 1976 - Aboriginals

| ICD Categories | 1971 | 1972 | 1973 | 1974 | 1975 | 1976 |
|---|---|---|---|---|---|---|
| Infective & Parasitic | 2,524 | 2,188 | 2,275 | 2,348 | 2,205 | 2,424 |
| Neoplasms | 72 | 91 | 105 | 90 | 88 | 89 |
| Endocrine, Nutritional, Metabolic | 260 | 293 | 368 | 363 | 351 | 388 |
| Blood & Blood Forming Organs | 84 | 125 | 110 | 98 | 173 | 102 |
| Mental Disorders | 139 | 175 | 252 | 224 | 253 | 292 |
| Nervous System & Sense Organs | 1,220 | 1,203 | 1,215 | 1,194 | 1,199 | 1,301 |
| Circulatory System | 331 | 346 | 370 | 413 | 453 | 460 |
| Respiratory System | 3,094 | 3,782 | 3,691 | 3,398 | 3,624 | 3,468 |
| Digestive System | 448 | 467 | 493 | 522 | 540 | 524 |
| Genito-Urinary System | 515 | 535 | 559 | 591 | 662 | 678 |
| Pregnancy & Childbirth | 1,286 | 1,320 | 1,321 | 1,316 | 1,418 | 1,276 |
| Skin & Subcutaneous Tissue | 1,120 | 993 | 1,045 | 888 | 919 | 957 |
| Musculoskeletal System | 189 | 201 | 185 | 211 | 287 | 251 |
| Congenital Anomalies | 59 | 66 | 73 | 74 | 58 | 48 |
| Perinatal Morbidity | 75 | 50 | 60 | 48 | 72 | 63 |
| Symptons & Ill-defined Condition | 1,344 | 1,342 | 1,456 | 1,471 | 1,694 | 1,472 |
| Accidents, Poisoning, Violence | 1,868 | 2,015 | 2,220 | 2,447 | 2,473 | 2,476 |
| Supplementary Classifications | 361 | 554 | 647 | 651 | 630 | 602 |
| Total | 14,989 | 15,746 | 16,445 | 16,347 | 17,099 | 16,821 |

APPENDIX 7

Hospital morbidity, principal condition, Western Australia 1971 to 1976 - Non-Aboriginals

| ICD Categories | 1971 | 1972 | 1973 | 1974 | 1975 | 1976 |
|---|---|---|---|---|---|---|
| Infective & Parasitic | 7,158 | 8,021 | 8,495 | 7,711 | 8,500 | 8,837 |
| Neoplasms | 7,307 | 8,003 | 8,368 | 8,653 | 9,538 | 9,434 |
| Endocrine, Nutritional, Metabolic | 2,051 | 2,392 | 2,571 | 2,617 | 2,846 | 2,705 |
| Blood & Blood Forming Organs | 976 | 1,046 | 1,113 | 1,198 | 1,150 | 1,211 |
| Mental Disorders | 3,726 | 4,381 | 4,639 | 5,106 | 5,749 | 5,869 |
| Nervous System & Sense Organs | 8,266 | 9,102 | 9,689 | 10,236 | 11,234 | 11,806 |
| Circulatory System | 13,061 | 13,745 | 14,644 | 14,637 | 15,794 | 16,086 |
| Respiratory System | 22,064 | 25,919 | 27,523 | 25,592 | 26,360 | 25,292 |
| Digestive System | 19,248 | 20,157 | 20,698 | 21,532 | 22,073 | 22,445 |
| Genito-Urinary System | 19,526 | 22,039 | 20,926 | 22,551 | 24,596 | 25,884 |
| Pregnancy & Childbirth | 29,770 | 28,846 | 27,295 | 27,523 | 27,355 | 26,660 |
| Skin & Subcutaneous Tissue | 5,496 | 5,549 | 5,593 | 6,299 | 6,729 | 7,228 |
| Musculoskeletal System | 7,246 | 8,479 | 9,027 | 10,555 | 12,603 | 13,248 |
| Congenital Anomalies | 1,699 | 1,856 | 1,870 | 2,061 | 2,156 | 2,457 |
| Perinatal Morbidity | 676 | 596 | 597 | 882 | 776 | 533 |
| Symptoms & Ill-defined Condition | 13,842 | 15,045 | 16,130 | 16,100 | 17,323 | 18,796 |
| Accidents, Poisoning, Violence | 25,544 | 27,010 | 28,269 | 28,678 | 28,739 | 28,531 |
| Supplementary Classifications | 8,704 | 11,661 | 13,742 | 15,425 | 17,180 | 19,299 |
| Total | 196,360 | 213,847 | 221,189 | 227,356 | 240,701 | 246,321 |

APPENDIX 8

Hospital morbidity, principal condition, Western Australia 1971 to 1976 - Aboriginals

Rate per 1,000 population

| ICD Categories | 1971 | 1972 | 1973 | 1974 | 1975 | 1976 |
|---|---|---|---|---|---|---|
| Infective & Parasitic | 114 | 96 | 97 | 98 | 89 | 95 |
| Neoplasms | 3 | 4 | 4 | 4 | 4 | 4 |
| Endocrine, Nutritional, Metabolic | 12 | 13 | 16 | 15 | 14 | 13 |
| Blood & Blood Forming Organs | 4 | 5 | 5 | 4 | 7 | 4 |
| Mental Disorders | 6 | 8 | 11 | 9 | 10 | 12 |
| Nervous System & Sense Organs | 55 | 53 | 52 | 50 | 49 | 51 |
| Circulatory System | 15 | 15 | 16 | 17 | 18 | 18 |
| Respiratory System | 139 | 166 | 158 | 141 | 147 | 137 |
| Digestive System | 20 | 21 | 21 | 22 | 22 | 21 |
| Genito-Urinary System | 23 | 23 | 24 | 25 | 27 | 27 |
| Pregnancy & Childbirth | 58 | 58 | 56 | 55 | 57 | 50 |
| Skin & Subcutaneous Tissue | 51 | 44 | 45 | 37 | 37 | 38 |
| Musculoskeletal System | 9 | 9 | 8 | 9 | 12 | 10 |
| Congenital Anomalies | 3 | 3 | 3 | 3 | 2 | 2 |
| Perinatal Morbidity | 3 | 2 | 3 | 2 | 3 | 2 |
| Symptoms & Ill-defined Condition | 61 | 59 | 62 | 61 | 69 | 58 |
| Accidents, Poisoning, Violence | 84 | 88 | 95 | 102 | 100 | 97 |
| Supplementary Classifications | 16 | 24 | 28 | 27 | 25 | 24 |
| Total | 676 | 691 | 704 | 681 | 692 | 663 |

APPENDIX 9

Hospital morbidity, principal condition, Western Australia 1971 to 1976 - Non-Aboriginals

Rate per 1,000 population

| ICD Categories | 1971 | 1972 | 1973 | 1974 | 1975 | 1976 |
|---|---|---|---|---|---|---|
| Infective & Parasitic | 7 | 8 | 8 | 7 | 8 | 8 |
| Neoplasms | 7 | 8 | 8 | 8 | 9 | 8 |
| Endocrine, Nutritional, Metabolic | 2 | 2 | 2 | 2 | 3 | 2 |
| Blood & Blood Forming Organs | 1 | 1 | 1 | 1 | 1 | 1 |
| Mental Disorders | 4 | 4 | 4 | 5 | 5 | 5 |
| Nervous System & Sense Organs | 8 | 9 | 9 | 9 | 10 | 10 |
| Circulatory System | 13 | 13 | 14 | 13 | 14 | 14 |
| Respiratory System | 22 | 25 | 26 | 23 | 24 | 22 |
| Digestive System | 19 | 19 | 19 | 20 | 20 | 20 |
| Genito-Urinary System | 19 | 21 | 20 | 21 | 22 | 22 |
| Pregnancy & Childbirth | 29 | 28 | 26 | 25 | 24 | 23 |
| Skin & Subcutaneous Tissue | 5 | 5 | 5 | 6 | 6 | 6 |
| Musculoskeletal System | 7 | 8 | 8 | 10 | 11 | 12 |
| Congenital Anomalies | 2 | 2 | 2 | 2 | 2 | 2 |
| Perinatal Morbidity | 1 | 1 | 1 | 1 | 1 | .. |
| Symptoms & Ill-defined Condition | 14 | 14 | 15 | 15 | 15 | 16 |
| Accidents, Poisoning, Violence | 25 | 26 | 27 | 26 | 26 | 25 |
| Supplementary Classifications | 9 | 11 | 13 | 14 | 15 | 17 |
| Total | 194 | 205 | 208 | 208 | 216 | 213 |

APPENDIX 10

Hospital morbidity, principal condition, Northern Territory 1974 to 1976

| ICD Categories | Aboriginals 1974 | Aboriginals 1975 | Aboriginals 1976 | Non-Aboriginals 1974 | Non-Aboriginals 1975 | Non-Aboriginals 1976 |
|---|---|---|---|---|---|---|
| Infective & Parasitic | 430 | 432 | 476 | 355 | 321 | 275 |
| Neoplasms | 56 | 63 | 52 | 274 | 300 | 351 |
| Endocrine,Nutritional,Metabolic) Blood & Blood Forming Organs ) | 260 | 220 | 213 | 210 | 200 | 242 |
| Mental Disorders | 81 | 107 | 107 | 557 | 711 | 720 |
| Nervous System & Sense Organs | 66 | 47 | 80 | 70 | 60 | 65 |
| Circulatory System | 152 | 176 | 174 | 601 | 545 | 641 |
| Respiratory System | 711 | 666 | 813 | 1,576 | 1,237 | 1,290 |
| Digestive System | (a) | (a) | (a) | (a) | (a) | (a) |
| Genito-Urinary System | (a) | (a) | (a) | (a) | (a) | (a) |
| Pregnancy & Childbirth | 577 | 627 | 660 | 2,745 | 2,015 | 2,629 |
| Skin and Subcutaneous Tissue | (a) | (a) | (a) | (a) | (a) | (a) |
| Musculoskeletal System | (a) | (a) | (a) | (a) | (a) | (a) |
| Congenital Anomalies | (a) | (a) | (a) | (a) | (a) | (a) |
| Perinatal Morbidity | (a) | (a) | (a) | (a) | (a) | (a) |
| Symptoms & Ill-defined Condition | (a) | (a) | (a) | (a) | (a) | (a) |
| Accidents, Poisoning,Violence | 711 | 745 | 866 | 2,373 | 2,375 | 2,382 |
| Supplementary Classifications | (a) | (a) | (a) | (a) | (a) | (a) |
| Other Conditions | 1,762 | 1,660 | 2,055 | 5,544 | 5,067 | 6,645 |
| Total | 4,808 | 4,743 | 5,496 | 14,405 | 12,831 | 15,240 |

(a) Not separately defined included in "other conditions".

Hospital morbidity, principal condition, Northern Territory 1974 to 1976 APPENDIX 11

Rate per 1,000 population

| ICD Categories | Aboriginals 1974 | 1975 | 1976 | Non-Aboriginals 1974 | 1975 | 1976 |
|---|---|---|---|---|---|---|
| Infective & Parasitic | 17 | 17 | 18 | 4 | 5 | 4 |
| Neoplasms | 2 | 2 | 2 | 5 | 5 | 5 |
| Endocrine, Nutritional, Metabolic) Blood & Blood Forming Organs ) | 10 | 8 | 8 | 3 | 3 | 3 |
| Mental Disorders | 3 | 4 | 4 | 7 | 11 | 10 |
| Nervous System & Sense Organs | 3 | 2 | 3 | 1 | 1 | 1 |
| Circulatory System | 6 | 7 | 7 | 8 | 9 | 9 |
| Respiratory System | 28 | 26 | 30 | 20 | 20 | 17 |
| Digestive System | (a) | (a) | (a) | (a) | (a) | (a) |
| Genito-Urinary System | (a) | (a) | (a) | (a) | (a) | (a) |
| Pregnancy & Childbirth | 23 | 24 | 25 | 35 | 32 | 35 |
| Skin & Subcutaneous Tissue | (a) | (a) | (a) | (a) | (a) | (a) |
| Musculoskeletal System | (a) | (a) | (a) | (a) | (a) | (a) |
| Congenital Anomalies | (a) | (a) | (a) | (a) | (a) | (a) |
| Perinatal Morbidity | (a) | (a) | (a) | (a) | (a) | (a) |
| Symptoms & Ill-defined Condition | (a) | (a) | (a) | (a) | (a) | (a) |
| Accidents, Poisoning, Violence | 28 | 29 | 32 | 30 | 37 | 32 |
| Supplementary Classifications | (a) | (a) | (a) | (a) | (a) | (a) |
| Other Conditions | 70 | 64 | 77 | 70 | 80 | 89 |
| Total | 190 | 182 | 205 | 182 | 203 | 204 |

(a) Not separately defined; included in "other conditions".

APPENDIX 12

LENGTH OF STAY IN HOSPITAL - WESTERN AUSTRALIA 1971-76

AVERAGE NUMBER OF DAYS

| | Aboriginal | Non-Aboriginal |
|---|---|---|
| 1971 | 9.6 | 8.6 |
| 1972 | 9.8 | 8.2 |
| 1973 | 9.6 | 8.0 |
| 1974 | 9.7 | 7.8 |
| 1975 | 9.3 | 7.5 |
| 1976 | 9.7 | 7.6 |

Source : Extracts from Annual Reports of the Commissioner of Public Health, Western Australia.

## NORTHERN TERRITORY HOSPITALS

### LENGTH OF STAY IN HOSPITAL - NORTHERN TERRITORY 1966-67 - 1977-78

AVERAGE NUMBER OF DAYS

| | Aboriginals | Non-Aboriginals |
|---|---|---|
| 1966-67 | 19.74 | 7.95 |
| 1967-68 | 18.43 | 7.82 |
| 1968-69 | 20.08 | 7.48 |
| 1969-70 | 19.78 | 8.24 |
| 1970-71 | 21.36 | 8.14 |
| 1971-72 | 19.29 | 7.23 |
| 1972-73 | 14.96 | 7.51 |
| 1973-74 | 11.78 | 7.87 |
| 1974-75 | 12.40 | 6.44 |
| 1975-76 | 10.51 | 6.45 |
| 1976-77 | 10.64 | 6.21 |
| 1977-78 | 11.72 | 5.95 |

Source : Unpublished, supplied by Statistical Section, Northern Territory Department of Health.

APPENDIX 14

QUEENSLAND

AVERAGE PERCENTAGE OF TOTAL CASES (INPATIENTS AND OUTPATIENTS) FOR THE 10 MOST PREVALENT CONDITIONS FOR ALL AGES FOR 14 ABORIGINAL COMMUNITIES AND MISSIONS (a) - 1976, 1977

| Condition | % of Total Cases | |
|---|---|---|
| | 1976 | 1977 |
| All Other Conditions Seen | 22 | 25.9 |
| Other Trauma | 13 | 15.0 |
| U.R.T.I.'s including Influenza, Colds, Tonsillitis, Sinusitis, Pharyngitis etc. | 17 | 14.1 |
| Bacterial Skin Infections e.g. Impetigo, Boils, Cellulitis, Secondary Infection of Tinea or Scabies | 14 | 11.5 |
| Discharging Ears | 6 | 4.6 |
| Acute Diarrhoea including Gastro-enteritis and other acute enteric infections | 6 | 4.4 |
| Acute Chest Infections including Pneumonia, Bronchitis etc. | 4 | 4.2 |
| Discharging Eyes or Conjunctivitis | 2 | 1.9 |
| Anaemia | 1 | 1.9 |
| Primary Fungal Skin Infections e.g. Tinea, Monila | 2 | 1.8 |

(a) Aurukun, Bamaga, Bloomfield river, Cherbourg, Doomadgee, Edward river, Hopevale, Kowanyama, Lockhart river, Mornington island, Palm island, Weipa south, Woorabinda and Yarrabah.

No returns for Yarrabah in 1976 and Aurukun for 1976 and 1977.

Source : Extracted from Evidence, p.1939.

PERCENTAGE OF TOTAL HOSPITAL ADMISSIONS FOR ABORIGINALS TO SEVEN HOSPITALS[a] BY MAJOR DIAGNOSIS[b] - NEW SOUTH WALES JULY-DECEMBER 1976

| Diagnosis | % of Total Admissions |
|---|---|
| Upper and Lower Respiratory Tract Infection | 22.3 |
| Obstructive Airways Disease | 8.4 |
| Gastro-intestinal Infections and Diarrhoea | 6.2 |
| Head Injuries, Other Injuries and Burns | 5.3 |
| Fractures and Dislocations | 4.2 |
| Alcohol-related Problems | 4.0 |
| Otitis Media | 2.7 |
| Normal Deliveries | 2.6 |
| Skin Infections | 2.4 |
| Complications of Pregnancy | 2.0 |
| Motor Vehicle Accidents | 1.6 |
| Hypertension and Hypertensive Heart Disease | 1.5 |
| Homicide and Injury Deliberately by Another Person | 1.3 |
| Neuroses and Psychoses | 1.2 |
| Coronary Artery Disease | 1.2 |
| Complications of Delivery | 1.1 |
| Drug Side Effects | 1.1 |
| Vitamin Deficiencies | 1.0 |

(a) Bourke, Brewarrina, Wilcannia, Nowra, Moree, Kempsey and Walgett.

(b) All diagnoses which account for 1% and above of total admissions.

Source : Extracts : 1976-77 Annual Report, Aboriginal Health Program, Health Commission of New South Wales.

APPENDIX 16

Method of water supply to Aboriginal communities (a), second half of 1977

| State or Territory | Most extensively used source | | | | |
|---|---|---|---|---|---|
| | Piped from mains | Piped from rain water tanks | Piped from well or other source (b) | Other or no source | Total |
| New South Wales(c) | | | | | |
| - communities | 107 | 6 | 13 | 4 | 130 |
| - population | 21,450 | 543 | 1,719 | 312 | 24,024 |
| Victoria | | | | | |
| - communities | 20 | 4 | .. | .. | 24 |
| - population | 3,036 | 155 | .. | .. | 3,191 |
| Queensland | | | | | |
| - communities | 114 | 6 | 31 | 9 | 160 |
| - population | 38,043 | 577 | 7,698 | 528 | 46,846 |
| South Australia | | | | | |
| - communities | 10 | 1 | 9 | 7 | 27 |
| - population | 2,615 | 388 | 1,242 | 616 | 4,861 |
| Western Australia | | | | | |
| - communities | 70 | 2 | 36 | 11 | 119 |
| - population | 14,210 | 191 | 6,211 | 1,249 | 21,861 |
| Tasmania | | | | | |
| - communities | 5 | 2 | .. | .. | 7 |
| - population | 1,034 | 111 | .. | .. | 1,145 |
| Northern Territory | | | | | |
| - communities | 34 | 1 | 101 | 72 | 208 |
| - population | 8,105 | 20 | 11,080 | 3,964 | 23,169 |
| Australia | | | | | |
| - communities | 360 | 22 | 190 | 103 | 675 |
| - population | 88,493 | 1,985 | 27,950 | 6,669 | 125,097 |

(a) Excluding communities in Sydney, Melbourne, Brisbane, Adelaide, Perth and Hobart.

(b) Including bore water sources.

(c) Including the Australian Capital Territory.

Source : Department of Aboriginal Affairs' Statistical Section Newsletter No.5.

APPENDIX 17

Method of sewerage disposal in Aboriginal communities (a), second half of 1977

| State or Territory | Most extensively used method | | | | |
|---|---|---|---|---|---|
| | Flush toilets | | Sanitary pan collection | Other or no method | Total |
| | Public sewerage | Individual systems(b) | | | |
| N.S.W. (c) | | | | | |
| - communities | 62 | 41 | 12 | 15 | 130 |
| - population | 16,814 | 3,949 | 2,238 | 1,023 | 24,024 |
| Victoria | | | | | |
| - communities | 14 | 10 | .. | .. | 24 |
| - population | 2,560 | 631 | .. | .. | 3,191 |
| Queensland | | | | | |
| - communities | 54 | 40 | 51 | 15 | 160 |
| - population | 26,478 | 6,539 | 12,846 | 983 | 46,846 |
| South Australia | | | | | |
| - communities | 7 | 9 | .. | 11 | 27 |
| - population | 1,923 | 1,709 | .. | 1,229 | 4,861 |
| Western Australia | | | | | |
| - communities | 19 | 73 | 1 | 26 | 119 |
| - population | 5,530 | 12,008 | 151 | 4,172 | 21,861 |
| Tasmania | | | | | |
| - communities | 3 | 3 | .. | 1 | 7 |
| - population | 916 | 175 | .. | 54 | 1,145 |
| Northern Territory | | | | | |
| - communities | 20 | 38 | 28 | 122 | 208 |
| - population | 6,184 | 8,142 | 1,193 | 7,650 | 23,169 |
| Australia | | | | | |
| - communities | 179 | 214 | 92 | 190 | 675 |
| - population | 60,405 | 33,153 | 16,428 | 15,111 | 125,097 |

(a) Excluding communities in Sydney, Melbourne, Brisbane, Adelaide, Perth and Hobart.

(b) Including septic tank systems.

(c) Including the Australian Capital Territory.

Source : Department of Aboriginal Affairs' Statistical Section Newsletter No.5.

APPENDIX 18

Method of electricity supply to Aboriginal communities (a), second half of 1977

| State or Territory | Connected to power lines | | Locally generated only | Not avail -able | Total |
|---|---|---|---|---|---|
| | Some dwellings | Most dwellings | | | |
| N.S.W. (b) | | | | | |
| - communities | 11 | 107 | 1 | 11 | 130 |
| - population | 2,131 | 21,148 | 115 | 630 | 24,024 |
| Victoria | | | | | |
| - communities | .. | 24 | .. | .. | 24 |
| - population | .. | 3,191 | .. | .. | 3,191 |
| Queensland | | | | | |
| - communities | 9 | 111 | 9 | 31 | 160 |
| - population | 854 | 39,577 | 3,632 | 2,782 | 46,845 |
| South Australia | | | | | |
| - communities | 3 | 12 | 5 | 7 | 27 |
| - population | 460 | 3,032 | 842 | 527 | 4,861 |
| Western Australia | | | | | |
| - communities | 6 | 71 | 22 | 20 | 119 |
| - population | 1,666 | 13,673 | 4,160 | 2,362 | 21,861 |
| Tasmania | | | | | |
| - communities | .. | 4 | 3 | .. | 7 |
| - population | .. | 980 | 165 | .. | 1,145 |
| Northern Territory | | | | | |
| - communities | 13 | 29 | 35 | 131 | 208 |
| - population | 3,662 | 9,169 | 4,900 | 5,438 | 23,169 |
| Australia | | | | | |
| - communities | 42 | 358 | 75 | 200 | 675 |
| - population | 8,774 | 90,770 | 13,814 | 11,739 | 125,097 |

(a) Excluding communities in Sydney, Melbourne, Brisbane, Adelaide, Perth and Hobart.

(b) Including the Australian Capital Territory.

Source : Department of Aboriginal Affairs' Statistical Section Newsletter No.5.

APPENDIX 19

Shelter in Aboriginal communities (a), second half of 1977

| State or Territory | Type of private dwelling(b) | | | | |
|---|---|---|---|---|---|
| | House, flat or unit | Improvised dwelling (c) | Mobile dwelling (d) | Other | Total |
| N.S.W.(e) | 2,998 | 457 | 110 | 4 | 3,569 |
| Victoria | 959 | 29 | 48 | .. | 1,036 |
| Queensland | 6,308 | 647 | 131 | 10 | 7,096 |
| South Australia | 482 | 290 | 17 | .. | 789 |
| Western Australia | 1,766 | 1,121 | 76 | 84 | 3,047 |
| Tasmania | 267 | 3 | 4 | 11 | 285 |
| Northern Territory | 1,466 | 2,135 | 52 | 39 | 3,692 |
| Australia | 14,246 | 4,682 | 438 | 148 | 19,514 |

(a) Excluding communities in Sydney, Melbourne, Brisbane, Adelaide, Perth and Hobart.

(b) Excluding non-private dwellings such as hostels, boarding houses, boarding schools, shearers' or stockmens' quarters, homes for aged people, communal quarters, prisons, hospitals and mental institutions.

(c) Wiltja, lean-to, shed, shanty, car-body, etc. By no means all Aboriginal families not in European-style housing in fact wish to be so housed. This particularly applies to centres from which Aboriginals are moving to outstations, apparently wishing to pursue a more traditional way of life, and in outstations themselves. The numbers of improvised dwellings in use is therefore not a measure of housing need.

(d) Caravan, car or bus. Car-bodies are included with improvised dwellings.

(e) Including the Australian Capital Territory.

Source : Department of Aboriginal Affairs' Statistical Section Newsletter No.5.

## OUTLAY ON ABORIGINAL AFFAIRS BY THE COMMONWEALTH GOVERNMENT

Total expenditure (a) under functional headings

$'000

| | Housing (b) | Health | Education (c) | Economic services (d) | Legal Aid | Other (e) | Total (f) |
|---|---|---|---|---|---|---|---|
| 1968-69 | 2,297 | 510 | 1,198 | 24 | .. | 4,766 | 8,796 |
| 1969-70 | 3,330 | 644 | 2,104 | 685 | .. | 7,186 | 13,949 |
| 1970-71 | 4,906 | 643 | 4,117 | 1,100 | 24 | 7,996 | 18,786 |
| 1971-72 | 6,258 | 1,408 | 5,090 | 1,796 | 28 | 8,019 | 22,599 |
| 1972-73 | 13,663 | 3,055 | 9,059 | 9,443 | 638 | 12,919 | 48,776 |
| 1973-74 | 24,797 | 9,355 | 12,687 | 13,600 | 1,190 | 21,307 | 82,936 |
| 1974-75 | 40,038 | 12,332 | 16,277 | 26,885 | 2,582 | 28,168 | 126,282 |
| 1975-76 | 45,301 | 16,711 | 20,817 | 37,009 | 3,746 | 27,291 | 150,875 |
| 1976-77 | 38,832 | 15,594 | 22,303 | 27,056 | 3,711 | 22,619 | 130,115 |
| 1977-78 | 36,246 | 17,633 | 26,881 | 32,442 | 3,890 | 22,821 | 140,911 |

(a) Excludes, as far as possible, expenditure on services to Aboriginals which are delivered as an integral part of services to the wider community. The figures in this table are aggregates of expenditure under appropriations which refer specifically to Aboriginal affairs, but excluding expenditure on salaries, administration, conferences and seminars. The figures shown include expenditure on the National Aboriginal Education Committee and on Torres Strait transport and communications, and investments by the Aboriginal Enterprises Fund in Aboriginal companies.

(b) Includes expenditure on hostels.

(c) Comprising education and training purposes.

(d) Comprising employment, enterprises, town management and public utilities purposes.

(e) Including expenditure by the Department of Construction for the Department of Aboriginal Affairs, general welfare and support expenditure in the Northern Territory, research expenditure, and expenditure on cultural, recreational and sporting activities.

(f) Discrepancies between sums of components and totals are due to rounding.

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Source : Unpublished, provided by and subject to revision by the Department of Aboriginal Affairs.

## GRANTS TO THE STATES FOR ABORIGINAL HEALTH

| | N.S.W. | VIC. | QLD* | W.A. | S.A. | TAS. | TOTAL |
|---|---|---|---|---|---|---|---|
| | $m | $m | $m | $m | $m | $m | $m |
| 1972-73 | 0.4 | 0.03 | 1.2 | 0.9 | 0.3 | 0.01 | 2.9 |
| 1973-74 | 1.0 | 0.1 | 2.2 | 4.1 | 1.0 | 0.01 | 8.3 |
| 1974-75 | 1.3 | 0.2 | 2.0 | 6.1 | 1.0 | 0.02 | 10.6 |
| 1975-76 | 1.7 | 0.2 | 3.6 | 7.4 | 1.1 | 0.02 | 14.1 |
| 1976-77 | 1.8 | 0.4 | 2.8 | 5.6 | 1.2 | 0.02 | 11.8 |
| 1977-78 | 1.7 | 0.4 | 2.9 | 6.1 | 1.2 | 0.02 | 12.4 |
| 1978-79 (est.) | 1.6 | 0.4 | 3.1* | 6.3 | 1.3 | 0.02 | 12.7 |

*Grants are made to the Aboriginal Health Program and the Department of Aboriginal and Islanders Advancement. As an indication of the amounts to each, the amount appropriated in 1978-79 was $2,514,000 to the Aboriginal Health Program and $576,000 to the Department of Aboriginal and Islanders Advancement.

Source : Budget Paper No.7 "Payments to or for the States and Local Government Authorities 1976-77", and Budget Paper No.7 "Payments to or for the States, the Northern Territory and Local Government Authorities 1978-79".

APPENDIX 22

## DIRECT EXPENDITURE ON ABORIGINAL HEALTH IN THE NORTHERN TERRITORY

| | $m |
|---|---|
| 1971-72 | 0.652 |
| 1972-73 | 1.425 |
| 1973-74 | 1.846 |
| 1974-75 | 3.224 |
| 1975-76 | 5.562 |
| 1976-77 | 3.970 |
| 1977-78 | 3.967 |
| 1978-79 (est.) | 4.661* |

* Includes $2.3m for the second half of 1978-79 which has been included in the global allocation to the Northern Territory Government.

Source : Evidence, p.15, and unpublished letter from the Department of Health, dated 19 December 1978.

APPENDIX 23

# POLICY STATEMENT ON ABORIGINAL HEALTH WORKER TRAINING
# DEPARTMENT OF HEALTH, NORTHERN TERRITORY

## Introduction

The need for Aboriginal people to be involved in their own health care has been recognised by the Department of Health for a number of years: in 1965 training of Hospital Assistants was begun at Darwin Hospital; concurrently a training course for Paramedical Workers in the detection and care of leprosy patients was established at the East Arm Leprosarium. Both of these programs were discontinued in 1972 and the Aboriginal Health Worker Training Scheme was introduced. In 1976 an Education and Training Task Force was formed to review and recommend policies relating to this new training scheme, and to provide support for ongoing and future training programs at all levels in the Northern Territory. With the conclusion of the Task Force's activities in June 1977 the firm establishment of Aboriginal Health Worker Training in the Northern Territory was achieved.

## The Policy

The Department's major thrust in the rural areas shall be the vigorous development of a program of Aboriginal Health Worker Training which will be designed to enable Aboriginal people to manage their day to day health care problems as soon as possible. Full implementation of this program means that all first contact health care shall be undertaken by Aboriginal Health Workers.

To enable greater community involvement with health services, the Department believes that wherever possible Aboriginal Health Workers should be employed by their own communities.

## Role of the Aboriginal Health Worker

He/She shall be a primary health worker who shall be selected by the community and trained in basic health concepts and skills. The Aboriginal Health Worker shall deal with most of the day to day health problems within the limits of his training and competence. When the need for referral arises the Aboriginal Health Worker shall refer/consult with the immediate supervisor (in most instances a nursing sister) or the medical emergency service (AMS or the nearest hospital).

The Aboriginal Health Worker shall be a multi-purpose health worker whose activities will include -

- treatment of common sicknesses
- implementation of preventive programs
- implementation of community health education programs
- promotion of environmental sanitation measures
- collection of epidemiological data
- management of the health centre

Selection of Persons for Training as Aboriginal Health Workers

Aboriginal communities shall be motivated to become increasingly responsible for their own health services, and to support those of their people selected for training as health workers.

Whilst the choice of younger, more literate people may be seen by the teacher as making his task easier, it is to be remembered that such people may in fact be too young or otherwise unacceptable for health work in their communities.

Whenever and wherever possible, each clan group within a community shall be represented by both men and women health workers. Every effort shall be made to encourage councils and communities to select suitable men for training as health workers and so ensure an overall health service to the total community.

The Training Program

Wherever possible, the principle of 'on-site' training shall be adopted. In contrast to training courses away from the homeland, on site training is orientated to local problems and closely involves the community and its leaders in an awareness of the increasing skills of the trainee health worker.

Inservice courses of short duration away from the homeland health centre shall be encouraged to enable health workers from a variety of areas to meet together and to have access to other Health Department staff and facilities. To facilitate this and to provide support for the whole program Regional training schools are being established.

The Basic Skills Health Course is the first level of the training program, and all health workers should acquire the skills and concepts in this course. With a grade 4 level of literacy and numeracy, accompanied by ongoing training in these skills, most health workers should become competent in the Basic Skills within a 6-12 month period. If the literacy level is lower than grade 4, this period may be extended a further 2 years if necessary.

The Post Basic Health Course is the second level of training and is broader in concept and content than the Basic Skills Health Course. Ongoing literacy and numeracy shall be an essential component of this course, which shall be taught according to local requirements. (For example, teaching about marine stings may be inappropriate for inland areas). With concurrent training in literacy and numeracy most health workers should become competent in Post Basic Skills within a period of approximately two years.

It is envisaged that parallel specialised courses will be developed in the fields of hygiene and dental health and that a promotional course to a third managerial level will be pursued.

Changes in Roles of Health Staff

The emphasis shall be on teaching, rather than practice, by all Health staff involved in the Aboriginal Health Worker Training program. This is particularly relevant in so far as field nursing staff are concerned. The Department will provide orientation and inservice programs aimed at enabling staff to adapt to their new role.

Field nursing staff require to be aware of the necessity for involving resource people such as adult educators to enable them to increase their teaching skills. The support of other Health staff - District Medical Officers, Health Inspectors, Dentists, Health Educators, Dieticians - is an essential component of the training program and such staff shall give priority to their involvement and to developing a co-ordinated team approach to the training of Aboriginal Health Workers.

Evaluation

The extent to which the objectives of the program are being achieved will be the subject of continuing evaluation.

Methods of evaluating the program shall be developed by the Department and criteria for such evaluation shall relate to the policy of the program as a whole and the role of Aboriginal Health Worker.

APPENDIX 24

## DECLARATION - INTERNATIONAL CONFERENCE ON PRIMARY HEALTH CARE ALMA-ATA, U.S.S.R., 1978 - WHO AND UNICEF

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organisations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII

Primary health care :

1. reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition, an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunisation against the major infectious diseases; prevention and control of locally endemic diseases; appropriate

treatment of common diseases and injuries; and provision of essential drugs;

4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

5. requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

6. should be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilise the country's resources and to use available external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this

context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

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The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organisations, as well as multilateral and bilateral agencies, non-governmental organisations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

Cat.No. 79 7333 x