

Aboriginal health: A discussion of some current issues

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Abstract

This paper explores some health status differences between the Aboriginal and total Australian populations, and investigates trends in Aboriginal mortality and morbidity within the context of some of the socioeconomic, lifestyle and environmental influences. It identifies that Aboriginal people continue to suffer from a number of health problems at significantly higher rates than the rest of the population, and discusses some of the effects of early fertility and alcohol misuse on health status. Drawing on some findings of the 1994 National Aboriginal and Torres Strait Islander Survey, the paper concludes with the proposition that it is impossible to consider the economic implications of sub-standard Aboriginal health without also considering the social issues, and that programs aimed at improving this situation must be demand-driven, economically responsible responses to identified problems in specific regions.

Introduction

Differences between the mortality patterns of the Aboriginal and total Australian populations are generally well documented and acknowledged. On all vital demographic statistics, such as age structures, fertility patterns and mortality rates, this minority group is differentiated from the total Australian population. This paper draws on some of the findings of the recent National Aboriginal and Torres Strait Islander Survey to discuss some of the trends in Aboriginal mortality over recent decades within the context of some of the socioeconomic, lifestyle and environmental factors which have been attributed with influencing the morbidity associated with Aboriginal mortality. It deals specifically with the issues of intense early fertility and alcohol misuse – the latter being a significant problem which is regarded simultaneously as a health problem, a cause of other health problems, and a symptom of socio-political problems.

The majority of Aboriginal people live in rural communities or minor urban areas, but regardless of where they live, it is alleged that their poor economic and physical environments are major contributors to their relatively poor health status and sub-standard mortality patterns. Governments and health service providers in Australia have been concerned for some time about the poor health status of Aboriginal people, and there is an increasing awareness that a significant portion of the Australian health budget is spent on what can be broadly referred to as *avoidable morbidity*, not only amongst the Aboriginal population where it is of particular concern, but amongst all population groups.

Because health services in Australia consume at least 8.5 per cent of gross domestic product, it is imperative that these economic resources are used to greatest effect for the whole population, and in a manner that is equitable for Aboriginal people and non-Aboriginal people alike. In this context, this paper discusses Aboriginal morbidity and mortality from the viewpoint that it is impossible to consider the economic implications of sub-standard Aboriginal health without also considering the social issues, and concludes that programs aimed at improving this situation must be demand-driven, equitable and economically responsible responses to identified problems in specific regions.

Policy, planning and economic background

In its report to the 1994 United Nations Conference on Population and Development (Commonwealth of Australia 1994, pp 64–66), the Australian Government identified a number of strategies it had developed during the late 1980s to attempt to improve the health status of Aboriginal people. For example, during 1989, consultation with the Aboriginal community resulted in the development and implementation of a National Aboriginal Health Strategy. At the same time, other developments such as the *Aboriginal and Torres Strait Islander Commission Act 1989* (Castles 1993, p 4) established the Aboriginal and Torres Strait Islander Commission (ATSIC). As a result, Australia was divided into 36 administrative regions in which indigenous Australians (that is, the Aboriginal and Torres Strait Islander population – see Endnote) could elect their own representative bodies (regional councils) whose role it is to make decisions about funding and development priorities for their region.

The goals and targets of the National Aboriginal Health Strategy, which were produced and endorsed by the Board of ATSIC, addressed five areas: health outcomes; access and equity; health support services; decision-making processes (including the progressive devolution of powers to regions which are structured to support indigenous self-determination); and education, training and

employment. The Royal Commission into Aboriginal Deaths in Custody (see Johnston 1991) had provided the catalyst for the government to take these and other initiatives, such as the National Aboriginal and Torres Strait Islander Survey which was conducted in April 1994 in the ATSIC regions to obtain a more comprehensive set of data than was available when the Aboriginal health strategy goals and targets were established. This survey of over 15 700 indigenous people from both urban and rural regions involved self-reporting on issues regarding family and culture, health, housing, education and training, employment and income, and law and justice (Madden 1995). Some of its findings are discussed in later sections of this paper.

Initiatives such as these need funding, and two sources of funds are identified here. The national health budget accounts for about 8.5 per cent of gross domestic product, and amounted to \$34 338 million in 1992 (Australian Institute of Health and Welfare 1994, p 122). Mainstream health services to Aboriginal people and non-Aboriginal people alike are funded this way. However, the Federal Government also committed itself to providing up to \$232 million, which was to be matched by States during the first five years of the National Aboriginal Health Strategy, for the purposes of improving the standards of health in Aboriginal communities by 'focusing on housing, water, sewerage, electricity, communications, roads, and the provision of, and information about, health services' (Commonwealth of Australia 1994, p 66). Since the federal election in March 1996, allegations of improper handling of public money by ATSIC have brought the progress of indigenous self-determination and the management of health improvement program funds under public scrutiny (*Western Advocate*, 17 April 1996, p 3). However, even before these allegations became public, it had been acknowledged that the extra money being invested in Aboriginal health was not producing the anticipated results (Commonwealth of Australia 1994, p 26).

Demographic background

The 1991 Australian census recorded a population of 16 849 496, with the Aboriginal population of 238 575 accounting for approximately 1.4 per cent of the total (Commonwealth of Australia 1992; Commonwealth of Australia 1994, pp 24–25). Whereas the majority of the Australian population live in major and minor urban areas, predominantly on the eastern seaboard, the majority of the Aboriginal population live in minor urban and rural areas, and remote communities (Castles 1994, pp 5–6), predominantly in the northern and central regions of the country (Grant & Lapsley 1992, pp 4, 20–21; Commonwealth of Australia 1994, p 27; Madden 1995, p 94). The greatest numbers of the

Aboriginal population live in New South Wales and Queensland (1 per cent and 2 per cent of each State respectively), but they represent 31 per cent of the population of the Northern Territory (Australian Institute of Health and Welfare 1994, p 9).

In 1991, 40 per cent of Australia's indigenous population were less than 15 years old compared with 22 per cent of the non-indigenous population (Commonwealth of Australia 1994, p 24), while only 6 per cent of the indigenous population in 1991 were aged over 55 years, compared with 20 per cent in the non-indigenous population. The differences in age distributions of the two populations are exemplified by the fact that in 1991 the median age of all Australians was 33 years, whereas it was 'under 20 years' for indigenous people (Commonwealth of Australia 1994, p 25).

There has been a decline in fertility amongst Australian women generally in the prime child bearing ages (20–29 years), with a trend to higher fertility from 30 years of age. Overall, mothers Australia-wide are producing an average of 1.9 children compared with 3.1 children per Aboriginal mother (Castles 1994, p 18). Aboriginal women aged 15–24 years have three times the fertility rate of the non-indigenous female population, and are five times more likely than non-indigenous females to commence child bearing before the age of 20 years (Castles 1994, p 19; Commonwealth of Australia 1994, p 26). In fact, about 35 per cent of all indigenous live births involve teenage mothers (Hogg & Thomson 1992, p 10), and a problem which is related to the high incidence of teenage fertility is the propensity of teenage indigenous mothers to produce low birth weight babies at a rate which is much higher than for their older counterparts (Hogg & Thomson 1992, p 10).

Castles (1994, p 20) highlighted that Aboriginal fertility is higher in rural than in urban areas, and concluded that 'differences in fertility (between indigenous and non-indigenous females) reflect differences in socioeconomic factors including urbanisation, education and labour force status'.

Table 1 summarises some of the principal demographic differences between the two populations.

Table 1: Principal demographic statistics for Aboriginal and total Australian population

Statistic	Australian Aboriginal	Australian (total)
Population (1991)	238 575	16 849 496
Proportion less than 15 years (1991)	40%	22%
Proportion older than 55 years (1991)	6%	20%
Median age (1991)	<20 years	33 years
Total fertility rate (1991)	3.1 children	1.9 children

Sources: Commonwealth of Australia 1992; Commonwealth of Australia 1994, pp 24–26.

There are numerous interrelated variables which make it difficult to forecast changes in the Aboriginal population, but the combined effect of current fertility rates, age structures and a successful Aboriginal health strategy is likely to result in a significant growth in the indigenous population in the medium term. However, the socioeconomic implications of this are not discussed in this paper.

Morbidity and mortality

During the past 20 years in Australia, mortality rates have continued to decline in all age groups for both males and females, and of particular significance has been the decline in the rates of adult mortality from heart disease and stroke. Over the last two decades, life expectancy at birth has increased by nearly six years for both males and females, from 68 and 75 years respectively (in the early 1970s) to 74 and 80 years in 1992. The decline in death rates is deemed to be the result of ‘continuing improvements in public health care, greater community awareness of health issues, advances in medical science and technology, and lifestyle changes’ (Commonwealth of Australia 1994, p 17). However, while there have been improvements in the overall life expectancy of Australians, life expectancies for indigenous males and females have changed little, and are about 18 and 20 years respectively less than for the total population (Commonwealth of Australia 1994, p 17).

The three major causes of death amongst Aboriginal people are diseases of the circulatory system, diseases of the respiratory system, and external causes of injury and poisoning (Hogg & Thomson 1992, pp 15–16). The extent of this morbidity is exemplified by the fact that between 1984 and 1990 ‘respiratory diseases caused 5.9 times more male deaths and 7.5 more female deaths than the

numbers expected from the rates for the total Australian population' (Hogg & Thomson 1992, p 16).

It should also be noted that the differences in morbidity are not limited to the major causes of death. For example, a recent report cited that Aboriginal women were dying from cervical cancer at four times the rate of non-Aboriginal women (*Western Advocate*, 13 May 1996, p 7). Furthermore, there is concern that the pattern of intense early fertility amongst indigenous females (mentioned earlier) is a factor which is contributing to female life expectancy being about 20 years less than that of their non-indigenous counterparts (Commonwealth of Australia 1994, p 26).

Other indicators of the poor health status of the indigenous population (compared with the overall population) include:

- up to three times more frequent hospital admissions
- 2.5 times higher death rates associated with diseases of the circulatory system
- a much higher incidence of chronic disability
- at least 10 per cent suffering from diabetes mellitus (far higher than the national average)
- a high incidence of eye disease (especially for those living in hot, dry areas) (Commonwealth of Australia 1994, p 26).

In the context of the preceding information, it is significant to note that the National Aboriginal and Torres Strait Islander Survey found that the majority (88 per cent) of those surveyed considered themselves to be in good to excellent health, despite the high levels of reported recent illness (40 per cent for males and 42 per cent for females) during the two weeks prior to the survey (Madden 1995, pp 11–12). These findings are not intended to dispute empirical data on disease and mortality patterns, but rather they serve to highlight that there is a social context within which quality of health expectations might need to be interpreted, and that some of the differences in the propensity of the two populations under scrutiny to seek health interventions could be attributed to this phenomenon. Health awareness education in Aboriginal communities could hold the key to a solution in this regard.

It is encouraging to note that significant improvements have been made in the area of infant and perinatal mortality. During the 20-year period in which the national infant mortality rates (that is, deaths of infants under one year) fell from 17 to 7.1 deaths per 1000 live births, Aboriginal infant mortality fell from about 78.8 to 15.6 deaths per 1000 live births (Commonwealth of Australia 1994, p 17).

Improvements have also been made in perinatal mortality (that is, infant deaths within 28 days of birth) at about the same rate of decline as in the total population (Hogg & Thomson 1992, p 19). Table 2 summarises some of the principal differences between the two populations.

Table 2: Vital mortality statistics for Aboriginal and total Australian population

Statistic	Australian Aboriginal	Australian (total)
Expectation of life at birth (males 1971)	58.4 years	68.0 years
Expectation of life at birth (males 1991)	56.3 years	74.5 years
Expectation of life at birth (females 1971)	62.7 years	75.0 years
Expectation of life at birth (females 1991)	60.6 years	80.4 years
Infant mortality rate (c.1971)/1000 live births	78.8	17.0
Infant mortality rate (c.1990)/1000 live births	15.6	7.1
Perinatal mortality rate (c.1971)/1000 live births	62.6	22.3
Perinatal mortality rate (c.1990)/1000 live births	26.9	10.7

Sources: Grant & Lapsley 1992, pp 6, 11, 33; AIHW 1994, pp 7, 28–29; Commonwealth of Australia 1994, pp 17, 24–26; Hogg & Thomson 1992, p 19.

Social factors

Despite the resources expended on well-meaning programs to deal with the disproportionately poor health status of Aboriginals, it has been alleged that disadvantages and barriers to access to government services and programs continue to be faced by Australia's indigenous people. Various reports have highlighted problems such as the following.

- Aboriginal people have three times the national unemployment rate.
- Aboriginal people have about two-thirds of the national average individual income, with the greatest disparity occurring in the Northern Territory where indigenous people represent about 31 per cent of the total population (Castles 1993, p 19).
- Inadequate housing and services compound problems of poor health, with many Aboriginal people in urban areas unable to find accommodation at basic standards. The 1991 census revealed that 2.5 per cent of the dwellings of indigenous Australians were classified as 'improvised' (Castles 1993, p 11).

- Only 85 per cent of children of compulsory school age are participating in primary and secondary education, compared with almost 100 per cent nationally (Commonwealth of Australia 1994, p 40).

Whilst problems of unemployment, low income and poor housing are undisputed (Madden 1995, pp 45–56), it is interesting to note from the 1991 Australian census that the labour force participation rates of indigenous males and females was only ‘about 6 percentage points lower than the comparable rates for non-indigenous people’ (Castles 1993, p 15), and that almost 50 per cent of all employed indigenous people work in public administration or community services.

It is also very interesting to note the findings of the National Aboriginal and Torres Strait Islander Survey in relation to access to health services and to Aboriginal people’s perception of the quality of their health services. The survey reported that about 81 per cent of households were located within 10 km of the nearest community health centre and within 25 km of the nearest hospital. However, in the more remote areas, only 40 per cent of households were within 25 km of the nearest hospital. When these data are considered within the context of the findings that 79 per cent of those surveyed said they were happy with the local health services provided (Madden 1995, p 13), it could be concluded that dissatisfaction with the local health services is related to problems of access to appropriate services – a remote area problem which is not limited to indigenous Australians.

Other concerns have been reported, but probably the most significant one is the issue of alcohol misuse amongst the indigenous population. Consideration of this ‘problem’ needs to be put into an historical perspective, because access to alcohol by Aboriginal people was restricted by law until the 1960s and 1970s (Hunter 1993, p 90). When prohibition ceased, many Aboriginal people associated this freedom to drink with their sense of social equality and empowerment, and there is a view that when Aboriginal people gained the legal right to drink alcohol, they saw it as the ‘most immediate and tangible expression of their attainment of “full rights”’ (Hunter 1993, p 90).

Hunter (1993, p 94) cites the National Aboriginal Health Strategy Working Party (1989) which concluded that ‘alcohol abuse is simultaneously a health problem, a cause of other health problems and a symptom of socio-political related problems’.

The principal conclusions drawn in Hunter’s extensive review of the literature are as follows.

- Alcohol has had a damaging impact on traditional life, family structure and health of Australia's indigenous population, and is associated with their high levels of arrest and imprisonment (at 20 times the rate for non-Aboriginal people), with almost one-third of this being due to drunkenness, which is three times the rate for non-Aboriginal people (McDonald 1990 cited in Hunter 1993, p 90).
- Alcohol abuse contributes significantly to Aboriginal ill-health and poor nutrition.
- Alcohol abuse is associated with problems such as diabetes mellitus.
- Alcohol contributes to premature Aboriginal mortality at a rate around four times higher than for the non-indigenous population. Some studies have reported up to 53 per cent of male deaths and 21 per cent of female deaths as being alcohol-related.
- Low birth weights (and thus neonatal survival) can be linked to alcohol abuse amongst mothers.
- Alcohol consumption is the major correlate in studies of hypertension amongst Aboriginal males.

While it is impossible to draw any useful conclusions from the data on the propensity to drink alcohol as presented in the findings of the National Aboriginal and Torres Strait Islander Survey, it is significant to note that 59 per cent of people aged over 13 years who were interviewed 'perceived alcohol to be one of the main health problems in their area' (Hunter 1993, p 14). In the Broome (WA) ATSI Region, 96.3 per cent of those surveyed felt this way, and the results in the capital cities ranged from 26.2 per cent in Hobart to 73.2 per cent in Perth (Madden 1995, p 15).

Some socioeconomic implications

The data presented in this paper, combined with the broad acknowledgement that Aboriginal morbidity varies greatly with location (AIHW 1994, pp 26–36), raise the question of whether it is possible that the extremely poor health status and mortality patterns of certain subsections of the Aboriginal population, particularly those living in the more isolated areas, are causing erroneous generalisations to be made about the Aboriginal health situation. If this is true, then the strategies to deal with Aboriginal health problems will not be universally applicable, and it will be necessary to direct resources to specific areas of identified need. (In suggesting this, there is no intention to downplay the fact that significant problems exist in the area of Aboriginal health.) The potential

exists for Aboriginal communities, via their ATSIC regional councils, to play a significant role in identifying areas of need, thereby facilitating the resourcing of specific services in these areas of need and reducing the risk of resource wastage which would result from 'universal solutions'.

For example, the National Aboriginal and Torres Strait Islander Survey (Madden 1995, p 12) identified that detoxification centres and Aboriginal Medical Services were less accessible to Aboriginal people than were mainstream health services, and this is a situation that needs to be redressed. It seems that a concerted effort to deal with the alcohol misuse problem is demanded. However, this needs to be handled with great sensitivity, because there is a body of opinion that suggests that a return to some form of legalised alcohol restriction would be a retrograde step from a self-determination and human rights perspective. Yet substantial difficulties exist in convincing Aboriginal people to alter their patterns of alcohol consumption, because of their association of 'empowerment' with their right to drink alcohol (Hunter 1993, p 95). If detoxification centres are already proving to be effective, then more facilities and support services need to be provided so that they are more accessible to the people in most need.

The problem of low birth weights of Aboriginal infants has been related to both intense early fertility and to maternal alcohol abuse, and appears to be most problematic in rural/remote areas where birth rates are higher than the Aboriginal average and labour force participation rates and incomes are lower than the Aboriginal average. Recognising the important contribution of good health in the formative years to health status in adult life, it is suggested that any strategy to improve Aboriginal health in the long term must target high-risk populations with culturally sensitive programs which focus on the issues of family planning and maternal and infant health.

In view of the strong support for the involvement of indigenous people in the provision of their health care (Madden 1995, p 13), it will be imperative to employ Aboriginal doctors and other health workers in increasing numbers in the full range of health services for Aboriginal people. In this connection, it was encouraging to note that there were 15 Aboriginal graduates from the University of Newcastle's Community Medicine program in 1996. (Hopefully, many of them will be committed to working amongst Aboriginal people.) This event exemplifies the types of financial investments which are being made in an effort to achieve the goals of the National Aboriginal Health Strategy, investments which, in the longer term, will hopefully prove to be more than cost-effective.

Conclusion

This paper has outlined some of the principal disparities in the health status of Aboriginal and non-Aboriginal Australians, and has attempted to highlight that it is impossible to consider how to deal with the problem of sub-standard Aboriginal health without also considering the related social issues. It has been proposed that strategies to deal with Aboriginal health problems are not universally applicable, and that programs aimed at improving this situation must be demand-driven and economically responsible responses to identified problems in specific ATSI regions.

Endnote

Of the total indigenous population of approximately 265 459 persons, only about 10 per cent are Torres Strait Islander people whose age distributions were marginally less than the Aboriginal population in the under 15 and over 55 year groups (Commonwealth of Australia 1994, pp 24–26). So for the purposes of this paper, it is proposed that the impact of including Torres Strait Islander data with the data for the Aboriginal population will be insignificant.

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