VICTORIA UNIVERSITY
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ESSAY WRITING

A MODEL ESSAY

TOPIC

Good health is the right of all Australians. How does the state of Aboriginal health care relate to that of non-Indigenous Australians? Why is this so and how can this situation be addressed so that there is parity across all segments of Australian society? Discuss.

> *"Good health is not just the physical wellbeing of an individual, but the social, emotional, and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total wellbeing of their community". (Anderson, 2000, para. 6)*

If we take Anderson's view as the definition of good health, then the fact that an Indigenous baby raised in an Aboriginal community can expect to live 20 years less than other babies strongly indicates that the relative health status of Australia's Indigenous population is indeed much poorer than that of the rest of the Australian population (Merston, 1999, p.32). This is largely due to inadequate living conditions, lifestyle, lack of education and employment, and historical conditions. To improve the health status of Australia's Indigenous population, the government not only needs to allocate more funds to health services and the improvement of overall living conditions, but also to investigate ways in which health services can be offered to better reflect the cultural needs of this group.

Indigenous Australians suffer a higher amount of illness and die at a younger age than non-Indigenous Australians. Available data shows that life expectancies in 1992-94 for Aboriginal and Torres Strait Islander men and women were 15 to 20 years below those of other Australians. This lower life expectancy is, in large part, a consequence of the mortality rates of Aboriginal people aged 25 to 54 years. These rates are five to seven times higher than for other Australians within the same

age category. The major causes of excess mortality are circulatory conditions which in 1997 accounted for 26 percent of deaths, injury and poisoning (6 percent), respiratory conditions (15 percent), and endocrine conditions, largely diabetes, (10 percent) (AMA Report, 1997, p.78). Similarly, despite significant declines over the past two to three decades, Aboriginal infant mortality rates remain typically about three times higher than the rates for non-Aboriginal infants. Also recorded deaths from diabetes rose rapidly in men in the late 1980s. Aboriginal and Torres Strait Islander death rates from diabetes in 1992-94 were 12 times higher for men and nearly 17 times higher for women than rates for other Australians. Indigenous people are also 15-18 times more likely to die from infectious diseases than their non-Indigenous counterparts (Merton, 1999, p31). Respiratory disease and injuries resulting from violence are significantly higher, and problems associated with drinking and smoking are responsible for one in three hospital admissions for Indigenous men. Indigenous people suffer significantly more illnesses and infectious diseases than the rest of Australians. There is no doubt that the health status of Aboriginal people is far lower than that of other Australians.

Poverty, coupled with living in remote locations, contributes significantly to the poor health of the Indigenous population. Making healthy food choices is more difficult in remote areas than in other areas of Australia because of the limited availability of fresh food and the high costs. Food costs in remote areas may range from150-180 percent of capital city prices. High costs of food are due primarily to high transport costs - in some places, freight charges may add more than $2 per kilogram to the price of the food. The availability and affordability of nutritious foods in remote areas of Australia is a problem for both Indigenous and non-Indigenous people. However, the social and economic status of many Indigenous people means that they are even more likely than non-Indigenous people to be affected. Expensive foods and low incomes mean that the food budget can represent from 56 percent to 89 percent of total household income among Indigenous people in remote areas, compared with a national average of 18 percent (George, 1996, para. 6).

The food choices of Indigenous people are heavily influenced by problems with (or a lack of) electricity, gas, water supply, cooking appliances and refrigeration. Thus, convenience foods are often chosen over fruits and vegetables, as they require little or no preparation and many do not require refrigerated storage. McKenzie (1997) cited in George (1999) states that a diet based heavily on

convenience foods impacts significantly on the health of Aboriginal and Torres Strait Islander people, predisposing many of them to diet-related conditions such as obesity, diabetes, cardiovascular disease and stroke (George, 1999, para. 9).

Poverty also results in poor living conditions that further contribute to the poor health of Indigenous people. Thirty percent of Indigenous people are living in private dwellings that are unacceptable due to overcrowding, lack of repairs and the poor state of basic facilities (Smail, Jullen, Magee, and Temple 1998, pp.6-7). In rural areas, there is a lack of toilets, absence of gas or electricity, and no running water for baths or showers. Sixty nine percent of Indigenous households live in rented premises compared with 27 percent of all Australians. (AMA Report, 1997, p.80). Many Indigenous people share a house - 4.1 percent of Indigenous people compared to 2.6 percent of non-Indigenous people (Smail et al, 1998, p.10). Such conditions lead to more illness and infectious disease in Aboriginal communities.

Another contributing factor to poor health is the major changes in the lives of Indigenous people after colonisation. Australia's colonial administrators separated Indigenous people from their land. They were forced to live on reserves, missions and government settlements. As well as losing contact with their families, they were precluded from living their traditional way of life, including learning about and accessing their natural healing practices. This, coupled with resulting low self-esteem and a sense of hopelessness, contributed to their taking up threatening lifestyle practices (NHMRC, Dec, 1996, p.4).

Larger proportions of Indigenous people take up life-threatening habits such as smoking at a younger age (Ferrari, April 1999, p11). Almost three-fifths (58 percent) of Indigenous people aged 13 years and older reported alcohol use as one of the main health problems in their local area. The next most frequently perceived health problems were drugs (30 percent), diabetes (22 percent), diet/nutrition (19 percent) and heart problems (14 percent) (ABS, 1966). The risks associated with smoking are not well understood by Indigenous people. Ferrari (Ferrari, April 1999, p12) found that one in three Aborigines surveyed believed it was safe to smoke a packet of cigarettes a day. According to Ferrari's studies, Indigenous people also take up drinking at an earlier age than non-Indigenous people. Contrary to popular opinion, by comparison, fewer Aborigines drink alcohol than non-Indigenous people with one

in three being drinkers compared to 45 percent of non-Indigenous people (ibid). However, those Indigenous people who do drink are more likely to drink in hazardous quantities.

If it is so apparent that there is such a disparity between Indigenous and non-Indigenous Australians' health then health monies need to be apportioned accordingly. Despite popular opinion, 30 percent less is spent on Aboriginal health per capita than on the health of the non-Indigenous populations (Ferrari, April 1999, p 15). But the far greater reason for the seemingly ineffective efforts of government at all levels to redress the health issue is the way that the money is managed. This is one of the underlying causes for continued poor health of Aborigines. Stephenie Bell (Acting Director, Central Australian Aboriginal Congress) in a paper presented to the 'Aboriginal Health: social and cultural transitions' Conference, Darwin, spoke on behalf of Indigenous people stating that the non-Aboriginal bureaucratic culture is a very 'top-down' model of problem solving and as such has failed the Aboriginal people:

> *"The decision-making power lies not with communities, the traditional and preferred arbitrators and proponents of change, but instead with distant and so inherently irrelevant government bureaucracies. This is seen to be true even if the bureaucracy is (was) ASTIC" (1995, para. 8)*

To address the problems of poor health in our Indigenous population, we need to attack the underlying causes of poverty, address the lack of health education and promotion, and restructure the administration of funds in a targeted and culturally relevant manner. Successive governments have grappled with the task of providing adequate health services to Indigenous people where the culture and lifestyles are often so different from non-Indigenous people. Effective provision of services in remote communities adds an additional geographic challenge. During the 1970s, Aboriginal community-controlled health services emerged as an Aboriginal community response to this problem. These services created a model for primary health care delivery that embedded the principles of self-determination within health care delivery structures. Self-determination remains a central plank within the framework for Aboriginal health policy and strategy. It is also crucial that commitment to self-determination is not seen as an excuse for the mainstream health system to abdicate its responsibility in Aboriginal health.

> *"Self-determination and shared responsibility are not mutually incompatible'" (Bell, 1995, para.14)*

Short term and long term targets need to be set. The immediate targets need to be designed to tackle the main diseases and conditions causing untimely death among Aboriginal people including: reducing the prevalence of the main causes of excess Aboriginal mortality - diabetes, cardiovascular disease, respiratory disease, cervical cancer and injury/poisoning; increasing immunisation and vaccination coverage for key conditions; and reducing the prevalence of smoking, obesity and dangerous levels of alcohol consumption. In the long term, the problems of under-employment, lower educational levels and low self-esteem need to be targeted by government policy, through greater allocation of funds to specific, relevant and proven successful programs, and by the national recognition of the past to enable the growth of self-determination and cultural pride. Likewise, we must invest in human resources to make this strategy happen. A well trained, culturally sensitive, financially rewarded workforce, complemented by linkages with specialist medical services, is essential if this plan is to work. The need for a skilled workforce is the way to long-term sustainability. Primary health care services need to continually be aware of what needs to happen and be equipped to respond (Anderson, 2000, para.12).

The structure to best effect this is one that incorporates a bottom up approach. Bell points out that the Commonwealth Health Department bureaucracy is not the authority on matters of the health of Aboriginal people and, if there are any such things as "experts" in Aboriginal health, they are the Aboriginal community-controlled health services:

> *"These services are intimately linked to the community they serve, by history, by culture, and by management. Staffed by, and under the day-to-day control of their community, they have been recognised by the National Aboriginal Health Strategy and the Royal Commission into Aboriginal Deaths In Custody as the voices of our people. They are the only organisations that can effectively address the health problems of our people." (Sept 1995, para. 5)*

To build effective Aboriginal health organisations means putting the emphasis on local and regional structures first, national ones second.

The low health status of Indigenous people, especially compared to the health of the wider Australian community, is a national and international disgrace. There are no quick fixes - it may take years to see appreciable improvements - but the framework needs to be laid to make change happen. Addressing the issues underpinning this situation is fundamental not only to achieving equity in health outcomes for Aboriginal people but is central to achieving a sustainable quality of life within all our Australian communities.

REFERENCES

Australian Medical Association 1999, AMA Report, Aus Med Volume 13, Number 21

Anderson, I. Sept 24, 1977, Overview of Indigenous health status in Australia. Shortened version of speech given by Dr Ian Anderson, Medical Adviser to the Office for Aboriginal and Torres Strait Islander Health Services, Commonwealth Department of Health and Family Services, to the World Health Organisation's Regional Committee for the Western Pacific. Retrieved November 2001 from the World Wide Web: www.healthinfonet.ecu.edu.au

Australian Bureau of Statistics 1996, National Aboriginal and Torres Strait Islander survey 1994: health of Indigenous Australians (Catalogue No. 4395.0). Australian Bureau of Statistics, Canberra.

Bell, S. September 1995, Building Aboriginal Health from the ground upwa rds.Paper presented to the "Aboriginal Health: social and cultural transitions" Conference, Darwin. Retrieved November 2001 from the World Wide Web: www.healthinfonet.ecu.edu.au

Ferreri, J. (April 1999), Distributing the health wealth, The Medical Journal ofAustralia, 176, 743-746.

George K L (1996), Community stores and the promotion of health: an assessment of community stores and their functions in the promotion of health in Aboriginal communities, Health Department of Western Australia, Perth (Nanga Services Pty Ltd.).

Merston, J. 1999, Bad Health, Bad Practice, Collins, Sydney.

National Health and Medical Research Council Dec.1999 NHMRC Report1999, Vol 34 No 7, 31 – 39

Smail P., Jullen, S., Magee, T. & Temple, M. B. 1998, Factors underpinning Indigenous Health (2nd Ed.) Rodin, Melbourne.