NATIONAL ABORIGINAL CONFERENCE

POSITION PAPER ON ABORIGINAL HEALTH AND RELATED MATTERS

1. Introduction

At the International Conference on Primary Health Care, Alma-Ata, U.S.S.R. in 1978 the following joint declaration was made by UNICEF and the World Health Organisation.

"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.

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

Australia is a signatory to the above declaration.

In its report on Aboriginal Health to the parliament of the Commonwealth of Australia the House of Representatives Standing Committee on Aboriginal Affairs made the following comments in its foreword:-

The standard of health of Aboriginals is far lower than that of the majority of Australians and would not be tolerated if it existed in the Australian community as a whole.

When innumerable reports on the poor state of Aboriginal health are released there are expressions of shock or surprise and outraged cries for immediate action. However, the reports appear to have no real impact and the appalling state of Aboriginal health is soon forgotten until another report is released.

The Committee found that the low standard of health apparent in the majority of Aboriginal communities can be largely attributed to the unsatisfactory environmental conditions in which Aboriginals live, to their low socio-economic status in the Australian community, and to the failure of health authorities to give sufficient attention to the special health needs of Aboriginals and to take proper account of their social and cultural beliefs and practices.

The Committee believes that if the Commonwealth and State Governments had recognised the importance of these factors and had accepted their full responsibilities the disastrous Aboriginal health situation would not exist.

The level of Aboriginal ill health will only be reduced if there are dramatic improvements in the physical environment, if there is maximum participation by Aboriginals in all stages of the planning and delivery of health care, and if Aboriginals, like all Australians, are given the opportunity to choose the type of health care they consider best suits their needs.

Dispossession and Dispersal

In order to understand how the situation of Aboriginal health developed to the point of being described above one needs to understand a little of the history of the dispossession and dispersal of the Aboriginal people.

Numbering approximately 300,000 in all Anthropologists believe the Aboriginals were spread over the entire continent in about 500 tribes. They lived together in small groups exploiting the natural environment in a nomadic hunter-gather lifestyle.

After their arrival the Europeans forced the growth of quite large concentrations of Aboriginals in settlements. Many such settlements are in areas which are ecologically fragile and delicate and in order to maintain that ecological balance the above lifestyle was adopted by the Aborigines. On the government settlements, however, large numbers of Aboriginal people, sometimes of several dialects and differing cultures and customs and with no traditional experience of such living conditions now had to learn to cope with new experiences even to the point of co-operating with old traditional enemies. Such settlements have been described as "total institutions" in which Aboriginals learned the lessons of survival, assimilation to the White man's culture and complete dependency on authority for virtually everything.

Prior to settlement most tribal Aboriginal communities had their own "witch doctor". Such a person had, however limited, some understanding of the types of illness with which their people were confronted and, in many cases, had some form of cure for that illness.

Upon contact with Europeans, and headed together into a non-traditional life-style Aboriginal people fell prey to many introduced and infectious diseases. Professor W.E.H. Stanner in dealing with the Socio-cultural aspects in "Better Health for Aborigines (Uni. of QLD. 1974) asks the question, "If we were then (1937) persuaded that whatever future lay before the Aborigines would turn intrinsically on our willingness and capacity to develop amongst them an adequate health programme in its proper fullness, diagnostic, curative and preventive, how shall we explain our disquiet with present conditions?"

HEALTH CARE SYSTEMS IN AUSTRALIA

Responsibility

The primary responsibility for health care in Australia rests with the State Governments who in turn accept the responsibility for the provision of health care within their respective status. Many different types of health care programmes have been established to provide a service for Aboriginals. These can be mainly decided into those which are provided by governments and their agencies, and those which are provided by Aboriginal and/a charitable organisations.

General health services such as the hospitals, clinics and medical centres etc. are mostly used by Aboriginals as a last resort and therefore at an advanced stage of their illness. This means that Aboriginals are in hospital for a longer period than their European counterparts and their treatment is therefore more costly.

Because of a history of contact which reveals attitudes ranging from outright racial discrimination to paternalism the Aboriginal patients' first point of contact is usually the general practitioner. If such attitudes were able to be changed for the better, preventive health care programs which are appropriate to their needs and lifestyle could be initiated in addition to establishing earlier contact with patients and giving better chances for a speedy recovery.

Unfortunately there is a concentration of specialist health care in major urban centres. This means that on occasions Aboriginals have to travel up to a thousand miles away from home for treatment. Travel away from one's home territory in times of sickness is something which is anti-cultural to Aboriginal people causing considerable emotional and psychological stress in addition to the illness already experienced.

Fear of not being able to return to his home or have his body transported back to his home often makes the Aboriginal person reluctant to leave in the first place. He also realises that the system and the environment will not be adapted to his cultural needs and values that he will face discrimination and humiliation at the hands of members of the medical staff. The task of the delivery of health care services becomes more complex, more misunderstood and more frustrating.

Realising the complexity of the task of providing adequate health care services to the Aboriginal people the then minister for Aboriginal Affairs Mr. Ian Viner said in a speech given in the National Press Club, July 1977 that "Aboriginals must believe that Health is their responsibility. It must find a place in the social and cultural systems of (Aboriginals) communities." He also announced in that speech that a special allocation of funding to establish an Aboriginal community health service using the community itself and traditional healer to provide that service would be forth coming.

By this time however Aboriginal Medical Service organisations had been set up in some areas densely populated by Aboriginals to cater for this specific need. A National Aboriginal and Islander Health Organisation has since been formed for the initiating, supporting and co-ordinating of health care services to Aboriginal people throughout the continent.

Senator Chaney subsequently issued the following objectives in his Ministerial Directive to the Department of Aboriginal Affairs.

Objectives

(1) To stimulate, support and co-ordinate health programs which would improve the standard of Aboriginal health and raise it to that of the Australian community.

(2) To progressively strengthen the community basis of health services with particular emphasis on Aboriginal responsibility for and involvement in the improvement of their own health.

(3) To expand Aboriginal participation in the identification of health needs, development of programs and delivery of services through, e.g. increased Aboriginal employment and training both in departments and in community organisations, and through recognition and adaption of traditional practices.

(4) To secure for Aboriginal communities satisfactory environmental conditions and in particular safe and adequate water supply and waste disposal.

Guidelines

In order for Senator Chaney's objectives to be reached two things had to happen. A reference framework had to be established and a funding programme had to be initiated.

The guidelines which established the frame of reference for the Department of Aboriginal Affairs is as below.

(1) State health authorities have a responsibility for providing Aboriginals with services which are normally available to the general community, such as hospitals, clinics, community health centres, and these services should not, except in special circumstances, be supported through DAA programs. Where DAA supplements State resources in the provision of such services (through State programs) the possibility of phasing out such support in consultation with the State should be explore

(2) Preference should be given to projects which improve Aboriginal access to, and acceptance of, normal community health services. Where existing services are not accepted by Aboriginals due to socio-cultural differences, the support of appropriate alternative services may be considered subject to prior consultation with the Commonwealth or State departments concerned which should establish whether those departments can appropriately and effectively provide the services.

(3) Such alternative services may be supported where there is a significant Aboriginal population and they should be operated as community-based health services equipped to meet the special health requirements of Aboriginals.

(4) In supporting community-based health services, emphasis should be placed on the participation of Aboriginals in the design, development and delivery of the services,especially in the fields of primary medical care, preventive and provotive services, and environmental health. Training and educating Aboriginal health personnel in support of these responsibilities should have high priority.

(5) Priority should be given to projects which deal with health problems that are widely prevalent among Aboriginals, such as infant morbidity and mortality, malnutrition, disease of the eye and ear, and diseases due to environmental factors. Surveys of Aboriginal health status should be actively encouraged.

(6) Aboriginal Medical Services should be encouraged and assisted to extend their access to other available sources of funding so that DAA funds may be limited to those aspects for which no alternative sources of funds are available and according to priority needs.

(7) Health authorities should be encouraged to give attention to promotive, preventive, and environmental health programs, and to programs that will be community-based and closely integrated with Aboriginal lifestyles.

(8) Special importance should be attached to health environmental projects, such as, provision of safe water supplies and effective waste disposal systems.

Prevalent Diseases

Of greatest concern to Aboriginal people and to a growing body of professional medical opinion cognizant of the situation of the general health of Aboriginal people is the appalling situation in relation to infectious diseases which with a minimum of fuss are able to be cured and able to be prevented.

Trachoma

This concern relates to the prevalence of trachoma and other eye diseases and to the high prevalence of respiratory diseases in many Aboriginal communities.

The National Trachoma and eye health program reported that:

Trachoma remains a prevalent disease among Aborigines in Australia, particularly in three major areas of the Continent: the Red Centre, including the Pitjantjatjara homelands communities in South and Western Australia, the Western Desert communities in the inland Pilbara region of Western Australia, and the Cattle Country of the Kimberleys WA, and the Northern Territory.

In these areas more than two in every three people seen had trachoma, with very high prevalences of follicular trachoma among the young and with up to 95 per cent of the elderly bearing the scars of cicatricial trachoma.

Surrounding these areas were seven regions in which the prevalence of trachoma was also very high, though not as high as the first three. These were the Goldfields region of Western Australia, the Coastal Towns and Missions of Western Australia, the Top End of the Northern Territory, and the arid inland regions of Queensland, New South Wales and South Australia. In these areas the prevalence of trachoma ranged from three to five of very 10 Aborigines seen, with prevalences among the elderly which suggest that in former years the disease was more common than now. In spite of this evidence of declining prevalences, however, a large proportion of children and adolescents have follicular trachoma and are developing cicatricial trachoma, indicating that without further intervention, the disease

Two zones in the north of Queensland, the Gulf and Cape Country and Torres Strait Islands, have prevalences of trachoma among Aborigines averaging about 15 per cent, significantly highly than in the three remaining areas screened, Coastal Queensland and New South Wales, and the south eastern mainland areas, where the average prevalence of the condition was about 8 per cent.

Overall, 38 per cent of all Aborigines seen had trachoma, including about one in three of all Aborigines under the age of 20 and over the age of 60. A significant proportion of the elderly had very marked cicatricial trachoma, of the sort conventionally described as blinding or potentially blinding resions.

By comparison, less than two in every 100 non-Aborigines seen had trachoma, and in no area was the prevalence of the condition among Aborigines lower than in the highest area of prevalence of non-Aborigines.

The trachoma seen tended to be most severe in the areas where the prevalence was highest; in the zones with lower prevalences, and in all zones for non-Aborigines, the more severe categories of trachoma were quite uncommon.

An important problem, of particular concern to Aborigines, is the high prevalence of respiratory disease in many communities. Among the forms of respiratory disease known to be very prevalent are otitis media (middle-ear inflammation); chronic nasal discharges; colds (severe and mild); acute and chronic brochitis and pneumonia; all, however, are believed to form part of a general chronic respiratory infection sydrome, of a form known to be common among under-privileged groups the world over.

Ear Disease

Aborigines suffer from significantly more ear disease than non-Aborigines of the same age.

About 38 per cent of Aborigines overall, compared with 15 per cent of non-Aborigines, had pathology (otitis media, scarring or red drum) in one of both ears, according to recent survey by the Trachoma medical team.

Not only did non-Aborigines have significantly lower prevalence of otitis media, but the composition of conditions which made up the diagnosis was significantly different, results show that a finding of otitis media is a finding unusual at any age in non-Aborigines, but is especially unusual from the age of 12 on. This contrasts to Aborigines, among whom the finding is common in children and adolescents, and even, by comparison with non-Aborigines, in adults. There was no Aboriginal age group in which the prevalence of otitis media was lower than the highest prevalence age group of non-Aborigines, 2 per cent. It would appear that Aboriginal groups have, in total hearing loss due to otitis media 200 times that of non-Aboriginal groups. Much of this hearing loss is concentrated in the key developmental years. Similar conditions of prevalence occur with it could be expected that when the facilities necessary to overcome this enormous overburden of avoidable ear diseases are made available to and used by Aboriginal Australians, the pattern and duration of disease will also be altered to resemble the non-Aboriginal rate.

See graph for recent comparison.

Nasal Discharge

In the centre of Australia the prevalence of nasal discharge among Aboriginal Children reached 77.6 per cent of all children seen including 87.7 of those children who were aged between two and three.

With Aboriginal children the peak age prevalence for the condition was among two and three-years-olds, with 58.2 per cent affected. In the age group below that 45.3 per cent were affected while 50.8 per cent of children aged four and five were. Thus more than half the children of pre-school age were affected. Of these, 11.3 per cent had a purulent or mucopurulent discharge.

The proportion of Aboriginal children affected was still very high in the early school-age years: 40.3 per cent of children aged six and seven were affected, and 29 per cent of those aged eight or nine were. Overall, 42.8 per cent of Aboriginal children under the age of 10 had a nasal discharg

The prevalence was still high among young adolescents, though the prevalence fell through the adolescent years into adulthood. The lowest prevalence was among persons aged between 40 and 49, with 0.8 per cent affected; it rose in persons aged 50 - 59 and again in persons aged 60 or more.

Respiratory Disease

The high prevalence of middle-ear disease and nasal discharge in many Aboriginal communities pointed to high levels of respiratory disease in these communities. A number of studies of the spectrum of respiratory disease in Aborigines has shown that otitis media and nasal discharge are but parts of a complex of respiratory disease - an ascending order of infection and long-term damage to the respiratory system.

In children aged 14 or less there was a significant association between the presence of a loose cough and the prescence of follicular trachoma and nasal discharge ($p = 0.001$), but only a trend, not significant, for loose cough to be associated with otitis media.

The same association was found with abnormal auscultatory sounds and follicular trachoma and nasal discharge, although in this case there was also a significant association between abnormal auscultatory sounds and otitis media.

THE FINDINGS SHOWED, IN SHORT, A MARKED RELATIONSHIP BETWEEN THE PRESENCE OF RESPIRATORY DISEASE, AS CONSERVATIVELY DEFINED, AND SUCH CONDITIONS AS OTITIS MEDIA AND NASAL DISCHARGE, AS WELL AS FOLLICULAR TRACHOMA.

They suggest a common base for such disease - environmental conditions - as well, of course, as some of the common pathogens involved.

Alcoholism

Aboriginal people are consistantly raising alcoholism as a major factor contributing to their ill-health. The substantial increase of approximately one million dollars allocated in the main to 35 Aboriginal organisations to help combat alcohol problems in 1978-79 is an indication of the seriousness with which Aboriginal people view the problem.

The difficulty experienced by most organisations is that the funding provides for a "band-aid" approach and is not adequate to allow for preventive programs and follow-up programs.

Aboriginal people with this problem therefore usually contribute to the crime statistics, health statistics, unemployment and social welfare statistics and sadly to the ultimate breakdown of traditions and cultural values. Such a situation should not be allowed to continue to rob a people of their dignity and well-being.

Mental Health

Mental illnesses caused by emotional stresses associated with loss of dignity and self-respect, loss of spiritual basis for life, pressure to conform with alien cultural norms and an inability to cope with life were unknown in pre-contact days.

Stress related conditions such as alcohol abuse, loss of land associated with spiritual/cultural life basis, depression, hypertension through conformity to A-cultural pressure the breakdown of social and authority structures, a perception that social and personal crises are beyond ones ability to control or change, hopelessness and powerlessness should make for a prevalence of mental health far in excess of the Australian norm.

Yet for all their dispossession dispersal and deprivation evidence has been gathered to show that the levels of major psychiatric morbidity in Aboriginal communities are only as high as those of non-Aboriginal

Skin Diseases

While skin diseases are largely diseases experienced in childhood, nevertheless in early childhood they are approximately 20% worse among Aboriginal children than among non-Aboriginal children. Such diseases include scabies, rignworm, dermatitis, chronia ulceration etc. and are relatively easy to prevent given the correct environmental conditions and the observance of basic hygeine.

Leprosy

Recorded in the Leprosy register of the Northern Territory were 710 Aboriginals' compared to 40 non-Aboriginals. Such figures exist despite the use of anti-leprosy preparations, separate hospitals which provide specialist services and rehabilitation centres.

Malnutrition

The findings of a study group which conducted a survey between 1969 and 1974 in South Australian Aboriginal communities again revealed that there exists a higher prevalance among Aboriginal people than among non-Aboriginal people.

In addition the disease lowers the individuals resistance to infections and can contribute to obesity diabetes and cardi-vascular disease.

The traditional moves, of their hunter-gatherer existance prior to settlement ensured that an adequate supply of high protein food was equally available to each member of the tribal clan or group.

populations. Given their history such a low prevalence rate is a tribute to their spiritual affinity with their environment and their mental adaptability in any given situation. This is not to suggest, a situation for complacency but a situation from which one might be encouraged further in an effort to overcome the problems surrounding a depressing situation in Aboriginal health.

Infant Mortality Rates

In the Aboriginal Health Bulletin No 1 (Aboriginal Vital Statistics: An Analysis of Trends) Dr L.R. Smith concluded that the rate of excess infant mortality is over three times the actual infant mortality rate in the total population. Expressed in another way, over 75% of Aboriginal infant deaths would not occur if the general rate applied.

At present these are about 266 infant deaths a year 203 of those deaths should not occur and there is no indication on present trends that such rates will fall significantly. In fact, if current trends prevail, Aboriginal infants will still be dying at 20 per thousand more than the average for the total population.

Physical Environment

It is generally accepted that the high incidence of many infectious diseases amongst Aboriginal people is larely the result of their unsatisfactory environmental conditions.

For satisfactory environmental conditions to prevail Aboriginal communities will need adequate supplies of housing, electricity and wastage disposal.

According to a survey of 25 larger traditional communities in the Northern Territory conducted by their division of the Department of Health in 1976, 57% of those communities did not have an adequate water supply.

Similar facts can be found to emphasize needs in housing, wastage disposal electricity and other factors which affect the physical environment. A program to improve living conditions is as important to the raising of the overall standard of health among Aboriginals as the delivery of preventive and curative medical services.

Spiritual Environment

While most research reports acknowledge the tremendous need for improvement in the physical environment, few are able to come to terms with those areas of Aboriginal society which have access to better living conditions yet still experience lower standards of health than other Australians.

A report by the University of Adelaide in 1964 on the comparison of human, spiritual and material values of Aboriginal society with non-Aboriginal society concluded that while the human values were approximately equal for both societies the spiritual and material were markedly different.

They concluded that in Aboriginal society spritual values made up approximately 80% of the total value system and material values approximately 20%.

Their conclusion regarding those values in non-Aboriginal society reversed the figures 20% spiritual and 80% material.

It is of paramount importance therefore that any program to improve the physical and mental well-being of Aboriginal people does not ignore their spiritual well-being and that for a balanced holistic growth and development all programs should be run concurrently.

Of course the largest single consideration in any program to promote their human dignity and self-esteem is to consider their attachment to their land (see paper on land) and their need for a power base in Australian society (see paper on Aboriginals and Law).

In addition the program needs to assist the Aboriginals through specialist education programs (see paper on Education) to determine what aspects of their culture need to be strengthened, altered or even eliminated to give authenticity and viability to their cultural existence in a constantly changing world. Such programs can only do that as they widen the scope of their life choices and make them more realistic.

Conclusion

As the introduction indicated the state of Aboriginal health is bad. One can therefore only conclude that the funding and/or the health care systems are inadequate. Social and stress-related conditions amongst Aboriginals increasingly become a concern for Aboriginal people.

On the basis of infant mortality rates, Aboriginal health is three to four times worse than that of non-Aboriginals. Environmental infectious diseases are up to 12 times higher for Aboriginals than for non-Aboriginals. Little progress, if any, has been made in raising the overall standard of Aboriginal Health. If this deplorable situation would not be tolerated for non-Aboriginals why should Aboriginal people suffer??

The Government is soon expected to announce a new comprehensive and long-awaited policy on Aboriginal health.

The House of Representatives Standing committee on Aboriginal Affairs report called for urgent changes in health care programs two years ago.

The National Trachoma and Eye Health Program report was subsequently made available and it too called for urgent changes and initiatives to be implemented.

Dr Len Smith compiled a statistical analysis report on aspects of Aboriginal Health and this too has been in the hands of the government for more than a year.

The Prime Minister in 1979 called for a report:

"to draw together information on the broad range of government programs which directly or indirectly aim to improve the health and lifestyle of Aborigines and to clarify the direction of government policy."

Jack Waterford, writing for the Canberra Times (25 February 1981) made the following comments:

"Alas, the report on reports has now assumed the status of just another report. While its preparation allowed breathing space for the bureaucratic interests that wanted merely to maintain what was being done, contrary to the strong recommendations of all of the reports, the end product did not satisfy them, mostly because it endorsed the line of the earlier reports.

About a month ago the Minister for Aboriginal Affairs, Senator Baume, discussing this hope that he would be able to present a Government statement on plans for Aboriginal health in this Parliamentary session, tried to shift emphasis away from the PER report to the Ruddock report, seeing the need to respond to this - albeit more than a year-and-a-half late - as the rationale for making such a statement at all.

The Ruddock report was strong in its denunciation of aults but sketchy, apart from principle, in saying what actually should be done. The PER report, on the other hand, recommended specific changes in the powers and responsibilities, as well as in the focus, of government bodies eeeking to improve health conditions.

The PER has not been made public, despite many calls that it should be. But Mr Fraser has discussed its broad line with Aboriginal health service leaders.

Like all ther other reports it said that change was urgently needed. It also endorsed their arguments that present government health care delivery systems are ineffective (in producing health changes), and waste government money in achieving the little that they do.

It recommended that the direction expenditure should shift away from direct government (State and Federal) programs, which it says are not producing the goods, towards community services controlled by Aborigines themselves, which it says are.

The Federal Departments of Health and Aboriginal Affairs are slated for the way in which each has assumed great power without being forced to accept responsibility. The report would give basic responsibility to the Department of Health but insist that it be more accountable, while giving specific supervisory powers and responsibilities to the Department of Aboriginal Affairs.

The Department of Aboriginal Affairs was initially pleased with the report but has now altogether lost its enthusiasm, particularly as it has become aware of the power it will lose.

The States, particularly those like Western Australia that will be most affected, oppose the recommendations cutting their funds and doubt the efficacy of community-based services.

On the other hand, Aboriginal groups such as the National Aboriginal and Islander Health Organisation have strongly supported the report, recognising that, if it does not go as far in their direction as they would like, it at least goes some of that way.

The last year or more of delay after delay in getting a policy together has reflected the to-and-fro of the various interests and the victories, so far, of those who want no real change to the existing, much criticised system.

Those successes have sapped much energy from those who want change, and made them unwilling to co-operate with further inquiries and reports.

Each inquiry, after all, comes up with much the same conclusions and recommendations and repeats that these should be urgently implemented. Those who don't agree then ask for more time to study the report, and for time to study again the old ones in conjunction with the new."

The National Aboriginal Conference is therefore extremely concerned at the plight of their people and the lack of positive action on the part of all concerned with the implementation of recommendations within those reports.

RECOMMENDATIONS

The following recommendations and suggestions are taken and adapted from the Aboriginal Health Report from the House of Representatives Standing Committee on Aboriginal Affairs.

on the physical environment

water

1. the highest priority be given and immediate action taken to provide clean and adequate water supplies to all Aboriginal communities.

2. a determined effort be undertaken to eliminate as soon as possible the unhygienic sanitary pan system in Aboriginal communities.

3. an advisory group comprising experts in middle level technology be established and in consultation with the National Aboriginal Conference, Department of Aboriginal Affairs, relevant departments and the Australian Institute of Aboriginal Studies to: research various options for the provision of community and household facilities that best suit their needs; advise them on the most appropriate facilities that best suits their needs; monitor implementation of its advice to communities; facilitate employment of technical advisers by Aboriginal communities; and report to the Minister for Aboriginal Affairs.

4. priority for Aboriginals living in towns and moving into towns away from the fringes, be given to the provision of funds for meeting and upgrading their housing needs.

5. the Department of Aboriginal Affairs consult relevant Commonwealth and State Departments, local authorities and Aboriginal communities and organisations to define the responsibility for safe water, public hygiene services, housing standards and inspection of premises in Aboriginal settlements and communities, particularly fringe camps.

on cultural factors -

6. Aboriginal cultural beliefs and practices which affect their health and their use of health services such as their fear of hospitalisation, their attitudes to pain and surgery, the role of traditional healers and the differing needs and roles of Aboriginal men and women, be fully taken into account in the design and implementation of health care programs.

on health care programs -

7. savings to the State funded health services which result from the Government funded State Aboriginal preventive health programs be directed to the further development of preventive programs.

8. an independent evaluation team responsible through the NAC 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.

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9. the full range of choice of the various types of programs delivering health care to Aboriginals be maintained and, where appropriate, support increased

on self-determination -

10. 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.

on community development -

11. an inquiry be held into the implementation of the policy of self-determination as it affects community development.

on Aboriginal involvement -

12. 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.

on employment of non-Aboriginals -

13. training hospitals for nurses, university medical faculties and other teritary institutions introduce into their curricula, both at undergraduate and graduate level, a component which deals with Aboriginal health.

14. 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 teritary institution for professionals actively involved in providing health care to Aboriginals..

15. governments introduce special allowances and entitlements which recognise the unusual working conditions and the geographical, social and progessional isolation experienced by personnel working in predominantly Aboriginal communities in remote areas.

SUGGESTIONS

In addition to the recommendations listed on pages xv-xix the Committee has made a number of suggestions on matters that it considers require attention.

Many of these suggestions have a direct bearing on the recommendations and should be read inconjunction with the recommendations and have not been included in the list below.

Other important suggestions which are not related to recommendations are:

on the physical environment -

1. authorities supplying electricity accept greater responsibility for the adequate provision of electricity to Aboriginal communities.

2. Aboriginals undergoing transition to town life recevie assistance through the use of 'homemaker services' such as presently provided in Western Australia.

on social factors -

3. full support be given to outstations to prevent a movement back to settlements where services are available but where health is worse.

on cultural factors -

4. live-in facilities for patients and kin (particularly for mothers and babies) be provided in hospitals.

5. limited inpatient facilities be provided in large settlements so that only serious cases be evacuated to distant hospitals.

6. The practice of evacuating pregnant women before the birth of their babies, beyond the reach of daily family visits, be abandoned except where actively sought by the patient or where complications are anticipated.

7. at best one midwifery sister be appointed to each isolated community or health centre, Aboriginal health workers be given training in midwofery and the services of traditional midwives be utilised wherever possible.

8. every effort be made never to separate an infant or child from its mother.

9. there is an urgent need for State health authorities to establis a procedure by which the bodies of patients who have died in hospital can be returned immediately to their families.

on health care programs -

10. a cautious approach be adopted when consideration is being given to requests to support task forces.

on self-determination -

11. State and Northern Territory Governments and their agencies offe partial or full control of existing or expanded health services to Aboriginal communities.

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12. all support be readily available to help communities which have chosen to control their own medical service and not be withdrawn simply because of a downturn in expectations.

13. there is a need for an exchange of views and information between all types of medical services meeting the needs of Aboriginal and that these matters be considered at sponsored conferences organised at local, State and/or national levels.

on Aboriginal involvement -

14 Aboriginal communities contribute significantly to decisions about the appointment of non-Aboriginal health personnel to their communities.

15. every effort be made to give Aboriginal patients (those, for instance, in hospitals) access to Aboriginal healers if they so request.

16. Aboriginals selected for training courses be given every support.

17. any regulations which stand in the way of greater access of Aboriginals to vocational training in the health professions be reviewed immediately.

18. the Aboriginal health Worker Training Program developed in the Northern Territory be model upon which State training programs be based.

19. there be 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.

20. Aboriginality be an important qualification for employment in hospitals.

21. hospitals at communities like Cherbourg and Palm Island have their own hospital board.

on integration and co-operation between existing services -

22. there be full integration of all the activities of the Depart ment of Health in each Aboriginal community.

23. patient records be amalgamated or, where appropriate, duplicate provided that confidentiality and privacy are maintained.

24. there be greater 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