Australia's Aborigines and the Coming of the Colonists

Aboriginal people have lived on the island continent for, perhaps, 50,000 years or more whereas Europeans have been here for a little over two centuries. As with other indigenous populations, foreign colonisation had devastating and permanent effects on the original inhabitants and their way of life. They were deprived of their traditional hunting, food gathering and fishing places which had sustained them for millennia. After that they went short of food, became dependent on the colonists for their essentials, or managed to get food by other means which were considered illegal by the new settlers; for example by stealing food items or killing newly introduced livestock such as sheep or cattle. The newcomers also introduced potentially harmful materials like alcohol and tobacco; these caused serious damage to the health of the Aborigines and had negative social and emotional impacts on their lives. The foreigners introduced microorganisms to which Aboriginal people had not previously been exposed and, therefore, had no acquired immune protection. The introduction of smallpox, measles and tuberculosis into Australia is an important example. Domination by the colonists severely damaged the cultural framework of traditional society; this affected such areas as their rich diversity of numerous languages, religions, customary beliefs and ceremonies, and their behavioural patterns between different people and groups. The dominance of the recently arrived colonists and the collective impacts of the other factors just mentioned marginalised the First Australians who became "Outcasts in White Australia" in the words of Professor Rowley.

The 'Aboriginal Health Problem'

There was a widely held expectation which lasted through the late nineteenth to the early twentieth century that the Aboriginal race would die out; this was reflected in government policies and practices at least until the 1930s and 1940s. Although anthropologists and pioneering medical doctors were interested in the origins and physiology of the Aborigines, little systematic information was available about their state of health until the 1960s. It was then shown conclusively that their health was inferior to that of other Australians. The main findings which became public were that: (a) infant death rates were very high; (b) malnutrition and infections, like gastroenteritis and pneumonia, were rife in Aboriginal infants and young children; (c) infestations with gut parasites were rampant; (d) outcomes of Aboriginal pregnancies, such as birth weights, were unsatisfactory; and (e) life expectancy seemed much reduced in comparison with that of other Australians at that time. This became known around Australia as the "Aboriginal Health Problem". Not surprisingly, these findings caused a public outcry and the government was forced to try to correct the situation. In the half century since then billions of dollars have been spent, and countless strategies and programs have been introduced in attempts to correct these inequities. There have been some important improvements in the decades which followed. These have been particularly in such areas as reduced infant death rates, better maternal health and improved pregnancy outcomes, suppression of vaccine-preventable diseases by immunisation programs, and much lower rates of serious infections like gastroenteritis in young children. However, over the past 30 or so years there has been serious deterioration in some aspects of the health of Indigenous Australians. These have been so serious that they threaten to erode the important advances which have been made.
Much of the deterioration that has occurred in Indigenous health over recent decades has been due to a surge in so-called “lifestyle diseases”. These chronic diseases are now widespread and serious causes of illnesses, disabilities and premature deaths. They include such disorders as overweight/obesity, diabetes and its complications, heart disease, high blood pressure, stroke, and chronic renal disease and kidney failure. Collectively, these are now the most important contributors to the discrepancies in health standards and the higher death rates and reduced life expectancy of Indigenous people compared with other Australians. This unfavourable disease burden is being made worse by the physical, social and emotional damage that results from alcohol misuse, drug addiction, sexually transmissible infections, petrol sniffing, accidents, poisonings and inter-personal violence including suicide and homicide.

The Close The Gap Strategy
The slow progress that was being made towards improving the health of Indigenous Australians prompted a formal *Statement of Intent* from the federal government in 2008 which committed to ensure that Indigenous and other Australians “have equal life chances”. That commitment followed the then Prime Minister Rudd’s comments which anticipated within a decade halving the widening gap in literacy, numeracy and employment opportunities. It also predicted better opportunities for Indigenous children so that, within a decade “the appalling gap in infant mortality rates between Indigenous and non-Indigenous children would be halved and, within a generation, the equally appalling 17-year life gap between Indigenous and non-Indigenous when it comes to life expectancy” would be closed.

At this point it should be mentioned that health status of human populations is the *end result* of several determinants; these include genetic and environmental factors and, in the case of indigenous peoples who have been colonised by foreigners, by historical, political and powerful socio-economic issues. All of those determinants or predisposing factors would need to be corrected if a wide range of inequities, such as those mentioned above, were to be fixed. It is also relevant that some predisposing factors can be trans-generational; that is, precipitating factors or events, not necessarily transmitted genetically, can persist from previous generations to those that follow. Maternal ill health or malnutrition and smoking or continued alcohol consumption during pregnancy can have serious effects on the developing foetus and these negative impacts can last for more than one generation. There is evidence that some such impacts may persist in a family line for several decades.

This was the background on which the so-called Close The Gap Strategy was established. The targets set by the Australian government seemed desirable and were generally well received by the public. However, their feasibility was brought into question soon after they were announced. The goal of closing the gap in life expectancy was said to be “probably unattainable” and the ability to eliminate the high rates of chronic diseases and the resultant deaths within the 22-year timetable set by the government was described as “implausible” by a distinguished medical expert in this field.

Impediments to reaching the Targets within One Generation
When the Australian government committed in 2008 to several ambitious targets in Indigenous health and related fields the Aboriginal population was severely burdened by a heavy load of chronic illnesses, disabilities and high rates of premature deaths. Most of these conditions are long-term and/or lifelong and some have permanent disabilities such as blindness, hearing loss, amputations, respiratory failure or end-stage renal disease which cannot be reversed and are likely to contribute to early death. Nationally, these chronic diseases and intentional or unintentional injuries are much more prevalent in Indigenous Australians and are major contributors to their unsatisfactory health statistics. Providing regular, timely and
competent clinical services and effective health promotion and disease prevention programs can be difficult with some Indigenous groups and communities, particularly in rural and remote areas; this can place strains on the delivery of these services. Further comments will be made about this later.

**Why the Strategy is Failing**

The federal government reports annually on the outcomes of the *Closing the Gap* program. The seventh report was published in 2015; eight years after the Council of Australian Governments (COAG) set their targets. The then Prime Minister Abbott said in February this year that the findings were “profoundly disappointing” because of the lack of progress. The goals which were lagging included:

- closing the life expectancy disparity within a generation
- access for all Indigenous 4-year-olds in remote areas to early childhood education
- halving the gap in reading, writing and numeracy
- halving the gap in employment outcomes between Indigenous and other Australians.

Even in areas where encouraging improvements had occurred, such as lowering Indigenous infant mortality rates (IMRs), those rates had also simultaneously improved for non-Indigenous infants so that an unacceptable gap in *relative rates* (Indigenous compared to non-indigenous) persisted. For the combined jurisdictions of NSW, Qld, WA, SA and the NT, the relative rate was more than double. It was recently predicted that Indigenous infants born between 2010 and 2012 are likely to have lives that will be about 9 to 10 years shorter than those of their non-Indigenous counterparts.

It is evident, then, that the strategy is failing. Why? Difficulties in providing access to preventive and curative clinical services, particularly in remote areas, have already been mentioned. The reluctance of some Indigenous people and their families to use “mainstream” clinical services is well known and is another reason that services are not well utilised. The “revolving door” scenario of recruiting clinical staff, such as doctors and nurses, to some areas is a real problem, particularly in some small towns and remote areas. The ways that clinical services and staff are organised into an effective workforce around the nation is another issue which we shall come to later. And, of course, the root causes of socio-economic disadvantage and inadequate living standards and healthy lifestyles need to be addressed to correct the wellbeing of the Indigenous population.

Looking back on the evolution of the so-called 'Close the Gap' strategy and its failures to date leads to several conclusions. These include that its design and implementation were:

- well-intentioned
- ill-informed
- not adequately thought through
- bureaucratically clumsy and top-heavy
- naively optimistic
- rhetorical rather than realistic
- ignored biological imperatives about the long lag phase in development of chronic disease
- probably driven by political expediency and opportunism

**Providing health and clinical services to Indigenous Australians**

It is pertinent to ask “who provides health and clinical services to Indigenous Australians”? There are three main components in the current system:
1. federal, state and territory government health authorities
2. Aboriginal or Indigenous Medical or Health Services, and
3. private practitioners in medical and related fields and other similar non-government services.

These three sectors are poorly coordinated and, overall, ineffective; a fourth sector is needed which would generate much more direct involvement from local Indigenous people. It would also reduce the “top-down” approach and allow local people to participate in their own health care services.

The current three-pronged system often sees rivalry rather than cooperation in their service delivery roles. These three components can be territorial and suspicious of one another and may not share clinical information about their common patients or clients. This is inefficient and can be unduly expensive by duplicating the facilities, staff and personnel required. This is an unsatisfactory way to provide good clinical care and follow-up supervision for many patients, particularly those with chronic diseases. Each of the sectors that currently provide clinical care for Indigenous people can have funding shortages and may suffer from mismanagement. In addition, some Indigenous-specific services, including Aboriginal Medical Services, have had serious management problems which in some instances have led to insolvencies.

Overall, the current approach to eliminating inequities in health standards between Indigenous and other Australians is failing. Apart from not delivering the much needed improvements that were anticipated, this failure is having adverse effects on many people, especially the wider Indigenous community. They feel let down, frustrated, and alienated. A new approach is needed to break this impasse.

A new way forward

The federal government should acknowledge that the current strategy and programs are failing to deliver. The ‘Close the Gap’ slogan itself is now associated with numerous, repeated failures and should be abandoned. Why use an advertising-type slogan anyway? The entire approach of governments and their agencies should be comprehensively overhauled. The ultimate aim should be to produce strategies and programs that are formulated within a realistically achievable timetable with gradual rather than dramatic targets. This new approach could be considered evolutionary rather than revolutionary but it is much more likely to succeed whereas the current model is failing. This must be done in an open, consultative way which involves Indigenous people and communities in ways that have not been used previously.

As mentioned above, a fourth sector should be enlisted to complement the current three-pronged approach to clinical service delivery to Indigenous people. This fourth sector would use community-based and community-appointed people at the “grass roots” level to represent the local people in this cooperative venture. This system of local involvement does not operate in the present method in which Aboriginal Medical Services are run with little involvement of local people themselves. This new model would have the joint advantages of simultaneously encouraging increased Indigenous involvement in and responsibility for their future health and wellbeing. An essential ingredient would be commitment of all four elements to work cooperatively at local, regional and national levels to reach their common goal; improvement of the health status of Indigenous Australians. Unless this happens it is predictable that Indigenous health will be dogged by continuing failures as it has for almost half a century. Could the Australian government or the people allow this to happen?

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References


