Inequality of health between Aborigines and non-Aborigines

Introduction

This paper argues that a paradigm shift is required to positively deal with the health problems of Aborigines, from understanding the health problems of Aboriginal peoples as caused by proximate factors, to a perspective that emphasises the existence of underlying causes rooted in problems stemming from inequality.

This shift in thinking emphasises the sociocultural context of Aboriginal well-being as ultimately connected to the person's relationship to the land. As a new paradigm would enable the development of Aboriginal-centred understanding of well-being, where illness is attributed to the violations of taboos, and healing involves working within the supernatural framework within which Aboriginal persons locate themselves.

The paper will provide an overview of the differential health status of Aboriginal and non - Aboriginal Australians, outline the key features of the current paradigm for dealing with Aboriginal health problems, and consider the application of human rights principles pertaining to indigenous peoples as a framework for improving Aboriginal health in Australia.

The concept of health

Health does not mean the physical well-being of an individual, but refers to the social, emotional and cultural well-being of the whole community. For Aboriginal people this is seen in terms of a whole life view, where illness is understood as a total social experience.

The differences between Aboriginal and non-Aboriginal peoples notions of health are summarised in Table 1.

Table 1 Aboriginal and non-Aboriginal notions of health[1]

	Non Aborigines	Aborigines
Concepts of health	Physical, mental and social well- being - biomedical theory of health.	Good social relationships, taking part in rituals, sociomedical theory of health.
Health maintenance	Good food, good housing and environment, hygiene, immunisation checks, avoidance of alcohol, tobacco.	Observing kinship responsibilities, and taking part in health rituals.
Ways of communicating about health	The home, school, health settings, public education	Participation in social and religious activities.

The accepted paradigm for understanding Aboriginal health problems is that it predicates remedial infrastructure measures as a necessary step in redressing the health differentials between Aborigines and non-Aborigines. However, such an approach is seriously flawed in that it fails to provide expenditure which may enable Aboriginal peoples to attain a degree of self-sufficiency, through being accorded the right to economic and social self-determination.

A consequence of this approach is that the resources that could possibly have been directed to land acquisition, are instead provided as welfare-oriented programs which have the effect of perpetuating dependency and fail to address the underlying context stemming from dispossession.

[1] From Mobbs R. “In sickness and health: the sociocultural context of Aboriginal well-being, illness, and healing”. In Reid J, Trompf P (eds). *The health of Aboriginal Australia*. Sydney, Harcourt Brace Janovich, 1991, 302.

An analysis of expenditure data according to a classification scheme devised by the Aboriginal Affairs Planning Authority in the Daube report shows there was $386,580,000 estimated total expenditure in the year 1992/93 on both specific and mainstream components of the Aboriginal affairs budget in this State, about 81 % of this funding went to social well-being programs and only 12% went to economic development initiatives.[2] (See Tables 2 and 3.)

Table 2: Expenditure by tertiary program category, 1992/93

	Aboriginal specific	Mainstream	All programs
Economic	$33 263,000	$13,763,000	$47,026,000
Reconciliation	$ 18,969,000	$ 1,539,000	$20,508,000
Self-determination	$3,974,000	$2,936,000	$6,910,000
Social	$50,580,800	$261,555,300	$312,136,100
All tertiary	$106,786,800	$279,793,300	$386,580,100
Economic	8.6%	3.6%	12.2%
Reconciliation	4.9%	0.4%	5.3%
Self-determination	1.0%	0.8%	1.8%
Social	13.1%	67.7%	80.7%
All tertiary	27.6%	72.4%	100.0%

Source: Task Force On Aboriginal Social Justice, April 1994, Vol 1.

An example of the infrastructure approach at the Commonwealth level is contained in a 1976 Commonwealth parliamentary report.

> *"We are of the opinion that improvements in the physical environment of Aborigines and, above all, in their housing standards, will contribute directly and dramatically to improvements in the general level of Aboriginal health. Better housing and better nutrition are the key elements in any program to improve Aboriginal health standards... (This also requires) changes in the attitudes and priorities of non-Aboriginal society ... if Aborigines are to improve their health standards".*[3]

By attempting to separate the causes of Aboriginal health problems into proximate and underlying causes the reader may obtain the erroneous impression these causes are conceptually distinct. Many of the studies referred to below deal with the proximate determinants of Aboriginal ill-health, such as poor environmental conditions, poor nutrition, and alcohol abuse.

However, these proximate causes, including extremely high levels of unemployment, limited educational opportunities, inadequate housing, grossly inadequate environmental facilities (eg substandard water supplies and sewerage services), and very limited community services (eg power supplies, sub-standard roads and access to public transport), are implicated in a complex causal web in which socio-economic conditions play a major determining role.

Underlying these profound social and economic disadvantages are deeper structural factors, including a history of cultural dislocation and under-valuing, marginalisation through dispossession, a history of political oppression and an experience of discrimination, alienation and entrenched racism.

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[2] Task Force on Aboriginal Social Justice (Daube M chairman). *Report*. Perth, Ministry of Premier and Cabinet, 1994, Vol 1, 139.

[3] Australia, Parliament, Senate, Select Committee on Aborigines and Torres Strait Islanders. *The environmental donditions of Aborigines and Torres Strait Islanders and the preservation of their sacred sites, Final Report*. Canberra, Australian Government Publishing Service, 1976, 137.

Table 3: Expenditure by secondary program category, 1992/93

	Aboriginal specific	Mainstream	All programs
Community development	$2,301,000	$2,967,800	$5 268,800
Consultation	$ 1,445,000	$ 1,445,000	
Cultural awareness	$12,885,000	$1,539,000	$14,424,000
Economic development	$885,000	-	$885,000
Education	$ 18,304,000	-	$ 18,304,000
Employment	$971,000	$971,000	
Employment & training	$5,632,000	-	$5,632,000
Family	-	$3 227,500	$3 227,500
Health	$ 16,556,000	$ 141,809,000	$ 158,365,000
Housing	$ 19,153,000	$ 13,456,000	$32,609,000
Infrastructure	$20,036,000	$13,763,000	$33,799,000
Land development	$6,882,000	-	$6,882,000
Miscellaneous	$427,000	$5,051,000	$5,478,000
Monitoring	$363,000	-	$363,000
Offender	$766,000	$96,657,000	$97,423,000
Youth	$ 180,000	$ 1,323,000	$ 1,503,000
All secondary	**$106,786,000**	**$279,793,300**	**$386,579,300**
Community development	0.6%	0.8%	1.4%
Consultation	0.4%	-	0.4%
Cultural awareness	3.3%	0.4%	3.7%
Economic development	0.2%	-	0.2%
Education	4.7%	-	4.7%
Employment	0.3%	-	0.3%
Employment & training	1.5%	-	1.5%
Family	-	0.8%	0.8%
Health	4.3%	36.7%	41.0%
Housing	5.0%	3.5%	8.4%
Infrastructure	5.2%	3.6%	8.7%
Land development	1.8%	-	1.8%
Miscellaneous	0.1%	1.3%	1.4%
Monitoring	0.1 %	-	0.1 %
Offender	0.2%	25.0%	25.2%
Youth	-	0.3%	0.4%
All secondary	27.6%	72.4%	100.0%

Source: Task Force On Aboriginal Social Justice, April 1994, Vol 1.

The health differential of Aborigines and non Aborigines

Aborigines[4] are the least healthy identifiable sub-population in Australia; across a wide spectrum of measures their health is below that for the non-Aboriginal population. This disparity in health between Aborigines and non-Aborigines, which has been referred as being like a 'fourth world' health status, has been extensively documented over a long period of time.[5] For example, in 1973 it was stated

[4] The term Aborigines used in this paper is intended to refer both Aborigines and Torres Strait Islanders.

[5] Australia, Parliament, House of Representatives, Standing Committee on Aboriginal Affairs. *Report on Aboriginal health and related matters in the South-West of Western Australia*. Canberra, Australian Government Publishing Service, 1976; Australia, Parliament, House of Representatives, Standing Committee on Aboriginal Affairs. *Aboriginal health*. Canberra, Australian Government Publishing Service, 1979; Gray D, Atkinson D. *Review of Aboriginal health policy In Western Australia*. Perth, Community Health Research and

"(i)f present Aboriginal birth and death rates continue unchanged, in the total Australian population by the end of the century Aborigines will contribute 4 per cent of the births, 20 per cent of the infant deaths, over 50 per cent of the deaths in the second year of life, and around 20 per cent of deaths in the remaining years of early childhood".[6]

These disparities can be summarised as follows:

- Aboriginal infant mortality rate is nearly three times higher than the rates for the Australian population;[7]
- Aboriginal women have a much greater proportion of low birth weight babies, ie less than 2,500 grams compared to non-Aboriginal women;[8]
- Aboriginal women have a much higher rate of fertility compared to non-Aboriginal women, largely due to the excess number of births involving young Aboriginal women;[9]
- disorders of growth and nutrition are prevalent among much of the Aboriginal population;
- Aborigines use health services more frequently than the non-Aboriginal population and are admitted to hospitals 2.5-3 times more frequently than non-Aborigines; and
- certain diseases disproportionately affect Aborigines, including diabetes mellitus, circulatory system disorders, respiratory disorders, ear disease, eye disorders, particular communicable diseases, cancer, urinary tract infections, mental disorders and injuries.[10]

One of the most striking indicators of the poor health status of Aboriginal people are their life expectancies and mortality rates. The life expectancy of an Aboriginal person born in Western Australia in 1989-1991 was 57 years for males and 62 years for females; for both sexes being 18 years less the life expectation at birth of an non-Aborigine.[11] The major reason for this low life expectancy is the high risk of death for young adult males. These life expectancies are similar to the life expectancy of 54 years reported in third world countries like Bangladesh in 1983.[12]

An examination of the leading causes of Aboriginal mortality in this State over the period 19831989 suggests a causal relationship between lifestyle, deculturation and patterns of diseases. For instance, the leading cause of death, due to diseases of the circulatory system, which occurred at 10-20 times the expected rate of other Australians in young and middle-aged adults, may be

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Training Unit, Department of General Practice, University of WA, 1990; Osborne PD. *The other Australia: the crisis in Aboriginal health*. Hobart, Department of Political Science, University of Tasmania, 1982; Reid J, Trompf P. *The health of Aboriginal Australia*. Sydney, Harcourt Brace Janovich, 1991; Wilson P. *Black death white hands*. Sydney, Allen and Unwin, 1982.

[6] Moodie PM. *Aboriginal health*. Canberra, Australian National University Press, 1973, 273 cited in Middleton MR, Francis SH. *Yuendumu and its children - life and health on an Aboriginal settlement*. Canberra, Australian Government Publishing Service, 1976, 1.

[7] Thomson N, Briscoe N. *Overview of Aboriginal Health status in Western Australia*. Australian Institute of Health Aboriginal and Torres Strait Islander Health Series No. 1. Canberra, Australian Government Publishing Service, 1991.

[8] In 1988, 13% of babies born to Aboriginal women, were of a low birth weight, compared to 6% of babies born to non-Aboriginal women: ibid.

[9] In 1988, 31.9% of Aboriginal women who had babies were 19 years or younger, compared with 5% of non-Aboriginal women: ibid.

[10] Western Australia, Task Force on Aboriginal Social Justice (Daube M chairman). *Report.* Perth, Ministry of Premier and Cabinet, 1994, Vol 1, 303-305.

[11] Unwin E, Thomson N, FitzGerald P. "Aboriginal health - current status, trends and projections". (1994) 4 *Health Statistics Western Australia*. Perth, Health Service Statistics and Epidemiology Branch, Health Department of WA, 1992; Veroni M, Rouse I, Gracey M. *Mortality in Western Australia 1983-1989 with particular reference to the Aboriginal population*. Perth, Health Service Statistics and Epidemiology Branch, Health Department of WA, 1992.

[12] Gray D, Atkinson D. *Review of Aboriginal health policy in Western Australia*. Perth, Community Health Research and Training Unit, Department of General Practice, University of WA, 1990.

> *"attributed to dietary changes, alcohol and tobacco usage, and to a more sedentary lifestyle ... particularly in more settled and urbanised areas".*[13]

The same study reported the emergence of so-called "lifestyle diseases", such as ischaemic heart disease, in Aboriginal peoples in Western Australia. The authors noted that whereas over the period 1972 to 1988 there was a decline of 50% in coronary heart disease mortality in non Aboriginal West Australians, such a decline did not occur in the Aboriginal population.[14]

The second ranked cause of mortality was reported to be due to endocrine, metabolic, nutritional and immune disorders, much of which was related to diabetes mellitus. The third ranked cause of mortality, due to genitourinary diseases, was higher in females than males and was highest in the remote regions of the State. This may have been a disease, and unlike some other diseases, most likely caused by environment factors in which more traditional Aborigines lived, as such being "related to predisposing factors such as dehydration, unsatisfactory sanitation and limited health care".[15]

The relationship between Aboriginal health problems and social dislocation is also indicated from mortality data over the period 1976 and 1980 from Queensland, which found deaths from cardiovascular disease are more than twice as frequent on Aboriginal reserves.

> *"Reserves which had significantly higher rates of death were those which were close to an urban centre and which had historically been established as receivers of Aborigines forcibly removed from other places."*[16]

Comparison with other indigenous peoples

The age structure of the Aboriginal population resembles that of a developing country. For instance, in 1986, 39.5% of Aboriginal people were less than 15 years of age, compared to 24.2% in the same age category in the non-Aboriginal population. In the same year, only 3.6% of Aboriginal people were aged 65 or over compared to 9.3% in the wider population.

> *"The Australian Aboriginal population has been described as being part of a 'fourth world' of dispossessed indigenous minority populations, which also includes such peoples as Maoris and native American Indians. While different in many ways, these populations share an experience of social disruption following imposed contact with an unfamiliar external culture. Dispossession and the consequent loss of control and autonomy manifest in many ways, and it has been argued that poor health is one."*[17]

A comparative study of indigenous mortality patterns of Australian Aborigines, Canadian Indians, and New Zealand Maoris, found a characteristic pattern of high mortality during early and middle adulthood across all groups, though there were some differences in the most important cause of death.[18]

The paradox of Aboriginal health, in common with other indigenous peoples, is that they experience diseases typically associated with poverty, substandard living conditions and deprivation, as well as diseases associated with Western affluence, such as chronic heart and vascular disease.

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[13] Veroni M, Gracey M, Rouse I. "Patterns of mortality in Western Australian Aborigines, 1983-1989". (1994) 23 *International Journal of Epidemiology*, 79.
[14] Id, 80.
[15] Id, 79.
[16] Hogg RS. "Indigenous mortality rates and causes - an international comparison between Australia, Canada and New Zealand". (1992) 16 *Aboriginal and lslander Health Worker Journal*, 14.
[17] Harrison J, Moller J. "Injury mortality amongst Aboriginal Australians". (1994) 7 *Australian Injury Prevention Bulletin*.
[18] Hogg RS. "Indigenous mortality rates and causes - an international comparison between Australia, Canada and New Zealand". (1992) 16 *Aboriginal and Islander Health Worker Journal*, 13.

> *"There are two contrasting interpretations that are possible of Aboriginal mortality: that for some Aboriginal people, excess mortality and morbidity are attributable to 'diseases such as infection and under nutrition which are usually associated with third world countries', whereas on the other hand, Aborigines die at a greater rate of diseases associated with a Western lifestyle."*[19]

Responding to Aboriginal health problems

Government responses towards improving Aboriginal health can be classified into four approaches.[20]

Firstly, by the provision of health services, especially the development of community controlled Aboriginal medical/health services. This approach has been underpinned by the formation of specialised agencies targeted to Aborigines, through state-wide community health services, regional Aboriginal medical services, and the employment of Aboriginal health workers.

Secondly, by improving environmental conditions, through the provision of housing, and basic infrastructure and the development of an Aboriginal environmental health worker training program.

Thirdly, by establishing services to deal with specific health problems. However, as only the more visible problems are likely to be resourced, this has meant that some programs have involved an allocation of resources which may not be commensurate with their importance. Examples include programs to treat trachoma and to treat Aboriginal infants and young children with impaired growth.

Fourthly, through health promotion. Health promotion suffers from the handicaps of being conducted in isolation from therapeutic activities and as it is likely to be based on non Aboriginal priorities, may be irrelevant to the daily problems faced by Aborigines. Also, compared to the other approaches, health promotion has tended to be less well funded.

It is submitted that each of these approaches are deficient, in that they focus

> *"solely upon diseases incidence, housing, and mortality and morbidity rates (while paying) ... scant attention to the Aboriginal word view of well-being, which is socially, not biologically or pathologically, determined and which begins, and ends, with the land and its rightful indigenous inhabitants: the people, the animals, and the plants".*[21]

Over the past two decades the Commonwealth government has assumed a primary responsibility for Aboriginal policy, except for matters to do with land administration.[22]

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[19] Western Australia, Task Force on Aboriginal Social Justice (Daube M chairman). *Report. Volume 1*. Perth, Ministry of Premier and Cabinet, 1994, 302.

[20] Adapted from Gray D, Atkinson D. Review of Aboriginal Health Policy In Western Australia. Perth, Community Health Research and Training Unit, Department of General Practice, University of WA,
1990.

[21] Mobbs R. "In sickness and health: the sociocultural context of Aboriginal well-being, illness, and healing". In Reid J, Trompf P (eds). The Health of Aboriginal Australia. Sydney, Harcourt Brace
Janovich, 1991, p. 297-298.

[22] However, this may change as a result of the judgment of Mabo (No 2), and the passage of the Native
Title Act 1993, which established the National Native Title Tribunal: Australia, Commonwealth Ministerial Committee On Mabo. Mabo - The High Court Decision On Native Title, Discussion Paper.
Canberra, Australian Government Publishing Service, 1993; Australia, Parliament, Department of Parliamentary Library. Mabo Papers, Parliamentary Research Service, Subject Collection No. 1.

Serious shortcomings have been detected in the way the Commonwealth funding has been utilised, as it has the effect of fostering separate and ineffective Aboriginal health services, with mainstream health services taking little account of the need for culturally appropriate and acceptable services.

States like Western Australia are able to eschew their responsibilities to ensure Aboriginal communities having the same entitlement as other citizens to mainstream services. This is done in a most ingenuous, if not reprehensible way, by disclaiming responsibility by claiming Aboriginal affairs is not a State matter.

> *"As a result of past Commonwealth/State agreements following the 1967 Referendum, the Commonwealth has a direct responsibility for funding specific services to Aboriginal communities that are a State responsibility to the wider community. This particularly relates to capital works associated with housing, water, electricity, sewerage and roads to remote areas."*[23]

Another means by which Aboriginal rights to the mainstream are infringed is detailed in a House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs report released in November 1993. In the example given SECWA, a State government trading enterprise, exacts a premium from the Commonwealth, as it will only connect electricity to Aboriginal communities if the Commonwealth pays the infrastructure cost plus a 20% administrative margin.

> *"Since being corporatised, the SECWA has no community service obligations and has been insisting on making a profit on Commonwealth funded projects which are, in the main, providing the services which SECWA should have provided in the first place. This is one of the most obscene examples the Committee has found, of Aboriginal Affairs funding being diverted into a top-up of mainstream service funding - a mainstream service which discriminates against Aboriginal citizens."*[24]

This approach has meant that many Aboriginal health services tend to be small organisations employing few health workers that are overwhelmed by large numbers of Aboriginal clients, as

> *"these organisations were originally intended to fill gaps in the health system. They have now virtually become the sole source of health care for many communities, because they are culturally appropriate and acceptable to Aboriginal and Torres Strait Islander people and take into account the special needs of Aboriginal and Torres Strait Islander people".*[25]

Problems arise as the Commonwealth mostly implements health programs by specific-purpose grants, usually through state-run organisations. It has been observed that as a result of these concurrent administrative arrangements there is "often a perception that each government's role is discretionary rather than a responsibility".[26]

Canberra, Australian Government Publishing Service, 1994; Australia, Parliament. Social Justice Statement 1994-95 - Budget Related Paper No. 1. Canberra, Australian Government Publishing Service, 1994.

[23] Western Australia, Commission to Review Public Sector Finances (McCarrey chairman). Agenda for Reform Volume 2. Perth, Western Australian Government Printer, 1993, 272.
[24] Australia, Parliament, House of Representatives, Standing Committee on Aboriginal and Torres Strait Islander Affairs. Access and Equity - Rhetoric or Reality? Canberra, Australian Government Publishing Service, 1993, 8.
[25] Australia, Parliament, House of Representatives, Standing Committee on Aboriginal and Torres Strait Islander Affairs. Access and Equity - Rhetoric or Reality? Canberra, Australian Government Publishing Service, 1993, 104-5.
[26] Robbins J. "Volatile substances: coordinating petrol-sniffing programs for Aboriginal communities in a Federal system". (1993) 52 Australian Journal of Public Administration 65, 66.

Problems also occur because of divergence between the way the Commonwealth and state-run programs conceptualise their goals and outcomes. Whereas Commonwealth policy tends to have a client-specific focus, at the state and regional level programs are delivered along functional lines.

Since the l990s there has been a greater willingness to reduce the disparities between Aboriginal and non-Aboriginal health status. The impetus for this effort can be traced to two primary influences, the National Aboriginal Health Strategy (NAHS), and the Royal Commission into Aboriginal Deaths In Custody (RCIADIC).

The components of the NAHS were developed by a working party that consulted extensively with Aboriginal peoples throughout Australia and presented its final report to a combined meeting of State, Territory and Commonwealth Ministers responsible for health and Aboriginal affairs in March 1989.[27] The Ministerial group established the Aboriginal Health Development Group to advise them on the report and the Commonwealth Government announced its response in December 1990.

Under the NAHS the Commonwealth will provide an additional commitment of $232 million over a five year implementation phase, 1990/91 to 1994/95. This spending will be in addition to the $1.3 billion estimated that will be provided by the Commonwealth over the five year period for Aboriginal health and related services.[28]

The RCIADIC was jointly established by the Commonwealth, Northern Territory and all State governments to investigate 99 Aboriginal deaths in police custody between 1 January 1980 and 31 May 1989.

Of these two influences, it is submitted the findings of the RCIADIC developed a much critical approach of the failings of institutional systems. This occurred as the Commission provided a comprehensive analysis of the social circumstances of Aboriginal peoples from the time of the settlement up to the end of the 1980s, their position of social and economic disadvantage and conclusively linked these underlying factors to Aboriginal people's rate of detention in custody,[29]

> *"The RCIADIC also found that those who died did not lose their lives as a result of unlawful violence or brutality. They were found to have lived lives as victims of entrenched and institutionalised racism and discrimination."*[30]

The Commonwealth's response to the RCIADIC was an additional $400 million, to be used for immediate activities involving legal and justice issues and programs for alcohol and substance abuse, and long-term programs to reduce dependency, increase employment participation, and improve the opportunities for young people.

The rights of indigenous peoples

The application of the rights of indigenous peoples needs to be weighed against this backdrop of complex health problems and constraints, to deal with proximate and underlying causes of Aboriginal ill-health.

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[27] Australia, Department of Community Services and Health. Australian Health Ministers' Conference and Associated Joint Meetings March 1989. Canberra, Australian Government Publishing Service, 1989.

[28] The NAHS funds will be used to address urgent needs in Aboriginal communities such as housing, water, sewerage, electricity, communications and roads; establish new, and enable upgrading of existing,
Aboriginal community controlled health services; augment the capacity of ATSIC; and expand alcohol
and other drug programs.

[29] Which was found to be 29 times higher than for the general community.

[30] Australia, Department of Foreign Affairs and Trade. Human Rights Manual. Canberra, Australian
Government Publishing Service, 1993, 109.

The principle of equality of all persons regardless of their race, sex, colour or ethnic origin can be traced back to the 1789 French Declaration of the Rights of Man and the Citizen, which states that “all men are born and remain free, and have equal rights”. This fundamental principle has become established as a norm under international law since 1945 and is contained in key human rights instruments. It is mentioned at a number of points in the Charter of the United Nations[31] and is contained in the Universal Declaration of Human Rights in Articles 1, 3 and 7.[32]

Article 1 provides that "All human beings are born free and equal in dignity and rights". It has been stated that Article 1

> *“defines the basic assumptions underlying the Declaration, namely - the right to liberty and equality is everyone's birthright and is inalienable, and that the human person is a rational and moral being and thus different from other creatures on earth and therefore entitled to certain rights and freedoms with other creatures do not enjoy”.*[33]

The principle of equality is reiterated in Common Article 2 of the two International Covenants on Human Rights, the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR).[34] A number of other international measures have been developed with the object of comprehensively dealing with racial discrimination and more latterly the concept of indigenous rights. These include:

- International Convention on the Elimination of all Forms of Racial Discrimination (ICERD);[35]
- International Labour Organisation (ILO) Convention Concerning Discrimination in respect of Employment and Occupation (ILO No. 111), which prohibits both racial and other forms of discrimination in the context of employment;[36]
- the 1976 International Convention on the Suppression and Crime of Apartheid, which defines the practice of apartheid as a “crime against humanity”;
- the 1962 UNESCO Convention against Discrimination in Education;
- International Labour Organisation Convention Concerning the Protection and Integration of Indigenous and Other Tribal and Semi-Tribal Populations in Independent Countries (ILO No. 107); and
- International Labour Organisation Convention Concerning Indigenous and Tribal Peoples in Independent Countries (ILO No. 169).

There has been a tortuous path along which the cause for self-determination, for autonomy and for recognition by indigenous peoples has trod (or more correctly stumbled?), has involved a slow, if somewhat protracted series of investigations, spread over nearly 40 years. ILO No. 107, adopted in June 1957, was, with the benefit of the wisdom of hindsight, a conservative document, in that it did not recognise indigenous groups within nation states as being people as understood by international law.

Indeed, a United Nations declaration of 14 December 1960 stated that

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[31] Established in October 1945.
[32] Proclaimed by the UN General Assembly in December 1948.
[33] Australia, Department of Foreign Affairs and Trade. Human Rights Manual. Canberra, Australian Government Publishing Service, 1993, 38.
[34] Both adopted by the UN General Assembly in December 1966, and came into force in January and March 1976, respectively.
[35] Came into force in January 1969, was ratified by Australia and included in the Schedule of the Racial Discrimination Act 1975.
[36] Ratified by Australia and included in First Schedule of the Human Rights and Equal Opportunity Commission Act 1986.

> *"Any attempt aimed at the partial or total disruption of the national unity and the territorial integrity of a country is incompatible with the purpose and principles of the Charter of the United Nations".*[37]

It was not until 1975 in the International Court of Justice, in the Advisory Opinion on Western Sahara case, has there been a broadening of the definition to self-determination, such that it became possible for nations to consider the existence of the articulated voice of indigenous peoples.[38]

ILO No. 169, adopted in June 1989, is arguably only a modest improvement on the paternalistic ILO No. 107, which used the terminology of "integration". The 1989 convention, while conceding in the preamble that States should recognise indigenous peoples have a right to

> *"exercise control over their own institutions, ways of life and economic development and to maintain and develop their identities, languages and religions, within the framework of the States in which they live".*

One commentator has recently suggested that an advantage for the indigenous inhabitants for the ratification of ILO No. 169 is that it "could give the indigenous peoples in that country more rights than they have at present".[39] However, a concern this writer has with the statement of rights pertaining to health in ILO No. 169, Article 25, is that does not challenge the biomedical scientific paradigm that is embodied in Western medicine. If the achievement of better health of indigenous peoples is understood as a matter of making the paradigm more "user friendly", then it is contended the well-being of indigenous peoples will not be advanced.

It is conceded that some of these reservations have been dealt with in the 1993 revision of the Draft Declaration of the Working Group on the Rights of Indigenous Peoples, as it includes provisions for special measures for improvement in social and economic conditions (Article 22), and provides for the use of traditional health practices (Article 24).

Conclusion

The paper has shown that mortality and morbidity patterns among Aboriginal people are complex, in some respects, the pattern of ill-health among them is similar to that amongst the non-Aboriginal population in the early years of this century. Therefore, to reduce the excess levels of mortality and morbidity among Aboriginal people, it may be instructive to look at the factors that have led to improvements in health among the non-Aboriginal population.

Most of this improvement can be attributed to the reduction of infectious disease through improvements in environmental conditions and the standard of living. Immunisation had a role, but therapeutic intervention has itself made little impact as most reductions in infectious disease mortality took place before the advent of any effective intervention, including immunisation. Therefore, we must recognise that spending on medical services is dealing with problems after the fact and will not in itself produce good health in a population.

It may be partially true that a poor knowledge of health issues is often a cause of health problems among Aboriginal people, particularly infectious and chronic diseases, this fails to take account of the interplay of many other factors in the health status of Aboriginal peoples.

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[37] Cited in Kamenka E, Tay AES. "The Aboriginal people of Australia: law, the constitution and Aboriginal rights". (1993) 18 Bulletin of Australian Society of Legal Philosophy 89, 91.

[38] Cf Mabo v Queensland (1992) 66 CLR 408 per Brennan J at 421-422; Kamenka E, Tay AES. "The Aboriginal people of Australia: law, the constitution and Aboriginal rights". (1993) 18 Bulletin of
Australian Society of Legal Philosophy 89.

[39] Iorns CJ. "Should the Australian government ratify International Labour Organisation Convention No.
169?" (1993) 3 (October) Aboriginal Law Bulletin 3.

> *"Substantial social and economic disadvantage, a history of cultural dislocation and undervaluing, a history of political oppression and an experience of substantial discrimination result in extremely poor health for Aborigines. These reasons vary according to the different circumstances of given Aboriginal communities. For example, remote communities have not seen the same improvements to their physical environment as have other Australians and this is reflected in their health problems. Many of these communities have, however, maintained social and cultural integrities which Aborigines living in urban communities have been unable to do. The latter experience health problems relating to their adverse social environment".*[40]

Optimally, health care services should strive to achieve the state where individuals are able to achieve their full potential as human beings, and bring about the total well-being of their communities. However, it is suggested because of the prevailing view that Aborigines don't have a credible set of precepts that constitute medical knowledge (as we understand it against the benchmark of established medicine) nor that they can claim to have a system of health care beliefs to be challenged, a paradigm shift is necessary.

This would mean giving equal validity to an Aboriginal world view of health and illness, which has been described in relation to a particular community, that as

> *"an individual's health status is largely a foregone conclusion, in that it is determined by that person's conception and birth ... as a group (the community) do not therefore entertain the notion that health and well-being can be achieved through human endeavour. Instead they implicitly accept the normality of individuals and their health status according to age and sex".*[41]

A key linkage to improving Aboriginal health is the establishment of the social context that is favourable to well-being. This step requires the direction of resources to economic development initiatives, for otherwise most Aboriginal people will remain in poverty unable to exercise any right of self-determination. Indeed, many will remain dependent upon government transfer payments, and as their numbers are increasing more rapidly than those of the non-Aboriginal population, are likely to consume a disproportionately greater amount of expenditure.

The development of the concept of indigenous rights contained in the Draft Declaration of the Working Group on the Rights of Indigenous Peoples, unlike earlier ILO Conventions, does have the potential for improving the health of Aboriginal peoples. It is suggested that these declarations need to adopt a broader notion of health than conventionally possible through the model embodied by Western scientific medicine.

The improvement of the well-being of Aborigines necessarily involves the recognition of underlying as well as proximate causes of illness, the adoption of a new paradigm to underpin an Aboriginal-centred understanding of well-being, where illness is attributed to the violations of taboos, and healing involves working within the supernatural framework within which Aboriginal persons locate themselves.

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