ABORIGINAL HEALTH (2000)

On 17 May 2000, I was invited to speak at the Warringah Shire Council north of Sydney. My topic was Aboriginal health. I argued against John Howard, who was in favour of the equal provision, person to person, of health for Indigenous Australians. I argued that Indigenous Australians needed more health provisions in order to be equal.

First, let us set some context. This is important, as things are not as simple as they may seem. Australia's health generally is that of an industrialised nation. Most children survive; there is not much infectious disease; people generally live until some part or other wears out.

Many emerging nations are worse. Certainly, they have some older people, but they have a lower percentage than we do and they have a higher mortality in infancy and childhood than we do, and they have a much higher incidence of infectious disease. That means that the average age is skewed downwards—many more children and young people.

Of course, one wonders how we can say even those things with confidence—well, we measure many things and can actually see some patterns. First, we should realise that there is no such thing really as the typical Australian experience. Health outcomes in Australia are viciously unequal. Our politicians may say that there is 'equality of access' (although that too can be contested—just ask anyone who has had a moment of need for themselves or their families), but there is certainly not 'equality of outcome' in spite of some egalitarian preferences which we seem to hold as a society.

To be better off financially means to have better health as well. So the richer and better educated are more healthy. The poorer and less educated are sicker and die earlier. This relationship is true for most things. It is even possible to draw maps of a city like Sydney and show that diseases occur unequally in different LGAs [local government areas] across the metropolitan area.

In the UK in 1911 the then registrar-general divided that society into five groups and that classification, although it is grossly imperfect, has lasted. For all its defects, it has allowed us to track events over time and to determine that social class and health outcomes are related. Health outcomes in Social Class I are better than those of Social Class V. What is more, the improvements of recent decades, while they have occurred for the richest and the poorest alike, have occurred more for the richest and less for the poorest—at least in the UK.

This relationship applies here too. The richer and better educated do better healthwise. It is only with these backgrounds that we can begin to look at health.

Australian Aboriginals make up about 1 per cent to 2 per cent of the population. It is actually hard to know exactly how many, as the current definition has three parts: being of Aboriginal descent; identifying as Aboriginal; being accepted by others as Aboriginal. The previous policy was assimilation and many people 'hid' any Aboriginality in their families. More people have identified themselves as Aboriginal with each census, but we are still probably under-reporting and underestimating the Aboriginal populations.

The second main thing we should understand is that Australian Aboriginals are economically depressed. They are poorer than whites, have worse housing, less education, more unemployment and vastly more imprisonment. On almost every socioeconomic indicator, they are way below the Australian average. These facts notwithstanding, the Aboriginal middle class is increasing fast. And people in that class behave like other people in that class, be they Aboriginal or non-Aboriginal.

Perhaps the proper comparator for Aboriginals is with Social Class V—but the comparison is made generally with the whole Australian community. This was the point in asking you to consider some context; you may wish now to compare Aboriginals with Social Class V; I have to tell you now that the only figures I have are for comparison with the whole Australian community.

A digression here. When I was minister for Aboriginal affairs, the then prime minister wanted to know what certain measures would have meant for poor white families. They certainly had need but we lacked resources to respond. These poorer whites with a sense of grievance and unfairness were the ones who are part of the constituency of Pauline Hanson.

Let us come back to Aboriginal Australia. Aboriginal mortality is worse: Aboriginals have about 15–20 less years of life than do Australians generally. This means that there is less benefit for Aboriginals from programs directed towards the old—yes, there are some elderly Aboriginals, but less than we would want and certainly less than in the whole population. So programs for the aged favour non-Aboriginal groups.

There is a higher age-specific mortality for that particular community. Let me explain. One can allow for different numbers at different ages by doing some simple mathematics and working out how a population might behave if it was composed of defined numbers at each age. But even when this is done, Aboriginals do worse and have an excess of mortality at every age.

Next, if we look at each disease group we find that the cause of death from almost every disease was higher. It would be wearisome for you to have to go through recitations of figures for heart disease, for respiratory disease, for accidents, and so on. But the figures are clear: for most diseases, the Aboriginal experience is worse.

Over recent decades there have been some improvements in mortality. It would be worthwhile seeing if Aboriginals had enjoyed more benefit—after all, that would narrow any gap. Figures show, however, that improvement was about equal in Aboriginal Australians and all Australians—so there was improvement in both, but the gap remained big in Australia.

But we should be aware of some findings.

- Aboriginal infant mortality is about two to four times the national average.
- Aboriginal still-births and perinatal mortality are about two to four times the national average.
- Low birth-weight babies are two to three times more likely to be born to Aboriginal women.
- The rate of hospitalisation of Aboriginals is about 50 per cent higher than for the whole population.
- There are risk factors for disease more apparent in Aboriginal Australians. They have more obesity, they smoke more, they have problems with alcohol, having more teetotallers but many more problem drinkers than the whole population.
- Their self-reported health status is worse for age comparable groups.

With that knowledge, let us think for a moment what should be expenditures. We might take a moment to consider that there is Commonwealth expenditure: Aboriginal medical services, pharmaceuticals and Medicare. There is state and territory expenditure—particularly on hospitals—and there is local government expenditure, things such as rubbish removal.

Lest anyone think that local government provides for all, let me take you back to the sight of Justice Marcus Einfeld weeping at Toomelah—weeping because the local government body there gave to Aboriginals an insufficiency of services—certainly less than they gave to others. So there was drainage water pooled on the ground there and there was uncollected rubbish around that community.

Expenditure for Aboriginals in 1995–96 was 44 per cent higher than for the national average, mainly because state and territory expenditures were higher. There was much less through Medicare and PBS [Pharmaceutical Benefits Scheme] and even if we add the costs of AMSs [Aboriginal Medical Services], the Commonwealth expenditure on Aboriginals does not approach what would be needed for a sick and depressed group. The problem seems real. Many of the problems are susceptible to public health measures—just as they are in many developing nations. And here there is a dilemma: many people like me see the need for more public health measures while many others see the need for more disease-specific measures.

Of course, both are right. During my time as minister for Aboriginal affairs, I introduced the Public Health Improvement Program for Indigenous Australians, but it has not produced the improvements that were hoped for it. It has not been 'owned' by Aboriginals, and this need to 'own' programs is one of the things that stands in the way of progress.

So there it is. We are a wealthy and industrialised country within which there lives an identifiable minority with abysmal health that is not improving quickly enough. It is a blot on us as a wealthy country.

This text is taken from *A Dissident Liberal: The Political Writings of Peter Baume*, by Peter Baume, edited by John Wanna and Marija Taflaga, published 2015 by ANU Press, The Australian National University, Canberra, Australia.