

# ORIGINS OF PERSISTING POOR ABORIGINAL HEALTH

## **An Historical Exploration of Poor Aboriginal Health and the Continuities of the Colonial Relationship as an Explanation of the Persistence of Poor Aboriginal Health**

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Submitted as requirement of MPH by Research

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August, 1998.

Abstract

The thesis examines the history of Central Australia and specifically the development of health services in the Northern Territory. The continuing colonial relationships between Aboriginal and non-Aboriginal Australia are explored as a reason for the persistence of poor Aboriginal health status, including the cycle of self destructive behaviours. It provides an explanation of the importance of community agency to address community problems, and the potential of community controlled Aboriginal health services as vehicles for such community action.

# ACKNOWLEDGMENTS

Many people have assisted in the development of my thinking about the issues around Aboriginal health presented in this thesis. Foremost have been the people I have worked with over the past 10 years in central Australia, especially at the Central Australian Aboriginal Congress. John Liddle, Betty Carter, Stephanie Bell, Lana Abbott, Helen Liddle, Doug Abbott, Dawn Ross, Lynette Stuart, Frank Ansell and Margie Liddle are some of those people.

Other people who have challenged my assumptions and thinking have been Pat Anderson, Tracey Pratt, David Scrimgeour, Shane Houston, Jenny Baker, Barbara Flick, Stephanie Short, Pat O'Shane, Rosemary McGuckin, Dave Alexander, Jane Lloyd, Jeannie Devitt, Steve Skov, Paula Rix, Colin Tatz, Peter Baume and Chris George.

I am especially grateful to Edward Tilton, David Legge, John Boffa, Deborah Durnan, Jo Harrison, Margie Collins, Bob Boughton, Carol Reid, Jock Collins, and Chris Elenor who, not only stimulated my thinking, but also critically read drafts and provided me with valuable feedback. Their inputs and criticisms were invaluable to my work.

I particularly wish to thank Fran Coughlan who gave me access to her previous research (including some of her interviews) on the history of central Australia. This was a most valuable input and provided me with a sound basis from which to work.

My supervisor, Charles Kerr provided me with sound advice and was always encouraging.

Finally special thanks to Pip Duncan and Jesse Booth who provided me with personal support and encouragement through the whole process.

## CHAPTER 1 - INTRODUCTION

As an 'activist' practitioner I have not found it easy to find the time and focus to develop the intellectual frameworks in which to locate my experiences and passions. Such intellectual frameworks are based on experiences and such experiences are themselves limited and particular. They are limited by the length of time spent in such a situation. They are limited by the experiences of our own backgrounds. That is, we interpret particular experiences in the light of previous experiences that have helped shape our attitudes and ideologies. New experiences are interpreted in those lights. This is particularly the case when we consider our experiences working and living in different societies to our own. Whilst being in a different society, we also remain outside that particular community. That is, we retain our advantageous differences, including our ability to choose to leave. This is usually the case when health professionals work in populations characterised by socio-economic disadvantage. In this case, health professionals have a degree of wealth not shared by their client community. There is a class difference. As well, educational advantages of most health professionals compared with their client communities results in a knowledge/ information differential which further increases their relative power.

With Aboriginal communities we are removed by another factor as well. We are of a different society. Aboriginal society and non-Aboriginal societies relate to each other in ways determined by the colonial relationship. However sympathetic we might be to the Aboriginal cause, we are also beneficiaries of the dispossession which is central to their present condition.

It has been a privilege for me to work with people who have taken on the struggle to better the lot of their people. Aboriginal Health Workers on wages little better than the dole take on the difficult front line work that is Aboriginal health. People are sick. We know this from our statistics. But for members of this 'high risk population' it is their life. Many Aboriginal people do not know that their experience of ill health and death is any different from the non-Aboriginal population. Others do. But an appreciation of this difference is still in the realm of an intellectual abstraction. It does not mean anything compared to the

grief and pain of frequent funerals. For an Aboriginal health service it means that on regular occasions, key staff are involved in “sorry business<sup>1</sup>”. This means a minimum of half a day to attend the funeral. Depending on the closeness of the relationship it might mean a week or more. And in the midst of this there are people who accept the responsibility of this struggle.

I have been privy to the community’s grief, and their struggle for a better life. I have seen politicians, bureaucrats, health professionals, health promoters, researchers come and interact with Congress leadership. I have not always been a passive observer. The majority of these visitors have been extremely well meaning. But most have also come with the parameters of their inquiry, or ideas for solutions quite firmly set. Few have managed to appreciate that they are at the frontier, or what this means. Henry Reynolds has written extensively about this. His research has been premised on an understanding of two societies clashing in almost all respects – economically, politically, philosophically, spiritually and militarily. Thus there are two stories. Neither side of this frontier knows the whole story.

If you are non-Aboriginal the stories you will have grown up with will be of the pioneering ‘father’s’ conquest of a harsh land, of unprovoked attacks by ‘savages’, of the inevitability of the extinction of blacks, and the humanitarian concern to ‘smooth the dying pillow’. Of the pioneering women who helped ‘make’ this country despite it being a man’s world. And now we can enjoy the benefits of the hard work of our predecessors.

If Aboriginal, the stories are more likely to be about enjoying the wealth of the land, until the white-man came. The stories are likely to be of heroic resistance against the odds. Stories about removal from country, massacres, forced settlements, gaol, taking the children away. Grief. Children are likely to have been warned not to trust the white man. Some of the stories now are about strategies for post-war reconstruction, and about reconciliation with the conquerors to facilitate this.

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<sup>1</sup> ‘Sorry business’ is the colloquial term used in Aboriginal communities to mean all the things involved in a

When I first went to Alice Springs in 1984, I was bewildered at the lack of anger expressed at this history of blatant injustices. I later came to appreciate that the anger is directed inwardly. Inwardly to family, and increasingly to self. The oppressed do not express their anger to the oppressors.

So a major issue, in writing this thesis, is how do I write in a way that is useful, and understandable whilst not betraying the privileged relationship, and not stripping it of the emotion and passion which ultimately must drive the required changes. Some degree of emotional response to the human catastrophe that is poor Aboriginal health status is appropriate. Grief ... Anger. An understanding of the situation requires there to be an appreciation of the emotions involved. This is not Eritrea where self-determination means defeating the oppressor, and establishing the organisational expression of self-determination, that is a sovereign government. Aboriginal people forever will be a minority in their own country. They will be dependent, to a significant extent on the attitudes of non-Aboriginal Australians. They will be shaped by these attitudes, and what responses government make. The availability of funding will also shape what happens, and most of this will be determined outside the Aboriginal politic. I see no escape from this. For Aboriginal Australia it will always be a matter of degree – the degree to which a government will consult; the degree to which Governments will support community initiative; the degree that liberal parameters will be drawn. Some Aboriginal leaders (eg Michael Mansel) have been quite explicit about the need to have a '*government to government*' relationship, and indeed have formed a Provisional Aboriginal Government. The idea of some notion of Aboriginal government has also been pursued in different ways in Northern Australia<sup>2</sup>. Inuit models have been explored and debated<sup>3</sup>. But the current political mood does not encourage such long-term political solutions. Many commentators emphasise the pre-colonial relationships between Aboriginal groups, and the lack of any singular Aboriginal identity to discredit any Aboriginal political movement or even Aboriginal organisations.

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death – the funeral, custom, and grief.

<sup>2</sup> Fletcher, C '*Aboriginal Non Democracy; A Case for Aboriginal Self-Government and Responsive Administration.*' ANU, North Australia Research Unit, Darwin, Discussion Paper No 23, October, 1994.

<sup>3</sup> Jull, P '*The Constitutional Culture of Nationhood, Northern Territories and Indigenous Peoples.*' ANU, North Australia Research Unit, Darwin, Discussion Paper No 6, May, 1992.

The environment in which I have worked has involved relationships with people. There have been too many funerals, too much heartache; and yet this is what drives some people to spend their lives in a struggle to improve things. It is in this context that I have become aware of the colonial relationship as a major barrier to improving Aboriginal health status. The lack of appreciation of this dynamic by most health professionals results in their inability to negotiate a way forward. Instead, the models used to deal with health problems of the mainstream society, or even occasionally other disadvantaged minorities of the mainstream, are attempted in Aboriginal health, and mostly with lack of success.

### **THEORETICAL ISSUES**

The health status of the Aboriginal population in Australia persists in being far worse than that for other Australians, and, indeed, worse than for similar 'fourth world'<sup>4</sup> peoples<sup>5,6</sup>. Efforts to address Aboriginal health problems have been evident since the early 1970s when the Commonwealth Government began playing a role in response to pressures from the Aboriginal community, especially in Redfern, and a more serious intellectual engagement of the issues<sup>7,8</sup>. Before that the responsibility for Aboriginal health rested solely with the States and there were few programs designed specifically for Aboriginal communities.

Two questions emerge from this scenario. The major question is '*Why have efforts to deal with Aboriginal health been relatively ineffective?*' This could be more narrowly focused on why the National Aboriginal Health Strategy (NAHS) failed to bring real improvements. Indeed the NAHS was evaluated<sup>9</sup>, and the major conclusion was that the

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<sup>4</sup> I am using the term 'fourth world' to mean those indigenous populations living in countries that have been dominated numerically by settlers from the main colonising countries. Specifically these countries are Australia, New Zealand, Canada and the USA.

<sup>5</sup> Bhatia, K & Anderson, P '*An Overview of Aboriginal and Torres Strait Islander Health: Present Status and Future Trends.*' Aboriginal & Torres Strait Islander Health Unit, Australian Institute of Health and Welfare, Canberra, 1995.

<sup>6</sup> Kunitz, SJ '*Disease and Social Diversity.*' Oxford University Press, New York, 1994.

<sup>7</sup> Moodie, PM '*Aboriginal Health.*' ANU, Canberra, 1973.

<sup>8</sup> Rowley, CD '*The Destruction of Aboriginal Society.*', '*Outcasts in White Australia*' and '*The Remote Aborigines.*' Penguin Books, Melbourne, 1972.

<sup>9</sup> Evaluation Committee '*The National Aboriginal Health Strategy: An Evaluation.*' December, 1994.

NAHS had never been implemented. So the question ought to really be '*Why was the NAHS never implemented.*'

In attempting to shed some light on these questions, I have initially explored the reasons for Aboriginal people having such a poor health status compared to other peoples.

In looking at this question I have taken an historical and colonial relations approach. I have focused particularly on central Australia, but have also attempted to track national issues both in terms of national policy developments and Aboriginal resistance. This is particularly important given that the occupation of central Australia was just beginning at a time when Aboriginal people in the southern cities and along the Eastern and South-western seaboard had already been pretty well defeated and lived in settlements marginalised from mainstream Australia.

In looking at this history I have tried to draw out historical continuities which might help explain some of the contemporary difficulties, and clarify the key issue of agency in overcoming these difficulties. Issues relevant to this are the notion of Aboriginality, the notion of community, the assumptions of the health care system, the issues of welfare dependency, and the issues of generational grief.

My approach emphasises a colonial relation's framework of viewing Aboriginal health disadvantage. However, this is not to argue that other views are inappropriate (although some are), and do not offer useful insights. However, none of them successfully explain the failure to implement the NAHS. An analysis based on a colonial relation's framework, sheds some light on that important issue, and is the justification for such a focus in this thesis.

### ***My Position and Prejudices.***

I am an Australian born male doctor of Anglo-Celtic heritage. I began my career in the health industry working as a Psychiatric Nurse in a large country psychiatric hospital at Kenmore near Goulburn. After two years I left to study Medicine. The experience of institutionalised care has helped shape my attitudes and understandings. I am cynical about the efficacy of some therapies offered by modern medicine, and particularly about processes that involve institutionalisation. That has led me to work in the community



health sector, and to develop a keen interest in the issues of community control, and consumer rights as a balance against the excesses of professionals and entrepreneurial medicine. I have been a critic of the medical establishment, and of what clinical medicine can achieve for improving people's health. On the other hand, I have also been critical of the public health paradigm and its tendency, at times, to be top down and authoritarian in its implementation of what the 'experts' consider good for people. In the current climate there is a risk that an over emphasis on health outcomes by the public health community ignores the humanitarian values of health services and their role in comforting and facilitating individuals to achieve dignified demise (death). This is particularly critical in Aboriginal communities where basic primary health care services are mostly inadequate, and people are often left to their own devices in times of crisis.

In this thesis when addressing the issues involved in health service development, I am not referring simply to the development of vehicles for medical interventions in Aboriginal communities. I am referring to the development of organisational vehicles for individual, family and community action for improved health whilst also being able to deliver appropriate medical interventions. In other words, primary health care services can be a resource for communities to organise support as they see appropriate, which will inevitably include the delivery of medical interventions.

My work in community organisations, and my overall perspective of health care, has enabled me to develop privileged relationships with significant Aboriginal health leaders in central Australia, and nationally.

My approach is descriptive and analytical and attempts to provide insights into the struggle for better Aboriginal health.

My analyses are, as stated above, based on a colonial relations perspective which emphasises the different positions of various players in that regard, and looks at various interactions at that interface to better understand how collaborative relationships might develop in that context.

In this thesis I will consider the occupation of central Australia, the development of health services in the NT, and national policy development in Aboriginal affairs, and specifically in Aboriginal health. I will also look at Aboriginal resistance as an important factor in a colonial relation's framework. I will relate this to developments nationally. Indeed what occurred in the NT was reflective of what was occurring at the national level, and the general processes of colonisation that have operated in the NT are not fundamentally different to the colonial processes in other Australian jurisdictions, or indeed other countries.

I will also consider matters that form a backdrop to these processes. These include constructs of Aboriginality and community, as well as attitudes of the dominant society that can better be understood in terms of a colonial relationship with Aboriginal Australia.

### ***Aboriginal Health Status***

The health of Australia's indigenous people remains significantly worse than for non-indigenous Australians. The details of Aboriginal & Torres Strait Islander ill health have been written about extensively, and I will not focus on such detail in this thesis.

However, in terms of evaluating possible strategies for improving Aboriginal health status, it is important to keep in mind that Aboriginal health status has changed over the past 20-30 years. Infant and child mortality has dropped from around 8 times the Australian rates to 3 times the Australian rates. Over the same period, however, young adult mortality has increased, and Aboriginal life expectancy is still around 20 years shorter than for other Australians<sup>10,11</sup>. An appreciation of the areas of efficacy of medical interventions, and the increasing problems of adult morbidity and mortality within Aboriginal communities has

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<sup>10</sup> Bhatia, K & Anderson, P, *op. cit.*

<sup>11</sup> Khalidi, NA 'Aboriginal Mortality in Central Australia, 1975-77 to 1985-86: A Comparative Analysis of Levels and Trends.' NCEPH, Canberra, 1989.

important implications when considering from where the agency<sup>12</sup> for further sustainable improvements will come.

### ***The Role of Medicine***

There are significant benefits to be gained from appropriate medical interventions from both an individual and population point of view. However, the most efficacious interventions are in the realm of communicable disease, and the treatment of trauma. Bacterial diseases are well treated by antibiotics, and many infectious diseases are well controlled through standard public health mechanisms based on a sound knowledge of the natural history of the particular infectious disease. Of course, the use of vaccines plays an important role in the prevention of a number of specific diseases. The development of relatively safe forms of anaesthesia coupled with the development of surgical skills has meant that trauma and a number of other diseases can also be effectively treated. However, there are many problems that are not effectively treated with current medical interventions. This includes many of the health problems experienced by Aboriginal communities in Australia today and include substance abuse, mental health problems, suicide, violence (domestic and other) and the so-called life style diseases related to poor nutrition and lack of exercise - ischaemic heart disease, hypertension and diabetes. Whilst there are effective treatments for ischaemic heart disease and hypertension, they are not cures, and require changes in how people live, and what they eat. These changes are difficult to achieve in the poverty ridden, and chaotic environments in which people live. Thus the efficacy of these treatments is significantly influenced by factors outside the power of the medicines being dispensed.

Western medical interventions can be understood as part of a system that, to some extent, serves those who have dominant control of it. Willis<sup>13</sup> has detailed some of these dynamics with a particular focus on optometry, chiropractic and midwifery. He recognises that part of the role of professionalisation is to develop a body of knowledge and to reassure the public that people recognised by the profession have attained certain standards of practise.

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<sup>12</sup> I use the term 'agency' to imply '*human action, collective or structural, as well as individual*' which will make a difference to Aboriginal health status. This definition is taken from the Collins Dictionary of Sociology by Jary D & J, Harper Collins, Glasgow, 1991.

However, much of the process of professionalisation is involved with the acquisition of, and defence of, privilege and power. Whilst this most obviously applies to doctors and medicine it can also be applied to other professional groups. In the public health arena this has most recently involved processes pursued by government employed health promotion officers who are involved in pursuing recognition as a professional group. Through the definition of competencies for health promotion, establishment of Associations, the organisation of conferences, etc. they assert their ownership of knowledge called 'health promotion', and then are able to demand appropriate recompense for 'their' knowledge, and also control who can share that status with them. This is despite the fundamental direction for health promotion expressed in the Ottawa Charter (the '*bible*' for health promotion) which asserts the need to re-orient health services to health promotion. That is, health promotion is everybody's business. In Aboriginal health, Aboriginal Health Workers are potentially on a similar track. Ironically, the more successful Aboriginal Health Workers are in achieving recognition and status, the more likely they are to become more removed from the communities from which they come. Increasingly the principles of primary health care that led to communities selecting their health worker will become more difficult to sustain as 'success' will be defined by those who gain even higher qualifications and work in centrally located institutions well removed from the community. In this game, community based Aboriginal Health Workers will continue to be seen as poorly qualified and of low status, even though they are the ones dealing with the crises in the community day after day.

These issues are relevant to the processes of improving Aboriginal health, and relate to the question of agency in that process. Is the agency for improving Aboriginal health vested in Aboriginal Health Workers as a professional group, or in the community leaders who often have no professional training or affiliation? Or is the agency of Aboriginal Health Workers, in part, by virtue of their being part of the community within which they live and serve?

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<sup>13</sup> Willis, E '*Medical Dominance*' Studies in Society, Allen & Unwin, Sydney, 1983.

How the different professional groups interact with the Aboriginal health politic is an important consideration in looking at why Aboriginal health has continued to be poor. An appreciation of the continuing colonial relationships can assist the development of positive interactions.

These concepts of medical dominance can be related to the histories of colonisation that involved the colonisers' dominance over the colonised. I will relate the role of medical services (at a time when they were not so efficacious) to the project of ensuring the success of colonial settlements rather than being primarily concerned about the health of the indigenes. Further, medical dominance was (and is) used to denigrate indigenous medicine although there is some evidence of increasing respect for traditional healers (Ngangkeres) and for the use of Aboriginal bush medicines<sup>14,15</sup>.

Medical and classic public health interventions are incapable of making major inroads into the main causes of adult mortality and morbidity that are predominantly related to substance abuse, mental health problems, and violence (including domestic violence and suicide). Thus health services, if they are to address these issues, must be more than a vehicle for delivering professionally driven health interventions. Health services mostly do deliver some level of medical and public health intervention both to individual clients and through population health programs, such as immunisations. Health services can also be vehicles for Aboriginal agency for addressing these other problems for which there are no effective medical interventions.

The difficulty many non-Aboriginal professionals have in either understanding these issues or applying them in their practice, is part of the cause of persisting poor health in Aboriginal communities. Biomedical insights provide only a small part of the answer to poor health status. Cultural, economic, social and political factors are probably more significant, and it is these factors which community agency has some potential to address.

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<sup>14</sup> Aboriginal Communities of the Northern Territory of Australia *'Traditional Bush Medicines: An Aboriginal Pharmacopoeia.'* Conservation Commission of the NT, Darwin, 1990.

### ***Why are Aboriginal People Sick?***

If Aboriginal health is to be improved, we must first understand why Aboriginal people are sick. The first aspect to this question is how we understand the causes of Aboriginal ill health. This is, of course, a sociological rather than a medical question.

My argument is that Aboriginal ill health relates to the histories of colonisation and dispossession. Colonisation and dispossession have resulted in significant depopulation of

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<sup>15</sup> Aboriginal Communities of the Northern Territory '*Traditional Aboriginal Medicines in the Northern Territory of Australia.*' Conservation Commission of the NT, Darwin, 1993.

communities, disruption of economic activity, and the herding of people together where health hardware issues (water, sewerage) are critical aspects of good health and where access to food has been problematic increasing the dependency of people on the colonisers. This is in line with a political economy view of the problem and this has been developed by a number of writers<sup>16,17</sup>, but emphasises the colonial relationship as a key factor in understanding Aboriginal health disadvantage. In other words, it is not just a matter of the poor in society. Poverty is a factor, but Aboriginal people are of a different society with different histories, different mores, and different cultural values. Thus solutions must be premised on an understanding of this relationship. This means proposed solutions must involve recognition of community leadership and be developed through negotiated strategies with that leadership.

Other frames for the understandings of Aboriginal health disadvantage are:

1. An epidemiological framework examines data on disease and death rates in Aboriginal communities and compares them with non-Aboriginal rates<sup>18</sup>. This framework provides a description of the problems, and, through the application of medical knowledge of particular diseases, it is possible to deduce some sense of underlying factors, eg poor nutrition. However, it gives little insight into the underlying social, cultural, economic or political reasons for such a state of affairs
2. Comparisons of Aboriginal health status with that of other colonised indigenous peoples, particularly in Fourth World situations, and to examine factors which might explain documented differences<sup>19</sup>. Comparative studies, such as has been done by Kunitz, allow for speculative analyses of factors and what might have made the difference and suggest policy directions that may be useful.

Comparative studies of indigenous health have often proceeded on an analysis that has emphasised the similarities of colonial experience. For example, the health

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<sup>16</sup> Siggers, S and Gray, D 'Aboriginal Health and Society: The Traditional and Contemporary Aboriginal Struggle for Better Health.' Allen & Unwin, Sydney, 1991.

<sup>17</sup> Reid, C 'Sick to Death: The Health of Aboriginal people in Australia & Canada.' In Bolaria, BS & Bolaria, R 'Racial Minorities Medicine and Health.' Fernwood Publishing, Nova Scotia, 1994, p297-311.

<sup>18</sup> For example, Plant, A, Condon, J and Durling G 'Northern Territory Health Outcomes: Morbidity & Mortality 1979 - 1991.' NT Department of Health & Community Services, 1995.

situation of countries who were colonised by European powers, but were never numerically dominated by European settlement tend to be characterised by a resource deficit for health advancement, and have emphasised the importance of community based primary health care developments as a way forward for better health. By contrast those indigenous communities who were colonised and dominated numerically by European settlement have tended to be in resource rich environments, but have been marginalised from the main society. In the US and New Zealand, there has been a more simplified bureaucratic arrangement for dealing with Indigenous health. Whilst in Australia there has been a fragmentary bureaucratic approach due to the competing responsibilities of different jurisdictions<sup>20</sup>.

A number of workers have looked at these communities that tend to include Australia, New Zealand, North America (USA and Canada), and northern European countries such as Norway. The studies raise further questions, particularly for Australia. The health status of North American Indians and Inuit and of Maori is significantly better than for Australian Aboriginal and Torres Strait Islander peoples. This is illustrated in the Table 1.

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<sup>19</sup> For example, Kunitz, S.J. *Disease and Social Diversity: The European Impact on the Health of Non-Europeans.* Oxford University Press, 1994.

<sup>20</sup> Bartlett B, Legge D *Beyond the Maze: Proposals for a more effective administration of Aboriginal health programs.* Congress, Alice Springs & ANU, Canberra, NCEPH Working Paper No 34, 1994.



Table 1 Life Expectancy at Birth, Indigenous Peoples, 1920s to 1980s

	Maoris <sup>21</sup>		US Indians <sup>22</sup>		Canadian Indians <sup>23</sup>		Aborigines <sup>24</sup>	
	Male	Female	Male	Female	Male	Female	Male	Female
1920s	47	45	NA	NA	NA	NA	NA	NA
1930s	46	46	NA	NA	NA	NA	NA	NA
1940s	48	54	51.3	51.9	NA	NA	NA	NA
1950s	57	58	58.1	62.2	NA	NA	NA	NA
1960s	61	65	60	65.7	59.6	63.5	50**	NA
1970s	63	67	60.7	71.2	57.8	60.3*	NA	NA
1980s	65	68	67.1	75.1	64	72.8	54	61.6

Source: Kunitz, S.J. *'Disease and Social Diversity: The European Impact on the Health of Non-Europeans.'* Oxford University Press, 1994, p24.

\* Alberta      \*\* Northern Territory

<sup>21</sup> Pomare EW *'Maori Standards of Health: A Study of the 20 Year Period 1955 - 1975'* (Auckland Medical Research Council of NZ, Special Report Series no 7, 1980); E.W. Pomare *Hauora: Maori Standards of Health: A Study of the Years 1970 - 1984* (Auckland Medical Research Council of NZ, Special Report Series no 78, 1988); I. Pool *'Mortality Trends and Differentials' in population of NZ* (Bangkok: Economic and Social Commission for Asia and the Pacific, 1985).

<sup>22</sup> Indian Health Service *'Trends in Indian Health - 1989. Tables'* (Rockville, MD: Division of Program Statistics, Office of Planning, Evaluation and Legislation, Public Health Service, Department of Health and Human Services, 1989).

<sup>23</sup> Millar, WJ *'Mortality Patterns in a Canadian Indian Population.'* Canadian Studies in population 9 (1982): 17-31; Ministry of National Health and Welfare *'Health Indicators Derived from Vital Statistics for Status Indians and Canadian Populations, 1978-1986'* Ottawa ministry of National Health and Welfare, September, 1988.; Medical Services, Department of National Health and Welfare *'Life Tables, Registered Canadian Indians, 1960 -64.'* Ottawa: Department of National Health and Welfare, n.d.' The registered Indian population of Alberta is about 12 to 13 percent of all registered Indians.

<sup>24</sup> Thomson, NJ *'Inequalities in Aboriginal Health'* (MPH thesis, University of Sydney, 1989) p 39; Gray, A *Discovering Determinants of Australian Aboriginal Population Health'* Working Paper, NCEPH, ANU, 1989, p11.

In Table 1, it can be seen that figures for Australian Aborigines were only available from the 1960s, and then only for the Northern Territory, which was still under Commonwealth Government administrative control. These figures show that the life expectancy for Maori and North American Indigenous peoples was about 10 years better than for NT Aborigines (although only male figures were available). However, perhaps the most telling feature of this table is the lack of figures for Australian Aboriginal and Torres Strait Islander peoples. This reflects the lack of attention being given to the issues, and further reflects the fragmentary bureaucratic responsibilities in relationship to indigenous health in Australia.

Clearly, the simple analyses that Aboriginal people have been colonised, that they have been numerically dominated by mass European settlement, and are thus marginalised, with traditional health care systems and economic activities destroyed, and living conditions imposed according to the needs of the invading settler society are inadequate explanations. All of these things are important ways of understanding much of the situation Indigenous Australians find themselves. The poverty, and accompanying poor living conditions, poor nutrition and societal fragmentation have all played a major part in the creation of a society where disease and death are so prominent. However, these factors also apply to the other countries under examination in Kunitz's comparative studies. Something else has made a difference to them, but not to Australia.

One factor is that, of the four countries under consideration, only Australia has failed to sign a treaty or other agreement with indigenous peoples. Until the High Court's Mabo decision of the early 1990s, Australian law formally took the view of *terra nullius* - that is, that the continent was legally empty of people. This obviously false absurdity set the tone for dealing with Aboriginal affairs.

What is the significance of a treaty, and why might this be important to the improvement of a people's health status? Firstly, a treaty implies some sort of sovereignty between two parties. Whilst it is beyond the scope of this thesis to pursue

the notion of sovereignty, I have assumed throughout that Aboriginal people are a distinct people who occupied this country for 50,000-140,000 years, and who identify themselves as belonging to this country in ways which those from elsewhere can barely imagine, and that this is a major consideration in how health services are developed and delivered, and how other social determinants of health have been shaped.

In Canada, part of the treaty obligations of the Canadian Government (at least to Treaty Indians) was the provision of health care services. Some of the resistance to current proposals of the Canadian Government to increase community control over health services is related to the fear by some that this will nullify the Canadian Government's Treaty obligations<sup>25</sup>.

There are other differences in colonial histories that might help inform us as to why such life expectancy differences persist. In the USA, the Indian Health Service (IHS) was developed over 100 years ago, initially under the auspices of the Federal Indian Affairs Bureau. In the 1970s the IHS became a branch of the US Public Health Service. As a national service it bi-passed the complexity of State/ Territory administrations, and developed into a service agency focused on health service delivery and an objective of being controlled and operated by Native American people, which has largely been achieved.

In New Zealand there are no states, and thus responsibility for Maori health has always rested with the central Government.

However, in Australia, it is the States that are constitutionally responsible for health services, and the Commonwealth Government only became involved in the early 1970s. Thus there is a fragmentary bureaucratic arrangement for the administration and funding of Aboriginal health that is confusing, opaque and allows cost shifting to occur.

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<sup>25</sup> Scrimgeour, D 'Community Involvement in Health Services for Indigenous Peoples of Canada, Norway and New Zealand.' Menzies School of Health Research, Alice Springs, 1994, pp5-6.

I do not intend to pursue these matters in detail, but in considering the administrative responsibilities for Aboriginal health in Australia, the lessons from this experience is useful.

3. A political economy view that relates Aboriginal health to the economic circumstance in which people live<sup>26, 27</sup>. This approach relates people's health status with their socio-economic status in society. A political economy analysis offers more detailed understandings of the underlying factors producing poor health status, and there is little doubt that this analysis is particularly relevant to Aboriginal health. People without economic activity have few options for improving their life condition, and are thrown into a state of dependency by poverty and reliance on welfare. But it is not immediately obvious what the policy ramifications of this analysis are, except to assert that it is a matter of keeping in mind the 'big picture' – that is that improved health status of populations come out of changes to people's socio-economic status. How policy can impact on this needs careful thought. In recent years housing, water and sewerage have become a proxy for socio-economic status in Aboriginal health. It has been the high priority of reports since the 1979 House of Representatives Report. Of course, inadequate housing, poor water and sewerage will create conditions perfect for the proliferation of micro-organisms, and thus infections of the gastro-intestinal tract, skin, eyes, ears and respiratory tract will be common, particularly amongst children living in such conditions. That is only part of the story involved with Aboriginal health. Substance abuse, for instance, is not easily explained by physical living conditions alone.
4. A culturist view understands Aboriginal health disadvantage as a problem of the clash of cultural assumptions and values<sup>28</sup>. This might also be referred to as *cultural dislocation*, focusing on disruption of Aboriginal culture, and the differences

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<sup>26</sup> Saggars, S and Gray, D, *op. cit.*

<sup>27</sup> National Health Strategy 'Enough to Make You Sick: How Income and Environment Affect Health.' National Health Strategy, Research Paper 1, 1992.

<sup>28</sup> Some health promotion programs in Aboriginal health have emphasised this view. An example is the Healthy Aboriginal Life Team (HALT) which emphasises a return to traditional kinship responsibilities as a way of overcoming petrol sniffing in remote communities.

between the dominant culture and Aboriginal culture. The culturist view offers insights into cultural values, which challenge assumptions of absolute values often made by dominant cultures. However, this view runs the risk of seeing culture as a static phenomenon, and has a tendency to look back at what was. Another view is that living cultures change constantly, and that this is a strength of a people, particularly in terms of their capacity to adapt to changing circumstance. An appreciation of cultural differences is an inadequate explanation of poor health status.

5. The health transitions literature has examined overseas experience in order to understand different ways populations have achieved better health status. Caldwell<sup>29</sup> has identified three aspects required to take the so-called low road to health. The high road to health has involved economic development that has enabled the bulk of populations to acquire the health hardware required of good health (shelter, clean water and sewerage) along with a standard of living that enables good nutrition and a generally high degree of control over ones life. The low road is the road to health that has been achieved in some countries such as Sri Lanka where the economic developments have not occurred. However life expectancies have increased dramatically and approach that of 'high road' nations. The factors thought to be necessary to this progress towards good health are:
  - The education of women;
  - Women having independence of agency;
  - A free or cheap (ie accessible) health care system;
  - Political fervour, vision.

In Australia, Aboriginal communities are caught in a developmental dilemma. The educational successes in many communities are limited, and indeed progress towards reasonable levels of literacy appears to have stalled. In some communities, women do have some independency of agency, but not in others. In most communities, there is access to

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<sup>29</sup> Caldwell, JC & P 'The Cultural, Social and Behavioural Components of Health improvement: The Evidence from Health Transition Studies.' In Robinson, G (Ed) 'Aboriginal Health: Social & Cultural Transitions' Proceedings of a conference at the NT University, Darwin, 29-31 September, 1995.

some sort of primary health care - probably mostly emergency medical care rather than a more comprehensive style of primary health care. However the political fervour and vision, a feature in the Aboriginal community controlled health service leadership, is frustrated by lack of acceptance and challenge to their legitimacy by government authorities, and some health professionals.

6. A racial inferiority or genetic view focuses on hypothesised differences in anatomical structure and/ or physiological function resulting in an increased susceptibility to disease. Anthropologists of yesteryear were preoccupied with measuring cranial capacities, facial angles, etc. Conclusions were reached as to the significance of these differences in terms of where Aboriginal people were in a notion of linear development of Homo sapiens to the highest form which was, of course, the Nordic races. Historically, Europeans commonly argued that Aboriginal people were sick because of genetic inferiority, and were doomed to extinction. Darwin's theory of evolution which talked about the survival of the fittest was applied to social considerations and formed a theory known as Social Darwinism. Whilst this view is no longer widely held in academic or professional circles, it was a widely held view in the past up until the 1940s - 1950s. It was central to the body of knowledge known as Eugenics<sup>30</sup>, which was the ideological underpinning of various projects in the UK, USA and Australia. It was also the ideological underpinning of the Third Reich in Germany. Eugenics fell into disrepute after the holocaust against Jews, Gipsies, homosexuals, communists and others.

Eugenics is based broadly on the theory of biological determinism. Few researchers are pursuing work based on this theory. However, the more scientifically grounded field of modern genetics is pursuing some genetic questions relevant to Aboriginal health in some very narrow and specific areas such as alcohol metabolism, and diabetes (eg the thrifty gene theory).

Eugenics is a racist theory and there is little evidence to support it. Further, it is not useful in informing the project of improving Aboriginal health.

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<sup>30</sup> Tucker, WH *'The Science and Politics of Racial Research.'* University of Illinios Press, Ulbana, 1994.

7. A psychosocial maladaptation view has been proposed as a major cause of Aboriginal ill health. Cawte, a psychiatrist who did work assessing mental health problems in some Aboriginal communities stressed the problems of what he called psychosocial adaptation<sup>31,32</sup>. Saggars and Gray<sup>33</sup> outline a criticism of Cawte's psychosocial maladaptation theory in terms of a probable overestimate of mental illness in Aboriginal communities due to methodological problems, his under-emphases on the influence of poverty and the economic environment in which Aboriginal people live, and his assumption that mental illness amongst Aborigines is a consequence of inappropriate cultural values rather than the injuries of colonisation. Further, a distinction should be made between mental illness as such and mental health or mental stress. A strong argument can be made that a degree of anxiety, and mental distress is a normal response to the high levels of morbidity and mortality Aboriginal people experience in their families and communities, the general living conditions and poverty in which they live, and the effects of dispossession. Emotional responses to these factors are indeed adaptive and part of normal human responses.

None of these frameworks for understanding poor Aboriginal health provide sufficient explanations on their own. Indeed, the last two frameworks are more problematic than useful.

Reid<sup>34</sup> proposed a framework including primary and secondary causes of Aboriginal ill health. She presented these factors as shown in Table 2<sup>35</sup>. Reid strongly advocates Aboriginal control of programs. She recognises the limitations of medical interventions in improving health status, and highlights the need for Aboriginal people to be involved at all stages of health service delivery and other aspects of community life.

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<sup>31</sup> Cawte, JE *'Cruel, Poor and Brutal Nations.'* University Press of Hawaii, Honolulu, 1972.

<sup>32</sup> Cawte, JE *'Social and Cultural Influences on Mental Health in Aboriginal Australia: A Summary of Ten Years Research.'* Transcultural Psychiatric Research Review 13, 1976. p28-38.

<sup>33</sup> Saggars, S and Gray, D, *'Aboriginal Health and Society: The traditional and contemporary Aboriginal struggle for better health.'* Allen & Unwin, 1991, pp 9-11.

<sup>34</sup> Reid, J *'Aboriginal Health in the 1970s and 1980s'* Cumberland College Reports, No 16, August, 1979. p5.

<sup>35</sup> *Ibid.*, p13.

She concludes her monograph<sup>36</sup>:

*'The political will to return to Aborigines a significant degree of autonomy of thought and action is only a decade old, and lately shows signs of faltering. However, if the policy of self-determination in health care, community development and lifestyle is faithfully pursued and the means made available to enable Aborigines themselves to implement programs they devise and value, the 1980s should be a watershed in Aboriginal affairs. If State and Federal government uniformly resolve to pursue an active land rights policy, to maintain viable levels of funding for Aboriginal projects (whether from grants or royalties) and to encourage Aborigines to develop lifestyles which have meaning to them there is every reason to expect substantial changes for the better in the health status of the original Australians.'*

However, there is little evidence that the States and Territories have ever supported self-determination in Aboriginal health or any other aspect of Aboriginal affairs. Indeed, the Program Effectiveness Review commissioned by the Fraser Cabinet made it clear that the States did not support Aboriginal control of health services. The Hawke Labour Government bowed to pressure from the States (particularly the WA Burke Labour Government) and shelved plans to implement national land right legislation. Funding levels are chronically inadequate and there is little to suggest that this will change in the short term, especially with the Howard Government in power.



Table 2 The Precursors of Aboriginal Ill Health

PRIMARY CAUSES	SECONDARY CAUSES		ILL HEALTH
<ul style="list-style-type: none"> <li>• European settlement of Australia</li> <li>• loss of land</li> <li>• depletion of numbers by imported disease (tuberculosis, smallpox, leprosy, etc.), dispossession and massacre</li> <li>• resettlement on missions, government reserves and cattle stations.</li> </ul>	<p><u>Social</u></p> <ul style="list-style-type: none"> <li>• poverty</li> <li>• dependence on European material and services</li> <li>• lack of access to Western and traditional resources</li> <li>• racism and discrimination</li> <li>• alcoholism</li> <li>• Western education and proselytisation and imposition of alien economic system</li> <li>• Erosion of Aboriginal culture and society with loss of traditional roles and self-respect</li> <li>• High birth rate and inadequate birth spacing</li> </ul>	<ul style="list-style-type: none"> <li>• Juvenile delinquency and petrol sniffing</li> <li>• Loss of power and control over personal and social matters</li> <li>• Lack of access to services and information, and minimal political representation</li> </ul> <p><u>Environmental</u></p> <ul style="list-style-type: none"> <li>• Inadequate water supplies, sewerage, sanitation and garbage disposal</li> <li>• Substandard and crowded housing</li> <li>• Limited access to energy resources (such as electricity)</li> <li>• Poor nutrition</li> </ul>	<ul style="list-style-type: none"> <li>• Infectious diseases (such as respiratory tract, intestinal and venereal)</li> <li>• Parasitic infections</li> <li>• Malnutrition and malabsorption</li> <li>• Degenerative diseases (such as diabetes, cardiovascular)</li> <li>• Mental illness and distress</li> </ul>



A colonial relations framework, I suggest, offers further insights into the question. An historical analysis which emphasises two divergent world views coming together with little shared understandings, and with one side prepared to pursue dominance at all costs, shows the roots of contemporary relationships played out in health service delivery. It helps explain the insistence of Aboriginal people on community control of primary health care, their distrust of governments and those working for them. It helps explain why Aboriginal health is persistently poor.

The development of dependency through imposed policies involving food rationing, communal kitchens, restriction of people's movement, reliance on pensions and other social security payments, and removal of children have helped shape the pattern of disease and suffering currently experienced by many Aboriginal people. This is related to Aboriginal people being defeated in Australia's forgotten war. The consequence of that defeat is the institutionalisation of Aboriginal society through Government settlements and missions, psychiatric hospitals and gaols. These are not merely the stories of poverty, and socio-economic marginalisation, but are the stories of colonial domination of a people. But whilst Aboriginal people were defeated, they have never ceded sovereignty and they continue to resist, albeit in subtle form.

The history of massacres, stolen children and continuing high mortality rates, coupled with marginalisation and discrimination has impacted on people's mental health status with recurrent grief being a dominant feature of Aboriginal lives. Generational and recurrent grief, along with some people's crises of identity (as a consequence of stolen generations and more general societal disruptions), play a role in undermining individual self-esteem and community efforts to improve social and economic conditions of life.

These factors underlying Aboriginal ill health are not amenable to medical interventions, although the process of delivering medical interventions offers opportunities for the strengthening of Aboriginal society. How medical interventions are delivered can either contribute to the long term solutions required to achieve

sustainable improvements in Aboriginal health, or further entrench the dependency and marginalisation which is at the centre of the problem.

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In this thesis, I will try to draw out the historical factors that have contributed to the persistence of poor health status, with a specific focus on central Australia. This includes an examination of the occupation of central Australia, the development of health services and their association with Aboriginal policy, the development of national Aboriginal policy and Aboriginal peoples resistance.

### **ABORIGINAL HEALTH POLICY DEVELOPMENT**

The other focus of this thesis is an examination of the development of Aboriginal health policy over the past 30 years, and especially the development of the National Aboriginal Health Strategy. The NAHS Evaluation clearly pointed out that the NAHS had never been implemented. So, the question I have focused on is why was it not implemented?

This policy analysis includes an examination of the central question of community control, and its application to primary health care and Aboriginal notions of health. I used my experience working in community controlled settings to contrast styles of practise with government or professional controlled services.

I examine the question of agency for the improvement of Aboriginal health, particularly in the light of mortality and morbidity patterns, and their relative responsiveness to medical and public health interventions.

### **AN ABORIGINAL HEALTH SYSTEM**

I then propose the development of an Aboriginal health system which specifies the necessary elements for a successful system which is based on and supports Aboriginal agency for improved health, and defines professional and technical functions as supports to that.

## CHAPTER 2 – BACKGROUND ISSUES

This chapter briefly examines background or underlying issues which have influenced both historical and contemporary aspects of colonial relationships in Australia, including government policies and practices impacting on Aboriginal health.

### NON-ABORIGINAL ATTITUDES TO ABORIGINAL AUSTRALIA

In 1994, the Aboriginal Reconciliation Branch of the Department of Prime Minister and Cabinet contracted a private social research organisation to:

*‘ provide a benchmark for, and information that will assist the Council’s communications and public awareness program for the 1995 - 1998 triennium, including but not limited to the issues arising from the Council’s social justice submission to the Commonwealth Government<sup>1</sup>.’*

The Sweeney Report involved the conduct of 31 focus groups across the country, and participants were categorised according to region, age and socio-economic group. Stimulus materials were used to prompt discussion on particular topic areas, and to evaluate some materials as to their usefulness as educational materials.

The results were not encouraging. Contrary to many views that there are pockets of reactionary racists in Australia, it is hard not to conclude that the reverse is the case. There are pockets of tolerance.

The report concluded that there is a strong and fairly uniform resistance to any re-examination of our history, and a widespread inability of non-Aboriginal people to relate the current disadvantage experienced by Aboriginal people to the history of dispossession. People do not think that they have any responsibility for the behaviour of their forefathers.

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<sup>1</sup> Brian Sweeney & Associates ‘A New Beginning: Community Attitudes Towards Aboriginal Reconciliation.’ Study No. 9413, Melbourne, January, 1996, p1.

Further, people in the focus groups tended to see Aboriginal people as advantaged in that they were recipients of benefits to which other Australians were not entitled. Many of these attitudes, of course, are not based on the facts. But these attitudes are widely held.

In regard to health, the common attitude was that Aboriginal people are sick because they don't look after themselves.

These attitudes tended to be consistent across all focus groups regardless of socio-economic status (class), gender, ethnic group, locality or age. However, younger people were more inclined to favour some process of reconciliation. There was generally great resistance to any approach that might be seen as confrontational.

Three common barriers to reconciliation were identified as ignorance, apathy and fear.

The study did, however, identify some themes that had some potential to promote reconciliation. These were:

- fear of a divided society;
- concept of a shared history;
- sharing and valuing cultures,
- exposure to information regarding:
  - ♦ the histories of child removal (stolen generations);
  - ♦ the fact Aborigines were not counted in census until after the 1967 referendum;
  - ♦ the facts about poor health status (but requiring explanations)
  - ♦ the retention of wages by authorities in Queensland and other jurisdictions;
  - ♦ the level of cultural activities in the 1990s.

The main issue in this study, however, was the widespread anti-Aboriginal attitudes in Australian society. This is relevant to the project of improving Aboriginal health, as any strategy will require resources for implementation and this will need a level of political support. Further, Aboriginal health status is not unrelated to the antagonistic attitudes of mainstream Australia towards Aboriginal Australia. Issues of self-esteem, intricately

linked to good health, are not enhanced by the negative attitudes expressed so often to Aboriginal people in shops, offices, and on the street.

The study confirms that people's attitudes are a dominant aspect of Aboriginal affairs. At this point of history, the majority of non-Aboriginal Australians have had no or little significant contact with Aborigines. Most have observed Aboriginal people from afar - in the street, on the football field, in the parks, and as portrayed on the media. But they have not interacted with Aborigines in the same way that they might interact with people from other ethnic groups who have come to this country with their own agenda involving establishing life here for personal, economic or political reasons. Often this has involved the establishment of small businesses<sup>2</sup>, or, failing that, entering into the workforce, often as unskilled labourers due to problems of English, being from an unskilled peasant background, and/ or the local lack of recognition of qualifications gained in a non-Anglo country. Whichever way, it has presented opportunities for some degree of social interaction with people from other ethnic origins, including the dominant Anglo society, through people from all sorts of backgrounds patronising these businesses or interacting in workplaces. The more people of different origins interact, the more they appreciate the diversity within ethnic groups. The fewer interactions people have, the more stereotyping is likely to occur.

Generally for Aboriginal people the conquest of this country has left them marginalised from an economic base, either Aboriginal or mainstream. Many live away from the major living centres – often on the periphery of country towns, or in particular poor suburbs of the cities, or in predominantly Aboriginal communities in remote Australia. They tend not to run businesses that other Australians patronise. The closest economic activity in this regard is the Aboriginal arts and crafts industry where Aboriginal people produce the goods, but it is usually non-Aboriginal people who market them. Of course, there are exceptions to this generalisation. In this context judgements are often made about Aboriginal people based only on these observations from afar, what people hear on talk back radio, or what people like Pauline Hanson have to say. But because of the centrality

of Aboriginal people to the establishment of modern, contemporary Australia, everybody has an opinion about Aboriginal people.

### **Current Political Climate**

During the 1996 election campaign, an endorsed Liberal Party candidate, Pauline Hanson, made public comments criticising the perceived special benefits received by Aborigines. She lost her Liberal Party endorsement, but it was too late for the Liberal Party to nominate another candidate. Hanson won the seat of Oxley easily. This had been the safest Labour Party seat in Queensland.

On the other side of the continent, Graeme Campbell, on a platform of anti-Asian immigration, and highly critical of Labour's Aboriginal self-determination policies had lost his ALP endorsement for the seat of Kalgoorlie because of his links with the League of Rights, an anti-Semitic organisation with small but significant roots in rural Australia. Some would argue that Campbell lost ALP endorsement because he had been highly critical of Prime Minister, Paul Keating. Either way, he stood as an independent candidate. The ALP fielded a strong local candidate, Ian Taylor, who had represented Kalgoorlie in the WA Parliament. Campbell won the seat easily.

Since that election Campbell and Hanson attempted to develop a political alliance with other right wing political forces such as Ted Drane, a spokesperson for the pro-gun lobby. This has failed to eventuate with Hanson launching her own Pauline Hanson's One Nation Party. There appeared to be a real possibility that a political force would develop which had racism as a central plank of its political position. This possibility subsided largely due to the inability of right wing political forces to work together. The results of the 1998 Queensland elections illustrate, however, that the 'Hanson' phenomenon has developed into a major political force, and that the political agendas are being set by this phenomenon. Belatedly, Prime Minister Howard has begun an attack on Hanson in an attempt to prevent a repeat of the Queensland result in the coming Federal elections.

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<sup>2</sup> Collins J, Gibson K, Alcorso C, Castles S, Tait D 'A Shop Full of Dreams: Ethnic Small Business in Australia.' Pluto Press, Sydney, 1995.



These political developments have meant a deterioration of the environment in which Aboriginal health is to be addressed. It has made a bi-partisan approach to Aboriginal issues, which has been a major feature of Aboriginal policy for the best part of the past 30 years, more difficult. It could be argued, however, that it may also force the three major parties to get back to bipartisan approaches which have broken down to some extent over the past few years. There is evidence that forces within the Liberal Party are attempting to re-establish a position that is non-racist and supportive of Aboriginal advancement.

These political events highlight many of the issues raised by the Sweeney report. A significant proportion of the Australian public is mis-informed, fearful and sometimes resentful of advantages perceived to be enjoyed by the Aboriginal population. This is further related to serious economic and social decline in rural Australia. There is little doubt that people who feel squeezed economically and marginalised from the mainstream find it appealing to find people who are obviously different to them to blame for their problems. Thus, the 'immigrants are taking our jobs' approach strikes a chord. But this flies in the face of available evidence that immigration has actually given a fillip to economic growth both through the supply of a labour force for jobs more established Australians are loathe to accept, and the economic activity that is associated with housing, clothing, feeding, etc the new immigrants<sup>3</sup>. In turn, many develop their own businesses that have further stimulated the economy and provided jobs that would otherwise not be there<sup>4</sup>.

Conservative politicians, notably Tim Fischer, Leader of the National Party and Deputy Prime Minister, have referred to Aboriginal programs as the 'guilt industry'. Prime Minister, John Howard has referred to the 'Aboriginal industry' and the 'black arm band' view of Australian history. These terms have invariably been used in a derogatory manner. Included in this 'guilt' or 'Aboriginal industry' are the organisations responsible for dealing with the health problems experienced by Aboriginal people. To categorise these efforts as efforts of guilt fails to comprehend the nature and extent of the problem, and the efforts being made by people under extraordinarily difficult conditions.

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<sup>3</sup> Collins, J *'Migrant Hands in a Distant Land'* Pluto Press, Sydney 1991 2nd Ed Ch 5.

Those who use such language are the ones who have thus far been unsuccessful in coming to terms with their association with the history of this country. Guilt is an inappropriate response to the problems, and is likely to result in the persistence of paternalism, rather than the development of more mature and equitable relationships between Aboriginal and non-Aboriginal people. Rather than guilt, what is required is for politicians to provide some leadership to the community at large about the nature of the problem, and what strategies Governments are pursuing to deal with them. This involves an acceptance of responsibility to deal with the present day expressions and impact of what has happened to people, and indeed is continuing to happen.

### **The Forgotten History**

One way of understanding the problems some Australians (and, possibly, particularly older Australians) have with dealing with Aboriginal issues, is to appreciate that there has been a collective suppression of memory about the details of the British invasion and occupation of this country and the impact this has had on the Aboriginal population. It should be remembered that a more balanced view of Australian history and Aboriginal society has only been incorporated into the education system in the past 15-20 years. Thus older Australians were unlikely to receive any information outside the sanitised versions. Psychoanalysts have discussed the phenomenon of repressed memory concerning individuals, with psychological defence mechanisms able to keep unpleasant memories from the conscious mind<sup>5</sup>. More relevant to social amnesia, is the recent discussion about the capacity of the German people to avoid 'knowing' what was happening to the Jewish and other minority populations during the holocaust. The basic thesis of Goldhagen's book<sup>6</sup> is that an attitude permeated German society where ordinary Germans participated in activities they knew were related to the murder of Jews but accepted it as unpleasant but justified. He argues that those building the equipment to fit out the gas chambers and concentration camps, the people required to dispose of the bodies, the transport of people

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<sup>4</sup> Collins J, et al, *op. cit.*, pp112-113, 156.

<sup>5</sup> I am not referring here to the more recent controversial phenomena of 'recovered memory'.

<sup>6</sup> Goldhagen, DJ *'Hitler's Willing Executioners: Ordinary Germans and the Holocaust.'* Abacus, London, 1997.

packed in trains and the like must have occurred with people quietly knowing. Goldhagen argues that there were four conditions necessary for the holocaust to occur<sup>7</sup>:

1. The Nazi leadership and specifically Hitler had to decide to undertake the extermination;
2. They had to have control over the Jews and specifically the areas where they lived;
3. They had to organise the extermination and devote sufficient resources to it.
4. They had to induce large numbers of people to carry out the killings.

He maintains that the last condition has largely been ignored or glossed over by commentators, and that the perpetrators were to some degree autonomous agents able to make their own judgements. He argues that the Nazi ideology with its anti-Semitism was an ideology largely embraced by ordinary Germans, and their actions in perpetrating the killings were a product of that motivating force. This part of the Nazi ideology (for there were also economic aspects that were about the organisation and ownership of industry) has its roots in the ideology of eugenics (see below).

I believe a similar phenomenon has operated in Australia in regard to the treatment of Aboriginal people – the forced settlement, the massacres, the discriminatory practices in regard to accessing services and social support, and the stolen generations all involved the active participation of many Australians, and many others would have learned something of this from them. People's participation in these genocidal and assimilationist events were partly the product of an ideology which concluded that these acts were the right thing to do, and they were the reflections of beliefs about racial superiority which were widely held in white Australian society. In Nazi Germany there tended to be a silence about the perpetrators with explanations of their actions revolving around their simply obeying orders, or that they were doing small jobs which were not obviously involved in genocide, and a similar silence has tended to pervade Australia. Whilst there were people who expressed concern at the way Aboriginal people were treated and, indeed, the dispossession of Aboriginal people itself, these were in a minority<sup>8</sup>. Some questioned whether there should have been negotiation and a treaty signed. However, these public

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<sup>7</sup> *Ibid.*, p13.

utterances were generally unwelcome, especially to the perpetrators of some of the worst incidents. Generally these things were not talked about. The histories of Aboriginal people were not found in Australian school textbooks until very recently. The images on cinema newsreels and magazines were in terms of the generosity of white families and authorities in rescuing these '*poor primitive*' children and giving them a chance for a civilised and educated life.

Now there is an attitude by some that persistent Aboriginal disadvantage is their own fault for not having taken up these opportunities to become like whites. Indeed, there is a tendency for some to want to continue this silence.

I do not want to stretch this comparison too far. Clearly the occupation of this country was highly organised and all convicts, settlers, soldiers and administrators knew something of the general resistance put up by Aboriginal people and of various confrontations. However massacres were not systematised as they were in Europe. Indeed many were carried out by squatters and settlers, sometimes with the assistance of local police and Aboriginal people themselves, and with some disapproval from significant sections of society and the colonial authorities. However, the forced settlement of Aboriginal people and the associated denial of their rights of movement, and the implementation of the assimilationist policy of the Stolen Generations was indeed systematised and involved all governments, as well as many health & welfare agencies and most churches.

Where there is a vacuum of silence, there are always misinformed views ready to fill it. Unfortunately, politicians (of all persuasions) are prone to exploiting the ill-informed attitudes and fears of many in the community for their own political gain. The obsession that Prime Minister Howard seems to have with 'political correctness' is a cover for giving permission to people with ill-informed ideas to express them, and give them legitimacy. Such an example was when Aboriginal Affairs Minister Herron launched a book by Partington called '*Hasluck versus Coombs*'. This book is full of misinformation, and would have been unheard of if Heron had not launched it. One example of the misinformation is a

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<sup>8</sup> Reynolds, H '*The Whispering in Our Hearts.*' Allen & Unwin, Sydney, 1998.

paragraph on the Aboriginal community controlled Yipirinya School in Alice Springs which was supported by Coombs.

Partington claimed:

*'... some Yipirinya (sic) regarded other Aboriginal groups as foreign and wanted to exclude them as well.'*<sup>9</sup>

'Yipirinya' is an Arrernte word for a type of caterpillar – a sacred caterpillar. There is no Yipirinya tribe in central Australia. Further, the Yipirinya School caters for a number of language groups and is attended by Arrernte, Warlpiri and Pitjantjatjara children.

Partington's story is not referenced and either is fabricated to support his political position that Aboriginal people have no identity as Aborigines, or reflects his ignorance of the topic that he has chosen to write about.

Such views have been given more credence than they deserve in the current political climate and have provided some 'intellectual' justification for the attack on Aboriginal organisations, reduction in funding, and the attacks on the High Court's decision on Native Title.

### ***Racism***

In trying to understand the reasons for poor health amongst Aborigines, the role of racism should not be underestimated. Racism occurs both in the course of individual interactions and through the operations of institutions.

Given the current difficulty Australia's political leaders have with the term 'racism', it is appropriate to define the term.

The Macquarie Dictionary provides the following definition<sup>10</sup>:

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<sup>9</sup> Partington, G *'Hasluck versus Coombs: White Politics and Australia's Aborigines.'* Quakers Hill Press, Sydney, 1996, p112.

<sup>10</sup> *'The Macquarie Dictionary'* Macquarie Library, Sydney, 1981, p1420.

*“1. The belief that human races have distinctive characteristics which determine their respective cultures, usu. involving the idea that one’s own race is superior and has the right to rule or dominate others. 2. offensive or aggressive behaviour to members of another race stemming from such a belief. 3. a policy or system of government and society based upon it.”*

The Collins Dictionary of Sociology<sup>11</sup> offers a similar definition:

*“a set of beliefs, ideologies and social processes that discriminate against others on the basis of their supposed membership of a ‘racial’ group. The term has been used in a variety of ways to describe both systems of thought and doctrines which justify the biological superiority of one social group over another, through to descriptions of practices and attitudes which produce racial discrimination and disadvantage.*

These definitions both include beliefs about the superiority of one race over another, and the discrimination by individuals or social systems against someone because of their race.

### ***Eugenics***

In many ways it was the ideology of eugenics that probably had the biggest impact on racial issues and attempts at social engineering. In Australia the eugenics movement was not as strong as in the USA, Britain and Europe (especially Germany). But it was nevertheless significant, and an example was the establishment of the Racial Hygiene Society in NSW<sup>12</sup>. This society was particularly concerned with the control of venereal disease after World War 1, and embraced positive Eugenics. Senior Australian policy makers were trained in the UK and would have incorporated Eugenic thinking into their work. Thus Australian attitudes were broadly influenced by British Eugenics, and these were an influence in the formulation of Aboriginal policy. CE Cook, Chief Protector of Aborigines and Chief Health Officer in the NT pursued eugenic policies with some vigour.

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<sup>11</sup> Jary D & Jary J ‘*Dictionary of Sociology.*’ Harper Collins, Glasgow, 1991, p517.

<sup>12</sup> The Racial Hygiene Society has transformed itself into the Family Planning Association and now has no policy or practice regarding racial or class purity.

He had control over marriages between Aboriginal and non-Aboriginal people. His view was that the best course of action was to breed out Aboriginality, and considered that the best way to do this was to '*breed him white*'<sup>13</sup>. This was his justification for removing mixed blood children from their families. Cook also advocated that he, or a tribunal, have the power to order sterilisation of 'defective' children of mixed descent, but this was not accepted by the government<sup>14</sup>.

The intent of eugenics was to create a better society through the manipulation of reproductive practises not dissimilar to the successful livestock breeding practices. According to positive eugenics<sup>15</sup> this meant encouraging the socially meritorious (ie high-class whites) to breed prolifically and selectively. A trend towards the negative eugenics that emphasised sterilisations and other involuntary acts aimed at encouraging the socially disadvantaged to breed less, was less evident in Australia.

Eugenics had its genesis with the publication of Francis Galton's eugenic ideas in "*Hereditary Genus*" published in 1869<sup>16</sup>. By the turn of the century, Eugenics was widely embraced, although there were different interpretations. There was a view that a large number of traits from mental illness, moral decadence, alcoholism and pauperism were inherited. The question was what to do about it. Some embraced a 'negative' eugenics whilst others embraced a 'positive' eugenics.

In the UK the focus of Eugenics was predominantly one of class, whilst in the US race and class shared eugenic concerns. Thus in the US eugenic ideas were incorporated into practices restricting immigration. Eugenic sterilisation laws were enacted in the USA and European countries such as Denmark, Sweden, Finland and Switzerland. However, sterilisation was not enacted in the UK. Intelligence tests were used by the US Army and by immigration authorities despite criticisms that they were educationally and culturally biased.

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<sup>13</sup> Markus, A '*Governing Savages.*' Allen & Unwin, Sydney, 1990, p93.

<sup>14</sup> Markus, A, *op. cit.*, p101.

<sup>15</sup> Kevles, DJ '*In the Name of Eugenics.*' Harvard University Press, Massachusetts, 4<sup>th</sup> print, 1995, p85.

<sup>16</sup> *Ibid.*, p3.

The dominance of the ideology of eugenics culminated with the rise of Fascism/ Nazism in 1930s and '40s. In Germany, with the rise of the Third Reich, eugenics policies were systematically enacted and eventually resulted in the holocaust against the Jews, Gipsies, homosexuals, communists and others, which finally resulted in the discrediting of these ideologies.

However, this did not stop the application of this ideology to Aboriginal people. Children continued to be taken away consciously as a tool of social engineering well into the 1960s.

Detailed accounts of the Eugenics movement can be found in Tucker's<sup>17</sup> *The Science and Politics of Racial Research* and Kelves<sup>18</sup> *In the Name of Eugenics*.

Eugenics is relevant to the assimilationist and genocidal policies pursued in Australia. Firstly was the widespread belief within white society that Nordic/ Anglo-Saxon races were superior to Aborigines on the evolutionary and intelligence scales. The second was the also widespread belief that it was possible to engineer social solutions. Thus, forcing Aborigines into Government settlements or missions (apart from simply keeping them out of the way of squatters, miners and other activities requiring dispossession) involved attempts at 'civilising' such as providing incentives for men to care for their wives and children through work. Further, taking children from their parents and communities was thought to result in a break with their Aboriginality, so that they could become like whites. It was also believed that by interbreeding with whites, their 'black blood' would be bred out.

Australia's obsession with the degree of Aboriginal 'blood' someone has is also related to eugenic ideas. The classification of Aboriginal people according to the degree of Aboriginal blood was used in allocating privilege or programs to Aboriginal people. Colin Tatz has written substantially about this question, and comparing Australian attitudes about racial classifications with that of South Africa where race classifications were written into

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<sup>17</sup> Tucker, WH, *op. cit.*



the law<sup>19</sup>. The degree of 'black' or 'white' blood someone had was supposed to predict his or her propensity to savagery or civilised behaviour. Tatz<sup>20</sup> explains it:

*'For the majority of Australians, visible colour alone is still the only criterion of who is or isn't Aboriginal. However, the public is hardly to blame. Until recently the 'scientific' equation was: the fuller the 'blood', the darker the skin, the closer one was to barbarism, savagery, heathenness, and childlikeness; the lighter the skin, the nearer one stood to civility, civilisation, and enlightenment. White society defined degrees of 'fullness', of mixture and of alleged 'impurity' on the sole criterion of what our eyes told us was full or half or quarter or eighth. Even the courts were not free of this 'what-a-person-looks-like-to-me' approach.'*

In Queensland, government record cards required a thumbprint of all Aborigines, followed by classifications of Full Blood, Half-caste or Quadroon. As discussed in Chapter 3, the Bungalow in Alice Springs was established for *'half castes'* before the war, and then, after the Second World War became an institution for *'full bloods'*. There was a clear policy to remove *half-caste* children, because the authorities believed that they could be trained to be citizens because of their European blood, whereas full bloods should be left with their people to share their ultimate fate of extinction. The preoccupations with degrees of blood persist today sometimes using different language.

In the period from late last century and into this, there was concern about inter-racial breeding and there was even a debate about whether black people were of the same species as Europeans. There was a popular view amongst Europeans that they were not and there were assertions that the offspring of mixed unions were sterile or that their fertility was not sustainable for more than a few generations<sup>21</sup>. Of course, the definition of a species is that members of the same species can produce fertile offspring, whereas intercourse between two different species produces sterile offspring or no offspring at all. For example, horses and donkeys can successfully breed, but the offspring is a mule, which is sterile. This is the

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<sup>18</sup> Kevles, DJ, *op. cit.*

<sup>19</sup> Tatz, C *'Obstacle Race: Aborigines in Sport.'* UNSW Press, Sydney, 1995, p20-27.

<sup>20</sup> *Ibid.*, p21.

<sup>21</sup> Hiatt, LR *'Arguments About Aborigines: Australia and the Evolution of Social Anthropology.'* Cambridge University Press,, Melbourne, 1996, p9.

origin of the term *mulatto*, which is commonly used to describe people of mixed African-European parentage in the Americas.

Further complicating the question of Aboriginality is the way Aborigines have been portrayed as representative of '*primitive Stone Age*' Homo sapiens in the discourses about the origins of the human species, and the nature of civilisation<sup>22</sup>. Aboriginal people have been a focus for much of the ideological debates of the past few centuries. Explanations of the declining population of Aborigines were thus easy to explain. European scholars argued that Aborigines were genetically inferior and evolutionary science was purported to show that they would disappear because of that inferiority and the natural law of survival of the fittest. Of course, most scholars would now challenge these simplistic extrapolations from Darwin's theory of evolution as unscientific and unfounded. However, it is worth remembering that many of these views were held at the time in the name of science.

Racism continues to be a major factor in determining Aboriginal well being. Few others in Australian society have had their identity placed under such scrutiny. Persisting negative stereotypes in Australian Society result in aboriginal people experiencing negative and discriminatory treatment in many day to day interactions in shops, schools, and workplaces. This has an impact on people's self esteem and confidence.

The practice of classification of Aboriginal people according to degrees of blood was developed as part of the institutionalisation of Aboriginal people under various laws and practices.

## **INSTITUTIONALISATION**

Institutions are run according to values and assumptions that tend to be seen by the authorities as value and culture free. Frequently this leads to institutions being based on assumptions that are racist. This does not mean that the individuals involved harbour hostile attitudes to people of different races, or that they think they are inferior. Rather it is a phenomenon that assumes that the ways in which the institution operates are value free.

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<sup>22</sup> *Ibid.*, p78-80.

However, the other way this may be perceived is that it assumes the absolute nature of the dominant culture's values.

The classic response of senior management of Alice Springs Hospital to questions about their cultural appropriateness, has tended to be '*We are not racist - we treat everybody the same.*' This response denies the values that are inevitably embedded in institutional practise, which are indeed culturally laden. The other response which is likely to come from some nursing staff on the ward, is to say, for instance, '*Aboriginal people don't like being alone*' and consequently put people together who may have an avoidance relationship - or may just not like each other. For non-Aboriginal patients the nursing staff is much more likely to ask what the patient would like. This highlights one of the problems of cross-cultural education for non-Aboriginal staff. Such courses are usually short, and tend to focus on traditional cultural practises such as kinship systems. It is then taken that *all* Aboriginal people operate within these mores, and consequent action is applied to all. This, in fact, is racist because it assumes that all of a people of a particular race will share the same values and cultural mores.

The other aspect of institutionalisation for Aboriginal Australia relates to how the authorities forced people into institutions as a means of control.

The characteristics of 'total institutions'<sup>23</sup> have been identified as:

1. All aspects of life are conducted in the same physical environment, and under the same authority;
2. Each aspect of life is carried out in the company of a large group of people who are all treated alike;
3. All aspects of daily life are tightly scheduled, and imposed from above through a system of rules and enforced by a body of officials;
4. Enforced activities are brought together in a single rational plan designed to fulfil the aims of the institution.

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<sup>23</sup> Goffman, E '*Asylums: Essays on the Social Situation of Mental Patients and Other Inmates.*' Anchor, New York, 1961, p6.

Goffman includes as institutions those aimed at caring for people who are incapable and harmless such as the blind, and mentally retarded; those for people who are incapable of looking after themselves, and are a threat to society such as TB sanatoria and mental hospitals; those for people who are seen as a threat to society where the welfare of inmates is secondary to the protection of society such as gaols, prisoner of war camps and concentration camps; those organised to carry out particular work tasks such as army barracks, work camps, boarding schools and colonial compounds; and those designed as retreats from the world such as monasteries, and convents.

It is clear that many of the missions, government settlements and homes for children fit into

these classifications. In Chapter 3, the occupation of central Australia is examined, and it can be seen that institutions have played a dominant role in Aboriginal affairs.

This institutionalisation of Aboriginal Australia has had an impact on how Aboriginal communities operate, and the degree of dependency that has developed. Institutionalisation has had a significant impact on the development of welfare colonialism, and has meant that the struggle for a more self-determinant future for Aboriginal people has been impeded. However, the development of self-determinant ways of living is made doubly important because of these histories. The alternative is continued dependency.

## **CONSTRUCTS OF ABORIGINALITY.**

*'We are many mobs with many countries, but we have become mixed up. We were put together without thought for our differences and our attachments to our countries. We were taken here and there, sometimes we went voluntarily; other times we were like cattle rounded up, slaughtered and bought and sold. We were made into what are called 'Australian Aborigines', or now 'Aboriginal Australians', though we never were a single mob. We were many, as many as the trees, as the different types*

*of animals. We are Nyungars, Nangas, Yolngus, Kooris, Murris, et al, all different, but all forming the indigenous people of Australia<sup>24</sup>.*

The slogan prominent on the front of the Land Rights News, the newspaper of the Central and Northern Land Councils reads '*One Mob, One Voice*'. This claim for pan-Aboriginality is in contrast to Mudrooroo's assertion that '*...we never were one mob.*' This apparent contradiction has been highlighted by some writers, and exploited by those opposing Aboriginal rights. However, Mudrooroo also points out that '*We were made into what are called 'Australian Aborigines' or now 'Aboriginal Australians' ...*' The point here is that both pan-Aboriginalism and many poly-Aboriginalism are now true. The processes of colonisation have forced indigenous people in Australia (and elsewhere) to share some things in common in relation to the processes of invasion and dispossession. And there is little doubt that an assertion of pan-Aboriginality has played a key role in overcoming the problems of the assimilationist era, and achieving some level of acceptance of land rights in the Parliaments and Courts of Australia. However, the diversity of Aboriginal people is also a reality, and has played its own part in ensuring Aboriginal survival. There is an Aboriginal network across the country which involves many aspects but includes Aboriginal people acknowledging each other wherever they go, and an Aboriginal English widely used.

However, whilst the assertion of pan-Aboriginalism has been important in Aboriginal survival, asserting sovereignty and in achieving some recognition of Land Rights, it is likely to be less useful when addressing health problems.

Health status is determined in large part by processes at a family and community level - especially the status of women and their educational achievements, and the availability of accessible and appropriate health services. The sort of community development required to achieve this is quite different to the processes of national negotiation (based on a premise of pan-Aboriginalism) for the achievement of land rights or Native Title. Community development processes must closely reflect and be entwined with the local politic, based on local perceptions and utilise local human and other resources.

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<sup>24</sup> Mudrooroo '*Us Mob. History, Culture, Struggle: An Introduction to Indigenous Australia.*' Harper Collins, Sydney, 1995, pv-vi.

It is common for people who embrace anti-Aboriginal positions to emphasise the lack of singular Aboriginal identity. It is, of course, true that Aboriginal people had no single identity as a people before colonisation. People identified themselves as belonging to a particular language group and clan. It was inevitable that Aborigines would identify themselves according to the 'other' in their experience. Before the invasion, the 'other' was a neighbouring clan, or the occasional Dutch sailor on the West coast, or Macasans in the North. After the invasion, the stark 'other' became the *white man*. Not only was this other stark because of skin colour, but also because the white man came, not just to visit or trade, but to possess, and to seize political control. The processes of colonisation forced Aboriginal people to come together in order to protect and pursue their interests. This is no different to any other section of society. People come together and form associations of various types with various objectives. Sporting bodies, social clubs, cultural groups, political parties - all of these organisations involve people identifying themselves with others of similar interest or concern. That does not mean that all members are the same, or indeed share all interests. Non-Aborigines often imagine homogeneity within Aboriginal society. The argument of poly-Aboriginalism, along with argument that contemporary Aboriginal organisations are not how Aboriginal people traditionally organised, is most commonly used to challenge the legitimacy of Aboriginal organisations (Land Councils, Aboriginal health services, etc.) However, this lack of homogeneity does not negate the legitimacy of these organisations, at both local and national levels, as one aspect of Aboriginal Australia's response to colonisation.

The construction of Aboriginality has played a major role in shaping the attitudes of people from early days when Aborigines were seen as 'primitive' and inferior, and, therefore, doomed to extinction, to attitudes today where, alongside persisting older attitudes, some romanticise the 'real' Aborigines and Aboriginal culture.

In Australia there has been an obsession with the amount of Aboriginal blood one had. Half-castes were (and still are) seen as different, as trouble makers<sup>25</sup>, but were also seen by some as the chance to 'breed out' Aboriginality. This was to some extent the rationale behind the stolen generations. From early days, there were attempts to separate *full blood*

from *half-caste*. The ideologies of social Darwinism were used as an explanation of the poor condition of Aborigines. Even the social movements calling for respect of human rights (eg the Anti Slavery Society) believed that Aboriginal people were doomed to extinction and should be protected against the cruelty of some of the pastoralists and others involved in the processes of dispossession. Indeed, the development of protectors was a government response to calls from these movements. It was felt that the *full bloods* could not adapt to the white society and should be protected from contact with non-Aborigines as much as possible and for as long as possible.

Today the attitudes about *real* Aborigines persist. Whilst some categorisation of Aboriginal people may be useful in order to communicate a range of factors about their living conditions, cultural values, and health needs, the historical continuities about categorisations have been deeply embedded. Care must be taken about the use of such categorisations. Language often involves a code that hides the real meaning, but is clearly implied. In central Australia code for *half-caste* is *town, urban, Aboriginal organisations*, and the like whilst code for *full blood*

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<sup>25</sup> Cook, CE 'Racism and Aborigines – Spontaneous or Induced?' In Tugby, D (Ed) 'Aboriginal Identity in Contemporary Australian Society' Jacaranda Press, Brisbane, 1973, pp46-53.

is *traditional, bush, family*. These categorisations are fairly meaningless. No Aboriginal people live traditionally in the way their ancestors did, which is often implied when the term is used. Indeed remote communities that pursue strong contemporary ceremony and other cultural practices are made up of both full-blood and half-caste Aborigines. Categorisations of people and communities can be an important tool in the identification of health needs and the planning of services. However, the assumptions behind the categorisations commonly used has continuities with past classifications which are clearly racist, and the heterogeneity of contemporary Aboriginal communities also means they are inaccurate. Useful classifications must be based on factors that have implications for service delivery (such as remoteness) and be careful to avoid tapping into deep seated and commonly held prejudices.

In the early 1990s Jimmy Barnes, a popular musician who lived in Bowral, NSW was involved with developing a relationship of sister schools between the local Bowral School and an East Arnhem school through his relationship with Mandaway Yunipingu of Yothu Yindi<sup>26</sup> fame. This received much publicity, and was used as a symbol of reconciliation between Aboriginal and non-Aboriginal Australia. No doubt this was so, but it overlooked the Aboriginal community in Nowra which is just down the road from Bowral. Therefore, it also helped perpetuate the idea that *real* Aborigines are in central or northern Australia - not in Redfern, Mount Druit, Campbelltown or Nowra. *Half-castes*, it is assumed, do not have culture, language, etc. These are the attitudes that pervade much of non-Aboriginal thinking and can become barriers to the strengthening of community and the provision of services.

Constructs of Aboriginality are also involved in the challenge to legitimacy of Aboriginal leadership made by some non-Aboriginal people involved in health service delivery. It underlies the downfall of the Healthy Aboriginal Life Team (HALT) which was run by a non-Aboriginal private company called Teslo Pty Ltd. The Directors of this company were adamantly opposed to Aboriginal organisations as these were seen as 'white' structures



inconsistent with traditional ways Aboriginal people organised themselves. The program run by HALT was evaluated by the Menzies School of Health Research<sup>27</sup> and found that the results were good in the community from which the main Aboriginal person involved with HALT came. But it was less successful in other communities. Discussions with HALT aimed at restructuring the company so that it would be under Aboriginal control failed. Inevitably, HALT lost its DAA funding. This was because Aboriginal people began asking questions about its funding and why funding for Aboriginal health promotion programs was going to a non-Aboriginal private company. The funding was lost, and the experience developed by HALT was also lost. The reasons relates in part to HALT's construct of Aboriginality, and consequently of Aboriginal organisations. The traditional cultural aspect of Aboriginality was prominent in the HALT ideology. Therefore, kinship systems, and who had responsibility for certain people was central to their program with the explicit aim of re-establishing traditional relationships and responsibilities to stop petrol sniffing. There is little doubt that this approach was and is relevant to some families. However, it fails to recognise the changing nature of living cultures and their diversity. Dead cultures do not change and adapt and representations of such cultures can be found in museums. Thus dealing with petrol sniffing or other substance abuse inevitably needs to involve a diversity of approaches to meet the diverse and changing needs of contemporary Aboriginal society. Any program based rigidly on a singular construct of Aboriginality is doomed to fail.

### **Contemporary Aboriginal Organisations**

As can be seen by the HALT story, some non-Aboriginal people assert that Aboriginal organisations are 'white fellah organisations'. As a consequence, one of the common themes of debate amongst non-Aboriginal people in central Australia appears to revolve around this question of legitimacy of Aboriginal organisations, and who represents whom. For example, it is often said that Aboriginal organisations in Alice Springs do not represent people in the bush. Of course, the people making such assertions certainly do not represent

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<sup>26</sup> Yothu Yindi is an internationally successful Aboriginal band playing both traditional and contemporary rock music.

<sup>27</sup> Rowse, T 'HALT: An Evaluation.' Menzies School of Health Research, Alice Springs, 1991.

people in the bush! These attitudes are contemporary versions of non-Aboriginal attitudes about 'traditional' Aborigines - the noble savage.

Aboriginal organisations must be incorporated according to Australian law before they can be recipients of Government funding. However, this has little to do with the legitimacy of such organisations as Aboriginal. Aboriginal organisations tend to operate somewhat differently to non-Aboriginal organisations. Aspects of administration have been adapted to fit better with Aboriginal priorities and thinking. Decisions are made through a process that is not always obvious to non-Aboriginal staff or observers. There is a community dynamic which is complex and determined by both traditional and contemporary ways of working and thinking. Traditional kinship relationships are only one (albeit important) aspect of this dynamic.

As in most contemporary societies, there are different authorities operating in different spheres of community activity in Aboriginal communities. For many Aboriginal people the elders are still the ones who carry spiritual responsibilities and authority, but these people are not expected to take responsibility for all the other aspects of life influencing the community. Nor is their leadership about traditional Aboriginal law and spirituality necessarily taken very seriously by many younger people, much to the concern of many older Aboriginal people.

One of the contradictions about the demands for accountability and evaluation of health services (and other Aboriginal organisations) by government, is that the criteria bureaucracies and politicians use to measure the appropriateness and effectiveness of programs, help shape the organisations to be more like white fellah organisations than they need to be. The style, and detail of accountability demands of government, often fails to reflect community agendas and priorities. Indeed Aboriginal organisations often operate as agents of mediation between the imperatives of Aboriginal people and communities, and those of the government.

The Royal Commission into Aboriginal Deaths in Custody commented on the development of Aboriginal organisations<sup>28</sup>:

*Aboriginal people have accepted the concept of representation through organisations and, as a result, specific Aboriginal programs should be run by those organisations in preference to service delivery through mainstream agencies.*

The support for Aboriginal organisations as legitimate agencies of Aboriginal community power does not, of course, mean that they always work in an optimal fashion, by either Aboriginal or non-Aboriginal standards. In that sense they are no different from any other organisation with variations in performance and reflection of community aspirations.

### **Representation and Leadership**

It is now 25 years since the establishment of the Central Australian Aboriginal Congress. At the time of its establishment, it was indeed a strongly representative body. It developed a Council that had two representatives from all major communities in the central Australian region. However, over the ensuing years, bush communities and out-stations have increasingly developed their own organisations and services. As such leaders from these groups have been less involved with Congress, and more involved with organisations serving their own community's needs, and the establishment of out-stations. Relationships between bush and town, however, persist not only through organisational links, but through family relationships. Central Australian Aboriginal people living in Alice Springs invariably have relatives living in remote communities in central Australia. Alice Springs remains a resource centre for the whole of the central Australian region.

Organisations like Congress have been important in the development of Aboriginal leadership, and especially Aboriginal leadership in health. This leadership is important for the development of appropriate infrastructure, and services for people throughout the

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<sup>28</sup> RCIADIC 'Final Report of the Royal Commission into Aboriginal Deaths in Custody.' AGPS, Canberra, 1991, Vol 4 p5.

region. This is a product of experience and knowledge of the region, health service development and delivery, and the way government bureaucracies work. The legitimacy of this leadership and its recognition are important because it is this leadership which needs to be involved in health service planning processes, which have been mostly pursued by government agencies with inadequate consultation. Issues relating narrowly to degree of representativeness and its legitimacy are irrelevant to the point.

## **RECONCILIATION**

As part of a recognition of the different histories of people, and the gap between understandings between Aboriginal and non-Aboriginal people, the Keating government established a Council of Aboriginal Reconciliation. This Council was charged with the responsibility of finding ways of improving understandings between the Aboriginal and non-Aboriginal communities, and to move towards a greater sense of shared history. Their motto has been *Walking Together*. For many Aboriginal people reconciliation is meaningless unless it involves overcoming the serious disadvantage they experience. Reconciliation is certainly meaningless unless there is an acceptance about what there is to reconcile. For those who wish to brush history aside, and just get on with the future, reconciliation is meaningless. The persistence of negative attitudes towards Aboriginal Australia by many (as revealed in the Sweeney Report) and the actions of the Howard Government in undermining the Council of Aboriginal Reconciliation, show how fragile this process is. This fragility is exacerbated by the deep hurt felt by many Aboriginal people at, not only the histories with which they have had to endure, but the reluctance of significant sections of non-Aboriginal Australia to acknowledge these damaging histories. Acknowledgment of the deeds, and the damage they caused, is a prerequisite for a process towards healing and reconstruction.

One of the attitudes discussed in the Sweeney report is the acceptance of many non-Aboriginal people that the Aboriginal people were a conquered people and that this is why there was no treaty<sup>29</sup>. This of course is open to a great deal of debate. It could be argued

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<sup>29</sup> Brian Sweeney & Associates, *op. cit.*, p6.

that a treaty is appropriate because Aborigines have some rights because of prior ownership regardless of whether they were a conquered people or not. However, Reynolds has shown that the Tasmanian Aborigines were, indeed, not conquered, and that, in fact a truce was agreed to because both sides recognised that neither could win militarily<sup>30</sup>. Further Aboriginal people have asserted many times that they have never ceded their sovereignty. What sovereignty actually means is contested in a debate that I do not want to pursue here.

It is often said that it is the victors that write the history and in so doing choose language and interpretations of events that cast the best light on the victors. Australia is no exception. The colonisers tended to sanitise history and chose to use words like '*settlers*' rather than '*invaders*'. It was easier to understand the previously declining Aboriginal population as a process of disease and genetic inferiority than to focus on the massacres, and the social and economic impacts of dispossession.

This process of sanitising history tends to deny Aboriginal people their version of history. The effect of this is to perpetuate the injuries of colonisation and dispossession. Continued non-Aboriginal denial of Australian atrocities keeps many Aborigines wounded and robbed of pride and strength of identity. It plays a central role in hiding the underlying reasons for Aboriginal anger and despair which underpin a good deal of Aboriginal ill health - especially that related to substance abuse, suicide, violence and mental health.

The Nuremburg trials in Europe after the European holocaust, and of the Truth and Reconciliation Commission in South Africa currently being conducted as a method of societal reconciliation, are examples of different ways some societies have tried to deal with horrific events in their history. Of course, the Nuremburg trials were to some extent symbolic, as whilst some were being tried for their offences, others, according to recent media reports, were being allowed to escape with the complicity of the USA, the Catholic Church, Argentina and other allied governments. Further they were imposed by the victors. Whilst reconstruction processes inevitably span generations, for reconstruction to occur at all requires acknowledgment of damage incurred.

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<sup>30</sup> Reynolds, H '*Fate of a Free People: A Radical Re-examination of the Tasmania Wars.*' Penguin

Some Aboriginal writers have recognised that a healing process is required to help overcome the ravages of colonialism.

*'To Us Indigenous Mobs, the arrival of the first wave of invaders (those who came to settle and take up land, dispossess and deprive us of our inheritance, so that what we once owned, what had passed down to us from our ancestors, no longer belonged to us) is but an interlude in our long possession of Australia. It is a traumatic period which needs healing and perhaps Aboriginal studies may be seen as part of that healing process.'*<sup>31</sup>

It is, of course, doubtful that complete healing can occur and, if it can, how long it will take is uncertain. The degree of trauma experienced historically is deeply embedded in the histories of a people, and they are not erased easily. Indeed, it would appear that some of the damaging behaviour patterns persist even in the absence of actual knowledge of the events that triggered such behaviour in previous generations. However, if the colonial process has inflicted injuries that are at the heart of persistent Aboriginal ill health, then processes that move towards healing are important to the project of improving health. Exactly what process is likely to be most efficacious is difficult to determine. However, acknowledgment of damage done, and the cessation of continuing damaging acts would seem to be a prerequisite.

Most importantly to reconciliation is the process of colonisers and colonised being able to develop a shared understanding of history. There is little doubt that the dominant Australian society has written and interpreted history from its point of view until very recent years. There has been a silence about certain aspects of the past, and these aspects are central to the pain, and persisting ill health of Aboriginal people. It is only in recent decades that Aboriginal voices have been heard to any extent in the dominant society.

The events which are categorised by some sections of society as being 'in the past' are events which live in the hearts and minds of many Aboriginal people today. Many Aboriginal people live

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Books, Melbourne, 1995.

<sup>31</sup> Mudrooroo, *op. cit.*, p. iv.

on the edge emotionally because of the breaking up of their families and communities by the policies perpetrated as part of the colonial processes of dispossession. Effectively, these practises have damaged the Aboriginal societal fabric. More people have become isolated from their roots, their families, their communities and their country.

It is difficult to estimate the magnitude of the atrocities perpetrated on Aboriginal people in this country. Continued denial exacerbates the present impact on Aboriginal people, and blocks the development of appropriate strategies for a better future.

### *International Comparisons*

In South Africa, which is still emerging from civil conflict where horrors were perpetrated on both sides, the Government has established a Truth and Reconciliation Commission as part of an attempted healing process that needs to occur in South Africa in order for a national unity to develop. The Commission has three Committees<sup>32</sup>. First is the Committee on Human Rights Violations, which hears from those effected by such violations. One of the emphases here is for people to be able to tell their story and they are encouraged to forgive. The hearing for this part of the process is now complete. There is also a Committee on Reparations and Rehabilitation that is charged with providing emergency aid, and recommending other types of reparations (eg counselling services, health care, economic support, or memorials to particular atrocities) as part of the process of national healing. And finally, there is the Amnesty Committee that is in its early stages, which can give amnesty to politically motivated atrocities provided that the perpetrators are truthful in their submissions. The Reparation and Rehabilitation Committee sees its role as balancing, for the victims, the amnesty given to perpetrators<sup>33</sup>. It, of course, remains to be seen whether this approach will be effective. But it is seen as an important part of healing. It is recognised that the families effected by the killings and the torture have to have an opportunity to have their pain recognised, and validated, before healing can occur. It is also important to recognise that the amnesty offered by the Commission to perpetrators of atrocities is not

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<sup>32</sup> 'Truth & Reconciliation Commission' Justice in Transition on behalf of the Ministry for Justice, Pamphlet, South Africa, 1995.

<sup>33</sup> Boraine, A 'Restitution – more than mere words.' Truth Talk, Official Newsletter of the Truth & Reconciliation Commission, Vol 3, No 1, Nov 97, p 4.

universally welcomed in South Africa. Many families who lost loved ones in these atrocities feel that such amnesty frustrates justice.

After the Nazi holocaust in Europe against Jews, Gipsies, communists, homosexuals and others deemed to be genetically inferior and as such a threat to the purity and supremacy of the Aryan race, there was also a process where some of the perpetrators were brought to trial at Nuremburg. Indeed organisations were set up in many countries, including Australia, to uncover people who had escaped justice, and attempts, at least, were made to bring them to trial. There is little doubt that many Jews see this as important to their quest for justice. It is difficult to know whether the partial application of justice to some perpetrators has a healing impact on the victims, especially when the same ideologies that resulted in the holocaust are again gaining momentum in certain countries, including Germany. However, these are two contrasting approaches to a societal response to horrendous events that live in the psyches and hearts of a people, and represent some attempt at a healing process. One relies on the pursuit of justice - proving the guilt of those who are to blame for the atrocities, and allocating appropriate punishments. The other relies more on a cathartic forgiveness, provided the truth of the matter is revealed. It requires honesty in admitting the details of the atrocities committed, the perpetrators facing their victims or families of the victims. Both involve an acknowledgment of the injustice against people. Such acknowledgment is a prerequisite for a healing process.

### ***The Australian Catastrophe***

In Australia there persists a strong tendency to deny the extent of the colonial catastrophe for Aboriginal society. However, the estimated decline in the Aboriginal population is testament to a major destruction of Aboriginal society. By 1888, the centenary of British colonisation of Australia, the non-Aboriginal population was almost 3 million, whilst the Aboriginal population was estimated to have fallen from at least 251,000<sup>34</sup> to 67,000<sup>35</sup>. Other estimates suggest that 600,000 people died in the years following British occupation, and that the total Aboriginal

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<sup>34</sup> A.R Radcliffe Brown's estimate in the '*Official Year Book of the Commonwealth of Australia. No 23 (1930)*' as quoted in Rowley, CD '*The Destruction of Aboriginal Society.*' Penguin Books, Melbourne, 1972, pp384.

<sup>35</sup> Clark, CMH '*A History of Australia.*' Melbourne University Press, Melbourne, Vol 5:1.



population at the time of the arrival of the First Fleet was upwards of 750,000<sup>36</sup>. On the most conservative figures the Aboriginal population was reduced by 73% as a consequence of the British invasion. This, of course, includes deaths from all causes and many were due to introduced infectious disease. The impact of such a massive depopulation can only be imagined, but almost certainly included strains on economic activity, grief, a general sense of insecurity, and mistrust of the newcomers.

The Royal Commission into Aboriginal Deaths in Custody<sup>37</sup> went a long way in outlining and analysing the histories and the consequent impacts on Aboriginal communities and recommended changes in policy and action to help overcome these impacts. The Commission found that the rates of death of people in custody were not greater amongst Aboriginal compared with non-Aboriginal prisoners, and that the real issue was the high proportion of Aboriginal people in custody compared with their numbers in the population. This disproportionate gaoling of Aboriginal people is evidence of a continuation of the marginalisation, institutionalisation and oppression of Aboriginal people. It reflects the persistence of the colonial relationship between Aboriginal and non-Aboriginal societies in this country. There has been little serious attempt by any government to move to implement the spirit of the recommendations of the Commission. Little has been done to stop the imprisonment of Aboriginal people. Indeed, at least two governments (WA and NT) have introduced mandatory prison terms for street crimes and crimes against property, and a 'truth in sentencing' approach which limits the possibilities of release on parole. Many commentators predict that these measures will increase the numbers of Aboriginal youth incarcerated.

Further Prime Minister Howard's reluctance to acknowledge the nasty side of our history does not sit well with the need for acknowledgment as a prerequisite for reconstruction.

The practices up until the 1960s of taking children away from their families involved the forced movement of people and the breaking up of families. It involved the institutionalisation of the

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<sup>36</sup> Dr Peter White quoted in '*British Invasion Claimed 600,000.*' Land Rights News, Vol2, No 3, June, 1987, p19.

<sup>37</sup> '*Final Report of the Royal Commission into Aboriginal Deaths in Custody.*' AGPS, Canberra, 1991, 11 volumes.

children taken away<sup>38</sup>. Some found army life an easy option as an adult due to the similarities of regimented army life with the regimentation of life in the homes. Gaol is also found by some to provide the regimentation of life that they have grown up with.

There has been little focus on the systematic removal of Aboriginal children from their families and communities until the recent Inquiry into the *Stolen Generations*. These histories tend to be hidden in the white Australian psyche. However, the pain is in the here and now in many Aboriginal hearts and minds. Society perpetuates these practices by continuing to take the children away through our social work/ welfare agencies and the courts<sup>39</sup>. Aboriginal parents, having been denied parenting roles due to their being taken away and institutionalised, are often deemed by social workers and magistrates as being unfit to look after their children, and so their children are taken away, and the cycle continues to the next generation. There is little evidence that the State does a better job at loving and child rearing than parents, even if they are disturbed by their own histories, and fail to bring their kids up within the framework of middle class European values that the social workers and magistrates tend to see as so important. Sally Morgan<sup>40</sup> and Roberta Sykes<sup>41</sup> (amongst others) have written compelling accounts of their childhoods revolving around fear of what authorities might do. Passing as white, for those who could, or obsessively avoiding contact with state authorities mark many people's experiences. Others talk about being hidden from view when welfare or other authorities were present.

So, an understanding of history is relevant to developing an understanding of the present pain felt by many Aboriginal people, to an understanding of the general condition of living of many people, and to the project of stopping the incarceration of Aborigines in prison, psychiatric institutions and foster homes or orphanages. And, indeed, to the project of improving Aboriginal health. An appreciation of history is also required from non-Aboriginal Australia and its institutions in order to develop a more appropriate and reflective practice that has some chance of

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<sup>38</sup> Wilson, R 'Bringing Them Home: National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families.' Human Rights & Equal Opportunities Commission, Sterling Press, Sydney, 1997.

<sup>39</sup> NSW Department of Community Services 'Child Protection Notifications, Client Information System', 1998.

<sup>40</sup> Morgan, S 'My Place' Fremantle Arts Centre Press, Fremantle, 1987.

<sup>41</sup> Sykes, R 'Snake Cradle' Allen & Unwin, Sydney, 1997.

breaking from the cyclical ways of dealing with the current social consequences of these practices.

The specific history that is explored in the next chapter also shows the mass institutionalisation of Aboriginal people in settlements or missions with people having to ask permission from the 'protectors' (usually police) to move from one Aboriginal settlement to another - even having to provide details about when and by what route they would travel.

This history has relevance to non-Aboriginal Australians, who need to come to terms with the roles played by our ancestors, if not as perpetrators, then as benefactors of the actions of ancestors, who were the immigrants of yester-year.

## **CONSTRUCTS OF COMMUNITY**

The notion of 'community' has become a common one in health and welfare circles. Concern with the notion of community comes from increasing recognition of the importance of *bottom up* processes in the delivery of services, and in the identification of needs and issues needing to be addressed. So, submission writers, governments, along with non-Government organisations, all need a relationship with community to legitimise their projects and programs. This is problematic in non-Aboriginal society, and there have been some debates amongst community health practitioners as to the nature of community. Is it a geographic area, or is it a community of people over, sometimes, vast areas but with commonly felt needs? The early 1970s was the time of the birth of community health in Australia, and a number of different models were developed. The mainstream community health program was, in fact, government initiated and many of these community health centres became agents of the large hospitals. However, various community groups developed their own versions. Aboriginal health services were developed from community initiative well before governments developed their programs for community health centres. Women's health centres (at Leichhardt and Liverpool) were organised by groups of women as health centres controlled by women providing services to women. Thus, their 'community' was a community of women. Similarly, the Workers Health Centre at Lidcombe, NSW began as a community health centre defining its community as a

community of workers, and focused on the specific health issues for workers. These projects were attempts at overcoming a too general notion of 'community' which it was felt left the health professionals in control, and used the language of community as a way of legitimising the activities of health professionals.

This necessitates some discussion on the nature of Aboriginal communities. I put the view that there are two aspects of this. One is a construct of the colonial processes, and tends to be more defined by location than by human relationships. That is, many Aboriginal communities were set up by governments or churches and became the focus for containing Aboriginal movement and autonomy, and for the provision of resources (initially food rations, but now education, health services, police, stores etc.). As far as contemporary Aboriginal communities in central Australia are concerned, they are all relatively recent and, as can be seen from the discussion on the occupation of central Australia, are clearly products of colonisation. Papunya, for example, was only established as a government settlement in 1959. Government or mission authorities controlled these communities, and the movement of Aboriginal people from these settlements was restricted. Tatz has described many of these 'communities' as concentration camps where the guards walked away in the 1960s<sup>42</sup>. Many of these communities are made up of a diversity of families and language groups. Power relationships among and between these groups are complex. They are not always in harmony. The degree of poverty and unemployment is high, and the country harsh. Substance abuse, commonly alcohol, and, in some communities, petrol sniffing, is both a response to these pressures, and further adds to them.

The other is a persistence of human movement and relationship that is primarily to do with relationships with family, language group, and country, but little to do with fixed locality in the sense meant by the common usage of the term 'community'.

Since the 1960s when the old assimilationist policies subsided, there has been a clear tendency for people to move back to smaller settlements or out-stations from these larger settlements. Thus the dynamics between people tend to occur within and between language groups across the region. Families straddle communities, and indeed move between them.

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<sup>42</sup> Tatz, C Address to the AMA's Summit on Aboriginal Health, Canberra, 1993.

Major centres like Alice Springs are an important resource for all communities in the region. The tendency to separate bush from town by the NT Government, the ATSIC Regional Council boundaries and indeed by individual non-Aboriginal health professionals prevents the resources (dollars and services) inevitably concentrated in Alice Springs being more equitably made available to people throughout the region.

In Aboriginal health, community control of Aboriginal primary health care services has been the major policy platform promoted by Aboriginal health activists and leaders since the late 1960s. Over 50 Aboriginal health services have been established around the country as community controlled health services. What community control means is a contested issue. The practise of community control also varies from place to place. In the Northern Territory, the NT Health Department (now called Territory Health Services) has been involved in attempts to implement a policy of community control. However, it has failed to form a collaborative relationship with the Aboriginal health leadership in the NT, and has, in effect, attempted to impose the responsibility for delivering health care services on to community councils. This has been a major issue of contest between Aboriginal Medical Services Alliance - Northern Territory<sup>43</sup> (AMSANT) and the NT Government.

In short, different players use the term 'community' in many ways. Primary health care demands that the 'community' legitimise its programs by 'participation', 'control' or 'endorsement'. Bureaucracies frequently include in their funding guidelines the notion of 'community', and policy development frequently involves 'consultation' with 'community'. Indeed Aboriginal people themselves often assert they are speaking for their 'community'. In other areas community is seen as being a space, or a group of homogeneous people with a common interest. In central Australia, however, 'community' can mean a place where a number of people (with various degrees of heterogeneity) live some of the time. It can also mean groups of people who interrelate to each other across often large geographic areas. I have tended to use this term to mean both of these as well as the wider dynamic that is involved in Aboriginal relationships across the central Australian region.

The policy of self-determination has also created difficulties between the notion of 'community' or the Aboriginal domain, and the imperatives of governance and administration. The definitions, notions, and constraints of governance limit the practice of self-determination. The traditions of colonial administration, with their tendency to paternalism and patronisation, have frequently been continued in the administration of Aboriginal affairs despite the clear policies of self-determination. Often there are major contradictions between these constraints and the way in which Aboriginal society operates. Aboriginal organisations tend to be mediators in this milieu. Many commentators have written about these tensions and contradictions. Rowse provides a good overview of these issues<sup>44</sup>.

'*Empowerment*' is a word commonly used in Aboriginal affairs. It is interesting that non-Aboriginal people in authority in various institutions often use it. However, there is little evidence that authorities are prepared to actually allow their power to be taken by Aboriginal people. The Commonwealth Government, for instance, established Batchelor College in 1974 as an education institution for training Aboriginal teaching assistants. It is now run by an NT Government appointed Board which is largely Aboriginal. Batchelor staff frequently identify empowerment of Aboriginal people as one of their key objectives. However, despite the number of years they have been operating and the number of Aboriginal graduates they have produced there are still very few Aboriginal lecturers. Similar criticisms could be made of the Menzies School of Health Research, and the Territory Health Services operations.

How is empowerment defined? Definition is crucial in order to make sense of this. Rody<sup>45</sup> defines empowerment as:

*'enhancing people's capacities to control their own lives by defining, analysing, and acting upon their health and nutrition problems to their own satisfaction.'*

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<sup>43</sup> AMSANT is the peak body of Aboriginal community controlled health services in the Northern Territory.

<sup>44</sup> Rowse, T '*Remote Possibilities: The Aboriginal Domain and the Administrative Imagination.*' NARU, ANU, Darwin, 1992.

<sup>45</sup> Rody, N '*Empowerment as Organisational Policy in Nutrition Intervention Programs: A Case Study from the Pacific Islands.*' Journal of Nutrition Education Vol 20 No. 3, 1988.

The primary concerns of Rody (that is health and nutrition) are included in her definition of empowerment. Thus, her priorities are embedded in the definition, and as such place limitations on empowerment. This is despite Rody's main argument against top down interventions. It reveals an intrinsic contradiction in the notion of empowerment. Who decided that nutrition was the main focus for empowerment? Why might it not be environmental health, or substance abuse, or the impact of cyclones, the quality of the roads, etc.? Who decided that 'health' is the main issue in the first place?

The Macquarie Dictionary<sup>46</sup> defines *empowerment* as:

*'1. To give power or authority to; authorise: "I empowered him to make the deal for me." 2. To enable or permit.'*

Within this definition is the idea that the 'someone' who gives the power actually has the power. It is indeed problematic. It is actually not possible to empower an individual or group, in the way that is meant by those talking about community development. People either take power or they don't. In order to discuss this it is necessary to address the issue of power in relationships. As far as Aboriginal society is concerned, the dominant society and its agencies hold power in most realms. Exceptions to this are in the area of Aboriginal community business (including certain sporting carnivals), law, and country. The powerful agencies in the health area are the health bureaucracy as a direct arm of government, the health care delivery system (hospitals, clinics, etc.) and the health professionals (doctors, nurses, and allied health professionals). Other agencies can also be extremely powerful - such as the Menzies School of Health Research and educational institutions such as Batchelor College<sup>47</sup>. These agencies all carry significant institutional power within the dominant society, and are sanctioned by the dominant society. Often this power is asserted without circumspection. That is, the individuals who carry this institutional power frequently appear not to appreciate that they do, and their exercise of power is performed without reflection. It is common for doctors and nurses to accept their roles, knowledge

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<sup>46</sup> *'The Macquarie Dictionary' op.cit., p589.*

<sup>47</sup> Batchelor College is an adult education institution for Aboriginal students established by the government in the mid-1960s as an annex of Kormilda College in Darwin. It was moved to Batchelor, the former mining town for the Rum Jungle uranium mines, in 1974. An Alice Springs campus opened in 1991

base, and professionalism as an absolute 'good' thing, and practise their professional roles with disregard for setting, and competing paradigms. It is also common for institutions such as Menzies to exploit their power as medical researchers in order to maintain their funding levels. Menzies interventions in Aboriginal health have often been muffled by their concern not to upset the NT Government, one of their major funders. Criticisms<sup>48</sup> made of Primary Health Care (PHC) services in Aboriginal communities as inappropriate for a country like Australia was made to the Health Minister Richardson without any investigation or consultation on the part of the author. Some felt that it was meant to apply to the NT Government services, but this was not explicit in the document.

In many Aboriginal communities, there are a stream of people (anthropologists, medical researchers, health promoters, various government instrumentalities) visiting a community wanting to have meetings with the community. Most have an approach that involves some notion of community empowerment. However, many of these people have not researched what the community has already said it wants before hand. Their agendas have been determined elsewhere with little regard for previously expressed community views.

Commissioner Elliott Johnson commented on this tendency<sup>49</sup>:

*'The perception of many Aboriginal people - and I might add the perception of many public servants with whom I have spoken - is that policies are propounded, programmes put forward, assistance offered in a form which has been largely pre-determined in the bureaucracies of the departments concerned; that there is a process of consultation with relevant Aboriginal bodies or communities but that the parameters of the consultation have been set in advance; that the agenda is being fixed by non-Aboriginal people, not by Aboriginal people.'*

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<sup>48</sup> Mathews, J 'Aboriginal Health Issues.' Paper prepared for Minister for Health Richardson, 1993, p7.

<sup>49</sup> RCIADIC 'Final Report of the Royal Commission into Aboriginal Deaths in Custody.' AGPS, Canberra, 1991, Vol.4, p20.



An example of the sort of clash that can come between Aboriginal needs and perceptions, and the predetermined agenda of a visiting group to an Aboriginal community is the following exchange recorded in Hansard of evidence from the residents of Kintore to the 1988 House of Representatives Standing Committee on Aboriginal Affairs. The Chairman, Mr Blanchard had called Kintore leaders Riley Major, Johnny Scobie and Joe Young to give evidence<sup>50</sup>:

*'CHAIRMAN: Do you members of the Council want to make a statement to the Committee?*

*MR MAJOR: The Community Council is worried about putting in a swimming pool.*

*CHAIRMAN: What have you done to plans for a swimming pool?*

*MR MAJOR: We have been talking about a swimming pool since Kintore was small, and we are still talking about it.*

*CHAIRMAN: What sized swimming pool are you after, as big pool or a small pool?*

*MR YOUNG: We need a pool for everyone here.*

*CHAIRMAN: Perhaps there are other things that you need first. Before we answer that, perhaps you could tell us how the Council operates. How do you elect your councillors?*

*MR YOUNG: We have been waiting five years for a swimming pool. We need it here for all the people.*

*CHAIRMAN: The question of a swimming pool will have to be addressed to either the Department of Aboriginal Affairs or the Northern Territory Government. Mr Cameron mentions that there is a local member (Warren Snowden) here. Does the Council meet regularly as a full council and how often does it meet?*

*MR MAJOR: The Council has been meeting often and discussing this issue of a swimming pool ... '*

Rowse comments:

*'Such striking disconnection between the concerns of consulters and consulted makes this a vignette of many Aboriginal people's contemporary relationship with the*

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<sup>50</sup> House of representatives Standing Committee on Aboriginal Affairs (HRSCAA) Hansard, 454 as quoted in Rowse, T, 1992, *op. cit.*, pvii.

*Australian state. The Committee wished to hear how Kintore people used the machinery of self-determination: the Kintore leaders wanted the government to understand the strength of their desire for a swimming pool. The result: polite and comic struggle over who was to set the agenda.'*

The Aboriginal community has its own power relationships and agencies of power. For instance Ngangkeroes<sup>51</sup> had (and to some extent still have) carriage of responsibility for the practise of medicine in Aboriginal communities for thousands of years. Women more generally have had the responsibility for collecting bush medicines along with food for the family. Aboriginal law is also seen as having a powerful impact on the community's health. These are all agencies of power from the Aboriginal point of view. These agencies of power operate in parallel with more contemporary agencies, particularly Aboriginal organisations.

Rarely have these agencies been given respect by the agencies within the dominant society. Aboriginal health agencies are poorly understood, and poorly supported. Rarely are they given more than scant recognition.

The creation of Aboriginal Health Workers has been seen as a way of bridging what has been recognised widely as a 'cultural gap'. From the dominant society's point of view this is so that it can better implement its health programs in Aboriginal communities. By using AHWs it is possible to reach more people - to vaccinate more children, to diagnose and treat more syphilis, to implement our HIV/ AIDS education program, etc. And in this context these progressive practitioners talk about empowerment. Rarely have these programs included in their analysis of the problem the issues of power, power relationships and the agencies of power both in the Aboriginal community and in the society from which the health professionals/ planners/ interventionists come.

Agencies of power that need to be considered include:

- ♦ Aboriginal organisations (usually organised around various sectors such as health, housing, land, women, childcare, legal issues, media, education, etc.) These

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<sup>51</sup> Ngangkeroes are traditional spiritual healers.

organisations are frequently the recipients of money from the dominant society - ie the government. These resources only flow if the organisations are established in a way that is satisfactory to the Government - that is an incorporated body under Australian (nee British) Law.

- ♦ Aboriginal law. It is inappropriate to discuss details of this. However, parallel with the power vested in the agencies of Aboriginal organisations, are traditional Aboriginal Law men and women.
- ♦ Contemporary community/ family structures. Within contemporary Aboriginal communities are diffuse power relationships that are premised on community respect for people who play particular roles within the community/ family. They are not organised according to the dominant society's legal requirements, and are not directly part of traditional Aboriginal law. But they are fundamental to Aboriginal survival and the way that contemporary communities and families operate.

A further factor effecting power relationships is the increasing number of Aboriginal people in central Australia engaging in mainstream economic activities. This includes some establishing small businesses such as tourism ventures, cattle grazing, and arts/ crafts activities. Others have sought employment either in the bureaucracy or in private enterprises. With the advent and growth of Aboriginal organisations, there has been the development of indigenous managers who have become economically significantly better off than many members of the community who are clients of the organisations. Others work in lowly paid positions within these organisations. Still others remain unemployed. This means that the class structures of Australian society are being steadily imposed on Aboriginal society.

Power relationships in various towns and regions will, of course, vary. However, in most (if not all) regions of Australia the history of Aboriginal - European contact has been less than friendly. Europeans used their sophisticated technology and superiority in numbers to dispossess Aboriginal populations who were often already weakened by infectious diseases (such as smallpox) before the invaders were physically present. The health care system shares historical continuities with the welfare system that was the official agency implementing policy for Aboriginal people. This includes the now widely understood assimilationist policy of taking the

children away. Indeed, as is discussed in Chapter 6, the Chief Medical Officer in the Northern Territory was also the Chief Protector of Aborigines.

Aboriginal survival has depended on Aboriginal resistance to domination and extermination. This resistance has included violent military resistance, and passive resistance. Without this resistance and assertion of autonomy it is possible that many fewer would have survived. To a significant extent it is the resisters within the Aboriginal community who are the key to improving Aboriginal health. Whilst many Aboriginal people are extraordinarily skilled at straddling two different worlds, those who work within the institutions of the dominant society are likely to be, to some extent, overwhelmed by the dominance of institutional power around them. Their effectiveness is likely to depend on their ongoing relationship with and support from the agencies of power within the community. Thus their work in the mainstream is nurtured from the community and this assists their effectiveness. Strengthening the community agencies is a key part of the project of improving Aboriginal health.

In the next chapter, I will examine the occupation and colonisation of central Australia.

# CHAPTER 3 - THE COLONISATION OF CENTRAL AUSTRALIA

## **FAMINE**

*“OK, I want to talk about Ireland  
Specifically I want to talk about the 'Famine'  
About the fact there never really was one  
There was no 'Famine'  
See Irish people were only ALLOWED to eat potatoes  
All of the other food  
Meat fish vegetables  
Were shipped out of the country under armed guard  
To England while the Irish people starved  
And then in the middle of all this  
They gave us money not to teach our children Irish  
And so we lost out history  
And this is what I think is still hurting me.*

*See we're like a child that has been battered  
Has to drive itself out of it's health because it's frightened  
Still feels all the painful feelings  
But they lose contact with the memory*

*And this leads to massive self-destruction  
Alcoholism drug addiction  
All desperate attempts at running  
And in it's worst form  
Becomes actual killing*

*And if there ever is gonna be healing  
There has to be remembering*

*And then grieving  
So that there can be forgiving  
There has to be knowledge and understanding*

*An American army regulation  
Says that you mustn't kill more than 10% of a nation  
'Cos to do so causes permanent 'psychological damage'  
It's not permanent but they don't know that*

*Anyway during the supposed 'famine'  
We lost a lot more than 10% of our nation  
Through deaths on land or on ships of emigration  
But what finally broke us was not starvation  
BUT ITS USE IN THE CONTROLLING OF OUR EDUCATION  
Schools go on about the 'Black '47'  
On and on about the 'Terrible Famine'  
But what they don't say is in truth  
There really never was one*

*So let's take a look shall we  
The highest statistic of child abuse in the EEC  
And we say we're a Christian country  
But we've lost contact with our history  
See we used to worship God as a mother  
We're suffering from POST TRAUMATIC STRESS DISORDER  
Look at all our old men in the pubs  
Look at all our young people on drugs  
We used to worship God as a mother  
Now look at what we're doing to each other  
We've even made killers of ourselves  
The most child-like trusting people in the Universe  
And this is what's wrong with us  
Our history books THE PARENT FIGURES lied to us.*

*I see the Irish  
As a race like a child  
That got itself bashed in the face*

*And if there ever is gonna be healing  
There has to be remembering  
And then grieving  
So that there then can be forgiving  
There has to be KNOWLEDGE and UNDERSTANDING.”*

## **WHY CONSIDER HISTORY?**

Before considering the history of colonisation of central Australia, I will briefly discuss the significance of an historical understanding to improving health status.

I have already discussed how the way we construct Aboriginality and community has an impact on how we perceive health service developments, and indeed the reasons Aboriginal people are sick. As I have become more aware of the details of the local histories, I have become more thoughtful and inquiring as to the nature of health services and the tendency to perpetuate patterns forged in the past. I have also appreciated more the Aboriginal voices demanding acknowledgment of the past as a prerequisite to reconstruction and reconciliation.

A better understanding of the histories which have shaped us and the settings in which we work ought to inform our practice. Some views suggest that history is about the past. Such views are frequently accompanied by appeals to forget the past, and look to the future. However, the present can only be understood in terms of history as it is history which explains how present circumstances came to be. It can help us understand how we got to where we are, and what have been the positive and negative aspects of our and our ancestors activities. Better understandings of how the past shaped the present can help develop strategic thinking about how to move towards a better future.

## **THE OCCUPATION OF CENTRAL AUSTRALIA<sup>1</sup>**

Central Australia was not colonised until the latter part of last century. It is evident, however, that central Australian Aborigines knew something about what had been happening in other parts of the country since the arrival of the First Fleet in 1788 long before the first explorers arrived. There is evidence that European artefacts travelled across the continent within a fairly short time of the establishment of the colony in Sydney<sup>2,3</sup>. There is also evidence that Aboriginal people in

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<sup>1</sup> I am grateful to Fran Coughlan whose research work contributed to much of what I have written in this chapter.

<sup>2</sup> Reynolds, H *'The Other Side of the Frontier.'* Penguin Books, Melbourne, 1982, Ch 1.

<sup>3</sup> Goodall, H *'Invasion to Embassy: Land in Aboriginal Politics in New South Wales, 1770-1972.'*

areas far away from European settlement knew some detail of white settlement and their technology such as guns and what they could do.

### ***The Ideological Background***

By the time of the colonial penetration of central Australia, there was concern in the UK about the treatment of *native* peoples. It was a time that the Anti-Slavery Society, the Exeter Hall humanitarians and others had moved some attention from slavery (since slavery had been abolished in the British colonies in 1833) to the plight of native colonised peoples<sup>4</sup>. Wilberforce had organised the Quaker committee to oppose slavery. It became a significant political force, and slavery in the UK was abolished by an Act of Parliament in 1807. The Quaker committee became the Anti-Slavery Society and continued to expand and organise to emancipate slaves, and to have slavery abolished in the colonies. Thomas Buxton, a British parliamentarian, took over from the ailing Wilberforce in 1824 and in 1833 slavery was abolished throughout the British Empire. Buxton then urged the British Parliament to appoint a Select Committee on Aboriginal Tribes to '*advise on the protection of their rights, the spread of civilisation amongst them, and the voluntary and peaceful reception of the Christian religion*'. The committee produced a report which documented a poor situation in regard to the condition of Aborigines, and promoted a British policy of developing more positive relationships with Aborigines as it was argued this would be in Britain's civil and commercial interest<sup>5,6</sup>.

The efforts of the reformers focused particularly on the development of the South Australian colony in Adelaide. Attempts were made to institutionalise recognition of Native Title of land in the SA colony. This was unsuccessful. Reformers were seen as new comers meddling in colony business<sup>7</sup>. This tendency to perceive reformers as coming from outside the jurisdiction under question has continued to the present day with claims in the NT and Queensland that

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Allen & Unwin, Sydney, 1996, p24.

<sup>4</sup> Goodall, H, 1996, *op. cit.*, p45.

<sup>5</sup> Hiatt, LR '*Arguments about Aborigines: Australia and the Evolution of Social Anthropology.*' Cambridge University Press, Melbourne, 1996, pp5-6.

<sup>6</sup> This is not dissimilar to some of the current arguments against the Pauline Hanson position which stress the economic damage done by her to the Asian trading partners of Australian capital, rather than the offence her position causes to Aboriginal and Asian peoples.

<sup>7</sup> Goodall, H, 1996, *op. cit.*, p46.

those seeking change are 'southern do-gooders', or in WA 'eastern staters'.

The appointment of Protectors of Aborigines and their associated administrative apparatus was a product of the influence of reformers, and began in Victoria with the establishment of a Board for the Protection of Aborigines in the mid-1850s<sup>8</sup>.

An exploratory expedition led by Stuart reached central Australia from Adelaide in 1860 with these political influences in the background. The justifications for the colonisation of central Australia included some notion of responsibility to Aboriginal people by the state along with religious, scientific and commercial interests. But the dominant objective related to the successful establishment of a settlement in the north, as there were fears that the 'yellow peril' would take advantage of the north coast's isolation. The establishment of the telegraph line was seen as key infrastructure related to this objective.

It has been estimated that, at that time, the Aboriginal population of central Australia was in excess of 10,000 people spread across a number of different language groups including Alyawarr, Anmatjera, Southern, Central, Western, Eastern and Northern Arrernte, Kaititja, Luritja, Ngaanyatjarra, Pintubi, Pitjantjatjara, Waramanga, Warlpiri and Yangkunjatjara. Of course, the bases of such estimates are fairly speculative.

#### Colonial Administrative Arrangements

The NSW colonial government held the administrative responsibility for central Australia. The NT was separated from NSW by the Imperial Government in 1863, and became the responsibility of South Australia, which retained administrative responsibility until 1911 when it was transferred to the Commonwealth Government. The Northern Territory gained a limited form of self government in 1978. Thus the Commonwealth government had complete jurisdiction in the NT from 1911 to 1978.

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<sup>8</sup> Goodall, H, 1996, *op. cit.*, p88.



### ***Period of Violent Pacification***

Early exploration was motivated by the need to find ways to support the attempts to establish a settlement and port in Darwin. Such attempts in the top end were problematic and initial efforts failed. Eventually a settlement, known as Palmerston, was established in 1869. It was opened as a port, and later became known as Darwin.

The building of the telegraph line helped open up central Australia, and the pastoral industry followed fairly quickly. Missionaries added their agendas, as did miners with their sporadic mining for gold, garnets (initially thought to be rubies) and mica.

The groups that took the brunt of the early contact tended to be the Arrernte, Alyawarr, Anmatjera, Kaititja, Luritja, Waramanga, and Warlpiri tribes.

The first sales of NT land were held in Adelaide in 1864, and the first settlers reached the MacDonnell Ranges near Alice Springs in 1866<sup>9</sup>.

#### The Telegraph Line

Darwin was to become the northern terminus of the overland telegraph cable which, in 1870, the SA Government decided to construct from Port Augusta to Port Darwin, with Charles Todd appointed to supervise construction<sup>10</sup>. The Charlotte Waters telegraph site was established in 1871 about 30 miles south of the junction of the Hugh and Finke Rivers. This was on Southern Arrernte country, and the Southern Arrernte resisted this development<sup>11</sup>. The Alice Springs depot was established by McMinn and Mills in 1871, and the Alice Springs telegraph station was completed in 1872 on Arrernte country.

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<sup>9</sup> Rowley, CD *'The Destruction of Aboriginal Society.'* Penguin Books, Melbourne, 1972, p206.

<sup>10</sup> Clark, CMH *'A History of Australia. The Earth Abideth for Ever 1851-1888.'* Melbourne University Press, Melbourne, 1981, Vol 4, pp239.

<sup>11</sup> Hartwig, MC *'The Progress of White Settlements in the Alice Springs District and its Effect on the Aboriginal Inhabitants, 1860-1894.'* PhD Thesis, University of Adelaide, 1965, pp204, 251-2.

## The Pastoralists

Between the 1870s and 1890s, the first pastoral properties in central Australia were established<sup>12</sup>. Squatters were arriving in the centre by the early 1870s, and the Undoolya and Owen Springs stations were established on 3,200 sq miles of Arrernte country surrounding Alice Springs<sup>13</sup>. Hartwig suggests that Aborigines were more detrimental to the pastoral industry than beneficial up to around 1894 due to their resistance<sup>14</sup>, which was a major stimulus for the development of policing in the centre. The first police stations in central Australia were established at the Barrow Creek telegraph station to the north of Alice Springs and Charlotte Waters to the south in 1873<sup>15</sup>.

The general policies of the colonisers initially were aimed at maintaining friendship with local Aborigines, whilst Aborigines tended to be cautious in their relationships with the new comers. Todd, who was in charge of the construction of the Alice Springs Telegraph Station, provided some rations to old and frail Aborigines. This was the beginning of a more developed food rationing to Aboriginal people.

It was not long before the uneasy stand off erupted into violence. In 1874 Kaititja people attacked the Barrow Creek telegraph station. A number of Kaititja were shot and two telegraph workers were killed in the incident. There was an outcry from Adelaide, and armed parties went looking for Kaititja. Officially 11 Kaititja people were shot, but unofficial reports suggest that 50-90 people were killed at Skull Creek alone<sup>16</sup>. This really marked the end of a conciliatory approach to Aboriginal people in central Australia, and the beginning of a period of pacification through the use of violence.

The SA Criminal Law Consolidation Act was passed in 1876 allowing the Governor to order that any sentence of death lawfully passed on any *Aboriginal native* be publicly carried out at

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<sup>12</sup> Heppell, M & Wigley, J '*Black Out in Alice: A History of the Establishment and Development of Town Camps in Alice Springs.*' Development Studies Centre, Monograph No. 26, ANU, Canberra, 1981.

<sup>13</sup> Hartwig, MC, *op. cit.*, pp128, 287, 292.

<sup>14</sup> *Ibid.*, p457.

<sup>15</sup> *Ibid.*, p260.

<sup>16</sup> Strehlow, TGH '*Songs of Central Australia.*' Angus & Robertson, Sydney, 1971, pp588-90.

the place where the crime was committed, or as near as convenient, and that the body be buried

at the place of execution or where expedient. This extraordinary power illustrates the seriousness of the situation, and underlines the fact that a war was taking place. This Act was eventually repealed by the Criminal Law Consolidation Act of 1935<sup>17</sup>.

The pastoral industry continued to expand and the country was fairly heavily stocked. From the early 1880s, Aborigines around Alice Springs began killing cattle for food, and the pastoralists retaliated. Patrolling police, settlers and armed trackers began punitive expeditions on local Aboriginal camps<sup>18</sup>.

Most of central Australia was held under application or lease by 1881. However, conditions of tenure were that the lease must be stocked within 3 years. The fact that many had to hand in their holdings by 1884, reflects the probable degree of speculation in this process<sup>19</sup>. Drought and economic depression hit central Australia in the late 1880s and early 1890s resulting in many more pastoral leases being abandoned or changing hands<sup>20</sup>.

Police were sent into central Australia as part of the pacification process, and explicitly to protect the settlers from Aboriginal attack. Many mass killings involving Kaititja, Western Arrernte, Eastern Arrernte and Anmatjera people took place around Alice Springs, Hermannsburg, Harts Range, and Glen Helen<sup>21,22</sup>. Police made few reports of their activities and few arrests of Aboriginal people were made. By 1886 the violent resistance of the Arrernte and Anmatyerr was virtually over, but resistance flared within an 80 mile radius of Alice at Tempe Downs, Erldunda, Glen Helen, Frew River and Elkedra<sup>23</sup>.

Violent pacification continued and caused tensions between police and missionaries. Allegations persisted against pastoralists and police, especially Constable Willshire who Strehlow, an Hermannsburg missionary, believed was continuing to massacre groups of

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<sup>17</sup> McCorquodale, J 'Aborigines and the Law: A Digest.' Aboriginal Studies Press, Canberra, 1987.

<sup>18</sup> Rowley, CD, *op. cit.*, p216.

<sup>19</sup> Hartwig, MC, *op. cit.*, pp231-324.

<sup>20</sup> *Ibid.*, pp283, 482.

<sup>21</sup> Strehlow, TGH, 1971, *op. cit.*, p7.

<sup>22</sup> Hartwig, MC, *op. cit.*, pp393-395, 422.

<sup>23</sup> *Ibid.*, p400.

Aborigines. In 1890 the SA Parliament Legislative Council commissioned Swan & Taplin to investigate and report on the allegations of mistreatment of Aborigines. Their inquiry found no evidence supporting the Hermannsburg missionaries' charges that the pastoralists wanted to exterminate the Aborigines. The report was sympathetic to the pastoralists needs to keep blacks away from water holes because cattle would not approach water holes where there were people. However, the report claimed that Aborigines were easily persuaded to leave such areas. Further, the report found no evidence to support mission accusations that police shot Aboriginal prisoners or entered Aboriginal camps and shot all in sight, and they found no evidence of sexual abuse of Aboriginal women by police or pastoralists. However, the report did recommend that Willshire's camp be moved from Boggy Waterhole, further away from Hermannsburg, and the establishment of reserves, not less than 200 miles apart and between 500 - 1000 sq miles in area, to be stocked and staffed with a manager and teacher, for Aboriginal people. The report insisted that Aborigines should be strongly encouraged to remain on the reserves, which should become self-supporting and that Aboriginal children be taught in English and not in their own language as was the practice at Hermannsburg<sup>24</sup>. This illustrates the attempt to both limit Aboriginal movement in central Australia and to teach Aborigines to be like Europeans. In 1890 the NT Crown Lands Act, making provision for the proclamation of areas of land as reserves for Aborigines, was passed<sup>25</sup>. By this time, nearly 40% of the NT was under pastoral leases<sup>26</sup>.

From around 1892, most Aboriginal offenders were taken to Port Augusta gaol via the local police courts which were established in Stuart (later to be renamed Alice Springs) in 1892 or the Port Augusta court circuit, rather than being shot. From 1904, offenders went to Alice Springs gaol<sup>27</sup>.

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<sup>24</sup> Swan, HC & Taplin, CE '*Report of Messrs Swan & Taplin on Their Visit to Finke, & Mission Stations.*' SA Parliamentary Papers 1890, Vol 4, Paper No.148.

<sup>25</sup> Von Trepp, R '*Aboriginal Reserves-Northern Territory.*' Australian Territories, Vol 4, No 1, February, 1964, p14.

<sup>26</sup> Rowley, CD, *op. cit.*, p212.

<sup>27</sup> Hartwig, MC, *op. cit.*, pp443-4.

By late 1894 the phase of armed resistance by Aboriginal people was virtually at an end in the whole of the occupied centre except for isolated trouble spots<sup>28</sup>. The consequences of the phase of resistance between 1881-1894 for Aboriginal people was severe depopulation, and increasing concentration of Aboriginal people in settlements. Sizeable camps of Aborigines were attached to every cattle and telegraph station in the Centre, except Frew River where local labour was not employed<sup>29</sup>.

Cattle prices dropped between 1889-1899. By the end of 1894, when the 1889-1894 drought ended, every station in the Centre except Erldunda, Frew River and Elkedra had been abandoned or had passed into new hands<sup>30</sup>. The failure of the big pastoralists resulted in their replacement by the 'small man' who had little or no capital, small herds, employed few Europeans and many Aborigines, and took Aboriginal women for sex. These small properties were more profitable as they were able to exploit local markets more effectively. Hartwig asserts that without the assistance of Aboriginal labour at this time, the cattle industry could not have developed as it did<sup>31</sup>.

#### The Mining Industry

In the mid 1880s a new influx of people arrived in central Australia - prospectors looking for rubies at Ruby Gorge and gold at Arltunga. By this time up to 200 Aboriginal people were camping at Heavitree Gap that was about 4 miles south of the Alice Springs telegraph station. With the discovery of gold at Arltunga, north east of Alice in the mid 1880s the population of prospectors reached around 600<sup>32</sup>, and a post office was opened there in 1891<sup>33</sup>. However, the gold rush was short lived and Arltunga was virtually abandoned by 1894. This was Eastern Arrernte country and there were around 100 Aboriginal people in this area.

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<sup>28</sup> *Ibid.*, p403.

<sup>29</sup> Hartwig, MC, *op. cit.* p447.

<sup>30</sup> *Ibid.*, p361.

<sup>31</sup> *Ibid.*, pp383-87, 457.

<sup>32</sup> Kimber, RG 'Man From Arltunga: Walter Smith, Australian Bushman.' Arltunga Hotel & Hesperian Press, Perth, 1986, p1.

<sup>33</sup> Hartwig, MC, *op. cit.*, pp566.

Mining of mica at Harts Range began around the same time, but proved unprofitable and was abandoned after 1 year<sup>34</sup>.

In 1894 the Horn Scientific Exploring Expedition came to central Australia with an interest in minerals. Baldwin Spencer, who later was to become a Special Commissioner and Chief

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<sup>34</sup> *Ibid.*, p562.

Protector of Aborigines in the NT, was a member of this expedition<sup>35</sup>.

In 1902 there was a gold rush at the Winnecke Depot, 50 miles N-E of the Alice Springs telegraph station. The population of Alice trebled. The 'calico village' at Winnecke lasted 4 years<sup>36</sup>. In 1934 large scale gold extraction began at Tennant Creek, which resulted in Waramanga people being removed from their reserve to Philip Creek<sup>37</sup>. This illustrates the tendency for Aboriginal people to be moved from one place to another as suits the exploitation of resources by the invaders, whether it be water resources for cattle, or the discovery of valuable mineral deposits. However, as mining activities were fairly localised, they probably were less a cause of Aboriginal concern at that time than the activities of pastoralists whose activities involved vast areas and especially the control of water holes. Generally, mining in central Australia has been less intense than in other regions such as the Pilbara in WA.

#### Missions

Lutheran missionaries established the Hermannsburg Mission in 1877, 83 miles west of Alice Springs, on western Arrernte country<sup>38</sup>. Regular food rations were provided from here from about 1879, and the Aboriginal population swelled to around 100<sup>39</sup>. In 1888-9 there was a severe influenza epidemic which hit Aborigines hard. This was followed in 1890 by a typhoid epidemic. By 1891 Hermannsburg missionaries were exhausted from treating Aborigines sick with influenza and typhoid. Further, there had been few converts with probably only 32 people baptised but still subject to *heathen* influences even though the Mission had been segregating children from their parents. As a result the missionaries left Hermannsburg in 1891 and were not replaced until the arrival of Strehlow in 1894<sup>40</sup>.

It is interesting to note the early practise of the missionaries of separating children from adults as a way of attempting to 'civilise' the children. This was the precursor of the more widespread practice of taking children away from their families, the '*Stolen Generations*'.

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<sup>35</sup> Hartwig, MC, *op. cit.*, pp568, 571.

<sup>36</sup> *Ibid.*, pp164-170.

<sup>37</sup> Rowley, CD, *op. cit.*, p316.

<sup>38</sup> *Ibid.*, p206.

<sup>39</sup> Hartwig, MC, *op. cit.*, pp 441, 449.

<sup>40</sup> *Ibid.*, pp514, 519.



### *Period of Protection and Segregation*

The establishment of reserves run by missions, and later government settlements, coupled with the fairly high rate of incarceration of Aboriginal people in gaols, was the beginning of the institutionalisation of Aboriginal people which has continued in various forms up until the present day.

Europeans commonly believed that Aborigines, being inferior to Europeans, were doomed to extinction. Some of the most progressive European views of the day (for example those of the Anti-Slavery Society) were that Aborigines should be protected. However, we shall see in Chapter 6 that much of the Chief Protector's role in the Northern Territory was explicitly about securing white settlement in Darwin. That is not to say, however, that missions did not play a role in 'protecting' Aborigines from the extreme behaviour of some police and pastoralists.

In 1891 Gillen was appointed Sub-Protector in Alice Springs, directly responsible to the Minister<sup>41</sup>, and in 1892 a 'protectorate' was established in central Australia. Around 1896, the Government Resident's Report to the Minister advocated that reserves should be dedicated to Aborigines and should include permanent waters and river frontages, and good quality land necessary for their sustenance. The report also suggested that a solution would be for the inland tribes to migrate to Melville Island. However, the report actually recommended the establishment of sizeable reserves in each tribe's country, and that the tribes be warned that they should not leave the reserves without giving notice of intention. The authorities would set the date and the specified route of travel. In response to this report, lands were set aside in the NT in 1888, 1892, 1901 and 1912<sup>42</sup>.

The reserve set aside for Southern Arrernte people at Charlotte Waters in 1892 was resumed within 9 months because of pressure from the cattle station owner<sup>43</sup>. This is another example of Aborigines being allocated land that was seen as little value to the invaders, and, more generally, the interests of the settlers or pastoralists overriding the interests of Aborigines.

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<sup>41</sup> Hartwig, MC, *op. cit.*, p440.

<sup>42</sup> Von Trepp, R, *op. cit.*, pp14-25.

<sup>43</sup> Hartwig, MC, *op. cit.*, p443.

The changes around this time were related to changes in public opinion in the southern cities where there had been a cessation of frontier conditions, with deterioration of the physical condition of Aborigines living within these 'pacified' areas. *Natives* tended to be viewed by white settlers as pitiable creatures in need of protection and assistance. There was, associated with these attitudes, a view that extinction of Aborigines was associated with contact with Europeans, and that they should, therefore, be segregated in reserves<sup>44</sup>. It was also a matter of out of sight, out of mind.

There was clearly a different attitude amongst white settlers towards *full blood* and *half castes*. These attitudes continue to impact on policy development and service delivery for Aboriginal people.

The SA Legislature failed to pass any legislation regarding Aboriginal affairs until 1910. A Bill had been previously rejected in 1899<sup>45</sup>. The 1910 NT Aborigines Act established an Aboriginal Department under the direction of the Chief Protector<sup>46</sup>. The Act defined Aboriginal and included *half-castes with Aboriginal spouses or habitual associates and all under 16 year olds*. Under the Act, the Chief Protector, represented by the protector in each protector's district, became the legal guardian of every Aboriginal child till 18 years old. This opened the way for light-skinned children to be removed from their mothers by the protector.

The Act also allowed for restrictions of the freedom of movement of Aboriginal people. This was determined to some extent by the employment status of the individual. The Chief Protector could declare any township a prohibited area for unemployed Aborigines and had control of any Aboriginal property and estates. The Protector of a district could issue a license to an employer which allowed that employer to employ Aboriginal labour, but there was no provision that wages be paid. Once a license was issued it could only be cancelled by the Chief Protector.

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<sup>44</sup> Hartwig, MC, *op. cit.*, pp438, 442.

<sup>45</sup> Rowley, CD, *op. cit.*, p206.

<sup>46</sup> *Ibid.*, pp230-1.

Because the authorities perceived ‘mixed blood’ people as a problem that needed to be controlled, the Act vested the Minister with the power to approve or disapprove ‘mixed marriages’. Whites also needed permission from the protectors to gain access to Aboriginal camps.

The Aboriginal Department was charged with protective duties:

*‘It was to exercise a general supervision and care over all matters affecting Aboriginal welfare.’<sup>47</sup>*

Responsibilities of the Department included employment issues, the management of reserves, controlling, maintaining and educating children, caring for aged and infirm, and provision of relief assistance, eg blankets<sup>48</sup>.

It is significant to the institutionalisation of Aboriginal people that the one government authority had control over all aspects of Aboriginal life – where people could live, what freedom of movement was allowed, which towns they could enter, which schools (if any) children attended, what employers they could have, and who they could have sexual intercourse with. This, coupled with the provision of food rations, develops a picture of Aboriginal communities forced into an overly dependant relationship on white Australia whilst being kept separate from it. This is part of the institutionalisation of Aboriginal Australia.

In 1911, the Commonwealth commissioned Basedow and Spencer to investigate and report on Aboriginal conditions in the Territory<sup>49</sup>. They found that:

- a) Aborigines around settlements were demoralised;
- b) Sexual intercourse between Aborigines and Chinese should be discouraged;
- c) Aborigines were of good service to pastoralists, travellers and police;
- d) Their value was recognised in the cattle industry and they were well treated;
- e) Attempts to civilise must deal with the children;

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<sup>47</sup> Rowley, CD, *op. cit.*, p232.

<sup>48</sup> *Ibid.*, pp230-233.

<sup>49</sup> Bleakley, JW *‘The Aborigines of Australia.’* Jacaranda Press, Brisbane, 1961, p240.

- f) Mission industrial stations should be established in various locations as a means of training Aborigines in work practices.

The Commonwealth Regulations gazetted under the 1910 NT Aboriginals Act in 1911 gave the Chief Protector wide sweeping powers and responsibility in regard to employment conditions and minimum wages for Aboriginal workers. The Chief Protector could insist that the wages be paid to him to hold on behalf of the Aboriginal worker. However, no fixed minimum wage was set for Aboriginal workers, and indeed the NT pastoral industry avoided paying cash wages until the 1940's<sup>50</sup>. It would take almost a further 30 years before award wages would be paid.

The 1911 Aboriginals Ordinance Bill incorporated the SA Act of 1910. It retained the same definition of Aboriginality. The Chief Protector or his representatives, who were police officers, could take any Aboriginal into custody for protection.

The Territory Administrator in Darwin had responsibility for Aboriginal Affairs in the Northern Territory. Basedow was appointed Chief Protector in 1911 and Baldwin Spencer was appointed to the position of Special Commissioner. They had a staff consisting of three inspectors of Aborigines and two medical inspectors. Basedow clashed with the Administrator and resigned after only six weeks after which Baldwin Spencer held the position of Chief Protector as well as that of Special Commissioner<sup>51</sup>. Spencer only lasted twelve months. The Chief Protector's position was impossible. He could not supervise Aboriginal welfare over vast areas. Regular communication across these areas was extremely limited. But most importantly was the actual priority of the government and administration to develop and settle the Territory. Thus the needs of pastoralists, miners and other white settlers consistently over shadowed the interests of Aborigines.

The dominant and widespread assumption amongst non-Aborigines was that Aborigines were a temporary problem. They were doomed to disappear. Whilst attitudes in the post-frontier

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<sup>50</sup> Rowley, CD, *op. cit.*, p233.

<sup>51</sup> *Ibid.*, pp233-34, 236.

settlements in the southern cities were concerned to treat Aborigines humanely until they died out - smoothing the dying pillow - for those involved with the new frontier, it was more a matter of placating outside criticism. The 'Protector' role was always secondary to other more valued roles. Protectors were police officers and their role as protector of Aborigines was secondary to serving the settler community of which they were a part<sup>52</sup>.

In 1913 Spencer, recommended the establishment of large reserves, protected against encroachment for other purposes and in which the native tribes would be isolated and protected from '*harmful contacts*'. Aborigines in settled areas were to be withdrawn to reserves, supervised and their children educated. He condemned existing reserves as haphazard, inappropriately located, and inadequate in size. He recommended that all but the Bathurst Island reserve be closed, and that compounds be established in towns where Aborigines in employment could be housed, cared for and confined after sunset, and that larger reserves be proclaimed in five areas in the Top End and around the Hermannsburg Mission<sup>53</sup>.

The Office of Chief Protector was abolished in 1914 with these duties being transferred to managers of government settlements and police<sup>54</sup>. At that time it was estimated that 120-140 Aborigines were permanently camped in Stuart<sup>55</sup>. The duties of Protector were eventually transferred from the Commissioner of Police to the Government Health Officer in 1927<sup>56</sup>.

The Aboriginal population continued in decline due to high mortality rates from infectious diseases such as influenza and tuberculosis, as well as poor nutrition due to the loss of bush tucker and water holes to stock. This particularly impacted on high infant mortality rates. Violent episodes also continued, although with less frequency. However, there was concern that the *half caste* population was increasing<sup>57</sup>.

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<sup>52</sup> Rowley, CD, *op. cit.*, p235.

<sup>53</sup> Von Trepp, R, *op. cit.*, pp14-15.

<sup>54</sup> Rowley, CD, *op. cit.*, p235.

<sup>55</sup> Heppell, M & Wigley, J, *op. cit.*, p7.

<sup>56</sup> Rowley, CD, *op. cit.*, p259.

<sup>57</sup> *Ibid.*, p235.

The 1928 Bleakley report recommended that there be more missions for ‘protective supervision’ of Aborigines, and for more financial support to the missions for care and training. The report caused some concern, and the Minister for Home Affairs called a conference in Melbourne<sup>58</sup>. All the major Church missions were strongly represented along with other non-Aboriginal community, women’s and anthropological groups. This was a significant meeting and all groups represented had representation from most States. The Minister had five items on the agenda that are indicative of the concerns of the day:

- ♦ Nomadic Aborigines;
- ♦ Aborigines in employment;
- ♦ Aborigines on stations;
- ♦ Aborigines in institutions;
- ♦ Half-castes.

Church missions were to become the main agencies for the implementation of government policies, starting with the distribution of rations, the training of Aborigines to be workers and to assimilate, and the running of institutions to house children taken from their families. This marks the beginnings of a more formal policy of assimilation rather than simply segregation.

It also illustrates the wider involvement of the Commonwealth Government in the development and implementation of policies including the taking of children from their families. Thus even though the States were constitutionally responsible for these matters, the Commonwealth played a clear role. Of course, the Commonwealth was directly involved in these matters in the Northern Territory.

#### Food Rationing

The provision of some limited food rations began in the earliest days with Todd distributing some food to elderly and frail Aborigines during the construction of the Telegraph Stations. This was extended with rations distributed regularly by the telegraph

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<sup>58</sup> *Ibid.*, p270.

station masters at Alice Springs, Barrow Creek, Tennant Creek, and the police at Ilamurta.

Sub-protectors, who were police or officers in charge of telegraph stations, were appointed in 1877, and had responsibility for handing out rations to the elderly or ill<sup>59</sup> until this role was taken over by missions, some pastoralists and later government settlements. The 1928 Bleakley Report expressed concern that the pastoralists might be unreliable in distributing government relief fairly, as they might be tempted to feed their workers, and let the aged and infirm fend for themselves. The administration thus stopped using pastoralists to distribute rations, and in the centre this role was taken over by the Hermannsburg missionaries of the Finke River Mission who developed other food rationing posts, such as Haasts Bluff<sup>60</sup>. Chief Protector Cook who did not want missions to be involved did not support this.

Rations were provided as part of a political view that Aborigines were doomed to extinction, but there should be compassion for them - *to smooth the dying pillow*. Of course, rations were important to Aboriginal survival given the restriction of Aboriginal people's freedom of movement, and the loss of access to bush foods due to the presence of cattle and sheep. However, the practice of rationing provided the opportunity for administrators to gain knowledge of Aboriginal people that would be used to govern them<sup>61</sup> and was also useful as an incentive for Aboriginal people to congregate in and near rationing depots. Rowse discusses the tensions in the 1930s between rationing as a cause of disintegration of Aboriginal culture and society, and rationing as necessary to sustenance. There is little doubt that both perspectives have their validity and represent a contradiction and crisis for the governance of the colonised. This is a significant continuity in a number of ways. It relates to the creation of dependency which could be seen as a loss of independent agency - that is that Aboriginal people were contained and fed, and this has set a pattern of dependency on non-Aboriginal people - as community advisers, health care workers, mechanics, store keepers, etc. The type of food rationed was white flour, sugar and tea, with occasional dried fruits and salted meat. Thus the

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<sup>59</sup> Rowley, CD, *op. cit.*, p216.

<sup>60</sup> Rowley, CD, *op. cit.*, p270.

<sup>61</sup> Rowse, T 'White Flour, White Power: From Rations to Citizenship in Central Australia.' Cambridge University Press, Cambridge, 1998, pp 5-7.

dietary influences that persist today can be traced back to the days of rationed food. And the legacy today is high rates of diabetes and heart disease.

#### Legislative Influences

After Federation in 1901, Aboriginal affairs remained the exclusive responsibility of the States. However, the Commonwealth did assume responsibility for Aboriginal affairs in the NT, when administrative responsibility for the Territory was transferred from SA to the Commonwealth in 1911.

Much of the legislation denied Aborigines rights enjoyed by other Australians. This is, of course, quite consistent with their being seen as a threat to successful settlement. The Commonwealth was explicitly prevented by the constitution from legislating on behalf of Aborigines in the States. This was clearly the prerogative of the States, and this did not change until after the referendum in 1967. So, for example, in 1908 the Commonwealth's Invalid and Old-Age Pensions Act was passed which included a provision that old age pensions were not available to Aborigines<sup>62</sup>.

#### The Situation for Aboriginal People

Bradshaw was the officer in charge of the Telegraph Station, and, as such, also played the role of Special Magistrate from 1899 - 1908<sup>63</sup>. Most of the cases he dealt with were Aboriginal people spearing cattle. Generally, Aborigines thus charged received six months gaol. Prisoners convicted were gaoled in Port Augusta. They walked 300-400 km from Alice Springs to Oodnadatta where they were put on the train to Port Augusta. Blackwell (Bradshaw's daughter) describes the scenes of Aboriginal prisoners with bleeding and swollen feet, chained together by wrists and feet<sup>64</sup>. She also describes the local police officer, Constable Brooks, bringing lines of Aboriginal prisoners chained by the neck into Alice Springs.

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<sup>62</sup> McCorquodale, J 'An Annotated Bibliography.', in Hanks, Peter & Keon-Cohen, Bryan (Eds) 'Aborigines and the Law.' George Allen and Unwin, Sydney, 1984, p 268.

<sup>63</sup> Blackwell, J & Lockwood, D 'Alice on the Line.' Rigby, Adelaide, 1965.



At this time the European population of Stuart was thirty. There were, however, about 150 - 200 Aborigines camped on the bank of the Todd River at the Telegraph Station<sup>65,66</sup>. Some were employed as domestic staff at the telegraph station. They worked for food and a stick of tobacco a day because they '*did not understand the value of money*'. The government supplied shirts and trousers for the men employed on the station. Local authorities were concerned at the number of Aboriginal camps around the stations on the telegraph line. In Alice there were also miners' camps along the Todd River from Heavitree Gap to the Telegraph Station. The town of Stuart was proclaimed in 1888, but people continued to call it 'the Alice' and eventually the town was officially renamed Alice Springs<sup>67</sup>.

The situation for central Australian Aborigines at this time was grim. In 1888-9 there was a severe influenza epidemic that hit Aborigines hard, and this was followed in 1890 by a typhoid epidemic. As a result the missionaries left Hermannsburg in 1891 and were not replaced until the arrival of Strehlow in 1894<sup>68</sup>. There was drought from 1894-1907<sup>69</sup>, and it is estimated that hundreds, maybe thousands, of Aborigines died around dried up water holes. Others were forced to come into places like Alice where rations were available<sup>70</sup>. Many Aborigines suffered from severe trachoma<sup>71</sup>. Baldwin Spencer noted that the Anmatjera people were nearly wiped out<sup>72</sup>.

In 1906 a ration station was established at Arltunga. Thirty of about one hundred Eastern Arrernte people who had attached themselves to miners' camps qualified for rations due to their being old and infirm<sup>73</sup>. The official estimate of the NT Aboriginal population in 1910 was 22,000<sup>74</sup>. At this same time the Arrernte population was in decline<sup>75</sup>.

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<sup>64</sup> *Ibid.*, pp26-27.

<sup>65</sup> Blackwell, J & Lockwood, D *op. cit.*, pp52, 92.

<sup>66</sup> Heppell, M & Wigley, J, *op. cit.*, p6.

<sup>67</sup> Hartwig, MC, *op. cit.*, pp578-79.

<sup>68</sup> *Ibid.*, pp514, 519.

<sup>69</sup> Kimber, RG, 1986, *op. cit.*, p9.

<sup>70</sup> Blackwell, J & Lockwood, D, *op. cit.*, p93.

<sup>71</sup> *Ibid.*, p114.

<sup>72</sup> Hartwig, MC, *op. cit.*, p 411.

<sup>73</sup> *Ibid.*, pp 442, 591.

<sup>74</sup> Foxcroft, EJB '*Australian Native Policy.*' Melbourne University Press, Melbourne, 1941, p134.

<sup>75</sup> Strehlow, TGH, *op. cit.*, pxxxv.

### *Period of Assimilation*

The details of the formal adoption of a policy of assimilation are discussed in Chapter 5. However, much of this policy was already being practised in missions with attempts to change Aboriginal behaviour so that they were 'civilised' and adopted European values. By the late 1930s, the policy was formally adopted but implementation was delayed by the Second World War. However, this marked the direct involvement of government in establishing and running settlements in central Australia.

The official policy in 1940 was to have three permanent camps or reserves for the Alice Springs Aboriginal population. Jay Creek was proclaimed in 1937, and was originally established 28 miles west of Alice Springs as a buffer between the semi-nomadic people living in far western regions and the more sophisticated inhabitants of Alice Springs and environs<sup>76</sup>. It was intended for the non-working, aged and infirm around Alice. Western Arrernte, Luritja and Pitjantjatjara people (generally with Lutheran associations - Catholics were associated with the Little Flower Mission which was moved to Arltunga) living in separate camps around Alice Springs were rounded up and moved to Jay Creek<sup>77</sup>, where they were fed in communal dining rooms. In 1943, following the strong recommendation of the Director of Native Affairs, it was decided to retain the reserve as a place where Aborigines could be taught to become 'useful citizens'. The area was extended in 1943, and again in 1945<sup>78</sup>. It was administered by the Native Welfare Department.

In the 1940s a group of Pitjantjatjara people from the Petermann area moved north east into the Yankunytjatjara country of Uluru (Ayers Rock) and Walara-Watarka (Kings Canyon) and to Hermannsburg which is in Arrernte country. They then moved to Areyonga (Utju), which is in the northern most part of Pitjantjatjara country, and the

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<sup>76</sup> Welfare Branch NT Administration 'Annual Report 1960-1961.' 1961.

<sup>77</sup> Nathan, P & Japanangka, DL 'Health Business.' Heinemann Educational Press, Melbourne, 1983, pp56-7.

<sup>78</sup> Von Trepp, R, *op. cit.*, p17.

Western most part of Arrernte country<sup>79</sup>. In 1942 the Hermannsburg Mission established a ration depot at Areyonga<sup>80</sup>.

The Haasts Bluff reservation was proclaimed in 1940. The area had been leased to a pastoralist but following complaints, no new license was granted and the existing license lapsed. An equivalent area of the South West Reserve was excised. Patrol Officer TGH Strehlow found the 2 smaller areas easier to supervise, and on his advice depots were placed inside reserves to attract Aborigines back onto them<sup>81</sup>. Hermannsburg Mission established a ration depot at the reserve<sup>82</sup>. By 1946 there were 198 adults and 40 children living at Haasts Bluff<sup>83</sup>.

In the 1950s the Hermannsburg mission withdrew for financial reasons and the depots were taken over by the Native Affairs Branch. However the mission continued to supply a nursing sister and teachers<sup>84</sup>.

From the 1930's Aborigines were walking out of the desert regions west of Alice Springs into cattle stations and missions to the east. During and after the 1939-45 war, desert people continued to come from western desert regions to ration depots established on the fringes of settlements at Haasts Bluff, Areyonga and Yuendumu<sup>85</sup>.

In 1946, people from the Tanami, Mt Doreen, and Thompson's Rock Hole moved to the Granites joining people already there. There were water shortages here resulting in some fighting. Some people moved away from Granites to Mt Doreen, which later became Yuendumu. There were between 200-400 Warlpiri people here, but water, firewood and food supplies were good. However, fighting continued, and tuberculosis was common<sup>86</sup>. Rations consisted of seven pounds of flour for each adult plus some tea and sugar. There

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<sup>79</sup> Ntaria Health Team '*Ntaria and it's Out-stations: Orientation Manual.*' 1<sup>st</sup> Ed, 1993, p13.

<sup>80</sup> Kimber, D. Interview with Fran Coughlan, Alice Springs, 23-3-1988.

<sup>81</sup> Von Trepp, R, *op. cit.*, p16.

<sup>82</sup> Nathan, P & Japanangka, DL 1983 (1) *op. cit.*, p55.

<sup>83</sup> Kettle, E '*Health Services in the Northern Territory - A History 1824-1970.*' ANU, NARU, Darwin, Volume 2, 1991, p68.

<sup>84</sup> *Ibid.*

<sup>85</sup> Long, JPM '*The Pintubi Patrols: Welfare Work with Desert Aborigines.*' Australian Territories, Vol 4, No 6, p43-48.

was concern that the diet would lead to malnutrition<sup>87</sup>. The health status of people at Tanami in 1945 was poor. People were sick with tuberculosis, trachoma, decayed teeth, blindness (probably from trachoma), malnutrition, sores, lameness and bad eyes. The Warlpiri people were in danger of extinction. As the population increased water and food supplies became more limited, and many people developed scurvy<sup>88</sup>. Baptist missionaries arrived in 1947 and opened a store<sup>89</sup>. Tuberculosis was common and in 1948 measles spread through central Australia. At Yuendumu, many people were seriously ill and eleven died<sup>90</sup>.

The Yuendumu reserve, about 300 kilometres from Alice, was officially proclaimed in 1952<sup>91</sup>. By the early 1960s the population had grown to 466, almost all of whom were Warlpiri people<sup>92</sup>. In 1969 (after the equal wages decision) the lease holder of Mt Doreen Station trucked people to Yuendumu<sup>93</sup>. This included some Pintupi people.

During the period of the Second World War, Alice Springs was turned into a major military centre, with the NT virtually under military control. However, over 1,000 Aboriginal people were employed by the military across northern Australia, and were paid cash wages, shared full canteen services and equal accommodation<sup>94</sup>. This was the first time Aboriginal people in central Australia had experienced equality of treatment on such a scale. Under the direction of the Army, the Bungalow in Alice was closed and its residents moved to Balaclava in SA<sup>95</sup> or Melville Island<sup>96</sup> in 1942.

The Little Flower Catholic Mission began in Alice Springs, but was moved to Arltunga, 110 kilometres east of Alice, at the beginning of the military occupation of Alice

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<sup>86</sup> O'Grady, F *'Francis of Central Australia.'* Wentworth, Sydney, 1977, pp118-19.

<sup>87</sup> Kettle, E, *op. cit.*, p70.

<sup>88</sup> O'Grady, F, *op. cit.*, pp97-8, 101-4.

<sup>89</sup> *Ibid.*, pp108-114.

<sup>90</sup> O'Grady, F, *op. cit.*, pp127-29.

<sup>91</sup> Von Trepp, R, *op. cit.*, p20.

<sup>92</sup> Welfare Branch NT Administration, 1961, *op. cit.*, p34.

<sup>93</sup> Flemming, Tom. Interview with Fran Coughlan, Alice Springs, 26-3-1988.

<sup>94</sup> Pittock, AB *'Beyond White Australia.'* Quaker Race Relations publication, Sydney, 1975, p19.

<sup>95</sup> Heppell, M & Wigley, J, *op. cit.*, p16.

<sup>96</sup> O'Grady, F, *op. cit.*, p72.

Springs<sup>97</sup>. Many Aborigines there were dying from tuberculosis, pneumonia, measles and malnutrition. Practically every adult had trachoma and infected gums. The mission population was between 150 and 200<sup>98</sup>, mostly Eastern Arrernte people<sup>99</sup>. However, there was a lack of water at Arltunga, and the mission was moved to Santa Teresa 80 kilometres south east of Alice Springs in 1953<sup>100</sup>. It became the centre for the dissemination of Christian (Catholic) teaching. It was also involved with cattle raising and training *natives* in European skills.

After the Second World War the policy of assimilation was again pursued. The Native Welfare Branch decided that a new settlement should be established outside the water supply catchment area of Alice Springs. The site of Amoonguna, 12 kilometres from Alice, was chosen in 1955<sup>101</sup> as a replacement for the Bungalow reserve<sup>102</sup> (see below). Construction work commenced in 1957, and 350 residents of the Alice Springs Bungalow reserve were transferred from the Bungalow in 1960<sup>103</sup>, with the Welfare Branch responsible for its administration<sup>104</sup>.

The authorities considered Amoonguna as being different from outlying settlements, in that it was to provide for transients and convalescents, as well as for a large resident population<sup>105</sup>. Aboriginal housing consisted of 51 kingstrand<sup>106</sup> houses with communal ablution facilities, only one of which had hot water<sup>107</sup>.

*'The principal role of Amoonguna is to provide a home and the conditions for social advancement for those Aborigines who have lived in or near Alice Springs*

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<sup>97</sup> *Ibid.* pp75-78.

<sup>98</sup> *Ibid.*, pp81-83.

<sup>99</sup> Welfare Branch NT Administration, 1961, *op. cit.*, p35.

<sup>100</sup> O'Grady, F, *op. cit.*, p136.

<sup>101</sup> Hocking, HM 'The Growth of a Town - From Stuart to Alice Springs.' Australian Territories, Vol 3, No 2, March, 1963, pp24-31.

<sup>102</sup> Von Trepp, R, *op. cit.*, p22.

<sup>103</sup> Hocking, HM, *op. cit.*, p30.

<sup>104</sup> Collmann, J 'Fringe-camps and the Development of Aboriginal Administration in Central Australia.' Social Analysis, No 2, November, 1979, p49.

<sup>105</sup> Welfare Branch NT Administration, 1961, *op. cit.*, p26.

<sup>106</sup> A type of tin shed built in a number of Aboriginal communities in central Australia during this period.

<sup>107</sup> Heppell, M & Wigley, J, *op. cit.*, pp16, 23.

*long enough to be termed 'permanent residents'. It has a secondary role as a transit and repatriation centre for Aborigines in Alice Springs for medical treatment or other reasons.*<sup>108</sup>,

*'Amoonguna was the place where the Social Welfare Branch expected all transient people to stay. However, all the language groups from all around central Australia were mixed together there, and there were a number of permanent residents. It was a place of regimentation and stress with much drinking and fighting as a result. Most Pitjantjatjara people, and some others, were afraid to go there. Unaccompanied women patients, or mothers accompanying sick children (into Alice Springs) were particularly vulnerable.*<sup>109</sup>,

Many Aborigines refused to be thus regimented. It was intended that, by establishing Amoonguna, it would reduce the number of fringe camp dwellers around Alice. However, the number actually increased as people moved to new locations to avoid the authorities. New camps were established around the hills north of Alice, and along the base of the ridges to the south around Amoonguna itself. These camps were an embarrassment to the Director of Welfare who gave orders for the people to be returned to the settlement. Efforts to do this were unsuccessful and the camps continued to appear. They left the Welfare Branch open to criticism from southern journalists and tourists<sup>110</sup>.

By 1965 the Aboriginal population at Amoonguna was 538, but no additional housing had been provided<sup>111</sup>. By 1973 the population had declined to its present size of 233<sup>112</sup>. The post war period also saw the establishment of other government settlements in remote areas. Papunya, 240 kilometres west north west of Alice Springs and 19 kilometres from Haasts Bluff, was established as a government settlement because of the inadequate water supply at Haasts Bluff<sup>113,114</sup>. It was occupied in 1959, but not officially

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<sup>108</sup> Welfare Branch NT Administration, 1961, *op. cit.*, p14.

<sup>109</sup> Downing, J 'Ngurra Walytja Country of my Spirit.' ANU, North Australia Research Unit, Darwin, 1988, p3.

<sup>110</sup> Collmann, J, *op. cit.*, p50.

<sup>111</sup> Heppell, M & Wigley, J, *op. cit.*, pp16, 23.

<sup>112</sup> DAA, NT Division 'Annual Report 1972-1973.' AGPS, Canberra, 1975, p43.

<sup>113</sup> Welfare Branch NT Administration, 1961, *op. cit.*, p29.

opened until December 1960. The population of Papunya had been less than 500 in 1958, around 600 by the early 1960s and over 700 by the mid-1960s. At this time it was the largest Aboriginal settlement in central Australia. This rapid increase was largely due to the influx of Pintubi people from the Western Desert into Papunya. There were some intentions at this time to establish out-stations to the west to relieve overcrowding<sup>115</sup>. After the establishment of Papunya, Haasts Bluff continued as a cattle project, with 38 people remaining<sup>116</sup>.

The Pintubi people inhabited the Western Desert regions. Some people had travelled

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<sup>114</sup> Nathan, P & Japanangka, DL, 1983 (2), *op. cit.*, p70.

<sup>115</sup> Long, JPM, *op. cit.*, p35.

<sup>116</sup> Welfare Branch NT Administration, 1961, *op. cit.*, p29.

into Papunya in the 1950s, and by the early 1960s some Pintubi had camped at Mt Doreen station, and later moved to Yuendumu<sup>117</sup>. In the winter of 1961, the National Mapping survey party graded a road running west from the Kintore Range into Western Australia and sank a well known as Jupiter Well at the end of the road around 600 kilometres west from Papunya<sup>118</sup>. In 1963, the Pintubi patrols attempted to contact people around Jupiter Well. The official version tells of many thin and malnourished people, with some suffering from Yaws<sup>119</sup>. Patrol reports claim that there was drought in the Western Desert which drove Pintubi people out of the desert. They were brought into Papunya by the 'Pintubi patrols'<sup>120</sup>. However, other versions suggest that there was strong pressure on Pintubi people to come in from the desert because of two particular government policies. One was the policy of assimilation. The other was the defence policy that led to the establishment of the Woomera Rocket Range. The course of rockets from Woomera was to be north west over the Western Desert - the Pintubi traditional lands. Two patrol officers were indeed employed by the Weapons Research Establishment (WRE) to patrol the Central Reserve and make sure that rockets would not hit Aborigines. Earlier patrols had found people generally healthy and well nourished<sup>121</sup>.

In 1964 the Pintubi patrol was carried out with the aim of contacting as many people as possible and offering transport out of the desert to all that wanted to leave. Long, who was one of the Patrol Officers involved in the patrols, claimed that it was realised that:

*'... desirable as it may be to leave people to follow their traditional life undisturbed in the desert, it was inhumane to neglect them now that it was known their social life was impoverished by depopulation of the area';*

Some were ill and undernourished; and they had clearly expressed a wish to be taken into a settlement<sup>122</sup>.

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<sup>117</sup> Welfare Branch NT Administration, 1961, *op. cit.*, p48.

<sup>118</sup> *Ibid.*, pp26, 28.

<sup>119</sup> *Ibid.*, p31.

<sup>120</sup> Nathan, P & Japanangka, DL, 1983 (2), *op. cit.*, pp56-7.

<sup>121</sup> *Ibid.*, p35-37.

<sup>122</sup> Long, JPM, *op. cit.*, p32-33.



Pam Nathan and Dick Japanangka's account is largely based on the Pintubi's own recollection of the events. Drought was, of course, a fairly regular phenomenon in the Western Desert, and the Pintubi had long survived these events. Few of the Pintubi's stories talked about this as a major problem, although many were attracted to some aspects of European food. The issues surrounding rocket ranges and defence activities have always, of course, been shrouded in secrecy and leaves much open to speculation. However, the Pintubi interviewed by Nathan and Japanangka at the time saw rockets as an issue. The movement of the Pintubi swelled the population of Papunya to around 700.

Docker River, as a site for an Aboriginal settlement, was initially approved in the early 1960s to provide rations to nomadic Aborigines. A bore at Docker supplied a small flow of potable water<sup>123</sup>. Docker River as a significant government settlement was eventually established in 1968<sup>124</sup>. This was the last welfare settlement established. It was established to encourage Pitjantjatjara people to settle there. Factors underlying this were<sup>125</sup>:

- ♦ the development of tourism at Ayers Rock, and the desire not to upset this development by the presence of Aborigines. Some of Uluru's traditional owners went to live at Docker River.
- ♦ the need to relieve overcrowding at Areyonga;
- ♦ the desire to contain the movement of the Ngaanyatjarra people from Western Australia into the NT.

Whilst Aboriginal people have always lived around Alice, as conditions in the bush became more difficult the population around Alice increased and a number of institutions were established to deal with what white settlers considered a problem.

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<sup>123</sup> Long, JPM, *op. cit.*, p35 - footnote.

<sup>124</sup> Welfare Branch NT Administration 'Annual Report 1967-1968.' 1968, p14.

<sup>125</sup> Toyne, P & Vachon, D 'Growing Up the Country. The Pitjantjatjara Struggle for their Land.' McPhee Gribble, Melbourne, 1984.

The Bungalow was established for *half caste* Aboriginal people in 1915. It consisted of initially one, and later three, corrugated iron sheds<sup>126</sup>. During the period of military occupation in the Second World War the Bungalow was closed and occupants were sent to other settlements or missions<sup>127</sup>. In 1945 the Bungalow re-opened but this time for '*full-blood*' Aborigines who were authorised visitors to town. The Native Affairs Branch administered it until 1953<sup>128</sup>. The Bungalow reserve became the semi-permanent home of some 300 Aborigines and was used to provide accommodation and welfare facilities for Aborigines.

The *half caste* Aboriginal children who had been sent away during the war had their return delayed until 1948 when the Church of England opened St Mary's hostel to accommodate them<sup>129</sup>. It was situated 5 kilometres from Alice Springs. By 1960, the hostel accommodated 60 children of both sexes, who attended local schools, and were fostered interstate for school holidays<sup>130</sup>. St Mary's continues today as a home for children who are either disabled or otherwise deemed 'at risk'.

Charles Perkins was born at the Bungalow in 1936 or 37<sup>131</sup>.

*'We were not allowed in town except on Saturday night to go to the pictures. People were allowed into the town for work, but they had to be out again before the sun set.'*

This ban on Aborigines in Alice Springs town continued into the 1960s.

Rainbow town in the Gap area of Alice Springs was established in 1946. It was made up of a number of austere cottages, with few facilities, which were built for the resident '*part-Aboriginal*' population. Its name was derived from the multiplicity of types and shades of colour of the people who lived there. The residents of Rainbow Town were described variously as '*low class whites*', '*half-castes*' and '*full-bloods*' all living there

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<sup>126</sup> Heppell, M & Wigley, J, *op. cit.*, p15.

<sup>127</sup> Von Trepp, R, *op. cit.*, p22-3.

<sup>128</sup> Collmann, J, *op. cit.*, p49.

<sup>129</sup> Heppell, M & Wigley, J, *op. cit.*, p16.

<sup>130</sup> Welfare Branch NT Administration, 1961, *op. cit.*, p84.

<sup>131</sup> Perkins, C '*A Bastard Like Me.*' Ure Smith, Sydney, 1975, p8-9, 17-18.

under 'camp conditions'. People were moved to new and better houses with more modern conveniences when they could demonstrate they wanted to adopt the new lifestyle (ie the European life style) and could cope with the responsibility. A good house was considered a consequence of progress towards assimilation, and a necessary step to further progress<sup>132</sup>.

After leaving the Bungalow, Perkins moved to Rainbow Town.

*'We then moved to a place they call Rainbow Town where all the Aboriginal people were living. All the skin colours gave Rainbow Town its name. The shacks were called the Cottages and the town was built especially for Aborigines, about a mile outside of Alice Springs. It is all demolished now and new housing is up there. We had to stay there. We were not allowed in Alice Springs after dark, only for the pictures on Saturday night, the same old pattern. ... We were just not allowed in town unless it was for a specific reason. The older people were taken in for work and brought out again. School was on the reserve itself. It was optional if you went or not.'*

*'The police ruled Aboriginal lives. The reserve kids were not allowed to speak to their tribal family, who were not allowed on the reserve, and lived outside the fence.'*

The white population of Alice Springs in 1947 was 1,871<sup>133</sup>, and by 1963 had grown to almost 5,000<sup>134</sup>. Tensions between the white settlers in Alice and local Aborigines continued. The Town Management Board (TMB) was established in 1961, and it wanted campers around the town evicted. They wanted legislation to prohibit persons camping on crown land within a three-mile radius of Alice<sup>135</sup>.

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<sup>132</sup> Collmann, J *'Fringe-Dwellers and Welfare.'* University of Queensland Press, Brisbane, 1988, p112.

<sup>133</sup> Heppell, M & Wigley, J, *op. cit.*, p1.

<sup>134</sup> Hocking, HM, *op. cit.*, pp4-25.

<sup>135</sup> Heppell, M & Wigley, J, *op. cit.*, p81.

In 1963, seventeen Aboriginal artists (including six members of the Namatjira family) sought the allotment of land at Morris Soak to the west of Alice. These people had been banned from camping at the Finke River Mission Block and could not go to Amoonguna. Their application was refused on the grounds that there had been problems with camp dogs and pastoralists' cattle at the drovers' camp in 1959; Aborigines would

not accept responsibility for the maintenance of the camp; and that no provision had been made in the application for wives and children (the group numbered 88 in all, with 48 children). It was suggested that those who wanted to live in Alice Springs could apply for Housing Commission houses, or could stay in the transitional cottages in the Gap area<sup>136</sup>. Previously, in the late 1950s, Albert Namatjira tried to buy land, but was unsuccessful. The Namatjiras were the first group of fringe campers to apply for a Special Purpose Lease in Alice Springs, but, again, were not successful<sup>137</sup>.

The Aboriginal camp population around Alice Springs in 1968 was estimated as between 100 - 120. The majority lived in camps composed of brush shelters and dilapidated huts in fairly permanent locations on the outskirts of town. The most conspicuous areas were:

- on the banks of the Charles River;
- the racecourse area;
- in and around Ilparpa, a complex of old huts just south of Heavitree Gap;
- the mission block - crown land adjacent to the Finke River Mission headquarters;
- the railway trucking yards (mainly itinerants stayed here);
- along the Todd River at Middle Park, approximately one mile north of the Todd River causeway.

Welfare officers visited these areas and where possible arranged for Aboriginals living in a sub-standard state to move to Amoonguna or other settlements. Unoccupied humpies were removed. Alcohol was a problem in town camps as well as at Amoonguna and Jay Creek, and was responsible for fighting and injuries<sup>138</sup>. Many people resisted attempts by welfare officers to force them to live at Amoonguna because of inappropriate relationships with the main groups living at Amoonguna, and for fear of alcohol related incidents. The non-Aboriginal population of Alice Springs continued to grow, and there were ongoing tensions between the new settlers and Aboriginal people camped at various places around the town in the late 1960s.

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<sup>136</sup> Heppell, M & Wigley, J, *op. cit.*, pp76-80.

<sup>137</sup> Tangentyere Council 'Annual Report, 1984-85.', Alice Springs, 1985.

<sup>138</sup> Welfare Branch NT Administration 'Annual Report - 1967-1968.' 1968, p56.

### *Period of Self-determination*

There were two developments which had objectives related to improving the situation for Aboriginal people. One was the Alice Springs Cross-Cultural Group that was formed in 1969. It consisted of a group of concerned white town residents including the Rev Jim Downing ‘with the goal of fostering understanding and good relations between white and black residents in the town’<sup>139</sup>. The issue of developing town camps was one issue of concern to the Cross-Cultural Group, as well as of the TMB<sup>140</sup>.

The other was the establishment of the Institute of Aboriginal Development (IAD) in 1969. It began as a Uniting Church initiative concerned to improve Aboriginal health and was based on a realisation that improved Aboriginal health would come not just from improved medical services but also from Aboriginal development. It was a cross-cultural community development education and resource agency and aimed to assist the struggle for self-determination through running educational courses. Rev Jim Downing and Yami Lester, a Yankunytjatjara man, were key players in IAD’s development.

This period marks the shift in policy from assimilation to self-determination. The political struggles leading to this shift of policy are discussed in Chapter 4, and the development of government policy in Aboriginal affairs is detailed in Chapter 5. In the late 1960s - early 1970s Welfare Branch patrol officers and social workers visited Aborigines camping in sub-standard conditions in Alice Springs to provide assistance in employment, social service benefits, check on child and family welfare, and get census information<sup>141</sup>. There were between 5,000 - 6,000 Aboriginal people in the environs of Alice Springs, who visited Alice for medical treatment, court attendance, employment, shopping and holidays. There were probably around 100 people living in Alice and at least another 100 camping around Alice. This figure was at times as high as 350. Welfare expected all transients to stay at Amoonguna, and all employed people to live in Housing Commission accommodation. However, people did not comply with this. Some tribal

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<sup>139</sup> Welfare Branch NT Administration ‘*Annual Report 1969-1970*’ 1971, p41.

<sup>140</sup> Heppell, M & Wigley, J, *op. cit.*, pp84-5, 88, 174.

<sup>141</sup> Welfare Branch NT Administration, 1971, *op. cit.*, p39.

groups (eg Pitjantjatjara) would not stay at Amoonguna. Various reasons were given - it was not their country, they were strangers there, it was too far from town, or they wished to stay with friends or family in town<sup>142</sup>. However, at Amoonguna all the language groups were mixed together and it was a place of regimentation and stress, with consequent drinking and fighting. Most Pitjantjatjara people along with some others were afraid to go there. After medical treatment, patients and those accompanying them were often abandoned in town<sup>143</sup>.

The TMB reported on objections to town campers in 1970 and listed the problems as too much noise, bad behaviour, health hazards, child welfare and education problems, drunkenness, untidiness, and impairment to the tourist image. The report recommended that five permanent camps with temporary facilities be developed as a trial for specific tribal groups - Arrernte, Pitjantjatjara, Warlpiri, Anmatjera and Pintubi. If successful after 6 months, it recommended that all other camping in the town area be banned. The report was submitted to the Welfare Branch in Darwin, but little action was forthcoming. In 1973 two of the sites were established. The Welfare Branch established Charles Creek Village and the Cross-Cultural Group established Little Sisters<sup>144</sup>.

The Interim Land Commission surveyed the camps with the Welfare Branch, and found at least '*16 specific sites ... were then identified as being those occupied either temporarily or permanently by Aboriginal people*'. Within some of those sites were subdivisions of smaller camps. Five areas were recommended for development as camping sites, and the report emphasised the need for Aboriginal consultation in both determining the sites, their boundaries, management, and the development of those sites. The report also suggested a hostel, and perhaps club facilities, and proper back up facilities such as social work assistance<sup>145</sup>.

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<sup>142</sup> Welfare Branch NT Administration, 1971, *op. cit.*, p40.

<sup>143</sup> Downing, Rev J, *op. cit.*, p3.

<sup>144</sup> Heppell, M & Wigley, J, *op. cit.*, p82-4.

The Alice Springs Town Council (ASTC) was established in 1971, replacing the TMB.

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<sup>145</sup> Ward, Justice, Interim Aboriginal Land Commission (NT) '*Alice Springs Urban Land Claims by Associated Aborigines in Alice Springs.*' Transcript of Proceedings before his Honour Mr Justice Ward, 1975, pp94-5.



The Interim Land Commissioner's report was accepted by the ASTC in 1973. Areas recommended by the TMB had included Sadden Range, Ootnarungatcha, Charles River, Basso's Farm and Inarleng (Little Sisters)<sup>146</sup>.

In late 1971, the Director of the Welfare Branch called a meeting in Alice Springs where he announced that the Branch would provide funds for an Aboriginal camping site chosen by the TMB on the west side of the Charles Creek, and would also fund other sites for Aboriginal town camps. However, submissions had to be submitted within 3 weeks. The Cross-Cultural Group applied for the Little Sisters camp, but no-one else was prepared. The Charles Creek project did not involve Aborigines in its planning or development<sup>147,148</sup>.

A meeting of Pitjantjatjara and Arrernte representatives with the Cross-Cultural Group in 1972 secured Arrernte permission for Pitjantjatjara buildings to go ahead at Little Sisters<sup>149</sup>.

By 1972, it was clear that there was a general decrease in the number of Aborigines employed on pastoral properties. This was attributed to the disinclination by pastoralists to employ Aborigines at award wages following the 1968 equal wages decision. Only short-term employment for work like mustering or branding was available. Previously whole families were taken out to the station and supported, but now only the men could go<sup>150</sup>.

The Welfare Branch recognised that fringe dwelling was not a problem to the fringe dwellers. They did not associate their living conditions with their health problems and other social worries. Welfare considered that there was a need for education programs to change habits and attitudes. Welfare also recognised the need for localised solutions and recommended that the following process should be followed:

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<sup>146</sup> Heppell, M & Wigley, J. *op. cit.*, p88.

<sup>147</sup> *Ibid.*, p84-5.

<sup>148</sup> Welfare Branch NT Administration 'Annual Report 1971-1972' 1973, p14.

<sup>149</sup> Heppell, M & Wigley, J. *op. cit.*, p89.

<sup>150</sup> Welfare Branch NT Administration, 1973, *op. cit.*, p27.

1. analyse each particular group;
2. forecast future changes;
3. provide basic camping facilities to improve their lot and eliminate infections that are hazards to the rest of the town<sup>151</sup>.

Note the concern about the hazard to the rest of the town, rather than as hazards to the people themselves.

With the advent of the Whitlam Government, the establishment of the Department of Aboriginal Affairs (DAA) and the new policy of self-determination came the opportunity for Aboriginal people to receive funds to run their own organisations. This movement had begun before the Whitlam Government took power with the establishment of the Redfern Aboriginal Medical Service and the Redfern Aboriginal Legal Service in NSW in 1971. Now Aboriginal controlled organisations sprang up around the country. In central Australia, the Central Australian Aboriginal Legal Aid Service and the Central Australian Aboriginal Congress were set up following community meetings in 1973<sup>152,153</sup>. Congress was initially focused on advocacy and political work concerned with the rights of central Australian Aborigines generally. One of the early programs was related to the lack of shelter and a tent program was developed which involved hiring out tents to people for a nominal rent. Later, in 1974 Dr Trevor Cutter worked for Congress to establish the medical service.

Housing issues were recognised at the national level as a major issue for Aboriginal communities. The Aboriginal Housing Panel was established in Sydney in 1972. It grew out of a joint seminar conducted by the Council for Aboriginal Affairs and the Royal Australian Institute of Architects to *'plan and coordinate the work of a number of study groups which would investigate and recommend on various aspects of the Aboriginal*

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<sup>151</sup> Welfare Branch NT Administration, 1973, *op. cit.*, p70.

<sup>152</sup> *'Report of the House of Representatives Standing Committee on Aboriginal Affairs'*, Canberra, 1980, p27.

<sup>153</sup> Central Australian Aboriginal Congress *'Annual Report 1986-87'*, Alice Springs, 1987, p2.

*housing program*<sup>154</sup>. The Panel was set up by the McMahon government to advise the Commonwealth on suitable low cost housing for remote Aborigines<sup>155</sup>.

The Housing Association scheme was adopted in 1972 as a means to accelerate the rate of suitable housing for Aborigines on settlements and missions, and to encourage their active interest in this aspect of their 'social advancement'. There was an emphasis on use of local materials, voluntary labour, rent payment, ownership and maintenance<sup>156</sup>.

In 1973 the NT Division of DAA and the NT Housing Commission (NTHC) conducted a study into the depth and nature of the problems faced by Aboriginal tenants of the NTHC in Alice Springs. It found that the major problems were socio-economic, accentuated by lack of educative support services. It recommended that certain programs be introduced to facilitate Aboriginal fringe dwellers to obtain NTHC accommodation. These included reviewing the design and location of houses, and a pre-tenancy orientation and education course on housekeeping and home making<sup>157</sup>.

DAA had not solved the problem of unhoused Aborigines in Alice Springs, and town campers continued to receive adverse publicity in the town. DAA called a meeting in February 1974 which was attended '*by people working with the different groups*' to discuss the '*problems*' of town campers. 13 people, mostly from the churches and only two being Aboriginal attended the meeting. They were informed that DAA had 'very considerable finance' to assist town campers. No town campers were invited to the meeting. At subsequent meetings it was decided that an association called Tangatjira (Tangentyere), meaning in Arrernte '*working together to help each other*', be set up to provide financial administration to a number of autonomous town camp housing associations. A committee of 5 Aborigines, including one town camper (Lindsay Turner), the manager of Charles Creek camp, and 4 whites was set up<sup>158,159</sup>.

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<sup>154</sup> Heppell, M & Wigley, J, *op. cit.*, p230.

<sup>155</sup> *Ibid.*, p106.

<sup>156</sup> Welfare Branch NT Administration, 1973, *op. cit.*, p15.

<sup>157</sup> DAA NT Division, 1975, *op. cit.*, p15.

<sup>158</sup> Downing, Rev J, *op. cit.*, p5-6.

According to Jim Downing, Tangentyere was set up to:

*'... help town campers to seek solutions to their need for leasehold and security of tenure, toilet and ablution facilities, housing, bus services to the camps for picking*

*up children for school, hostels for the accommodation of young and old, and for transients, services to camps, liaison with other organisations with similar or complementary aims, liaison with governments and government departments on behalf of town camp people*<sup>160</sup>.

But within 3 months the Tangentyere meetings collapsed. According to Geoff Shaw (long term Manager of Tangentyere until his retirement in 1997) this was because:

*'Chairman Downing was replaced by someone who did not understand camp conditions and our way of doing things;*

*We felt that the whites, especially the officials, did not really listen to us;*

*The meetings were too late in the evening;*

*They produced no obvious results.*<sup>161</sup>,

Despite this Mt Nancy and Anthepe got leases to their land in 1974.

Wenten Rubuntja, who was vice-chairman and the first full-time Aboriginal employee of Central Land Council, held two weeks of creek bed meetings in Alice Springs about the need for town camp leases. He initially worked with the senior Aboriginal men with traditional land in the Alice Springs area, and they discussed the needs of all the groups in Alice, and went from camp to camp negotiating a solution. Town campers, especially those from Mt Nancy, were eager participants. They organised one claim incorporating 12 sections of land. Justice Ward was very impressed, and publicly announced he was likely to recommend all land sought be granted, and rejected objections of town planners and others<sup>162</sup>.

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<sup>160</sup> Downing, Rev J, *op. cit.*, p7.

<sup>161</sup> Shaw, G Interview with Fran Coughlan, Alice Springs, 26-3-1988.

<sup>162</sup> Eames, G *'The Central Land Council: The Politics of Change.'* In Peterson, N and Langton, M (Eds) *'Aborigines, Land and Land Rights.'* AIAS, Canberra, 1983, p270.

From late 1974 to early 1976, on the basis of the draft Land Rights Bill, Mr Justice Ward who was interim Land Commissioner began hearing claims based on the needs of residents in 13 town camp areas in Alice Springs<sup>163,164</sup>. These claims were<sup>165</sup>:

1. Mt Nancy.
2. Ilparpa (Anthepe). Ntapa Housing Association. 60-80 people permanently camped at old site, after they had moved there from the Finke River Mission. Occupants were mainly Western Arrernte people.
3. Charles River and extension (Anthelk-Ewlpaye). There were about 70 permanent residents in this area, plus visitors. People were mainly Anmatjera and Arrernte.
4. Ootnarungatcha (Trucking yards, or Nyewente) Western Arrernte people had camped in this area for a long time, and people here had a traditional attachment to the area. There were at least 2 clearly defined camps with a population of between 42 and 80 people, plus visitors from stations including Coniston and Papunya.
5. Artists (Carmichael's or Kere kwatye).
6. Basso's Farm: Alyawarr and Arrernte people, specifically off stations of Alcoota, Utopia, MacDonald Downs and Amaroo camped here.
7. Dalgety's Paddock (Warlpiri camp, or Ilperle Tyathe) This claim was made by mainly Warlpiri people with some Anmatjera who were living in scattered camps along the Charles River, including Hoppy's shop camp or Dick Jungala's camp. The hills in this area are of cultural significance to Arrernte people. People from Yuendumu and Papunya also stayed here when in town, swelling the population to up to 200 people.
8. Alec Simpson's camp (Morris Soak, or Akngwertnarre) People had been camping in this area for at least 10 years.
9. Sadadeen Range area (Eastside or Ewyenper-Atwatye/ Hidden Valley) There had been at least five separate camps of Eastern Arrernte people along Undoolya Rd which would move to this area if the claim was successful. There were about 80

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<sup>163</sup> Central Land Council 'Annual Report 1983-1984.' Commonwealth of Australia, Canberra, 1984, p9.

<sup>164</sup> Eames, G, *op. cit.*, p270.

<sup>165</sup> Ward, Justice, *op. cit.*, pp73-94.

permanent campers plus visitors from Undoolya and Stirling stations, and Santa Teresa mission. The site was traditionally significant, and had been the site of ceremonies.

10. Heavitree Gap (Larapinta Valley or Yarrenyty-Arltere) It involved an attempt to reunite a western Arrernte tribal group that had been separated over the years. The country was traditionally relevant to this group and large enough for some separate living. There were 35 - 40 permanent residents plus visitors from Hermannsburg and Haasts Bluff, swelling the population to 200 at times.
11. Lot 1442 claim: Yirara. (Karnte )
12. Dick Palmer's camp: (Aper-Alwerrknge).

Karnte was one of these groups in the Ward hearings, claiming land behind the now defunct Drive In. They have been camping on this land since<sup>166</sup>. The Karnte Housing Association was incorporated in 1983. In early 1984, the NT Lands Department attempted to block Karnte from getting a water tap and pipe running from Anthepe<sup>167</sup>. In 1987 a lease was granted.

Inarlenge (Little Sisters) was not included on the list because a lease had already been granted in the name of the Cross-Cultural Group in 1973<sup>168</sup>.

The Ward hearings were never completed due to the sacking of the Whitlam Government in November 1975. However, the point had been made. Bureaucrats had been forced to publicly defend their actions and explain their opposition to land rights. The town campers had had their victory<sup>169</sup>.

Fifteen town camps were proposed with water and toilet facilities. There was continued opposition from the Alice Springs Town Council who was concerned that these areas would become permanent camps<sup>170</sup>.

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<sup>166</sup> Tangentyere Council 'Annual Report 1984-1985.' Alice Springs, 1985, p10.

<sup>167</sup> *Ibid.*

<sup>168</sup> Durnan, R Interview with Fran Coughlan, Alice Springs, 26-3-1988

<sup>169</sup> Eames, G, *op. cit.*, p270.

<sup>170</sup> Heppell, M & Wigley, J, *op. cit.*, p104.

There was growing frustration at the delays in granting leases. In July 1976 a meeting of representatives from the town camps, Congress, Central Land Council, and the Central Australian Aboriginal Legal Aid Service decided that a 'Tangentyere' was necessary to push things ahead, and to effectively negotiate with government departments<sup>171</sup>. Thus Tangentyere Council was finally incorporated in 1979. In that same year a number of

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<sup>171</sup> *Ibid.*, p177.



Housing Associations representing residents of particular camps were incorporated including Ilparpa, Mpwetyerre (BP or Abbotts Camp) and Ilpeye-Ilpeye (Golders Camp), and leases were granted to Ilperle-Tyathe (Warlpiri Camp) and Aper-Alwerrkngge (Palmers Camp).

By mid-1979 the housing situation on town camps was<sup>172,173</sup>:

- ♦ Mt Nancy: 8 completed houses;
- ♦ Anthepe (Drive In): 6 completed houses;
- ♦ Ilperle Tyathe (Warlpiri Camp): 6 houses partially complete;
- ♦ Nyewente (Trucking Yards): 7 houses partially complete;
- ♦ Aper-Alwerrkngge (Palmers Camp): 2 houses under construction.
- ♦ Inarlenge (Little Sisters): 5 houses under construction;
- ♦ Akngwertnarre (Morris Soak): Tenders to be called for construction of 5 houses in July 1979.
- ♦ Anthelk-Ewlpaye (Charles Creek): Tenders to be called for construction of 8 houses in July 1979.

In 1979 there were 1,016 Aboriginal people living on 35 camps in Alice Springs. So it can be seen from this that there were only 14 completed houses for a population of more than 1,000 people in 1979<sup>174</sup>. Clearly the issue of shelter remained a major public health issue.

Further Housing Associations were incorporated in 1980 and included Ilwempe-Akerte (White Ghost Gum Gap)<sup>175</sup>. However this area was already being developed for white settlers, and this group were forced out. A lease was never granted<sup>176</sup>. Leases were granted to Ewyenper-Atwatye (Larapinta Valley), Ilparpa and Mpwetyerre (BP/Abbotts).

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<sup>172</sup> Braddock, M 'Aboriginal Housing in Alice Springs.' Report to the SA Housing Board, Paper 1, 1979, p17.

<sup>173</sup> Heppell, M & Wigley, J, *op. cit.*, p198.

<sup>174</sup> Beck, E 'The Enigma of Aboriginal Health: Interaction between biological, social & economic factors in Alice Springs Town Camps.' AIAS, Canberra, 1985, p14.

<sup>175</sup> Durnan, R Interview with Fran Coughlan, Alice Springs, December, 1988.

<sup>176</sup> Durnan R, Interview with Ben Bartlett, March, 1998.

The NT Government announced a freeze on new leases to Aboriginal town campers in

Alice Springs in July 1981 until ‘adequate and rational use is made by Aboriginals of existing land grants’<sup>177,178</sup>. The water authority stopped installing water metres on new houses in town camps in the same year. In 1984 the water authority agreed to read the sub meters on houses, but still insisted on billing the Housing Associations collectively<sup>179</sup>.

Tangentyere Council also developed programs to deal with the social issues on the camps. Alcohol problems were a major issue on many of the Town Camps, and Tangentyere Council formed the Tangentyere Liquor Committee was formed in 1983<sup>180</sup>. This Committee, in collaboration with Congress, opposed further take-away outlets in Alice Springs. The Committee also developed proposals for a number of social clubs appropriate for the different language groups around Alice Springs. Hotels and bars in Alice Springs use dress regulations to exclude most Aboriginal patrons. Only one social club was ever established. The Tyeweretye Club near the Show Grounds south of Heavitree Gap was opened in 1993. However, it was initially refused a liquor license, despite both Commonwealth and NT government funding support. It eventually was granted a license in 1994.

The care of old people was also an issue. The NT Health Department and the Commonwealth Department of Social Services funded research into the needs of old people in the town camps 1983-84 and as a result Tangentyere Council established an Old People's Committee in 1985<sup>181</sup>. Since then Tangentyere has provided an old people's service, including meals on wheels, to the elderly residents of Town Camps. There were inadequate services for old people within Alice Springs town, and in the early 1990s the Arrernte Council developed an old peoples program to meet these un-met needs.

Further Housing Associations were incorporated including Lhenpe-Artuwe (Anmatyerre Camp) in 1986 and Anhelke (Namatjira's Camp) in 1987. In 1986 a lease was granted to

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<sup>177</sup> Letter to Tangentyere from John Pinney, Director, Department of Lands, 17-7-81.

<sup>178</sup> Tangentyere Council, 1985, *op. cit.*, p8.

<sup>179</sup> *Ibid.*, p9.

<sup>180</sup> *Ibid.*, p11.

<sup>181</sup> Tangentyere Council ‘*Annual Report 1985-1986.*’ Alice Springs, 1986, p3.

Ilpeye-Ilpeye (Golder's Camp), but at a cost. In June 1986 the NT government argued that town campers must either buy their land or pay for essential service installation. The NT government extracted money out of the Commonwealth for part of the cost of supplying essential services to Ilpeye-Ilpeye<sup>182</sup>.

It can be seen that there are some fairly consistent threads running through this history. Firstly there is the general hostility to Aboriginal camps by many of the non-Aboriginal residents of Alice Springs. In the early days Aboriginal people were banned from being in the town unless on authorised business, or on Saturday nights for the movies. Later there were attempts to prevent Aboriginal people from camping in the vicinity of the town. In the 1990s there have been vocal attempts to send people from bush communities back to those communities.

Secondly there is the obstruction by the Northern Territory government authorities to prevent the granting of leases, and access to services. This latter point is to do with Territory government's primary concern to establish settlement and independent economic development. The meeting of Aboriginal needs is seen as inconsistent with these objectives.

The NT government has also been concerned about optimising its finances through claiming a proportion of Commonwealth funds for Treasury, or more generally diverting Commonwealth funds for Aboriginal advancement to the NT Government. In the example mentioned above, the Aboriginal Housing Associations and Tangentyere Council (let alone individual town camp residents) had no resources of their own to pay for services. The NT authorities continue to argue that Commonwealth funds be channelled through the NT Government. Aboriginal organisations have argued that funds should go directly to the community organisations providing the services because of continued concern that the NT Government diverts Commonwealth to the NT Treasury for use to underwrite non-Aboriginal business enterprise (especially tourism) and to develop well resourced suburban living environments in order to attract new settlers (eg Palmerston outside Darwin). This illustrates the continued priority of NT authorities to secure settlement and to stimulate economic enterprise as part of that.

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<sup>182</sup> Tangentyere Council, 1986, *op. cit.*, p9.

### *Land Rights*

From the above discussion it can be seen that the issue of land, culturally and spiritually significant sites, and the need for shelter and other amenities have been inter-twined.

The issue of land rights received national attention when the Gurindji people walked off Wave Hill station in 1966 and set up camp at Wattie Creek.

With the election of the Whitlam Government (who had a clear policy of supporting land rights) in 1972, a number of pastoral leases were bought by the Commonwealth and handed to traditional owners, and a number of inquiries were established to look at land rights issues in the Northern Territory. Willowra was a cattle station held under pastoral lease by the Parkinson family<sup>183</sup>. As with many pastoral leases significant numbers of Aboriginal people lived on their land and coexisted with the pastoralist. Indeed, many pastoralists would not have managed to survive economically had it not been for the assistance provided by local Aborigines. By 1968, Edgar Parkinson wanted to sell his lease for health reasons. He approached the NT Administration with the suggestion that they purchase the lease on behalf of the Aboriginal people who were the traditional owners of that land. The NT Administration rejected this as it was against policy to allow Aborigines to own pastoral leases. Prime Minister Holt had established the Council of Aboriginal Affairs, and, in 1968, the Council had persuaded PM Gorton to establish a Capital Fund for Indigenous enterprise. Nuggett Coombs, at around the same time met with Stumpy Martin and other senior Warlpiri people from Willowra who asked for assistance in getting some of their land back, and informed him of the support they were receiving from the current pastoralist lease holder. When Coombs raised this with senior bureaucrats in the Department of the Interior, he was met with overt hostility and the issue was not resolved.

However, in 1972, Whitlam announced in the election campaign<sup>184</sup>:

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<sup>183</sup> Coombs, HC 'Willowra' North Australia Research Unit, ANU, Darwin, Discussion Paper No 12, Feb 1993.

<sup>184</sup> *Ibid.*, p5.

*'We will legislate to give Aborigines Land Rights, not just because their case is beyond argument, but because all of us as Australians, are diminished while Aborigines are denied their rightful place in this nation.'*

Within days of the Whitlam Labour Government taking office Willowra was purchased on behalf of the Willowra Pastoral Company with Stumpy Martin as its chairman. Within a few years the Company was strong enough to purchase the neighbouring Mount Barklay property which was also traditional Warlpiri land.

Utopia Station had also been a pastoral lease where the pastoral leaseholder (the Chalmers family) was amenable to selling to the local traditional owners. The station is part of the Anmatyerr and the Alyawarr traditional lands. Most of these traditional lands remain part of pastoral leases controlled by non-Aboriginal pastoralists. In 1975 the Commonwealth Government bought the property via the Aboriginal Land Fund Commission (now defunct) on behalf of traditional owners. Eventually, in the early 1980s, after protracted legal hearings because of NT Government opposition the title was converted to inalienable freehold title and 4 Alyawarr and 1 Anmatyerr patri-clans numbering a total of around 400 people became the legal owners<sup>185</sup>.

Utopia is extraordinary because it has never developed a centre as such. The health service is located in one place, the store in another, and there are around 17 out-stations in the area. This style of living has meant that around 25% of the diet is from bush tucker, and hunting and gathering activities are major economic activities. Indeed, one out-station provides 40% of its diet from bush foods<sup>186</sup>. Other economic activity is the production of batik and other styles of painting and artefacts. There are no cattle on Utopia any more, and this fact has led conservative politicians in the NT Government to intermittently attack Aboriginal ownership of land on the basis that economic enterprise has failed. However, the bush foods now flourish because there are no cattle to eat them and contribute more to sustain the population than the cattle station did. The population of this area was estimated as 600 in 1980. In the 1986 census there were 890 people.

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<sup>185</sup> Devitt, J *'Apmerr Anwekantherrenh: Our Country. An introduction to the Anmatyerr and Alyawarr people of the Sandover River Region, Central Australia.'* Urapuntja Health Service Council, 1994, p30.

More out-stations have developed as the population has grown<sup>187</sup>. The current population is estimated as 850.

The establishment of inquiries by the Whitlam government to investigate how land rights could be effected, led to the establishment of both the Northern and Central Land Councils. The Northern Land Council produced the first edition of Land Rights News in July, 1976. Its early editions were roneoed A4 sheets, and focused on the development of the Land Rights Act in the NT. Later it became a joint production of the Northern and Central Land Councils. The 1976 Land Rights Act established the Land Councils as statutory bodies. In 1978, the Central and Northern Land Councils made a claim to the Land Commissioner to convert the Willowra pastoral lease to inalienable freehold title in accordance with the Land Rights (NT) Act. This was the first claim under this Act and was opposed by the NT Conservation Commission and various community conservation groups such as Friends of the Earth<sup>188</sup>. The Pitjantjatjara Council was formed in 1976<sup>189</sup>.

Following the enactment of the Land Rights Act many groups have gained title to areas of their country. With the change in policy and an administrative apparatus that had a limited capacity to resource Aboriginal communities, many groups left the main communities that had been missions or government settlements to establish out-stations. Thus the population of the major settlements such as Papunya and Hermannsburg have declined substantially over the past 20 years, whilst the number of people living on out-stations has increased.

A significant movement of people involved the Pintubi people. By the late 1970s they were dissatisfied with their situation at Papunya. There was a lot of alcohol consumption, and too many people had died. The Pintubi leaders decided that they wanted to return to their homelands, and a resource base was established at Kintore with the support of the DAA. From here it was intended that the Pintubi would reoccupy the Western Desert through the establishment of out-stations. Whilst some out-stations were established,

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<sup>186</sup> Gault, A 'Urapuntja Health Service Health Survey.' IAD, Alice Springs, 1990, p2.

<sup>187</sup> Devitt, J, *op. cit.*, p32.

<sup>188</sup> Coombs, HC, 1993, *op. cit.*, p6.

<sup>189</sup> Land Rights News 'A Cultural History of Australia.' Vol 2, No 6, January, 1988, p29.

Kintore has continued to be a significant population centre with a population of around 500 people.

Whilst the Land Rights Act had provided secure tenure to many Aboriginal communities in remote areas, most of these were in desert areas not taken up under pastoral leases or other non-Aboriginal use. For many people whose country Alice Springs was built on, or whose country had been taken by a pastoral lease, they remained dispossessed.

Many of the Town Camp residents were in this position. In 1984 five families (the Lynches, Palmers, Turners, Rices and McMillans) moved out of the town camps to set up camps along the stock route on Yambah Station 80-100 kilometres north of Alice Springs. The stock routes, known as Red Areas, were long and narrow strips of land which were strictly defined as Crown Land, and thus were theoretically claimable. Eventually the Commonwealth handed title to small areas of this land to the traditional owners in the early 1990s. This allowed more permanent occupation of these areas with infrastructure such as houses and bores able to be established. However, the lack of services, including schools and health services, have made permanent occupation difficult for many of the families.

In 1984 the Ingkerreke Council was established as an out-station resource centre<sup>190</sup>. It was initially established under the auspices of Tangentyere Council, but eventually found its own premises and autonomy.

In many of the out-stations potable water was not available, as such resources had been incorporated into the Pastoral Lease of Yambah Station to which the people had limited access. Thus Ingkerreke spent a great deal of their resources in carting water to these families.

Other tasks were providing assistance to basic construction work, and assisting with the supply of food. Since the early 1990s Congress has also provided some basic health care support to the out-stations within 100kms from Alice.

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<sup>190</sup> Carne, D, Interview with Fran Coughlan, Alice Springs, 14-3-1988.



Over the past 15 years there has also been significant movement from Jay Creek and Alice Springs to out-stations to the West of Alice in the Jay Creek area. Similar movements of people have also occurred around Hermannsburg and Papunya.

The current demographics of central Australia are marked by continued high levels of

mobility with people moving from out-stations to their associated communities and to Alice Springs<sup>191</sup>. There has been a plethora of out-stations developed with small family groups moving away from some of the disruptions of life in the larger settlements. People often have multiple residences – a bush community, an out-station, a town camp or town house in Alice Springs. Reasons for high mobility can include deaths (sorry business), other cultural and ceremonial business, social security, shopping, sporting events, visiting relatives in hospital or gaol, police business, and the need to access services such as education and health care. The movement of people occurs without regard for administrative jurisdictions, and indeed crosses State/ Territory borders, as well as smaller administrative regions, and the recognised language group areas.

There are changing relationships between groups of people within and beyond communities and language group areas ('sorry business' and disputes). It is common that places of residence are vacated after a death. The length of time people stay away is extremely variable depending on the importance of the person, the significance of place and other factors. This accounts for the vacancy of a number of out-stations throughout central Australia. The history of particular 'communities' in central Australia has been that different language groups and families were forced together. This has played a role in determining the nature of these communities. The relationships between different groups are not always harmonious and have been further complicated by non-Aboriginal influences.

The mobility of the population has implications for service delivery. Young has argued that the pre-occupation of planners with collecting accurate population data is misplaced, and advocates that a behavioural assessment of population mobility needs to be included in the planning process, rather than attempting to eradicate (or ignore) such mobility<sup>192</sup>.

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<sup>191</sup> Young, E & Doohan, K *'Mobility for Survival: A process analysis of Aboriginal population movement in Central Australia.'* ANU North Australia Research Unit, Darwin, 1989.

<sup>192</sup> Young, E *'Aboriginal Population Mobility and Service Provision: A Framework for Analysis.'* Chapter 15, p 186-196 in Meehan, B & White N (Eds) *'Hunter-Gatherer Demography: Past and Present.'* Oceania Monograph 39, Sydney, 1990.

## Aboriginal Organisations

The period of self-determination has enabled the development of significant Aboriginal organisations through the programs administered through the Commonwealth's Department of Aboriginal Affairs (DAA) which was established in 1973. However many of these organisations were initially established without government resources through the efforts of Aboriginal people themselves determined to address their social, economic, health and other problems.

The development of Tangentyere, Central Land Council and Ingkerreke has been covered in the above discussions. The development of the Central Australian Aboriginal Congress (Congress) will be covered in Chapter 6 on the development of health services.

### *Yipirinya School*

In 1978 Town Camp leaders got Tangentyere Council support for an Aboriginal school, Yipirinya<sup>193</sup>. Yipirinya began as a research project out of left-over consultancy money that Tangentyere had at the end of June. Their job was to consult with parents and do a report to Tangentyere about what parents at Anthepe and Nyewente wanted to do about problems their children were having with schooling. DAA reacted very angrily to the project, and applied strong pressure in an effort to get Tangentyere to drop the project and cease being concerned with education issues<sup>194</sup>. However, Yipirinya School began by providing education to primary school children in the Town Camps from around 1978. In 1983, the NT Minister for Education, Marshall Perron registered the school as a non government school<sup>195</sup>. Ten years after its tentative beginning the Yipirinya School Council opened their new school in Alice Springs in 1988. The school provides education to primary school children including Aboriginal cultural matters and local languages.

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<sup>193</sup> Durnan, R, 1988, *op. cit.*

<sup>194</sup> *Ibid.*

<sup>195</sup> Yeperenye Yeye (Newsletter of the Yipirinya School Council), Vol 3, No 1, January, 1984, p3.

*Central Australian Aboriginal Media Association.*

In 1980 the Central Australian Aboriginal Media Association (CAAMA) was formed in Alice Springs with the aim of improving communications between Aborigines and Europeans in the region and to strengthen Aboriginal culture. It was funded by DAA in January 1981<sup>196</sup>.

In 1987, Imparja, a subsidiary of CAAMA, was granted a TV licence to operate the remote commercial television service in the central 'footprint' or transmission zone, Alice Springs. The Australian Broadcasting Tribunal, ABT, had convened two hearings in 1986 to decide which of the 2 applicants to recommend. The unsuccessful applicant and the NT government lodged Federal Court appeals against the ABT decision, delaying implementation of the service<sup>197</sup>. Initially CAAMA ran the television station, a radio station and a production unit. However, a review in the mid 1990s resulted in a separation of the television facility from CAAMA.

CAAMA has also been instrumental in supporting Aboriginal musicians through their recording program, and the development of arts and crafts work in some remote communities by acting as agents for the artists.

*Institute of Aboriginal Development*

As mentioned above IAD began as an initiative of the Uniting Church in the late 1960s, but was restructured under Aboriginal control in the late 1970s. It is now an adult education institution providing accredited courses in a range of areas, including management. It also provides a publishing facility and support to cultural activities, providing the opportunities for interaction between mainly older and younger women. It has also been involved with cross-cultural education. IAD continues to struggle for recognition and adequate funding. It has a vision of becoming an Indigenous University.

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<sup>196</sup> DAA 'Annual Report 1980-1981.' AGPS, Canberra, 1981, p14.

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<sup>197</sup> DAA *'Annual Report 1986-1987.'* AGPS, Canberra, 1987, p104.

### *Combined Aboriginal Organisations*

The Combined Aboriginal Organisations (CAO) was a loose body involving all of the Aboriginal organisations in Alice Springs, and was instrumental in providing strategic support to development for the benefit of Aboriginal people. It met regularly and discussed policy issues, difficulties with particular government bureaucracies, and the priorities for funding of programs. It provided a forum for Aboriginal leaders to collaborate in the reconstruction of Aboriginal society in central Australia.

An example of the work of the CAO is illustrated by the development of the Aboriginal Organisations Training program. In 1986 the CAO negotiated with the Department of Employment and Industrial Relations for funds to research all the Aboriginal organisations training needs<sup>198</sup>. As a result the Aboriginal Organisations Training (AOT) program was introduced under the Aboriginal Education Development Program (AEDP). The program provided training for members and staff of Aboriginal community councils, organisations and communities<sup>199</sup>. IAD was funded by AEDP under this program specifically to assemble course materials for an organisations' training package, and to conduct workshops for Alice Springs Aboriginal organisation employees<sup>200</sup>. The CAO acted at its best as a strategy group for Aboriginal organisations and communities in Alice Springs. However, with the advent of ATSIC, its functioning and influence has declined. This is discussed further in Chapter 5. However, there continue to be calls for its resurrection in order to create a forum where organisations can deal with their differences, and it appears that there are serious moves being made toward this.

Other Aboriginal organisations that have developed in central Australia include:

- ♦ Aboriginal Child Care Agency which was developed by Congress but is now independent;
- ♦ Arrernte Council;

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<sup>198</sup> Tangentyere Council, 1986, *op. cit.*, p4.

<sup>199</sup> DAA, 1987, *op. cit.*, p46.

<sup>200</sup> *Ibid.*, p102.

- ♦ Aboriginal Housing Advisory Service, which was begun by Congress, and is now administered by the Arrernte Council;
- ♦ Central Australian Aboriginal Alcohol Programs Unit (CAAAPU) which was begun by abstinence activists and nurtured by Tangentyere Council and Congress, but is an autonomous organisation.
- ♦ Central Australian Aboriginal Legal Aid Service which began in 1971.
- ♦ Alice Springs Night Patrol which operates under the auspices of Tangentyere Council.
- ♦ Four Corners Council that is a forum for traditional owners from the different language groups established by Tangentyere Council as part of a Social Behaviour project. Its intent was to involve traditional Aboriginal authority in dealing with contemporary behaviour problems.
- ♦ As well most communities are now administered by incorporated community councils and many have women's centres. There are also a number of Arts and Crafts organisations, and tourist ventures.

In this chapter we have traced the history of central Australia from the beginnings of dispossession to the present day.

The processes of colonisation resulted in serious depopulation of Aboriginal people in central Australia, forced settlement on missions and government settlements for many, reduced access to traditional sources of food, the incarceration of many in gaols, and the separation of many children from their families. There was also an increase in disease, particularly infectious disease. There is little doubt that the impact was devastating on the social cohesiveness of Aboriginal life, and created an unhealthy dependency on the invaders which, nevertheless, contributed to many people's survival.

However, since the 1970s, with the embracing of a new policy of self-determination, a period of reconstruction has begun. This period has produced a great deal of change with many Aboriginal organisations active in running their own affairs. Over the past 25 years more people have reasonable housing, clean water and sewerage disposal, with

improved access to food. However, there is still a long way to go with Aboriginal people still having limited access to viable economic activity, high unemployment rates, and poor education outcomes.

The different periods of colonisation, whilst clear cut in terms of stated government policy, are not so clear cut in terms of implementation. Despite the policy of self-determination, governments, both politicians and bureaucrats, have had difficulty in developing administrative practices that actually support such self-determination. The fiasco of the National Aboriginal Health Strategy discussed in Chapter 8 illustrates this difficulty. The current lack of bi-partisanship in Aboriginal affairs means that it is now even more difficult to improve such implementation.

The next chapter will briefly explore Aboriginal resistance to the processes of colonisation.





## CHAPTER 4 - ABORIGINAL RESISTANCE

This chapter provides a brief overview of the resistance of Aboriginal people to occupation and colonisation. It does not purport to provide a comprehensive view of such resistance, but attempts to illustrate the widespread nature of such resistance, and the development of Aboriginal activist organisations which have been critical to the development of Aboriginal affairs policy.

Aboriginal resistance in the early days of the colony was mostly local, or regional. This to some extent reflected the nature of the processes of colonisation with small and autonomous colonies under the British crown developing virtually independently from each other. It wasn't until 1901 that an Australian national government was created, and even then State Governments retained control of most land issues and Aboriginal affairs. It also reflects the nature of Aboriginal society with identity being determined by local conditions and affiliations more than by country wide issues.

Markus<sup>1</sup> points out that the Aboriginal influence on the British political process began from the earliest times of the settlement due to Aboriginal physical resistance to 'settlement', and was probably strongest when they operated totally outside the 'system' – when they knew little of the workings of the British system. However, much of the early resistance can only be discerned from the writings of the colonisers, as Aboriginal communication was based on an oral rather than written tradition.

In the 1850s there were a number of deputations of Aborigines to colonial authorities regarding land issues. In the 1870s-80s, Victorian Aborigines of the Coranderrk reserve used strikes, petitions and deputations to achieve some security of title to their reserve<sup>2</sup>. Around the country there were many other local Aboriginal actions to curtail the

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<sup>1</sup> Markus, A *'Blood From a Stone: William Cooper & the Australian Aborigines' League.* Allen & Unwin, Sydney, 1988, p2.

<sup>2</sup> *Ibid.*

activities of authorities, and settlers, and to assert Aboriginal entitlement to land. Many of these involved the right to use land, including for cultivation<sup>3</sup>.

However, slowly this century Aboriginal organisations (or at least organisations concerned with the welfare of Aborigines) began to develop. Aboriginal activists also became an increasingly common part of the Australian political landscape.

The Australian Aboriginal Progressive Association (AAPA) formed in the early 1920s. Its main spokesperson was a Hunter River Koori, Fred Maynard<sup>4</sup>. The AAPA linked the activities of a number of communities and within six months claimed eleven branches and a membership of 500 people. Its early activities revolved around helping children who had been taken from their families. Its political demands included<sup>5,6</sup>:

- ♦ the recognition of land as an economic base for Aboriginal people;
- ♦ compensation for dispossession;
- ♦ halting the forcible removal of Aboriginal children from their families;
- ♦ full Australian citizenship;
- ♦ abolition of the Protection Board and its replacement by one composed of Aborigines, with a government appointed Chairman.

The AAPA was officially launched in February, 1925, and remained active until at least 1927.

In Western Australia it took a massacre to stimulate action. The Onmalmeri massacre in the East Kimberley took place in 1926. There was an outcry in Perth, which prompted the establishment of a Royal Commission to investigate. The attempts made by the 'posse' to hide the bodies by burning them, and their conspiracy of silence, made it

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<sup>3</sup> Goodall, H *'Invasion to Embassy: Land in Aboriginal Politics in New South Wales, 1770-1972.'* Allen & Unwin, Sydney, 1996, p125-148.

<sup>4</sup> *Ibid.*, p149-150.

<sup>5</sup> Markus, A *'Blood From a Stone: William Cooper & the Australian Aborigines' League.'* Allen & Unwin, Sydney, 1988.

<sup>6</sup> Goodall, H *'A History of Aboriginal Communities in NSW, 1909-1939.'* PhD Thesis, University of Sydney, 1982, pp 228-249.

impossible to know how many were killed<sup>7</sup>. In November, 1926 Aborigines in the South West formed a union '*in order to obtain the protection of the same laws that govern white man*' because they were '*tired of being robbed and shot down, or run into miserable compounds*.'<sup>8</sup>

William Harris played a leading role at this time.

The beginnings of a new policy began to emerge in the 1930s. It was becoming clear that Aborigines were not headed for extinction. Aboriginal groups were developing, and they received some support from non-Aboriginal sympathisers, including clergymen, academics, female philanthropists, trade unionists, communists, businessmen and politicians. They urged governments to accept that extinction was not inevitable, and that it was possible for Aborigines to 'advance' towards 'civilisation'<sup>9</sup>.

A turning point in attitudes came with the killing of 5 Japanese crewmembers at Caledon Bay and of a policeman, Constable McColl, at Woodah Island in Arnhem Land in 1933<sup>10</sup>. The standard government response to these sorts of episodes had been to send out a punitive expedition to deal with the culprits. These sorts of episodes had led to killings and sometimes massacres in the past. Missionaries, with support from southern cities and some newspapers challenged this approach and offered to send their own delegation to find the killer and bring him back for a fair trial. This they did. However, the issue of a fair trial was another matter. Three Aborigines were tried, convicted and sentenced to 20 years gaol for the 5 Japanese murders. Tuckiar was tried and sentenced to death by the same Judge Wells for the death of McColl in August 1934. The trial was condemned. The Judge had refused to take cultural factors into account, and it appeared that the only difference in the two cases was that Tuckiar had killed a white man. An appeal in

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<sup>7</sup> Biskup, P '*Not Slaves, Not Citizens: The Aboriginal Problem in Western Australia, 1898-1954*.' University of Queensland Press, Brisbane, 1973, pp84-85.

<sup>8</sup> Biskup, P *op.cit.*, p85.

<sup>9</sup> Markus, A, 1988. *op. cit.*, p4.

<sup>10</sup> Rowley, CD '*The Destruction of Aboriginal Society*.' Penguin Books, Melbourne, 1972, pp290-97.

November 1934, to the High Court, quashed the conviction. However, it is thought that Tuckiar was probably murdered, as he never reached home after being released.

This and other cases brought huge public protests, including from Elkin in Sydney and TGH Strehlow in Adelaide, missionaries, humanitarians, and the Association for the Protection of Native Races<sup>11</sup>. Elkin pointed out over a decade later that a white jury would invariably find an Aborigine accused of killing a white guilty<sup>12</sup>. The Church Missionary Society that had brought in Tuckiar and the three other prisoners came under attack for failing to put any effort into finding witnesses to the incident that would help achieve a fair trial.

This case brought the question of cross-cultural justice into focus. The issue of justice for Aboriginal people in Australia's justice system has been a vexed question since those times, and is still not resolved. However, whilst not resolved there have been many incidents where Courts have recognised the existence of a parallel system of justice and accordingly have made some allowance in sentencing offenders. This is another example of the persisting colonial relationship.

However, the point to draw from this episode is the changing attitudes of white Australia, and this led to a reconsideration of policy by the government. In 1937 the first nationwide conference of administrators with control over Aborigines met in Canberra<sup>13</sup>.

In 1932 William Cooper, along with others such as Margaret Tucker and Douglas Nichols, formed the Australian Aborigines League in Melbourne<sup>14</sup>. There was anger about the lack of justice over the Coniston massacre in central Australia and the inhumane practice of separating Aboriginal children from their families<sup>15</sup>. In Perth, the

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<sup>11</sup> Rowley, CD, 1972, *op. cit.*, pp290-93.

<sup>12</sup> Elkin, AP '*Aboriginal Evidence and Justice in North Australia.*' Oceania, March, 1947.

<sup>13</sup> Markus, A, 1988, *op. cit.*, pp16-17.

<sup>14</sup> Elkin, AP '*Citizenship for the Aborigines.*' Australasian Publishing Co., Sydney, 1944, pp18-19.

<sup>15</sup> Clark, CMH '*A History of Australia.*' Melbourne University Press, Melbourne, 1997, Vol. 6, p427.

Australian Aborigines Amelioration Association was established in 1932<sup>16</sup>. The Aborigines' Uplift Society, made up of non-Aboriginal supporters, was formed in Melbourne in 1937<sup>17</sup>. Around the same time the Aborigines Progressive Association of NSW was formed by Aboriginal activists William Ferguson and John Patten<sup>18</sup>.

Links were made between these organisations and contacts were developed around the country<sup>19</sup>. They received support from church groups, some militant trade unions and the Communist Party of Australia. Such groups campaigned against various local forms of oppression, eg ineffective and paternalistic State Aboriginal Welfare Boards and they took up individual grievances as well as providing various forms of welfare assistance<sup>20</sup>.

Pressure was building for changes to government Aboriginal affairs policies. Calls were for the Commonwealth Government to<sup>21</sup>:

- ♦ adopt a positive policy for the development of Aborigines;
- ♦ secure Aboriginal reserves; and
- ♦ take responsibility for creating centres of influence on reserves for the advantage of Aborigines.

The Waramanga people being removed from their reserve when gold was found in Tennant Creek highlighted concern about the security of reserves<sup>22,23</sup>.

William Cooper was active in Victoria and used a number of organisational names including the Australian Aborigines' League, Real Australian Aboriginal Society and the Real Australian Native Society. A constitution of the Australian Aborigines' League was

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<sup>16</sup> Elkin, AP, 1944, *op. cit.*, pp18-19.

<sup>17</sup> *Ibid.*, p19.

<sup>18</sup> Markus, A, 1988, *op. cit.*, p11.

<sup>19</sup> Markus, A, 1988, *op. cit.*, pp12, 77.

<sup>20</sup> Pittock, AB '*Beyond White Australia.*' Quaker Race Relations Publication, Sydney, 1975, p18.

<sup>21</sup> Elkin, AP, 1944, *op.cit.*, p17.

<sup>22</sup> Rowley, CD, 1972, *op. cit.*, p316.

<sup>23</sup> Elkin, AP '*Citizenship for the Aborigines.*' Australasian Publishing, Sydney, p17.

drafted in 1936<sup>24</sup>. The League took a broad view of their social struggle as can be judged by their affiliation with the United Peace Council<sup>25</sup> and their representations to the German Government condemning the '*cruel persecution of the Jewish people by the Nazi Government of Germany*'<sup>26</sup>.

Aboriginal activists, with the support of some non-Aboriginal intellectuals, such as Mary Gilmore, had published a journal, '*The Australian Abo Call*', for some years. The

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<sup>24</sup> Markus, A, 1988, *op. cit.*, pp10-11, 40-43.

<sup>25</sup> *Ibid.*, p57.

<sup>26</sup> *Ibid.*, p100.

Aborigines Progressive Association in NSW, under the leadership of Bill Ferguson and John Patten, held a *'Day of Mourning and Protest'* in 1938 to mark the 150th anniversary of the first white settlement<sup>27</sup>. *'We do not ask for your protection.'* they said, *'No thanks! We have had 150 years of that! We only ask for justice, decency and fair play. Do not be guided by religious and scientific persons ... Let the Aborigines themselves tell you what they want'*<sup>28</sup>. They protested about NSW Aborigines not being allowed to vote, bans on Aborigines drinking alcohol, and the restrictions on Aborigines to maternity allowance or old-age and invalid pensions. In the same year the Committee for Aboriginal Citizenship was formed in Sydney<sup>29</sup>.

These organisations played a pivotal role in pushing Australia from a protectorate policy towards a welfare approach. This early activism set the basis for an Aboriginal rights movement incorporating land rights, citizenship rights, workers rights and human rights.

One difference that tended to exist between the Aboriginal organisations and the non-Aboriginal support groups was to do with a differentiated attitude to *full bloods* and *half-castes*. The 1936 Annual Report of the Australian Aborigines League stated<sup>30</sup>:

*'We should nail our colours to the mast in respect of this matter, making our slogan "Full equality for the dark race with the white race, and no differentiation between the full-blood and those of mixed blood."'*

However, most non-Aboriginal groups continued to call for different strategies to deal with *full-bloods* and those of *mixed-blood*. In 1939 the Sydney Trades and Labour Council endorsed the centralisation of affairs affecting *full-bloods* in the hands of the Commonwealth Government, and the granting of full citizenship rights to all *'mixed bloods'*<sup>31</sup>. Elkin also called for such differentiation.

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<sup>27</sup> Land Rights News, Vol 2, No 6, January, 1988, p38.

<sup>28</sup> Rowley, CD *'Recover. The Politics of Aboriginal Reform.'* ANU Press, Canberra, 1986, pp116.

<sup>29</sup> Elkin, AP, 1944, *op. cit.*, p17.

<sup>30</sup> As quoted in Goodall, H, 1996, *op. cit.*, p188.

<sup>31</sup> Elkin, AP, 1944 *op. cit.*, p19.



It is interesting to note that calls were made by Aboriginal organisations for the

Commonwealth Government to take over responsibility for Aboriginal affairs from the States. This has been a fairly constant Aboriginal demand for over 60 years. Demands also reflected the Aboriginal struggle for health with concern being expressed about the high infant mortality rate, housing problems and the quality of food supplies<sup>32</sup>.

The attitudes in the 1930s were mixed up with the ideology of eugenics that fed Nazism in Europe, anti-Semitism, and ideas of genetic inferiority. Part of this ideology was the importance of racial purity. Aboriginal resistance involved opposition to these ideas and practises, and there was a fairly natural alliance between some Aboriginal groups and non-Aboriginal anti-fascist groups. However, within the dominant society there was a fear of '*half-castes*'. Some of these attitudes may have played a part in the establishment of organisations such as the Association for the Protection of Native Races. This Sydney based association was the most prominent of a number of organisations attempting to influence a change in government policy. It was exclusively white. The Aboriginal and non-Aboriginal organisations tended to remain separate, whilst mutually supportive<sup>33</sup>. Elkin addressed this particular organisation in 1931 arguing that the lack of Aboriginal policy was responsible for Aborigines being on the '*high road to extinction*'<sup>34</sup>.

In 1944, Elkin suggested a national policy for Aborigines<sup>35</sup>.

*'The aim must be full citizenship, with all its rights, privileges and responsibilities - for all persons of Aboriginal descent'*.

He called for:

- a) immediate citizenship for persons of '*half-caste or of less caste than half*' if they lived independently in the general community;
- b) issuing of certificates of exemption from Aboriginal Acts to people with a *preponderance of Aboriginal blood* but who have demonstrated a capacity to support themselves and their families in any normal '*accepted way*'; and
- c) citizenship for Aboriginal people living on reserves, settlements or missions who are employed full time on the staff, have regular employment off the

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<sup>32</sup> Markus, A, 1988, *op. cit.*, pp59,109.

<sup>33</sup> *Ibid.*, p5.

<sup>34</sup> Elkin, AP '*Understanding the Australian Aborigine.*' St Johns College Press, Sydney, 1931.

<sup>35</sup> Elkin, AP, 1944, *op. cit.*, pp43-44.

settlement, or display active membership of a cooperative community in which usual civilised economic, educated and social activities are followed.

Numerous groups of white liberals campaigned for reforms, notably for Federal controls over Aboriginal affairs and more positive approaches to education, health and housing. Elkin was their most prominent theorist and publicist. These reforms formed the basis of the assimilation policy<sup>36</sup>.

Aboriginal pastoral workers in the Pilbara went on strike in 1946. The WA government backed the station management and a succession of strike 'leaders' were arrested and gaoled. Publicity resulted in money and supplies being sent north from sympathetic white groups, notably the Seamen's Union<sup>37</sup>. The strike lasted for 3 years, and even then about 600 Aborigines decided to stay away from white-controlled cattle stations in the future. In the 1960s this group split into two groups – one going to Yandeyarra Station and the other forming the Nomads who gained ownership of Strelley Station in the 1970s<sup>38</sup>. With the assistance of Don McLeod, a non-Aboriginal communist who devoted his life to assisting the Strelley mob, they survived by alluvial mining, hunting, and fishing, and eventually bought their own cattle stations<sup>39</sup>.

A Royal Commission was set up in 1956 following the release of a film showing starvation and disease amongst Aborigines in the Warburton Ranges, WA<sup>40</sup>. This provided the impetus for the founding of the Aborigines Advancement League in Victoria, and Federal Council for the Advancement of Aborigines and Torres Strait Islanders (FCAATSI) in 1957<sup>41</sup>. FCAATSI, first called Federal Council for the

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<sup>36</sup> Pittock, AB, *op. cit.*, p18.

<sup>37</sup> *Ibid.*, p19.

<sup>38</sup> Wilson, J 'The Pilbara Aboriginal Social Movement: An Outline of its Background and Significance' in Berndt, RM & Berndt CH (Eds) 'Aborigines of the West: Their Past and Their Present.' Nedlands, University of Western Australia Press, 1980, pp151-168.

<sup>39</sup> Roberts, J 'Massacres to Mining.' Dove Communications, Melbourne, 1981.

<sup>40</sup> Bandler, F 'Turning the Tide: A Personal History of the Federal Council for the Advancement of Aborigines and Torres Strait Islanders.' Aboriginal Studies Press, Canberra, 1989, p10.

<sup>41</sup> Pittock, AB, *op. cit.*, p19.

Advancement of Aborigines, was the first national political body concerned with Aboriginal affairs and played a national coordinating role, with membership of many societies and voluntary organisations, churches and unions. It became a powerful lobbying body.

During the 1950s the Aboriginal rights movement consisted largely of sympathetic Christian, liberal and left wing white groups, including affiliated trade unions, peace committees, and church groups. Churches however were deeply divided because of 'red-smear' tactics, and the fear of being labelled as communist. Aborigines themselves were seldom heard in public, with a few notable exceptions. White sympathisers initially dominated FCAATSI, with Aboriginal people scarcely participating<sup>42</sup>. It had whites in leadership and policy-making positions and was largely assimilationist<sup>43</sup>. Prominent people involved in the formation of FCAATSI included Pearl Gibbs, Faith Bandler, Jessie Street, Gordon Bryant, and Charles Duguid<sup>44</sup>. The Council focused on equal wages for Aborigines, land rights, and general issues of discrimination. However, their major campaign was for the Aboriginal rights referendum in 1967.

The 1960s saw a new mood develop. Australian capitalism had enjoyed economic boom conditions since the end of the war. There was virtually full employment. There were strikes in the metal and other industries for better wages. Industry could afford to pay, and did.

The cold war was a major influence on foreign policy, and Australia followed the United States in opposing the liberation struggle in Vietnam. The baby boomers, who had enjoyed an unprecedented period of prosperity had other things on their mind. It was a time of change and Aboriginal issues were to gain increasing focus (see Chapter 5).

In 1963 the Yirrkala people from the NT Gove Peninsula, with the assistance of Gordon Bryant, ALP member of parliament and an executive member of FCAATSI, presented a

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<sup>42</sup> Wright, J 'We Call for a Treaty.' Fontana, Sydney, 1985, pp3-4, 109.

<sup>43</sup> Pittock, AB, *op. cit.*, p20.

<sup>44</sup> Bandler, F, *op. cit.*, pp6-11.

petition on bark in their language to the House of Representatives opposing a mining proposal on their land. The French company originally involved in the mining venture eventually withdrew, but Nabalco was granted a mining lease, despite traditional owner objections, in 1965<sup>45</sup>.

In 1965, Charles Perkins, the first Aborigine to study at the University of Sydney, and other university students and academics embarked on what became known as the Freedom Rides. They went by bus through western NSW highlighting Aboriginal conditions, discrimination, racism, and segregation<sup>46</sup>. Publicity of the Freedom Rides increased the pressure on Australian and State governments. This brought the plight of Aboriginal communities in rural Australia into national prominence.

In 1966, Northern Territory Aborigines appealed to the United Nations for help in getting equal rights<sup>47</sup>. In this same year Holt signed the Pine Gap agreement with the US Government. Over 200 houses were built in Alice Springs for personnel, CIA employees, attached to the Base<sup>48,49</sup>.

The Gurindji people at Wave Hill cattle station, owned by Lord Vestey, walked off the station in 1966, in protest against intolerable working conditions and inadequate wages. They established a camp at Wattie Creek and demanded the return of some of their traditional lands. They remained on strike for a decade and a tide of public opinion and political support changed in their favour. In April 1968, Federal Minister, W.C. Wentworth visited the Gurindji strike camp at Wattie Creek. He supported the resumption of 8 sq miles for the Aborigines, but Cabinet squashed the idea. The Gurindji had to wait until the election of the Whitlam Government before they won their land

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<sup>45</sup> Pittock, AB, *op. cit.*, p21.

<sup>46</sup> Perkins, C 'A Bastard Like Me.' Ure Smith, Sydney, 1975, p8-9, 74-91.

<sup>47</sup> Watson, D 'The Story of Australia.' McPhee Gribble, Melbourne, 1984, p163.

<sup>48</sup> Alice Springs Peace Group 'Pine Gap: Some Facts.' Undated.

<sup>49</sup> Heppell, M & Wigley, J 'Black Out in Alice: A History of the Establishment and Development of Town Camps in Alice Springs.' Development Studies Centre, Monograph No 26, ANU, Canberra, 1981, p3.

back in 1973<sup>50</sup>. They were granted 1,000 square miles of their country back, as leasehold, in the first Land Rights victory<sup>51,52,53,54</sup>.

In 1967, FCAATSI mounted a major campaign supporting Aboriginal land rights with the active support of Abschol, a national student group, and other affiliates. This was a new phase, with Aboriginal initiatives stimulating a national response through movements operating on a national basis<sup>55</sup>.

On 1st December 1968, Aborigines were included in the NT Cattle Industries Award<sup>56</sup>. Aborigines were awarded the right to the same wages as white station hands. The cattle industry reacted by phasing out Aboriginal labour and driving Aboriginal communities progressively off properties that are their traditional lands<sup>57</sup>. As a consequence, settlements became more overcrowded, understaffed, unhealthy and alienating<sup>58</sup>.

Minister Wentworth established the Aboriginal Sports Foundation in 1969 to encourage Aboriginal people to participate in all forms of sport<sup>59</sup>. The National Aboriginal Sports Council representing thirty-two sporting communities eventually replaced the Foundation<sup>60</sup>

1969 saw the influence of the American Black Power Movement in Australia. An Aboriginal member of FCAATSI challenged the organisation over issues of white paternalism. The Australian Aborigines League of Victoria, a major affiliate of FCAATSI, supported Black Power in principle without necessarily condoning all its methods<sup>61</sup>. By 1970, FCAATSI was controlled by Aboriginal people<sup>62</sup>. A bitter debate

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<sup>50</sup> Watson, D, *op. cit.*, p179.

<sup>51</sup> Land Rights News, 1988, *op. cit.*, p29.

<sup>52</sup> Rowley, CD, 1972, *op. cit.*, p218.

<sup>53</sup> Roberts, J, *op. cit.*, p64.

<sup>54</sup> Hardy, F *'The Unlucky Australians.'* Thomas Nelson, Melbourne, 1968.

<sup>55</sup> Pittock, AB, *op. cit.*, pp21-22.

<sup>56</sup> Welfare Branch, NT Administration *'Annual Report 1967-1968.'* 1968, p11.

<sup>57</sup> Land Rights News, 1988, *op. cit.*, p29.

<sup>58</sup> Tangentyere Council *'Tangentyere Annual Report 1984-1985.'*, Alice Springs, 1985, p2.

<sup>59</sup> DAA *'Annual Report 1980-1981.'* AGPS, Canberra, 1981, p15.

<sup>60</sup> Tatz, C *'Obstacle Race: Aborigines in Sport.'* UNSW Press, Sydney, 1995, p315.

<sup>61</sup> Pittock, AB, *op. cit.*, pp22-23.

at the Annual Conference resulted in a constitutional amendment that '*only individuals of Australian Aboriginal or Islander descent may exercise the vote*' being narrowly defeated. In 1978 the name was changed to the National Aboriginal and Islander Liberation Movement (NAILM).

The National Tribal Council, set up and led by Ooderoo Noonuccal (Kath Walker) and

Pastor Doug Nicholls of the Australian Aborigines League, held its first conference in September 1970. It urged the end of the failed policy of assimilation and encouraged bi-culturalism. It became more or less moribund by 1972<sup>63</sup>.

FCAATSI held its 14th annual conference in Townsville following the Blackburn decision on the Gove case. It was the first conference held away from southern capital cities, and was attended by nearly twice as many Aborigines as whites. The Commonwealth and State Ministers concerned with Aboriginal affairs, also held their annual conference in north Queensland<sup>64</sup>. Five Aborigines attended this meeting uninvited, and demanded:

- a) Aborigines right to attend all such conferences;
- b) the abolition of the 1971 Queensland Acts;
- c) the Commonwealth assume its responsibilities from the 1967 referendum, and administer Queensland Aboriginal and Islander affairs.

The Aboriginal flag, designed by an Arrernte man, Harold Thomas, was first flown in SA on Aborigines Day in 1971<sup>65</sup>.

### **The Aboriginal Embassy**

On 14<sup>th</sup> July, 1972 Aboriginal protesters erected a tent 'Aboriginal Embassy' on the lawn in front of Parliament House, Canberra, and received wide local and overseas media attention<sup>66</sup>. It was forcibly removed from Parliament House by police on 20<sup>th</sup> July<sup>67,68</sup>. It was re-established following widespread expressions of outrage in the media and confrontations between protestors and police.

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<sup>63</sup> Pittock, AB, *op. cit.*, pp23-24.

<sup>64</sup> Wright, J, *op. cit.*, p10-11.

<sup>65</sup> Aboriginaland Diary 1988, p January 4-10.

<sup>66</sup> Pittock, AB, *op. cit.*, p29.

<sup>67</sup> Land Rights News, 1988, *op. cit.*, p29.

<sup>68</sup> Coombs, HC *'Trial Balance. Issues of My Working Life.'* Sun Books, Melbourne, 1983, p290.



The Embassy was an important expression of Aboriginal sentiments that they were foreigners in their own land. It underlined the fact that Aboriginal people had not ceded their sovereignty and sought negotiations with government on the basis of their being a sovereign people.

With the election of the Whitlam Labour government in 1972, the period of assimilation was at an end. Whitlam was elected on a platform of self-determination for Aborigines. Since that time Aboriginal resistance has been largely shaped by relationships between governments and Aboriginal organisations. This has involved negotiations with Aboriginal groups and organisations, and governments have had to support some formation of Aboriginal representative bodies who they could negotiate with.

The next chapter examines the development of government Aboriginal affairs policy, largely developed as a response to the pressures increasingly applied by continued Aboriginal resistance and activism.



## CHAPTER 5 – THE DEVELOPMENT OF ABORIGINAL AFFAIRS POLICY

This chapter examines the development of Aboriginal affairs policy from assimilation to self-determination. This history illustrates the continuation of control that the governments has attempted to exert over Aboriginal people, and the difficulty that governments have had in allowing the transfer of power to Aboriginal communities and their organisations. Whilst it is convenient to discuss the history of colonisation in terms of the dominant policy practices, they are not, in fact, distinct stages. The views about colonial administration and management of Indigenous affairs have always been contested. Indeed the earliest missionary activities had elements of assimilation as well as protectionism. Likewise during the era of formal assimilation policy, aspects of protection and segregation persisted. Over the past few decades continued assimilationist attitudes and practices have hampered the implementation of self-determination policies.

The Commonwealth's approach in the NT was broadly in accord with approaches pursued by the States, as all jurisdictions pursued similar agendas in dealing with the Aboriginal 'problem'. Indeed, the first inter-governmental conference on Aboriginal Affairs was held in Canberra in 1937<sup>1</sup>. It was at this conference that the policy of assimilation was enunciated.

As detailed in Chapter 3, the period of protection/ segregation was marked by extraordinary attempts to control the lives of Aboriginal people. The degree of control asserted over the Aboriginal population impacted on all aspects of life. There were attempts at preventing inter racial breeding through the 1933 Ordinance which tightened the law against miscegenation with heavy penalties that had already proved ineffective. It had sections against inter-racial soliciting, and Aboriginal people drinking or possessing alcohol. The Ordinance went even further and allowed, amongst other things, for the cancelling of an employment license for any employer found having sex with an Aborigine outside marriage. The Chief Protector in the NT, Dr CE Cook, had extraordinary powers

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<sup>1</sup> Rowley, CD *The Destruction of Aboriginal Society.* Penguin Books, Melbourne, 1972, p145.

over Aboriginal people, including the power to exempt '*mixed blood*' Aborigines from the provisions of the Ordinance.

Whilst resources for implementation were inadequate, these measures illustrate the degree of control over the Aboriginal population which reflects a type of institutionalisation of a people. Of course, many Aboriginal people managed to escape the worst aspects of this institutionalisation. Those settlements that were situated on pastoral leases, rather than being part of a mission or Government settlements, tended to have greater freedom to pursue ceremonial and hunting and gathering activities thus retaining a greater degree of autonomy.

Chief Protector Cook was concerned that the *half-caste* population would become a dissident minority and a threat to the development of white settlement in the north<sup>2</sup>. He was vigorous in the program of taking part-Aboriginal children from the camps to the homes, and moving unmarried females into institutions. These measures were largely an attempt to limit the size and movement of the *part-Aboriginal* population. One effect of the great depression all over Australia was the rigid containment of Aborigines in institutions<sup>3</sup>.

The development of organisations calling for Aboriginal rights in the 1930s (as discussed in the last chapter) contributed to a shift in government policy from that of protection and segregation. Whilst the demands by Aboriginal groups tended toward a policy closer to self-determination, governments embraced a policy of welfare and assimilation involving an increased emphasis on training and socialising Aborigines to become part of European society in Australia. This new period of assimilation continued to use state authority to control the movement of Aborigines, and indeed remove children from their families. Separate reserves were set aside for part-Aborigines, generally in town areas. Other reserves were set aside where children and others could be trained and the aged and infirm could be cared for. Jay Creek, west of Alice Springs, was established in 1937 along these lines. Pastoral training was given to Aborigines on some reserves<sup>4</sup>. This process was influenced by the assumption that solutions could be found through social engineering that

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<sup>2</sup> Cook CE '*Racism & Aborigines – Spontaneous or Induced?*' in Tugby, D '*Aboriginal Identity in Contemporary Australian Society.*' Jacaranda Press, Brisbane, 1973, pp46-53.

<sup>3</sup> Rowley, CD, 1972, *op. cit.*, pp280-81.

<sup>4</sup> Von Trepp, R '*Aboriginal Reserves - Northern Territory.*' Australian Territories, Vol 4, No 1, February, 1964, pp17-18.

was consistent with eugenic and other positivist ideologies which were widespread at the time. It also involved the continued institutionalisation of people that is at the core of problems for some communities today and reflective of the continued colonial relationship between Aborigines and the Australian authorities.

The McEwan memorandum of 1939 purported to reflect a new Federal outlook on Aboriginal affairs<sup>5</sup>. It expressed the objective of the Government as raising the status of Aboriginal people so as to entitle them by right and by qualification to the ordinary right of citizenship, and to enable them to share in the opportunities of their own country<sup>6</sup>. Again this assumed the superiority of European values, and it was Aboriginal people who were expected to become like Europeans, rather than Europeans expected to be accepting of different cultural and social values. However, developments tended to be put on hold with the outbreak of World War 2 in 1939.

In the post-war period the eugenic ideology had been largely discredited, and new policy formulations, with less emphasis on things like inter-breeding were inevitable. In 1945 the Native Affairs Branch plans involved<sup>7</sup>:

- a) establishing technical and domestic training on reserves;
- b) assisting missions to do the same, with the emphasis on economic pursuits and self-sufficiency;
- c) provision of effective health and medical care;
- d) emphasising the importance of anthropology for patrol officers;
- e) improving education and support; and
- f) maintaining reserves for desert tribes.

State and Commonwealth officials endorsed a national policy of assimilation at their second meeting in 1951<sup>8,9</sup>. Assimilation seemed to offer the solution to the Aboriginal '*problem*'. However, no Aboriginal people were involved in these conferences, and none

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<sup>5</sup> Nathan, P & Japanangka, DL '*Health Business.*' Heinemann Educational Press, Melbourne, 1983, p59.

<sup>6</sup> Tatz, CM '*Aboriginal Administration in the Northern Territory.*' PhD Thesis, ANU, Canberra, 1964.

<sup>7</sup> Bleakley, JW '*The Aborigines of Australia.*' Jacaranda Press, Brisbane, 1961, pp244-5.

<sup>8</sup> Hanks, P '*Aborigines and Government: The Developing Framework.*' In Hanks, P & Keon-Cohen, B '*Aborigines and the Law.*' George Allen and Unwin, Sydney, 1984.

<sup>9</sup> DAA '*Report of the Activities for Period 19 December 1972 - 30 June 1974.*' AGPS, Canberra, 1974, p4.

were employed in the bureaucracy or as advisers. Again this reflects the persistence of the colonial relationship with the authorities making decisions about people without those people present to represent their interests and aspirations.

In 1953 the Commonwealth enacted the Welfare Ordinance which replaced the 1918 Ordinance. This was to be the vehicle for assimilation<sup>10</sup>. It made no mention of race, but referred to wards, and the Director of Welfare was made the guardian of all wards. Objections by non-indigenous Territorians that they could be subject to this Ordinance resulted in an amendment that those with voting rights could not be made wards, thus limiting it to Aborigines, who did not have voting rights.

Government intention was to promote and direct social change amongst Aborigines in ways which, whilst maintaining people's pride in their ancestry, resulted in them becoming indistinguishable from European Australians. This reveals a quite extraordinary contradiction, and reflects how the basic attitudes about European values being equated with civilised values continued. It was recognised that this approach meant Aboriginal people shedding their group identity and becoming individuals in the general community. The purpose, therefore, of government settlements and missions was not to isolate Aborigines (although it also achieved this), but to act as training centres in social change for Aborigines. The impact of this was particularly felt on settlements and reserves. Rather than being places for hunting and gathering (at least as much as pastoral and mining operations would allow) and the practice of ceremonial rites, they increasingly became the focus of social experimentation. An example of this was the communal eating arrangements at settlements like Papunya and other central Australian government settlements. Thus, on these settlements meals were served 3 times a day, 5-7 days a week<sup>11</sup>. Activities were also directed to developing employment opportunities. Functions included the development of pastoral projects so Aborigines could be trained to make use of and develop the reserve land. The idea was that urban settlements would function as the final staging point for their ultimate assimilation into town life. However, segregated centres in towns, eg a 'native quarter', were to be avoided<sup>12</sup>. The flaws in this approach are

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<sup>10</sup> Wilson, R *'Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families.'* Sterling, Sydney, 1997, pp143-144.

<sup>11</sup> Welfare Branch NT Administration *'Annual Report 1960-1961.'* 1961, pp7, 8, 24.

<sup>12</sup> Von Trepp, R *'Aboriginal Reserves - Northern Territory.'* Australian Territories, Vol 4, No 1, February 1964, pp18, 21.

now very evident. The assumption that Aboriginal people would easily take up pastoral or other operations given their hunting and gathering life style is one barrier. The other barrier relates to the traditional ownership of the reserve, and who had responsibility in regard to the use of that land. The colonial arrangements failed to take these issues into account. The lack of resources allocated to these projects tended to further undermine any chance of success.

Training was directed at domestic skills for women, and low level labour or stockman skills for men. The stated intention of self-reliance and self-sufficiency was spiked by the continued control and institutionalisation imposed by the state apparatus.

In the NT, only people of wholly Aboriginal descent were regarded as Aborigines by the Department of Territories and on this basis there were 19,334 Aborigines in the NT, about 40% of the total NT population, in 1964. Of the 5,000 employed:

- ♦ about 2,000 worked in private industry (1,500 in the pastoral industry as stockmen and drovers, and 500 in towns as municipal workers);
- ♦ about 3,000 worked on missions and settlements.

Aboriginal labour was characterised by a low level of education and skill, low cash wages, and a small degree of social and economic mobility<sup>13</sup>.

The Department's solution to the employment problems were to:

- ♦ move the Aboriginal labour force interstate;
- ♦ establish industries; and
- ♦ stimulate economic activities in Aboriginal settlements and reserves.

At the same time children were taken from their families and either fostered to middle class European families, or sent to institutions<sup>14</sup>. The practice of removing children from their families began in many of the missions where children were taken from their families and looked after separately in the mission. In the period of assimilation children were more systematically taken away from, not only their families, but from their communities and brought up with white families or institutions in distant places with the intent of teaching

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<sup>13</sup> Hennessy, LF 'Some Problems of Aboriginal Employment in the NT.' Australian Territories, Vol 4, No 4, July, 1964, pp38-44.

<sup>14</sup> Wilson R, *op. cit.*, pp131-146.

the children to be like Europeans and breeding out Aboriginal blood from those of mixed descent. The new era of assimilation continued this practice. From the mid 1950s until the late 1960s Aboriginal children were removed from the Territory and placed in foster homes, or institutions in the southern states.

In 1965 the Commonwealth and State Ministers' conference on Aboriginal welfare re-stated the 'assimilation' policy<sup>15</sup>:

*'The policy of assimilation seeks that all persons of Aboriginal descent will choose to attain a similar manner and standard of living to that of other Australians and live as members of a single Australian community - enjoying the same rights and privileges, accepting the same responsibilities and influenced by the same hopes and loyalties ... Any special measures taken are regarded as temporary measures, not based on race, but intended to meet their need for special care and assistance to make the transition from one stage to another in such a way as will be favourable to their social, economic and political advancement.'*

The other significant event which changed the situation for Aboriginal people was the Arbitration Commission's 1965 decision granting equal wages to Aborigines in the pastoral industry. However, this was introduced in stages over 3 years<sup>16</sup>. The response of the pastoral industry was to largely shed itself of Aboriginal labour.

## **THE 1967 REFERENDUM**

During the 1960's there were three major issues regarding justice of Aboriginal people on the political agenda. These were<sup>17</sup>:

1. that Aboriginal people be given the right to vote in all Commonwealth elections.
2. that Aboriginal people be counted in the national census.
3. that the Commonwealth government be given the power to pass special legislation regarding Aboriginal people living in the States.

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<sup>15</sup> Welfare Branch NT Administration 'Annual Report 1965-1966.' 1966, p6.

<sup>16</sup> Pittock, AB 'Beyond White Australia.' Quaker Race Relations Publication, Sydney, 1975, p20.

<sup>17</sup> Hanks, P, *op. cit.*, p23.



FCAATSI played a leading organisational role lobbying government to change the Constitution and the campaign for a YES vote in the 1967 Referendum. The Referendum question put to the people on 27th May 1967 was:

*Do you approve the proposed law for the alteration of the Constitution entitled- 'An Act to alter the Constitution so as to omit certain words relating to the People of the Aboriginal Race in any State and so that Aboriginals are to be counted in reckoning the Population'?*

The YES vote of 90.77% was (and remains) the highest for any constitution referendum in this country<sup>18</sup>. The referendum gave the Federal Government concurrent and if necessary over-riding power in Aboriginal Affairs with respect to the States, although little use has been made of this power by successive governments. However, it irrevocably shifted the focus of the Aboriginal movement away from the state capitals to Canberra and the sphere of federal politics<sup>19</sup>.

After the Referendum the assimilation policy was abandoned or at least less often referred to and a policy, claimed by many to be indistinguishable from its predecessor, labelled 'integration' was declared<sup>20</sup>.

## **COUNCIL FOR ABORIGINAL AFFAIRS**

Coombs<sup>21</sup> describes how, in the wake of the referendum result, the Council for Aboriginal Affairs was established by Prime Minister Holt to advise the Federal Government on policies for its new responsibilities. The Office of Aboriginal Affairs was established within the Prime Minister's Department and headed by the executive member of the Council. This Council was made up of three white men - Dr Coombs, Prof WEH Stanner, an academic anthropologist and Mr Barrie Dexter, a diplomat. However, after Holt's death in December 1967, John Gorton became Prime Minister and he was not supportive of the Council or of Aboriginal affairs generally. When McMahon became Prime Minister in March 1971, it was expected that Aboriginal affairs would receive greater support, but despite McMahon's personal support he was hampered by strong Country Party opposition

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<sup>18</sup> Bennett, S *'The 1967 Referendum.'* Australian Aboriginal Studies, No 2, 1985, p26-31.

<sup>19</sup> Pittock, AB, *op. cit.*, p22.

<sup>20</sup> DAA, 1974, *op. cit.*, p5.

<sup>21</sup> Coombs, HC *'Kulinma; Listening to Aboriginal People.'* ANU Press, Canberra, 1978.

and the Minister for the Arts, Environment and Aboriginal Affairs, Peter Howson was more sympathetic to Country Party views, and those of the pastoral and mining industries than to Aboriginal people for which he had portfolio responsibilities. Thus the work of the Council was hampered. The transition from the previous era to the new was inevitably full of contradictions. The fact there was no Aboriginal presence on the Council illustrates this. Of course, the previous era had made it almost impossible for a sustained Aboriginal politic to develop. FCAATSI was the main national organisation representing Aboriginal interests, but was itself made up largely of non-Aboriginal people.

Thus the Council was established without any Aboriginal input, and whilst sympathetic to Aboriginal rights and development, continued to operate within the established colonial relationship.

There was a shift from the policies of assimilation to one of integration with Prime Minister McMahon defining 'Integration' in 1971 as:

*'a desire to ensure that Aborigines generally had equal opportunity in Australian society and that they would be encouraged to take pride in their identity, traditions and culture.'*

McMahon's intention was to 'encourage' Aborigines' capacity to manage their own affairs'<sup>22</sup>. In 1972, McMahon described the government's general policies in terms that showed a desire to ensure Aborigines genuinely had equal opportunities in Australian society, and encouraging them *'to maintain and take pride in their identity, traditions and culture'*. The government's program was to:

1. encourage and increase Aborigines' capacity to manage their own affairs;
2. increase economic independence;
3. reduce existing social and other handicaps in health, housing, education and vocational training; and
4. eliminate discriminating legislation and promote civil liberties<sup>23</sup>.

In his long policy statement he talked about 'general purpose leases', but not a legal right to land. However, there was little support for ensuring equal opportunity in his government.

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<sup>22</sup> Heppell, M *'A Black Reality. Aboriginal Camps and Housing in Remote Australia.'* Australian Institute of Aboriginal Studies, Canberra, 1979, p17.

Indeed the contradiction between the stated intent and the lack of recognition of the centrality of land to Aboriginal people meant it had little chance of success.

The Australian Labour Party policy of self-determination was first articulated at its national conference in Launceston in 1971, and included support for land rights and the aim to house all Aboriginal families in 10 years<sup>24</sup>. Whilst some senior ALP members had close relationships with Aboriginal people through their involvement with organisations like FCAATSI (eg Gordon Bryant), no Aboriginal people were part of the conference. However, this policy had the potential to break from the past with the possibility of government support for Aboriginal people to determine their own destiny.

## **THE GROWING SOCIAL MOVEMENT**

The late 60s and early 70s was a time for change. The post war years had produced a prolonged economic boom. The post war generation (the baby boomers) had high expectations of life. Gone were their parents' insecurities built on war and economic depression. The Vietnam War had politicised many young people, and there was a greater awareness of issues of social justice. The media had brought the horrors of the Vietnam War into the lounge rooms. But they also brought the plight of many Aboriginal people into the lounge rooms. They challenged our sense of national pride - were we barbarians too? Aboriginal people, whilst being part of the anti-Apartheid demonstrations culminating in the anti-Springbok Tour campaign of 1971, were loudly critical of non-Aboriginal people who were so outraged by what was happening in South Africa, but not doing anything about the condition of Aboriginal Australia. The Aboriginal Tent Embassy was established by Aboriginal activists in early 1972 on the lawns opposite Parliament House as a political protest at the continued discrimination and lack of government action on Aboriginal rights, particularly land rights. When Commonwealth Police were instructed to remove it six months later, there was further outrage from the media and sections of the public. There was also a growing women's rights movement.

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<sup>23</sup> DAA, 1974 , *op. cit.*, p5-6.

<sup>24</sup> Heppell, M , *op. cit.*, p19-20.

State governments, who had been responsible for Aboriginal affairs, were universally seen in the Aboriginal rights movement as a barrier to Aboriginal advancement. It was predominantly the State administrations that had presided over the dispossession of Aboriginal people, including the practice of taking the children away. In fact, the Commonwealth had been part of these policies. However, there was a specific focus on the need for the Commonwealth to assert its authority over the States in Aboriginal affairs.

So a better deal for Aboriginal Australia became part of the broad movement for change. The issue of Aboriginal rights was to be part of the tapestry of the 1972 election with the ALP, led by Gough Whitlam, embracing the rights of Aboriginal Australians.

### **THE ERA OF SELF-DETERMINATION**

The Whitlam Labour Government was elected in December 1972, and was the first Labour Government federally for 23 years. The Department of Aboriginal Affairs (DAA) was established almost immediately<sup>25-26</sup>. DAA effectively replaced the Council for Aboriginal Affairs. The National Aboriginal Consultative Committee (NACC) was established in 1973 with the Committee's first elections held in November, '73. However the Committee was never given any real authority, and was limited to an advisory role. Thus the potential that the ALP policy of self-determination had to break from the colonial relationship was limited by the inability to accept an Aboriginal authority to represent and act for Aboriginal Australians.

However, the election of the Whitlam government gave great hope to Aboriginal people and provided opportunities for a fundamental change in direction of Aboriginal policy. For the first time an elected government had explicitly included support for land rights and other reforms in their electoral platform. The policy and programs of the Commonwealth Government in 1973 were intended to<sup>27</sup>:

1. encourage and strengthen the capacity of Aboriginal people to manage their own affairs;

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<sup>25</sup> Pittock, AB, *op. cit.*, p27.

<sup>26</sup> Rowley, CD *'Recovery. The Politics of Aboriginal Reform.'* ANU Press, Canberra, 1986, p33.

<sup>27</sup> DAA NT Division *'Annual Report 1972-1973.'* AGPS, Canberra, 1975, pp5-6.

2. increase their economic independence;
3. reduce their handicaps in health, housing, education and vocational training; and
4. promote their enjoyment of civil liberties and remove remaining laws discriminative against them.

Indeed, apart from the explicit support for land rights, the ALP platform was not dissimilar to the previous McMahon government's approach, but it was given more administrative capacity and focus.

Activities and programs of this period included:

1. The Woodward Commission was announced in December 1972 to investigate Aboriginal land rights;
2. Extension of Aboriginal Secondary Grants Scheme for all Aboriginal children rather than only those above statutory school leaving age;
3. Extension of the role of Aboriginal housing associations;
4. Introduction of preventative health programs;
5. Establishment of Aboriginal legal services for legal advice and representation;
6. Establishment of the NACC;
7. Implementation of recommendations of the Gibb Committee<sup>28</sup>.

Aborigines living in communities or reserves in remote areas became eligible for Unemployment Benefits in April 1973. This was a move away from the Government being directly responsible for Aborigines on reserves, and the encouragement of employment<sup>29,30</sup>. However, the impact of this was mixed. Rather than such payments acting as a safety net for a minority not able to find employment or engage in independent economic activity, for many Aboriginal communities social security payments became their main means of economic survival. In the NT such payments have become known as '*sit down money*'.

The Whitlam Government also did the groundwork for the Aboriginal Councils and Associations Act that was eventually passed by Parliament in 1976. This Act gave

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<sup>28</sup> *Ibid.*, pp5-6.

<sup>29</sup> *Ibid.*, pp12, 28.

<sup>30</sup> Tangentyere Council '*Tangentyere Annual Report 1984.*' Alice Springs, 1984, p2.

communities the opportunity to establish legally constituted Aboriginal Councils or other community organisations<sup>31</sup>.

#### NT Self Government

The NT Legislative Assembly was established in 1974, replacing the Legislative Council that was established in 1948. Members of the Legislative Assembly were elected for a term of 4 years, and elected one of their members as Speaker. Under the Transfer of Powers (Self-Government) Ordinance 1978, the word 'Minister' was inserted in lieu of 'Administrator' following self-government. On 1st July 1978, the NT (Self-Government) Act that is the NT constitution came into effect<sup>32</sup>. This remains the constitutional basis of the Northern Territory government that gives it powers short of that of a State. Since that time there has been a fairly constant conflict between Aboriginal organisation (including Aboriginal health services) and the NT Government. The NT Government has taken a fairly classic frontier colonial position in opposing Aboriginal land rights, and promoting increased non-Aboriginal settlement. This has led Aboriginal organisations to call for the Commonwealth to take responsibility for Aboriginal affairs and to fund Aboriginal programs directly through community organisations rather than through the NT Government.

On 11th November 1975 the Whitlam government was dismissed by the Governor-General John Kerr who appointed Malcolm Fraser acting Prime Minister. Fraser's Liberal - Country Party Coalition won the election on 13th December 1975<sup>33</sup>. For Aboriginal Affairs this meant that the slogan of self-determination of the Whitlam years was replaced with the slogan of self-management. It suggested the restriction of Aboriginal authority and capacity to management of the means rather than determination of the ends<sup>34</sup>. The Liberal-National Party policy was essentially that of self-management and self-sufficiency, land rights and additional funds.

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<sup>31</sup> Coombs, HC *'Aboriginal Autonomy: Issues and Strategies.'* Cambridge University Press, Cambridge, 1994, p173.

<sup>32</sup> McCorquodale, J *'An Annotated Bibliography.'*, in Hanks, Peter & Keon-Cohen, Bryan (Eds) *'Aborigines and the Law.'* George Allen and Unwin, Sydney, 1984, pp271, 283.

<sup>33</sup> Coombs, HC, 1983, *op. cit.*, pviii.

<sup>34</sup> Coombs, HC *'Aboriginal Australian 1967-1976. A Decade of Progress?'* Murdoch University, Perth, 1976.

Self-management meant that Aborigines would play a significant role<sup>35</sup> in setting the long term goals and objectives which the Government should pursue, the priorities for expenditure and in evaluating existing programmes and formulating new ones. However, the move away from a policy of self-determination reveals a continuing concern of the conservative parties that Aboriginal people should become part of Australia like other Australians. However, the impact of this policy change, given the difficulty that politicians and bureaucrats has with implementing policies of self-determination, was fairly subtle.

Self-sufficiency appeared to be a necessary prelude to self-management. Under self-sufficiency the government promised to '*demolish unnecessary bureaucratic barriers between Aborigines and the programmes intended to assist them towards self-management*'<sup>36</sup>. This does not appear to have been achieved and the influence and power of the bureaucracy have continued to play a major role in shaping Aboriginal programs and organisations. Indeed, after 1976, DAA became more stringent on Aboriginal organisations requiring funding. More accountability, budgeting, forward planning, performance indicators and the like were demanded. Aboriginal communities and organisations had to be incorporated so that they could be legally accountable and responsible for their actions<sup>37</sup>. This bureaucratic obsession with accountability, often meaningless in terms of program outcomes, has dogged Aboriginal programs since that time. Of course, it was and continues to be fuelled by anti-Aboriginal politicians who have put Aboriginal organisations and their funding and accountability requirements under the microscope through the processes of forums such as the Senate Estimates Committee, and also through the media playing to populist misconceptions.

Whilst Fraser and some of his Ministers of Aboriginal Affairs like Viner, Chaney and Baume took the view that it was '*never good enough for politicians and bureaucrats to impose on Aborigines their concept of what was best for them*'<sup>38</sup>, programs tended to reflect the priorities on the government's list, such as education programs, rather than ones

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<sup>35</sup> DAA 'Annual Report 1975-1976.' AGPS, 1976, pp5-7.

<sup>36</sup> Heppell, M, *op. cit.*, pp36-7.

<sup>37</sup> Heppell, M & Wigley, J 'Black Out in Alice: A History of the Establishment and Development of Town Camps in Alice Springs.' Development Studies Centre, Monograph No 26, ANU, Canberra, 1981, p172.

<sup>38</sup> Quoted in Heppell, M, *op. cit.*, p230.

set by Aboriginal organisations. The NACC recommendations to government included only 5 on education, but 26 on housing<sup>39</sup>. Again this difference between Aboriginal aspirations and that of Government reflect the continuation of a colonial relationship which shapes what programs are implemented and puts limits on the colonised's aspirations.

In September 1978 DAA became responsible for the coordination of all Commonwealth programs addressing Aboriginal needs.

On 5th March, 1983 the Australian Labor Party won the national election and Bob Hawke became Prime Minister<sup>40</sup>. The new government's Aboriginal policy<sup>41</sup> was one of consultation and self-determination, and included the Aboriginalisation of the public service where knowledge of Aboriginal culture and/or ability to communicate with Aboriginals was deemed desirable. All DAA positions were involved. Consultation took place between DAA and the major Aboriginal organisations within its portfolio: NAC, ADC, Australian Institute of Aboriginal Studies (AIAS) and Aboriginal Hostels, regarding major policy issues. The NAC powers were increased, with them being responsible for advising the Minister on long term goals and objectives, policy determination, and other aspects of decision making processes. Areas vital to Aboriginal advancement that were focused on included land rights, heritage protection, employment and training, education, health, cultural identity, public awareness, and legal aid. From March 1983 DAA re-organised with the development of major new policies and commitments.

In 1986 the Human Rights and Equal Opportunities Commission Act was passed by the Commonwealth Parliament.

In 1986 the responsibility DAA had for coordinating all Commonwealth programs addressing Aboriginal needs was extended with the government deciding to streamline the provision of advice it receives on all matters concerning Aboriginal people. Under the new coordination arrangements, DAA's role was to<sup>42</sup>:

- a) advise on the totality of needs of Aboriginals;
- b) develop strategies and programs to respond to those needs;

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<sup>39</sup> Heppell, M, *op. cit.*, p37.

<sup>40</sup> Watson, D 'The Story of Australia.' McPhee Gribble, Melbourne, 1984, p179.

<sup>41</sup> DAA 'Annual Report 1983-1984.' AGPS, Canberra, 1984, pp1, 2, 41, 42.

<sup>42</sup> DAA 'Annual Report 1986-1987.' AGPS, Canberra, 1987, p6.



- c) advise on priorities of all Commonwealth strategies and programs directed to meet those needs;
- d) analyse the results of these strategies and programs;
- e) assess the use of all Commonwealth administrative resources involved in the delivery of programs for Aboriginals.
- f) coordinate the policies of all portfolio organisations, in accordance with the Minister's priorities; and
- g) to liaise with States and territories on the development of programs requiring cooperation between the Commonwealth and States and Territories.

Thus, from the time of the disbanding of the NAC to the establishment of the ATSIC Board of Commissioners, the DAA bureaucracy was the main adviser to the Minister. Whilst some of these were Aboriginal people, they did not necessarily speak with authority from Aboriginal people. Of course, Aboriginal organisations lobbied the minister directly. In central Australia these organisations had formed the Combined Aboriginal Organisations (CAO) which enabled organisations to work together in their support for particular policies and program development.

In 1987 the government policy recognised that<sup>43</sup>:

*'... as a consequence of European settlement of Australia, the rights of the original owners and prior occupiers, the Aboriginal people, were disregarded. The original inhabitants were dispossessed and dispersed, their culture disrupted and threatened and, today, their descendants are the most disadvantaged people in Australian society:*

*- the average Aboriginal life expectancy at birth is 20 years less than that for other Australians:*

*- Aboriginal infant mortality, while improving, is still nearly three times that for non-Aboriginal Australians;*

*-32% of Aboriginal children aged 0-9, as against 1.6% of non-Aboriginal children, have some form of trachoma;*

*- Aboriginal unemployment is 6 times the national average;*

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<sup>43</sup> DAA, 1987, *op. cit.*, p1.

- *on average, Aboriginals earn only half the income of other Australians;*
- *a large proportion of Aboriginal families live in sub-standard housing or temporary shelter; and*
- *Aboriginal imprisonment rates are up to 20 times higher than those for other Australians’.*

The basis of Government policy was to maintain and support the cultural identity of Aboriginal people and to enhance their dignity and general well being. The long-term objective was to<sup>44</sup>:

*‘... achieve a situation of justice and equality where Aboriginals have sufficient economic and social independence to enjoy their rights as Australian citizens.*

*The Government believes that:*

- *Aboriginal culture should be recognised as an integral and distinctive part of Australia's cultural life and heritage; and*
- *Government and other services should be adapted and expanded as necessary and certain special benefits - not generally available to other citizens - should recognise Aboriginals' unique circumstances, their history and identity.’*

DAA was responsible for programs requiring arrangements between the Commonwealth and States and Territories. States had primary responsibility for providing health care, welfare and other services to the community at large, and received general revenue grants from the Commonwealth for this as well as special purpose funding. Aboriginal people were assumed to have access to these services. States also provided an extensive range of special services to Aboriginals. The Australian Aboriginal Affairs Council (AAAC) consisting of all Aboriginal Affairs ministers, federal, state and NT, was seen as an important mechanism for coordinating Commonwealth and State/ Territory effort in the appropriate development of infrastructure and services to Aboriginal communities<sup>45</sup>. However, it is difficult to see where such arrangements actually worked to the benefit of

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<sup>44</sup> DAA, 1987, *op. cit.*, p2.

<sup>45</sup> DAA, 1987, *op. cit.*, p21.

Aboriginal people. Despite high principled pronouncements and policies by both Commonwealth and state/ territory governments, implementation has at best been patchy and largely determined by mainstream agendas.

Successive governments from 1972 to 1996 had pursued what was essentially a policy of self-determination, although terms like self-management and self-sufficiency were commonly used by the Fraser Coalition Government. These governments also enjoyed, to a large extent, bipartisan support at least until the early 1990s when there were differences between the conservative parties and the ALP over issues such as the High Court's Mabo decision, and the need for a Treaty. Since the election of the Howard Government in 1996 and the rise of Hanson, bipartisanship in Aboriginal affairs has dissipated.

### ***Land Rights***

Land Rights have been a central concern of Aboriginal activists. This is consistent with the centrality of land to Aboriginal spiritual and cultural values. It is important to appreciate the fundamentally different way of viewing land from a European (and particularly colonialist) point of view and an Aboriginal point of view. Firstly, colonisers have no previous history or relationship with the land they are involved in colonising. Whilst attachment to land after a generation or so can be profound, it does not match the relationship that spans many thousands of years with particular sites intertwined with creation stories. Thus the dominant role of land in the colonial society is that of land as a commodity. We buy and sell it, we use it agriculturally and to graze stock or we mine it to extract minerals with a market value. On the other hand, Aboriginal people see themselves as custodians of particular tracts of land, which relate intimately to creation stories. They do not 'own' the land in a European sense. Thus it is closely related to their spirituality, their identity and well being. Of course there are also economic aspects in this relationship as land is the source of food, water and shelter, and these practical aspects of the land are also intertwined with creation stories. However, the Aboriginal struggle to maintain or regain relationship with land has inevitably involved interactions with the dominant society's understanding of land ownership which is enshrined in British and Australian law.

The Gove Case (Millirpum and Others vs Nabalco Pty Ltd and Commonwealth) was heard by Justice Blackburn of the NT Supreme Court in 1971. He decided against the recognition of Aborigines' prior ownership of this country stating that although Aborigines did have a system of land tenure it could not be recognised as legal title under Australian law. There was no unified Aboriginal political and legal system or authoritative representative with whom to negotiate a settlement and the terms of colonisation<sup>46</sup>. However, this did not stop the political struggle for the recognition of Aboriginal land rights.

The McMahon government established the Gibb Committee to inquire into the social and economic circumstances of Aborigines on pastoral properties throughout the NT; make recommendations on their social, economic and educational advancement; and to examine ways cattle station Aborigines might maintain some of their traditions as an ongoing part of the cultural diversity of Australian society. The Committee reported in 1971 that Aborigines employed on pastoral properties had declined over the period 1965-71. It recommended that, by agreement with a particular pastoralist, or by excision, an area of land be provided for the establishment of an Aboriginal community. The government was to assist Aborigines with basic services like water and housing, and other community services. Its recommendations attempted to provide for the creation of independent, economically viable communities; continuation of small Aboriginal groups associated with the pastoral industry, and to provide Aboriginal communities with land '*for limited village, economic and recreational purposes ...*'<sup>47</sup>. In 1973 the NT Division of the Department of Aboriginal Affairs (DAA) moved to implement the recommendations<sup>48</sup>.

As discussed above, Land Rights became part of the ALP platform, and were pursued by the Whitlam Government. Mr Justice Woodward was appointed Aboriginal Land Rights Commissioner in 1973 with the task of inquiring into how land rights might be achieved in the NT. In his first of two reports, Woodward recommended that a Northern and Central Land Council be established to present to him the views of Aboriginal people in the NT on their land rights. The Central Land Council was thus established in 1974<sup>49</sup>. Until Woodward there had been no recognition of Aboriginal land rights based on traditional

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<sup>46</sup> Peterson, N & Langton, M '*Aborigines, Land & Land Rights.*' AIAS, Canberra, 1983, p3.

<sup>47</sup> Heppell, M, *op. cit.*, pp18, 118, 183.

<sup>48</sup> DAA NT Division, 1975, *op. cit.*, p6.

ownership<sup>50:51:52:53</sup>. The 2nd Woodward Report was presented in 1974 and contained four crucial recommendations<sup>54:55:56</sup>:

1. Aboriginals to have title to reserves in perpetuity;
2. Right to claim unoccupied crown land, including town areas;
3. Aboriginal Land Commission to hear claims and make recommendations;
4. Aboriginal Land Fund to buy land in other parts of Australia.

A number of other bodies were established in 1974 with the aim of assisting Aboriginal people to overcome their disadvantage. These included<sup>57</sup>:

1. the Aboriginal Loans Commission Act 1974 established a statutory commission with power to advance loans to Aboriginal business enterprises and Aborigines for housing.
2. the Aboriginal Land Fund Act 1974 established another statutory commission with power to grant money to Aboriginal corporations and land trusts to buy land to be occupied by Aborigines.

Of course, paralleling these changes in Aboriginal Affairs was a hostile reaction by some. In 1973, the '*Rights for Territorians*' group in Katherine claimed that these changes involved '*discrimination against whites, and in particular whites in needy circumstances who do not receive the same monetary benefits as Aborigines or part-coloured people*'. They wanted a Royal Commission into the operations of DAA<sup>58</sup>.

In 1975 the Federal Parliament passed the Commonwealth Racial Discrimination Act. In the same year Whitlam's draft Land Rights Bill included provision for 'need-claims', that is, for town campers and others to claim a living area, not on the basis of traditional

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49 Central Land Council '*Annual Report 1983-1984.*' 1984, p9.

50 *Ibid.*

51 Rowley, CD, 1986, *op. cit.*, p50-1.

52 Heppell, M & Wigley, J, *op. cit.*, p91-2.

53 Land Rights News '*A Cultural History of Australia.*' Vol 2, No 6, January, 1988, p29.

54 Heppell, M & Wigley, J, *op. cit.*, p92.

55 Rowley, CD, 1986, , *op. cit.*, pp50-1

56 Land Rights News, 1988, *op. cit.*, p29.

57 Hanks, P, *op. cit.*, p25.

58 DAA NT Division, 1975, *op. cit.*, p17.

ownership, but on the basis of need<sup>59</sup>. It also made provision for an interim-Aboriginal Land Rights Commissioner, Mr Justice Ward, to hear 'needs' claims and recommend the granting of leases in perpetuity. Ward was encouraged to commence hearings despite the fact that the land rights legislation was not yet passed<sup>60</sup>.

The Aboriginal Land Rights (NT) Act 1976 provided recognition of Aboriginal land ownership to about 11,000 Aboriginal people<sup>61</sup>. However the provision for 'needs claims' for town campers and others had been removed by the Fraser Government from the original Act drafted by the Whitlam Government. Thus Land Councils could no longer represent them, and their applications for land had to be submitted to the NT Lands Board rather than to the Lands Commissioner. Claims based on 'need' were thus separated from those based on traditional ownership, and placed in the same category as any public application for land<sup>62</sup>. This reduced the capacity of dispossessed Aboriginal people who could not establish traditional links with available land under the Act to develop economic self-sufficiency, the stated intent of the Government.

The other significant legislation enacted in 1976 was the Aboriginal Councils and Associations Act 1976 that provided for the incorporation of Aboriginal community councils and Aboriginal associations<sup>63</sup>. Most Aboriginal health services are constituted under this Act.

The Federation of Land Councils was formed in September 1980 to give a national voice for Land Rights<sup>64</sup>. In 1981, the passing of the Pitjantjatjara Land Rights Act (SA) through the SA Parliament resulted in the Pitjantjatjara, Yangkunjatjara and Ngaanyatjarra peoples receiving title to 102,603 sq km of their land in the north west corner of South Australia<sup>65-66</sup>. The question of land rights in states other than the NT and SA was still largely unresolved.

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<sup>59</sup> Central Land Council, *op. cit.*, p9.

<sup>60</sup> Eames, G 'The Central Land Council: The Politics of Change.' In Peterson, N and Langton, M (Eds) 'Aborigines, Land and Land Rights.' AIAS, Canberra, 1983, p268.

<sup>61</sup> Land Rights News, 1988, *op. cit.*, p29.

<sup>62</sup> Heppell, M & Wigley, J, *op. cit.*, p93.

<sup>63</sup> Hanks, P, *op. cit.*, p25.

<sup>64</sup> Land Rights News, 1988, *op. cit.*, p29.

<sup>65</sup> *Ibid.*

<sup>66</sup> Aboriginaland Diary 1988, pNov 4.

In 1984 the Hawke government's discussion paper on their preferred model for national Aboriginal land rights was released. The model was advanced as a basis for discussion with Aboriginal groups, State and Territory governments, and other interest groups such as pastoral and mining interests<sup>67</sup>. At around the same time the NAC released its discussion paper on 'National Aboriginal Land Rights Legislation' prepared for the Aboriginal Land Rights Steering Committee by a panel of lawyers representing the Federation of Land Councils, the NLC, the NAC and the Minister for Aboriginal Affairs.

The Minister for Aboriginal Affairs, Clyde Holding, released a document setting down the Commonwealth's preferred approach to national land rights in 1985. Aboriginal people rejected this model and the government's proposed amendments to the NT Land Rights Act, which were intended to bring the existing legislation in line with the preferred model<sup>68</sup>. The basis for Aboriginal concern was that the proposed changes in the preferred model reduced the control Aboriginal traditional owners had over development (particularly mining) on their land, and that this limitation would be imposed on Aboriginal people in other States. Aboriginal relationships with Minister Holding and the Hawke government was at an all time low. The NAC had been scrapped by Holding in July 1985 and had not been replaced by another body. This illustrated that the NAC was an instrument of Government rather than an autonomous body and was unable to survive when the Government moved against it. The NAC had made criticisms that the government had caved in both to public opinion polls (which showed support for Aboriginal rights lagging) and to the anti-land rights lobby made up of miners, pastoralists and their political representatives in State Governments. Aboriginal activists were critical of the government for having failed to provide financial support through the DAA Public Awareness Fund to better inform public opinion and counter the propaganda from the anti-land rights lobby<sup>69</sup>.

State Governments, particularly the WA Burke Labour Government, were opposed to any national land rights legislation. In the end, proposed Commonwealth legislation for

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<sup>67</sup> DAA 'Annual Report 1984-1985.' AGPS, Canberra, 1985, p3.

<sup>68</sup> Land Rights News, 1988, *op. cit.*, p29.

national land rights was abandoned in March 1986<sup>70, 71</sup>. However changes were made to the 1976 Land Right (NT) Act. It removed the right of Aborigines to claim vacant crown land<sup>72</sup>.

In 1985 the NT Government issued '*Living Area Guidelines*' under which Aboriginal groups were able to apply for excisions which involved secure title to small community living areas on pastoral properties and public purpose land. The DAA was to fund essential services to excisions. The purpose of excisions was to assist Aboriginal people living in poor circumstances on pastoral properties, and others also living in poor circumstances (often as urban fringe dwellers) to return to properties where they have a traditional attachment or an historical association. The lack of title had meant that the DAA could not provide infrastructure support to these groups. Excisions involving clear title would enable the DAA to provide this support<sup>73</sup>. Between April '85 and June '87 sixteen Aboriginal groups in the NT had received title to excisions, and another 28 applications were being processed<sup>74</sup>.

### ***Social and Economic Conditions***

In 1977 the National Employment Strategy for Aboriginals (NESA) was introduced. It recognised the need to make special efforts on Aboriginal employment and was the joint responsibility of the Minister for Aboriginal Affairs and the Minister for Employment and Industrial Relations. NESA included<sup>75</sup>:

- ♦ Department of Employment and Industrial Relations (DEIR) training programs;
- ♦ Community Development Employment Program (CDEP) scheme which was formed in 1976-7 to enhance the ability of a community to take control of its own community development processes, including handling chronic unemployment.

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<sup>69</sup> Riley, R '*The Government that Wants to Turn Back the Clock.*' Land Rights News Vol 1, No 35, Sept 1985, p10.

<sup>70</sup> DAA, 1985, *op. cit.*, p18.

<sup>71</sup> DAA '*Annual Report 1985-1986.*' AGPS, Canberra, 1986, p64.

<sup>72</sup> Land Rights News '*Land Rights Saved ... At a Cost.*' Vol 2, No 1, Nov 1986, p1.

<sup>73</sup> DAA, 1987, *op. cit.*, p28.

<sup>74</sup> *Ibid.*, p4.

<sup>75</sup> DAA, 1985, *op. cit.*, pp41-3.



CDEP was introduced in 1977 in response to requests from Aboriginal communities for an alternative to the payment of Unemployment Benefits to individuals<sup>76</sup>;

- ♦ National Aboriginal Employment Development Committee (NAEDC) comprising members of Aboriginal communities, unions, private sector and government; and
- ♦ Employment in the Australian Public Service.

Housing had been a priority of Aboriginal activists and by the mid 1970s Housing Associations were a central feature of the government's Aboriginal housing policy<sup>77</sup>. The Aboriginal Development Commission (ADC) Act 1980 established a statutory commission to take over the functions of the Aboriginal Loans Commission and the Aboriginal Land Fund Commission<sup>78,79</sup>. The ADC was governed by a board of 10 Aboriginal Commissioners with the task of furthering the economic and social development of Aboriginal people, including the acquisition of land for Aboriginal communities and groups, lending money to Aborigines for housing and personal purposes and financing business enterprises<sup>80,81</sup>. Enterprise funding, a key component of assistance towards self-sufficiency was also transferred to the ADC. Homelands or out-stations were supported with grants for basic necessities especially safe water, shelter, communications, and transport. Community initiative and control were encouraged. Resource organisations under Aboriginal control were funded, especially those supporting out-stations. Land management, research, and Aboriginal broadcasting programs were also supported. The stated objective was to raise the health, and overall status of Aboriginals to that of the rest of the community. There was an emphasis on Aboriginal participation in policy and program development<sup>82</sup>. Whilst much of this attempted both to stimulate Aboriginal enterprise and to place the process under a degree of Aboriginal control, it was organised at a national level and had inevitable difficulties in taking account of the diversity of Aboriginal identity and circumstance.

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<sup>76</sup> DAA, 1987, *op. cit.*, p45.

<sup>77</sup> Heppell, M, *op. cit.*, p21.

<sup>78</sup> Hanks, P, *op. cit.*, p42.

<sup>79</sup> McCorquodale, J, *op. cit.*, p272.

<sup>80</sup> DAA 'Annual Report 1980-1981.' AGPS, Canberra, 1981, p1.

<sup>81</sup> ADC 'Annual Report 1985-1986.' AGPS, Canberra, 1987, pix, s.3.

<sup>82</sup> DAA, 1981, *op. cit.*, pp12-14, 27, 32.

The Aboriginal housing policy was directed to the provision of accommodation of a type, and at locations, which would enable Aboriginals to enjoy accepted standards of health and social wellbeing and to pursue a lifestyle of their choice. This was the same as the Whitlam government's approach. Government assistance to out-station groups was limited to the provision of essential needs: water, shelter, communication and transport. Policy was directed at the promotion of greater independence and self-sufficiency, where people could resume control of their own affairs. Support was provided for resource centres for out-stations, homeland centres and pastoral excursions, to provide bore drilling, shelter, transport, communication, stores, mechanical, and accountancy services.

Whilst the new era moved Aboriginal policy away from assimilation, it continued to effectively control what was possible through a new style of bureaucratic control which is not applied to other sections of the Australian population. One Government department (DAA) was responsible for almost all aspects of Aboriginal life, and no distinction was made between Indigenous Rights, such as land rights, and Human Rights, such as health, which all people should enjoy. This allowed mainstream departments to ignore the needs of Aboriginal communities.

In 1987 Aboriginal Affairs Minister Gerry Hand was keen to fix up infrastructure problems once and for all. He initiated the accelerated community development program where large amounts of funds were made available to be spent over a fairly short time frame to get housing and other community infrastructure in place. Particular communities were selected for this program. Around 70 out-stations and homeland groups were included. Criteria for funding were based on commitment and stability of residence, and funds were made available for basic shelter, communications and electricity<sup>83</sup>.

In May 1987, the House of Representatives Standing Committee on Aboriginal Affairs, which had conducted an inquiry into the needs of out-stations/ homeland centres since June 1985, tabled a unanimous report in Parliament. It defined homeland centres or out-stations as *'small decentralised communities of close kin established by the movement of Aboriginal people to land of social, cultural and economic significance to them'*. The Report identified

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<sup>83</sup> DAA, 1987, *op. cit.*, p102.

588 homeland centre communities in the NT, SA, WA and Queensland with a population of about 9,500, plus 111 pastoral excision communities in the NT with a population of about 3,900<sup>84</sup>. The Commonwealth's political support for the out-station or homeland movement is contrasted with State & Territory concerns about possible encroachment on development (especially mining and agricultural), and the pressure to provide infrastructure to a large number of places with small populations. Some DAA and Treasury officials no doubt shared these concerns. Certainly DAA officers in central Australia put enormous pressure on some dispersed communities, such as Utopia, to geographically centralise community resources such as the store, power generation, health service, community council services and the like. Further Canberra politicians were disinclined to fight for the resources required to mirror their rhetorical support for the out-station movement, so as to alleviate the real pressure DAA bureaucrats were under in terms of limited resources and expanding demands.

The Hawke Government was committed to help Aborigines gain education suited to their aspirations and needs which would provide them with opportunities to achieve an improved socio-economic position in society, and supported Aboriginal participation in planning, management and delivery of education services<sup>85</sup>. However, the application of this policy failed to establish appropriate education strategies, and continued to impose mainstream assumptions. Aboriginal controlled education bodies (such as the Institute of Aboriginal Development) were not funded at the same level as mainstream institutions that were less able to flexibly accommodate Aboriginal educational needs.

In 1986 Prime Minister Hawke announced the Aboriginal Employment Development Policy (AEDP) which replaced NESAs and was represented as a shift away from welfare dependency towards enhancing Aboriginal economic independence and long-term employment in the conventional labour market<sup>86</sup>.

The programs were aimed at<sup>87</sup>:

- ♦ ensuring Aboriginal people had fair access to jobs in the conventional labour market;

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<sup>84</sup> *Ibid.*, p76.

<sup>85</sup> DAA, 1984, *op. cit.*, pp34-35.

<sup>86</sup> DAA, 1987, *op. cit.*, p4.

- ♦ establishing and expanding the Aboriginal economic base especially in rural areas, so that Aboriginals could contribute to their own livelihood as an alternative to indefinite reliance on welfare payments; and
- ♦ improving educational and training opportunities for Aboriginal people.

CDEP projects had begun in 1977 and were expanded in 1986 with an additional 23 communities taking up the program, making a total of 63 communities and involving some 12,500 Aboriginal workers and their dependents. Under these arrangements, communities received the aggregate notional value of unemployment benefits for which unemployed members would be eligible, plus a grant of up to 20% to cover costs of administration and materials<sup>88</sup>. However, this program did not overcome the basic problem of the lack of an economic base for most communities, and was criticised by some as offering meaningless work. However, it did provide some work activity for many people who would otherwise have little to do, and there is little doubt that CDEP remains popular in many communities.

It can be seen that there has been a surprising similarity in the intent of government policy from the 1970s. It is also the case that major changes have occurred with more Aboriginal people working in the Commonwealth and state public services, and many more Aboriginal people having access to housing. However, the poor state of Aboriginal health indicates that major problems remain. It is probable that government policies are impotent to create the changes in a society necessary for good health after such a long period of containment of Aboriginal initiative, at least in the short term. The massive depopulation of Aboriginal Australia has had significant impact which is not easily reversed. The impact of policies of forced settlement and control, and the taking of children away from families are difficult to reverse. The inability of government to allow Aboriginal control despite the policy pronouncements, and the lack of political will of politicians to allocate adequate resources further handicap programs in achieving their intent.

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87 *Ibid.*, pp44-45.

88 *Ibid.*, pp45-46.

### ***The Development of National Aboriginal Representative Bodies***

As the assimilation policy collapsed the Commonwealth sought to develop various Aboriginal representative bodies with which they could consult and be advised in order to give some meaning to the new policy of self-determination. Thus the expressions of the colonial relationship changed from one of direct state control of the Aboriginal population to one of allowing Aboriginal communities, and the broader Aboriginal politic some direct say in their affairs. Alas, old habits die hard.

The National Aboriginal Consultative Committee (NACC) was established in 1973 to advise the Minister directly on Aboriginal matters. It consisted of 41 national delegates<sup>89</sup>. The limitation of its role to advisory resulted, not surprisingly, in the NACC agitating for more significant powers, and eventually, in April, 1976, an *Inquiry into the Role of the NACC* was appointed by Minister Ian Viner with Dr LR Hiatt (an anthropologist) as chair. It reported to the government in November 1976, recommending that a National Aboriginal Congress be established with more than an advisory role. However, this was not implemented and instead the National Aboriginal Conference (NAC) was established in 1977, replacing the NACC. It consisted of 35 members. Instead of being a vehicle of direct Government-Aboriginal consultation, the NAC became a forum in which Aboriginal views could be expressed on goals and objectives that the Government should pursue and programs it should adopt in Aboriginal affairs<sup>90</sup>.

Aboriginal activists and government did not always agree on the roles of these bodies and there were ongoing tensions between the NAC and Government. These tensions resulted in the abolition of the NAC by Minister Clyde Holding in 1986. This is an example of the clash between the needs of Government to corporatise the Aboriginal politic so that they can have a representative body to negotiate or consult with and legitimise their decisions, versus the Aboriginal agenda which has tended to be based on advocacy and lobbying for the needs of communities. There is a tension between the Government recognising these bodies but expecting them to endorse their policy directions, and how these bodies see their role. These bodies also involve a tension between maintaining a meaningful dialogue with government and their legitimacy in the eyes of the Aboriginal community politic. This is particularly compounded by the complexities involved in the notion of a singular

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<sup>89</sup> Hanks, P, *op. cit.*, p38.

Aboriginal identity on which national bodies tend to be premised and the diversity of Aboriginal identities across the country. These tensions highlight the difficulty in changing from the old way where governments had absolute control to one where the policies were about Aboriginal people having control (self-determination) but the Government being unable or unwilling to relinquish control. Of course there are constitutional difficulties about powers vested in the Parliament which cannot easily be transferred to other bodies. Thus despite the policy of self-determination, the old colonial relationships have tended to continue.

#### Review of the NAC

In April 1984, the Coombs' report, commissioned by the Australian government on '*The Role of the National Aboriginal Conference*', was released<sup>91</sup>. It recommended that:

- a) the NAC was unsuitable for and ineffective as a national Aboriginal representative body;
- b) a new national Aboriginal organisation be established which:
  - (i) derived authority from, and was accountable to local groups and communities and their organisations;
  - (ii) integrated Aboriginal controlled organisations through which Aboriginal political initiative was already being significantly exercised;
  - (iii) had access to expertise for policy formation;
  - (iv) had significant responsibility for decisions about the total and the allocation of funding for expenditure on Aboriginal Affairs;
- c) an interim representative body based upon existing Aboriginal organisations be set up to act for Aborigines and to advise the Minister at the national level.

He also recommended that the NAC be terminated<sup>92</sup>.

The recommendations were significant because they recognised the need to localise or regionalise Aboriginal authority which was better able to take account of Aboriginal diversity, and the need to base such bodies on the existing expressions of Aboriginal self-

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<sup>90</sup> Hanks, P, *op. cit.*, p42.

<sup>91</sup> Coombs, HC '*The Role of the National Aboriginal Conference*' Report to the Hon Clyde Holding, Minister for Aboriginal Affairs. AGPS, Canberra, 1984, pp33-34.

<sup>92</sup> Coombs, HC, 1984, *op. cit.*, p103.

determination which had been largely developed outside the initiative of government legislation and policy, that is the Aboriginal community controlled organisations.

However, the government axed the NAC, but did not adopt the other recommendations in the Coombs' report<sup>93</sup>. The report was not received well in the bureaucracy and a joint NAC/ DAA Task Force was established to report on options. Ms Lois O'Donoghue was appointed in April 1985 to consult with Aboriginal communities and organisations and to advise the Minister on a new consultative structure to be based on Aboriginal communities and to draw representatives from existing Aboriginal organisations.

In June 1985 interim arrangements of the Government/ Aboriginal consultation were announced. The government was to continue to consult with Aboriginal portfolio organisations. National Aboriginal service organisations would join these portfolio meetings on matters specifically concerning them, and the government would seek advice from service organisations on specific issues. In the meantime Ms O'Donoghue was to continue her consultations on the development of a new national Aboriginal consultative organisation<sup>94</sup>.

In October, 1986 Lois O'Donoghue presented her report, '*An Aboriginal and Islander Consultative Organisation*', to the Minister. It recommended a staged development of a new organisation based on regional assemblies comprising representatives of local Aboriginal communities<sup>95</sup>. This proposal was to be eventually implemented with the establishment of the Aboriginal and Torres Strait Islander Commission (ATSIC).

### ***ATSIC***

In 1987 the Minister for Aboriginal Affairs, Gerry Hand, presented to the House of Representatives a document entitled '*Foundations for the Future*'. This set out a proposal for an Aboriginal Affairs commission, to be known as the Aboriginal and Torres Strait Islander Commission, ATSIC. A consultation process was then embarked on to sell the concept to Aboriginal communities and organisations. Of course, ATSIC was to replace

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<sup>93</sup> DAA, 1986, *op. cit.*, p20.

<sup>94</sup> DAA, 1985, *op. cit.*, p14.

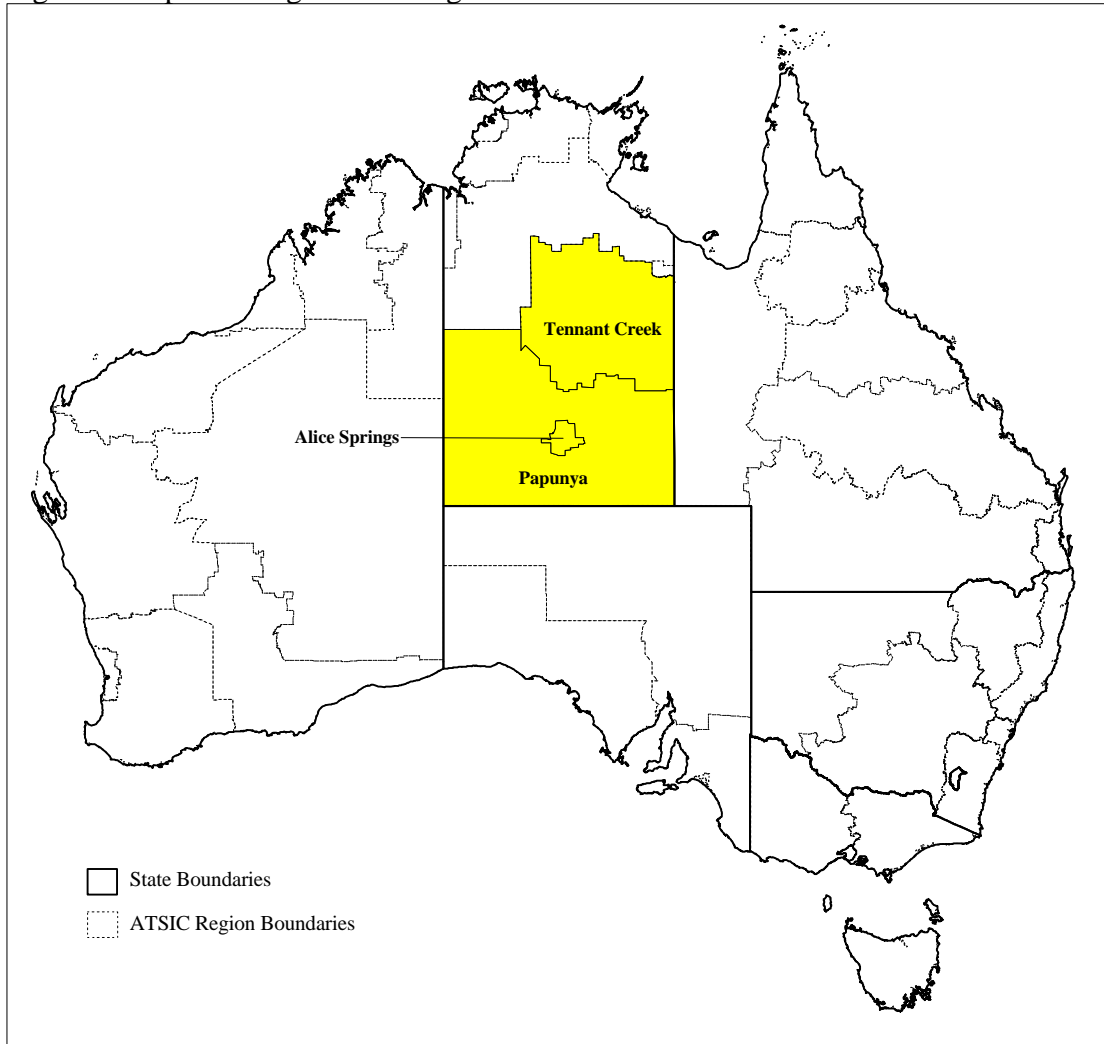
<sup>95</sup> DAA, 1987, *op. cit.*, p20.

the now defunct NAC as has been discussed above. But more than this, the Commissioners were to head the bureaucracy as well. Thus ATSIC would integrate the Aboriginal representative body with the bureaucracy, DAA.

The proposal divided the country up into a number of regions. A number of these regions formed a Zone. The map in Figure 1 shows the boundaries of the ATSIC Regions and Zones, with the Central Australian Zone highlighted. Each region had a regional council elected by Aboriginal people in each region. The regional councils in each zone elected a Zone Commissioner. As well, the Minister appointed the Chair of the Commission and two other Commissioners.



Figure 1 Map Showing ATSIC Regions.



Source: ATSIC, Canberra.

This electoral process resulted in Aboriginal leaders standing against each other. Inevitably factions developed in many Regions. In the first ATSIC elections the number of electors were very small in most regions, but this improved in subsequent polls.

Some Aboriginal leaders felt that ATSIC was a con in as much as it handed Aboriginal people the responsibility of making funding decisions but with inadequate funds to meet overwhelming community need. It let the politicians off the hook. Others felt it was an opportunity for Aboriginal people to take control of their affairs. Both points of view have validity.

Historically it has been common for colonial administrations to develop some way of dealing with indigenous populations. The nature of these populations has often been difficult for administrations, with each village or tribe having high levels of autonomy. This has been further complicated, particularly in Australia, by the complexity of indigenous responsibility and authority over particular areas of country or particular sites. There is not one person who can legitimately speak for all. In the past colonisers often anointed compliant individuals as 'kings' or 'queens'. This made negotiations simpler by having one person with whom colonial authorities could negotiate. Often a struggle for legitimacy would then occur, with the colonial authorities using their resources to bolster support for those they had anointed, and other tribal influences asserting their more traditional authorities within the tribe. Often communities became split between those who were resisting and those who were collaborating. The establishment of the Aboriginal and Torres Strait Islander Commission (ATSIC) can be understood as a modern form of this colonial tradition. It is a corporatisation of Aboriginal affairs which suits the imperatives of central governments.

However, ATSIC also offers important opportunities for Aboriginal self-determination at a national level. Indeed, as ATSIC has matured it has been more able to develop a degree of control over the bureaucracy that was never possible for the NAC. This is even though there was a very strong continuity between the old DAA bureaucracy and the new under ATSIC. Initially it was virtually the same structure and people. ATSIC Commissioners did not gain control over the hiring and firing of staff, but over time the influence of Regional Councils and the Board of Commissioners has shaped the bureaucracy to some extent in line with Aboriginal priorities and aspirations.

However, contradictions remain. In Chapter 2, the constructs of Aboriginality were discussed. Pan-Aboriginalism has been an important development for the achievement of land rights and other indigenous rights. The development of a national voice for Aboriginal people through which negotiations can occur with the Commonwealth Government have proved problematic, though critical. ATSIC is the latest form of attempts to develop such a body. ATSIC is part of the expression of a national self-determination. However, self-determination must also operate at a local level. This is particularly important for the attainment of the conditions for better health. The actual day to day needs of Aboriginal

people in their communities require local organisations that can deliver services in a way which suits the living circumstances, their beliefs systems, and their priorities. This is self-determination at the grass roots.

ATSIC has had to face a major difficulty. The documented needs of Aboriginal Australia in almost all areas are enormous, but the resources available to ATSIC are not sufficient to come anywhere near meeting those needs. Inevitably communities will continue to agitate for their housing, infrastructure, health and education needs to be met. Under DAA the Minister received much of this pressure. Now it is the elected Aboriginal representatives. Part of the strategy that was being pursued by National Aboriginal Community Controlled Health Organisation (NACCHO) in calling for the responsibility for funding of Aboriginal health services to Commonwealth Health, was to gain access to the mainstream health funding rather than to continue having to compete with other legitimate community needs. The media tended to portray this as sacrificing self-determination in order to improve health. This is a superficial understanding of self-determination and tends to assume that self-determination can be delivered through a statutory body. Anderson<sup>96</sup> comments on this in response to an *Age* editorial<sup>97</sup>:

*‘There are two key problems with this understanding. First, the application of the principle of self-determination is limited to a statutory body, whereas self-determination is typically understood as a more general principle of action of Aboriginal people and their communities, especially in relation to non-Aboriginal institutions and society. Quite contrary to this, the Age implies that in seeking to have funding transferred out of ATSIC, Aboriginal health services actively undermined Aboriginal self-determination to achieve a better deal for themselves. Were this true, the Aboriginal health movement would have dispensed with one of its central tenets. Second, the kind of view put by the Age implies that improvements in Aboriginal health can be realised in isolation from processes of self-determination. Again, this narrow understanding of self-determination conflicts with the widely held view in Aboriginal health that Aboriginal empowerment is fundamental to achieving improvements in health status.’*

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<sup>96</sup> Anderson, I ‘*Powers of Health.*’ *Arena Magazine*, June-July ’94, p33.

<sup>97</sup> The *Age* ‘*Black Health Crisis.*’ 4<sup>th</sup> November ’94.

Thus self-determination is a phenomenon that is rooted in Aboriginal family and community agency. This level of self-determination is fundamental to improving health status. On the other hand ATSIC represent another level of self-determination – that of a national level process that is critical to a range of indigenous rights, including land rights, and to the development of appropriate Government policy and programs. But these roles are also dependent on active and conscious actions at the community level, and it is this that the Regional Councils and Commissioners struggle to represent.

### ***Aboriginal Resistance Continues***

Throughout this period Aboriginal resistance has continued. Various struggles between Aboriginal people and mining companies have occurred. A prominent example was in 1980 when the Yungnogora people in WA fought to stop the Amax mining company drilling on their land and sacred sites. The WA Government, under Premier Charles Court, gave police protection to an Amax convoy escorting the oil-drilling rig to Noonkenbah. Aboriginal people and their supporters (including trade unionists and church people) from all over the country protested, but the drilling went ahead<sup>98</sup>. The Commonwealth did not intervene.

From this it can be seen that there was some attempt made to turn around some of the underlying problems for Aboriginal people which not only relate to their poverty and marginalisation from the mainstream but also underlie their poor health status. It was recognised that land issues, economic developments, and education strategies were needed if the policy of self-determination was to have meaning. However there continued to be an inadequate funding allocation to achieve what was necessary, and the practice of both politicians and bureaucrats fell short of the policy rhetoric. For politicians and bureaucrats, as well as for the public at large, there is a significant gap between being able to espouse new policy directions and to incorporate changes in understanding and attitude necessary for their implementation. The old colonial relationships persist.

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<sup>98</sup> Land Rights News, 1988, *op. cit.*, p29.

### *Aboriginal Deaths in Custody*

In 1987 the Committee to Defend Black Rights focused public attention on Aboriginals who have died in custody. DAA and the Australian Institute of Criminology collected details of 35 Aboriginal people who had died in police or prison custody since 1980. The Committee to Defend Black Rights was given a grant by DAA to prepare evidence in support of its call for a Royal Commission into deaths in custody. In April of that same year the Minister for Aboriginal Affairs asked a House of Representatives Standing Committee on Aboriginal Affairs to inquire into the interaction between Aboriginals and the criminal justice system. Terms of reference include Aboriginals' knowledge of the law, Aboriginal-police relations, treatment of Aboriginals in prisons and preventive and rehabilitation measures. In June the work of the committee lapsed with the end of session of Parliament. The Human Rights and Equal Opportunity Commission took up the inquiry<sup>99</sup>. In August 1987 the Minister announced the establishment of the Royal Commission into Aboriginal Deaths in Custody since 1980. A total of 44 deaths were to be investigated. By January 1988 the number of deaths to be investigated had risen to 98<sup>100</sup>. By April of that year the number had grown further to 106.

David Biles, Deputy Director of the Australian Institute of Criminology, and the Commission's chief researcher, stressed concern that these deaths come from only 1.3 % of the Australian population, that more than half the deaths occurred in police custody with the rest in prison custody, and that many of the Aborigines who died in custody had been detained for minor offences<sup>101</sup>.

Thus the Royal Commission grew. It found that the rate of deaths of Aboriginal people in custody was actually no higher than that of non-Aboriginal people, but that Aboriginal people were seriously over represented in the prison population. Special Issues Units were established to investigate the underlying issues effecting this over-representation. The recommendations of the Commission cover a wide range of issues, and remain the most comprehensive overview of the situation in Aboriginal Australia, and what needs to be done.

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<sup>99</sup> DAA, 1987, *op. cit.*, p68.

<sup>100</sup> The Age, 29<sup>th</sup> January, 1988, p5.

<sup>101</sup> The Age, 12<sup>th</sup> April, 1988, p5.

## *The Bicentennial*

In 1988 non-Aboriginal Australia celebrated 200 years of colonisation, whilst Aboriginal Australia organised separate celebrations focusing on their survival.

The August '88 sittings of Parliament began with an historical resolution to recognise the prior occupation of Aborigines in Australia. The heads of Australia's 14 churches proposed the resolution. It failed to win bipartisan support, but was passed by a Government majority in the House of Representatives and the Senate<sup>102</sup>. (Age 24-8-88:3) The resolution had had bipartisan support until 10th August or after, when the opposition insisted on an amendment to one clause that affirmed 'entitlement of Aborigines and Torres Strait Islanders to self-management and self-determination, subject to the Constitution and the laws of the Commonwealth of Australia'. The opposition wished to insert the words '*in common with all other Australians*' after self-determination. Churches and the government rejected this amendment. It was defeated in both chambers.

In June 1988, at the Burunga Festival, Prime Minister Bob Hawke and Minister for Aboriginal Affairs Gerry Hand, were presented with the *Burunga Statement*. The statement was drawn up from the National Federations of Land Councils' policy, and the UN's Draft Declaration on Indigenous Rights. In response, Hawke gave five undertakings:

1. to negotiate a treaty with Aboriginal people;
2. that Aborigines would be able to decide what they believed should be in it;
3. that Aborigines would be given necessary support to carry out consultations and negotiations, which could include the formation of a committee of 7 senior Aborigines to oversee the process and call a national meeting;
4. that the Government would negotiate the proposals;
5. to aim to commence negotiations before the end of 1988, and agree on Treaty before the end of the current Parliament.

The Burunga Statement was signed by Wenten Rubuntja, Galarrwuy Yunupingu, Bob Hawke and Gerry Hand on 12<sup>th</sup> June, 1988.

However, bipartisan support for a Treaty was not forthcoming. There were suggestions that instead of a treaty a compact would be developed. This was also not forthcoming. This

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<sup>102</sup> The Age, 24<sup>th</sup> August, 1988, p3, and 27<sup>th</sup> August, 1988, p27.

clearly portrays the lack of political will that has tended to mark government policy in Aboriginal affairs. The policies of successive governments since the early 1970s have been noble and well intended. However, success has depended on both the allocation of adequate resources, and the political will to tackle difficult issues that operate as barriers to implementation. Politicians have not delivered either. This is best understood as another example of the continued operation of the colonial relationship.

In the end, the Government adopted a process of Reconciliation. A Council of Reconciliation was appointed, and proceeded to develop materials for both Aboriginal and non-Aboriginal Australians under a slogan of '*Walking Together*'.

The vision of the Council was<sup>103</sup>:

*'A united Australia which respects this land of ours, values the Aboriginal and Torres Strait Islander heritage, and provides justice and equity for all.'*

The Council was formed in 1991 with the unanimous support of the Federal Parliament. In pursuit of the reconciliation process, the Council has focused on community education and awareness raising. It has encouraged local community projects between Aboriginal and non-Aboriginal Australians. Key areas of effort for the Council have been<sup>104</sup>:

1. Understanding country;
2. Improving relationships;
3. Valuing cultures;
4. Sharing histories;
5. Addressing disadvantage;
6. Responding to custody levels;
7. Agreeing on a document;
8. Controlling destinies.

Since the election of the Howard Government in March 1996, there has been pressure on this process. It appears that, at best, the government is suspicious of the previous government's appointees, and has been equally suspicious of the agenda. However, the

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<sup>103</sup> Council For Aboriginal Reconciliation '*Walking Together: The First Steps – Report of the Council for Aboriginal Reconciliation to Federal Parliament 1991-1994.*' AGPS, Canberra, 1994, piii.

government has maintained some support to the Council and have appointed a new Chair of the Council, Ms Evelyn Scott to replace Pat Dodson who stood down amongst a good deal of public controversy.

It remains to be seen how this Council performs in the new political environment involving the government's apparent lack of sensitivity to the traumas of the practice of taking children from their families, and the intent to give priority to pastoralists' security of land tenure above that of indigenous people. However, some of the most significant and pervasive issues impacting on Aboriginal health relate to the histories of the colonial relationship, and how that has and is being dealt with. The high rates of incarceration in institutions, suicide rates, domestic and other violence in communities, and the high rates on mental illness are the products of these colonial histories. A process of reconstruction is imperative if these sorts of issues are to be overcome. This process requires, at its centre, an acknowledgment by non-Aboriginal Australia that these histories occurred, that they were ill conceived, and that they were very damaging to Aboriginal people who continue to be affected today. An apology by governments wouldn't hurt either. Potentially the work of the Council of Reconciliation could play a pivotal role in Australian society in achieving reconstruction.

### ***Mabo***

The other momentous event in Aboriginal affairs in recent history has been the High Court's decision in what has become widely known as the Mabo case. Eddie Mabo, along with two other claimants from Murray Island in North Queensland (David Passi and James Rice) instituted proceedings against the Queensland government in the High Court in 1982. They claimed legal ownership of the islands asserting that the Meriam people had owned and occupied these islands since time immemorial<sup>105</sup>. The High Court found in favour of the Meriam people on the grounds that:

1. Native Title existed in Common Law;
2. The basis of this title was traditional connection to or occupation of the specified land;

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<sup>104</sup> Council For Aboriginal Reconciliation, *op. cit.*, pxii.

<sup>105</sup> Bartlett, RH *'The Mabo Decision.'* Butterworths, Sydney, 1993, vi-vii.



3. The concept and content of native title was determined by the traditional practises of the native titleholders.

However, the Court also found that governments could extinguish Native Title by the exercise of their valid powers, provided it was explicitly done. Such extinguishment must also not be in breach of the 1975 Racial Discrimination Act.

In the wake of this decision there were many divergent reactions. Claims were made that the decision threw all existing titles into doubt. The mining and pastoral industry claimed it would put a halt to economic developments. Some conservative politicians claimed it put Australian back yards at risk. On the other hand Aboriginal people, churches and many others welcomed the decision as the beginning of dealing with the real history of this country, and that it was the basis of a socially just solution for dispossessed Aboriginal people. Of course, both positions are overstated. The decision certainly put into question the absolute rights of pastoralists over their land where Aboriginal people had some continuity of relationship. It also put mining companies into a position of needing to negotiate and accommodate Aboriginal interests in their exploration and mining ventures. It put some limits on the capacity of the State and territory governments to have absolute power over land issues. From the other perspective, many Aboriginal people cannot show continued relationship with country<sup>106</sup>. Many were forced from their country and relocated to other places. Some, indeed, are so removed and fractured from their roots, that they do not know their country or their families. Some Aboriginal people also pointed out the futility of land ownership if the social problems, and health status was so poor that people could not enjoy the benefits of their land. Clearly the issue is both complex and diverse.

Prime Minister Keating announced in October 1992 that the government would legislate a response to the Mabo decision. Rowse<sup>107</sup> provides an overview of the process that occurred in developing the Native Title Act. There was pressure to validate all existing titles issued since the passing of the Racial Discrimination Act of 1975. These titles were at risk because, in the light of the Mabo decision, they were in breach of this Act. Many Native

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<sup>106</sup> Pearson, N 'From Remnant Title to Social Justice.' In Goot, M & Rowse, T (Eds) *Make a Better Offer: The Politics of Mabo.* Pluto Press, Sydney, 1994, p179.

<sup>107</sup> Rowse, T 'How we got a Native Title Act.' In Goot, M & Rowse, T, *op. cit.*, pp111-132.

Title claims were made around the country. Whilst there was general agreement that many of these could not succeed given the detail of the Court's decision, it did cause some anxiety in some quarters. Five months of difficult negotiations were to take place before a final form was to be worked out. Aboriginal leaders, the mining and pastoral industries, and State/ Territory governments all organised and lobbied the Commonwealth about how the legislation might resolve the uncertainty surrounding land title. In 1993 400 Aboriginal people met at Eva Valley Station to discuss the issues and what positions would be taken. The resultant Eva Valley Statement included a reminder to the Commonwealth about its International Human Rights obligations, and demanded that Native Title should not be extinguished. Western Australia, which was perceived as having the most to 'lose', attempted unilateral action, but this failed. Keating cleverly orchestrated negotiations and eventually gained support from the Aboriginal negotiators, the National Farmers Federation and some of the premiers. He allowed the financial implications of large compensation pay-outs and lengthy litigation to work to reach a compromise. Conservative politicians were split. Many supported Aboriginal advancement, and saw the opportunity to lay the foundation for a new era in Aboriginal – non-Aboriginal relations. Others were hostile, and portrayed Native Title as giving Aboriginal people rights that other Australians did not have. In the end the Native Title Act was passed. One of the important issues to flow from this from an Aboriginal perspective is the recognition of dispossessed Aboriginal people through the establishment of a Land Acquisition Fund. The Council of Australian Governments' Statement on Mabo of June '93 included a section on '*the wider response to Mabo*'. This was tacit recognition of the fact that the Mabo decision itself did not allow resolution of the problems of dispossession and disadvantage for the majority of Aboriginal people. It raised a number of objectives<sup>108</sup>:

1. the establishment of a national land acquisition fund;
2. means of giving a greater indigenous stake in resource development;
3. transfer of secure title of reserves to Indigenous people;
4. recognising native title over unalienated Crown land;
5. transferring other areas of Crown land to Aboriginal and Torres Strait Islander people;
6. advancement of heritage protection laws; and
7. further consideration of the broader reconciliation process.

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<sup>108</sup> 'Council of Australian Government's Statement on Mabo', June 1993, In Goot, M & Rowse, T, *op.*

## **Wik**

The other significant High Court decision on this matter has become known as the Wik decision after the Wik people who put their claims to the High Court about coexistence of Native Title with Pastoral Leases. In fact this case also involved the Thayorre people whose claim overlapped the claim of the Wik people. The claim for Native Title was made in 1993, and involved an area of land that had been subjected to a number of pastoral leases over the years. However, none of these leases had been fully taken up, and the local people had occupied this country continuously. In December 1996 the Court ruled<sup>109</sup>:

1. that native title can only be extinguished by a written law or Act of Parliament involving a clear intent to extinguish;
2. that Pastoral leases are part of statutory law, not common law, and do not give exclusive possession;
3. that the grant of a lease does not extinguish native title rights, and that they could coexist; and
4. that if a conflict over the exercise of rights existed, that the pastoral lease holder's rights were dominant to native title holders rights.

Pastoralists and conservative politicians were outraged. They claimed this breached an agreement they had with the Keating Government that Pastoral leases would indeed extinguish Native Title. However, the reality in many parts of WA, NT and Queensland is that coexistence is a day to day reality. Of course, there are situations where there is serious hostility between Pastoral Leaseholders and the traditional owners. But coexistence is a common situation, especially if hunting and gathering activities of Aboriginal people are considered.

The Howard Government's response is encapsulated in the 10 Point Plan. I do not wish to go into the details of this plan here. However, the public perceptions have been that this plan removes some Aboriginal rights, whilst strengthening non-Aboriginal rights. The impact of this sort of debate is possibly more important as far as health matters are concerned than the detail of the legal situation.

The current debate around the High Court's discovery of Native Title in common law, the Wik decision asserting that Native Title can coexist with Pastoral Leases, and the Wik legislation based on Howard's 10 Point Plan, illustrate the continuing struggle that Aboriginal Australians must continue if the conditions for better health are to be achieved. It also highlights the contradictory policy stance of the Howard Government. On the one hand, the Coalition Government has asserted that it will put increased effort into Aboriginal health and education strategies. On the other hand it is prepared to affirm the dispossession of Aboriginal people through the Wik legislation. Reducing the strategies for better health to health services alone reduces Aboriginal people to patients/ clients of services. This implies a passivity which is contrasted with the community activity required for change – especially to the social and emotional well being issues which underlay the high young adult mortality rates.

So how does Wik, racism and the debate around the stolen generations impact on Aboriginal health<sup>109</sup>?

For some Aboriginal people continued access to their land has an economic component. Hunting and gathering continue across many parts of the continent and much of this occurs on pastoral leases. Restricting access by extinguishing Aboriginal people's common law rights will remove this part of an Aboriginal economy.

This will also impact on the nutrition of some people. Less access to land and the consequent reduced access to bush foods will push people into greater reliance on store food, which is nutritionally inferior to bush foods.

Land has a fundamental spiritual meaning for Aboriginal people. Restriction of access to sacred sites (whether formally registered or not) is likely to result in a worsening of health status through increased substance abuse and other destructive behaviours.

The first two points probably only directly affect a small proportion of Aboriginal people. Many have already lost most access with land so that the economic and nutritional advantages have also been lost. However, this is not the case in regard to spiritual issues as many people have maintained connection with place for these purposes. However, there is also the impact of the national debates involving the characterisation of a people already marginalised in this society, and this impact is generalised to the whole Aboriginal

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<sup>109</sup> Native Title & Land Rights Branch, ATSIC 'A Plain English Guide to the Wik Case.' Canberra, 1997.

population with the inevitable stereotyping. This impact is negative for many people and makes the issues of lack of self-esteem, identity and a vision for a better future more difficult. The attack on Aboriginal common law rights impact on the health of Aboriginal people who have no chance of directly benefiting from the High Court's decision because of their almost complete historical dispossession. The High Court's Mabo decision and the Keating Government's preparedness to accept that ruling and to commit to a process of reconciliation were a high for Aboriginal Australia. Despite the health problems, the poverty, and the dispossession of country for many that could not be reversed by either the Mabo or Wik decisions, there appeared to be a new found respect for Aboriginal people. Keating's Redfern Park Speech which acknowledged the terrible impact that colonisation had had on Aboriginal people was greeted with surprised joy. Recognition of injustice is the first step to rectifying it. Acknowledgment of pain and suffering is a prerequisite for reconstruction. This amounts to a lift in people's spirit and self esteem, a greater confidence in getting on to fulfil aspirations, and to make a better life. However, Prime Minister Howard's approach to Hanson, his insistence that nobody is racist, his attack on ATSIC in the first days of his Government, and his 10 Point Plan put the lid back on. There are reports of more overt abuse of Aboriginal people and Asian people since Hanson has been promoting her ill-informed racist views. There have been occasions when this abuse has turned to physical attack.

The impact of all of this on people's health, whilst hard to demonstrate epidemiologically, is none-the-less obvious. Oppression of people, the denial of human rights, is likely to cause people to metaphorically cringe – to remain unobtrusive for fear of attack. Young people see a more introspective, cautious community leadership. To be Aboriginal is to be abused, is to be seen as less than human. These factors are likely to result in more self-destructive behaviour. A mood of reconciliation has enabled a variety of programs across the country involving relationships that have previously not occurred, such as programs aimed at getting businesses to employ Aboriginal people. But we are now in a time when the highest elected office in the land denies that generalised stereotyping of a racial group is racist, and fails to assert leadership to ensure acceptance and respect of minority groups. It is a metaphor for pushing Aboriginal people back to the fringes of our society. If this is allowed to continue we can expect adult mortality to rise.

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<sup>110</sup> Bartlett, B '*Aboriginal Health.*' *New Doctor*, No 68, Summer 1998, pp23-26.

The next chapter examines the development of health services in the Northern Territory, and particularly central Australia.

## **CHAPTER 6 - DEVELOPMENT OF HEALTH SERVICES IN THE NORTHERN TERRITORY**

This chapter examines the development of health services in the Northern Territory. It is clear that initially health services were part of the processes of colonisation central to which was the dispossession of Aboriginal people. Thus health services were associated directly and indirectly with the eras of violent containment, protection, and assimilation. The chapter then examines the development of community controlled health services which were an expression of Aboriginal people's self-determination and represented a break with colonial services. Since then the current government services, a continuation of the colonial era, have been playing catch up, including attempts to redefine community control and self-determination, or attempting to draw containment lines around what community controlled health services should be doing.

### **COLONIAL HEALTH SERVICES – FOR WHOM?**

The establishment of colonial mainstream health services throughout the country has been premised on the needs and on the ways of living of non-Aboriginal settler society. Hospitals are located in towns. Doctors have tended to be private practitioners working from the towns. Home visits might be made to some of the closer farms/ stations, but the services are basically town-based. The GP doctor was part of the process of settlement that invariably involved dispossession. Other doctors, such as the District Medical Officers, were employed by the Government and involved in health administration and the delivery of services in places not serviced by private practitioners. It appears that many of the functions of these doctors was to protect the non-Aboriginal settlers from Aboriginal people - for example the use of police to bring in Aboriginal people for the treatment of sexually transmitted diseases. This was largely to protect the non-Aboriginal men (and their wives and children) from STDs that, of course, Aboriginal people had actually contracted initially from Europeans. Surveys also seemed to play a big part of the administration's 'health' activities. Indeed, the early nursing staff employed by the medical services in the Northern Territory were called Survey Sisters. A great deal of the effort of the Government system was public health activities involving the gathering of

data which were necessary for the system to construct an understanding of the health status of people, and what risks they might present.

Aboriginal health has been of limited concern to other Australians except in fairly isolated circumstances. One of the most remarkable things when looking at Aboriginal health policies over the past 20 years is that there has always been widespread agreement about what needs to be done, but an apparent inability of Governments to implement what they have agreed should be done.

One of the issues involved in this inability is related to assumptions made by the dominant society about the level of penetration of health services, and their nature. Health services are assumed to be 'good' - that is they are there to help people. These are the internalised values of our health care system. To challenge this fundamental assumption creates significant anxiety amongst those who have internalised such values, especially many health care professionals. However, much has been written which suggests that there are many situations where the health system has served interests other than those of individual sick people or the wider public.

Critical analyses that incorporate a political economy perspective<sup>1,2,3</sup> have shown how the medical profession has tended to serve the interests of the ruling elites (of which they tend to be a part) since early times. In more recent times, there has been some attempt made in medical schools, the literature and the medical colleges to address this issue in terms of a better understanding of the social issues impacting on 'patients' and how factors like poverty might influence the effective management of their illness.

The medical profession and other professional groups have tended to pursue their narrow interests, and to utilise resources allocated by governments to address these interests. For example, despite the obvious discrepancy in levels of educational support and wages for Aboriginal Health Workers, new resources available to Aboriginal health in the 1990s

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<sup>1</sup> Doyal, Lesley *'The Political Economy of Health.'* Pluto Press, London, 1979.

<sup>2</sup> Singer, M & Baer, H *'Critical Medical Anthropology.'* Critical Approaches in the Health Social Sciences Series, Baywood, New York, 1995.

<sup>3</sup> Gray, D & Siggers, S *'Aboriginal Health & Society: The Traditional & Contemporary Aboriginal Struggle for Better Health.'* Allen & Unwin, Sydney, 1991.



have tended to go to doctors. Salaries of doctors, partly due to the Rural Incentives Program (now known as Remote Health Workforce Agencies) have now pushed the salary of medical officer to remote communities to \$120,000 pa, plus other generous support for relocation and ongoing education. Further some services have been able to package salaries further improving their worth. Thus the gap between AHWs and medical officers has increased.

Philosophical positions incorporating the ethical principles about the sanctity of all human life, and the rights of all to have equitable access to health care, are relatively recent. But even in the context of this ethic, there is considerable evidence that the health care system (especially through its most powerful elite, the medical profession) has perpetuated systemic causes of ill health. For example there is well-documented evidence of medical complicity in the cover up of asbestos diseases, and in other environmental and workplace causes of cancer<sup>4</sup>.

Farley<sup>5</sup>, by focusing on Bilharzia, a tropical disease by which the colonialists were *not* troubled, shows that the main concern of health services in the colonies was to protect the health of armies and settlers so that the objectives of the mother colonial state could be achieved. These objectives had nought to do with the health of the indigenes.

It is evident that the promise of western medicine in the 20th century was and is selectively available to settler societies in the colonised world<sup>6</sup>. In other words the benefits of western medicine, as well as of the broader health care system, were not equitably available to colonised populations, but depended on the relationship of colonised to coloniser. Indigenous workers were more likely to receive medical advice and treatment than others, because they were of some use to the colonisers, and had an entry point to accessing the system.

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<sup>4</sup> Epstein, S *'The Politics of Cancer.'* Sierra Club, San Francisco, 1978, pp 83-100.

<sup>5</sup> Farley, J *'Bilharzia: A History of Imperial Tropical Medicine.'* Cambridge University Press, Cambridge, 1991.

<sup>6</sup> Denoon, D *'Temperate Medicine and Settler Capitalism: on the Reception of Western Medical Ideas.'* In Macleod, R & Lewis, M (Eds) *'Disease Medicine and Empire.'* Routledge, London, 1988, p121.

The development of Tropical Medicine was implicitly racist, but in Queensland it was explicit. The Australian Institute of Tropical Medicine in Townsville established in 1910 had an explicit agenda of promoting the health of whites in tropical area, and this was a significant focus of the Institute's work<sup>7</sup>.

Parry<sup>8</sup> has shown that the main attitudes driving the development of health services in the NT revolved around the need to protect settlers' health *from* Aboriginal people, not to provide health services *to* them.

Facilities were established through the agency of the Chief Medical Officer which isolated sick Aboriginal people from white settlers, but offered little in the way of medical treatment although they did incorporate a limited health care role. Surveillance of whole Aboriginal communities was developed, not with the idea of better understanding the health status of Aboriginal people so as to provide more appropriate services to them, but to identify leprosy, tuberculosis and venereal disease, which were seen as a threat to white settlers. Segregation was one of the main means used to protect the settler society. This segregation extended to the banning of Aboriginal people from the areas of white settlement, except for particular occasions.

Further, as Parry<sup>9</sup> states:

*'The exercise of this dominance and the inherent power forces at play were manifest in several ways, the most obvious of which was through legislation. To be Aboriginal and suffering particular diseases, notably venereal diseases, tuberculosis and leprosy, meant that white authorities had power over employment conditions, place & mode of living and the nature and length of treatment.'*

She goes on to explain that whites suffering similar diseases could legally be treated in the same way (ie forced segregation), but had more access to private medical advice, and were in a better position to constrain the behaviour of officials. Her example of the practice of treating Aboriginal and non-Aboriginal people differently was the outbreak of measles in the 1930s where the community as a whole was urged to keep their children at home. This

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<sup>7</sup> Denoon, D, *op. cit.*, p125.

<sup>8</sup> Parry, S 'Disease, Medicine and Settlement: The Role of Health and Medical Services of the Northern Territory 1911-1939.' PhD Thesis, University of Queensland, 1992.

<sup>9</sup> *Ibid.*, pp321-322.

was largely ignored amongst the white settlers, but Aboriginal people were forcibly kept confined at the Kahlin compound in Darwin.

In these early days the forced settlement of some sections of the Aboriginal population of the Northern Territory, coupled with the introduction of cattle (and sheep), resulted in a dramatic decline in the access and availability of traditional medicines - it was not just the bush tucker that cattle ate. This increased the dependency Aboriginal people had on the newcomers when they fell ill or were injured. Adding to this was the introduction of infectious diseases (influenza, measles, tuberculosis, syphilis and gonorrhoea) previously unknown which devastated many communities, disrupting their social relationships and their societal capacity to maintain their own health care system, and indeed other survival technologies and relationships.

Infectious diseases were a major part of life in Australia. In 1919 the troopship 'Sardinia' arrived in Sydney. It brought with it Spanish Influenza which killed 12,000 people<sup>10</sup>. This flu wiped out the bulk of the ageing and chronically undernourished Southern and Central Arrernte people, and also devastated Eastern Arrernte people<sup>11</sup>. It is possible that many thousands of Aborigines died. They would not have been counted in the figure of 12,000.

Western medicine was used in many colonial settings by colonialists to win the admiration and support of indigenous peoples. However, this occurred as part of a process of negotiation and constant struggle to gain legitimacy in the eyes of the colonised. In Australia, the influence of medicine in this way may have been somewhat lessened by resentments Aboriginal people had over the way it was implemented<sup>12</sup>.

Beck claims that the Commonwealth, when it assumed responsibility in 1911, attempted to establish a complete welfare and medical organisation for the Aboriginal population,

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<sup>10</sup> Clarke, CMH 'A History of Australia.' Melbourne University Press, Melbourne, Vol VI, pp113-114.

<sup>11</sup> Strehlow, TGH 'Songs of Central Australia.' Angus & Robertson, Sydney, 1971, p158-159.

<sup>12</sup> Nathan, P & Japanangka, DL 'Health Business.' Heinemann Educational Press, Melbourne, 1983.

which failed<sup>13</sup>. Beck's source is an article in the Australian Medical Journal by Cook, who was Chief Medical Officer and Chief Protector in the NT in the 1920s and 30s. Other sources (eg Parry<sup>14</sup>) would suggest that Beck overstated the intention. Prior to 1913, the medical officer was also the Protector of Aborigines, but confined medical activities to the north (Darwin), and there was virtually no health service available elsewhere in the NT<sup>15</sup>. The role of Protector of Aborigines was transferred to the police, and any health care was organised through them. Around 1913, medical chests were distributed to some non-Aboriginal people living in isolated areas, but these were not available to Aboriginal people, except through the benevolence of the non-Aboriginal holder. This is still the situation in some parts of central Australia, although the current Health Care Agents Subsidy Scheme assumes that these medicine kit holders will provide care to local Aboriginal populations, and the size of the subsidy is scaled according to the numbers of people in the vicinity.

Generally health services established for non-Aboriginal people were not available for Aboriginal people. The whites did not accept blacks in the hospitals, and in the NT special compounds were established for Aboriginal patients. However, these amounted to no more than a tin shed and were not staffed<sup>16</sup>. The doctor visited, but little ongoing treatment as offered to whites was available. In Darwin the Kahlin Compound, which was established in 1914, played this role, and in Alice Springs a hut separate to the hospital was established in 1934. Here Aboriginal people were treated. '*Half castes*' or people of '*mixed race*' were treated at the Bungalow and whites were treated at John Flynn's Australian Inland Mission (AIM) Hostel. Finally, a hospital was established in Alice Springs in 1939. Aborigines were still treated separately.

Around this time the popular white attitude was still that Aborigines were doomed to extinction. However, in 1929 Victorian Aboriginal activists began a campaign for employment, education and training, and the transfer of control over Aborigines from the

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<sup>13</sup> Beck, E *The Enigma of Aboriginal Health: Interaction Between Biological, Social and Economic Factors in Alice Springs Town Camps.* Australian Institute of Aboriginal Studies, Canberra, 1985, p11.

<sup>14</sup> Parry, S, *op. cit.*

<sup>15</sup> Nathan, P & Japanangka, DL, 1983 (1), *op. cit.*, pp25-27.

<sup>16</sup> Parry, S, *op. cit.*, p320.

states to the Commonwealth. They were emphatic that Aborigines were not doomed to extinction, and that the Commonwealth government should assume responsibility for Aborigines from the states, as they believed that the states had failed their responsibilities<sup>17</sup>.

In 1929, Bleakley reported on Aboriginal conditions in the NT. He found<sup>18</sup>:

- ♦ the Aboriginal population was 21,000 (8,000 *half-castes*, 14,000 *nomadic*).
- ♦ abuse and exploitation of Aborigines were rife;
- ♦ Aborigines' rights to hunt and use surface waters were denied in many pastoral areas;
- ♦ health and medical care were inadequate, and that relief provided for the aged, young and sick in camps was of a low standard;
- ♦ employment was generally without payment except the provision of rations and tobacco for the Aborigine employed and their dependants. They were treated unjustly and abused;
- ♦ accommodation provided for '*half-caste*' and orphan children in Darwin and Alice Springs was overcrowded and unhygienic; and
- ♦ subsidies paid to missions were insufficient and administrative staff were inadequate and ineffective.

He recommended that:

- ♦ Tribal land should be reserved, and that missions provide protective supervision on these reserves;
- ♦ finance be provided for training and care to assist people to attain a settled life and to be self-supporting;
- ♦ administration needed to be more effective;
- ♦ Aborigines be provided with fair employment conditions and remuneration;
- ♦ facilities for technical and domestic training be provided for '*half-castes*', and that they be provided with care and education;
- ♦ moral protection be provided for females;
- ♦ improved medical care and relief for the destitute be provided; and

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<sup>17</sup> Markus, A '*Blood from a Stone: William Cooper and the Australian Aborigines League.*' Allen & Unwin, Sydney, 1988, pp6, 27.

<sup>18</sup> Bleakley, JW '*The Aborigines of Australia.*' Jacaranda Press, Brisbane, 1961, pp241-242.

- ♦ special courts for tribal offences be established.

Cook, the Chief Medical Officer, was not particularly supportive of Bleakley. Cook did not support missions to deliver 'protection' to Aborigines, and he had had the responsibility for Aboriginal affairs as Chief Protector of Aborigines of which Bleakley was critical.

In 1928 the NT Medical Service was established with the Chief Medical Officer, Dr Cook, at its head. This was in response to the Bleakley report<sup>19</sup>. The first government medical officer in Alice Springs was appointed in 1929<sup>20</sup>. It is interesting to note that Bleakley's report advocated increased attention, including regular examination of Aboriginal people outside the main white settlements with the argument that this would be in the interest of white settlers as well as Aboriginal people. In practise the appointment of the medical officer, Dr Kirkwood, in Alice Springs did not make too much difference to Aboriginal groups, as the majority of his time was spent treating people in Alice Springs. Occasional visits were made to places like Hermannsburg, but most of the medical officer's time was spent caring for patients (mostly non-Aboriginal) in Alice Springs.

In the 1930s health care facilities in Alice Springs included a galvanised iron shed with four rooms and located around 2 miles out of the town. The Bungalow was under government control and housed around 180 *half-caste* children. When these children reached 14 years of age, they were sent to work on the cattle stations. TB, yaws and glaucoma were prevalent amongst Aborigines around Alice<sup>21</sup>.

In 1934 there was an outbreak of gonococcal conjunctivitis in and around Alice Springs. The response was to establish a medical hut for treating Aborigines. This was despite the existence, since 1915, of the AIM Hostel for the care of sick people. However, it did not admit Aborigines. The methods of attempting to control the outbreak of gonococcal conjunctivitis involved the proclamation of prohibited areas, compulsory examination of all Aboriginal people near stock routes, and the removal of all infected people, the arrest

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<sup>19</sup> Kettle, E 'Health Services in the Northern Territory - A History 1824 - 1970.' ANU North Australia Research Unit, Darwin, 1991, Vol 1, p93.

<sup>20</sup> *Ibid.*, p 213.

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<sup>21</sup> O'Grady, F '*Francis of Central Australia.*' Wentworth Books, Sydney, 1977, pp14, 19.

detention of infected Aboriginals under the Venereal Diseases Ordinance and the issue of prophylactic and therapeutic equipment for sale by storekeepers and others along the road<sup>22</sup>. This is a prime illustration of the association of police action and the denial of freedom, with the development of health services.

In 1935 the Little Flower Catholic Mission began working with the Tjuritja camp at the presbytery, and started a school for the children. Some '*full-bloods*' began attending and prompted complaints from the police, and threats to arrest McGarry who ran the mission. Alice Springs now had the Little Flower school, the Bungalow, and the town public school<sup>23</sup>. It was estimated that one third of 'blacks' at the Little Flower Mission showed signs of TB in 1939<sup>24</sup>.

The NT Aboriginal population was estimated as 17,730 in 1936<sup>25</sup>. Prior to 1949 few Aboriginal births in the NT were registered, but between 1949-55 some attempt was begun to record Aboriginal births on missions and government settlements<sup>26</sup>.

In 1939 the Aero Medical Service began operating from Alice Springs which provided some level of health care to people in remote locations. However access to this service was generally not available to Aborigines. In that same year a hospital was established in Alice Springs. It included a 'blacks' ward which was separate from the rest of the hospital<sup>27</sup>. The new Commonwealth Department of Native Welfare was established in 1939 with responsibilities covering hygiene, nursing services, nutrition, housing and environmental sanitation to those on settlements, pastoral leases and missions.

Responsibility for health services generally in the NT passed from the NT Administration to the Commonwealth Department of Health. However, the Native Affairs Branch was

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22 Nathan, P & Japanangka, DL, 1983 (1), *op. cit.*, p27.

23 O'Grady, F, *op. cit.*, pp21-27.

24 *Ibid.*, p60.

25 Foxcroft, EJB '*Australian Native Policy.*' Melbourne University Press, Melbourne, 1941, p139.

26 Welfare Division NT Administration '*Annual report 1971-1972.*' 1973, p72.

27 O'Grady, F, *op. cit.*, p66.



responsible for all aspects of Aboriginal affairs and established its first medical centres for Aborigines in 1939<sup>28</sup>, including medical treatment centres and holding beds.

Clearly, then, the provision of health services to Aboriginal people in the NT has involved measures that have denied Aboriginal people their liberty. Such measures were not imposed on the non-Aboriginal populations. Further, the roles of policing, welfare, and health care have been rolled into one. It is only in more recent decades that policing has been administratively quite separate. Welfare (often called community or family services these days) has retained a close administrative link with health.

As a way of understanding the political mood and attitudes of the day, it is worth remembering that 1928 was the year of the Coniston massacre in central Australia where a number of Aboriginal people were shot to death by police. The official figure was 31 people killed, but Pastor Albrecht estimated that the figure was over 100<sup>29</sup>. All of these killings were declared justifiable by the subsequent inquiries. The Warlpiri people remember this period as the 'killing times'<sup>30</sup>.

Parry<sup>31</sup> quotes Chief Medical Officer Cook from original records as follows:

*'The 'White Australia' Policy is the keynote of Australian nationalism. Medical opinion is agreed that there is no reason why the white race should not successfully settle tropical Australia, provided protection from endemic tropical disease is assured. The native, after decades of uncontrolled exposure to tropical disease, had become the natural host of endemic disease by which successful white settlement is gravely menaced, and it is manifestly impossible for the hygienist, with any pretence to bona fides, to undertake the safeguarding of the health of the white community and its future unless he has full powers over the native population, not only in regard to treatment for apparent ailment, but also in relation to hygiene, community life, migration and dispersion through the white community.'*<sup>32</sup>

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28 Welfare Division NT Administration, *op. cit.*

29 Kettle, E, Vol 1, *op. cit.*, pp2,13.

30 Cribbin, J *'The Killing Times: The Coniston Massacre 1928.'* Fontana, Sydney, 1984.

31 Parry, S, *op. cit.*, p337.

32 AAC, CRS A452/1, Item 52/451 Part 2, Cook to McEwen, 2 September, 1938.

This is perhaps the most explicit evidence that health services for Aboriginal people were actually being established to protect and advance the development of white settlement in the North. From an Aboriginal perspective, this clearly associates health services with the colonial apparatus that dispossessed people. Further, it follows logically the use of police and other means of coercion against Aboriginal people in regard to the control of disease. This is despite the fact that most of the diseases of concern were actually introduced by Europeans into Aboriginal society. The diseases of main concern to white settlement were tuberculosis, leprosy, malaria and venereal disease. Whilst there is some evidence that contact with the Macasans resulted in some cases of venereal disease and other diseases such as leprosy and malaria may have been present before white settlement, it certainly appears that many infectious diseases of concern did not become endemic in Aboriginal communities until after the arrival of whites. Yaws (which was sometimes mistaken for syphilis) was endemic, but this did not present a high risk to the colonisers<sup>33</sup>. It is, therefore, not surprising that many Aboriginal people avoided contact with health services, as contact was associated with arrest, detention, and separation from family and country.

During the Second World War, the military effectively took over administration of the Northern Territory, including the running of the hospitals in Alice Springs and Tennant Creek. After the War, assimilationist policies were articulated and adopted by both Commonwealth and state governments. The Commonwealth Department of Health assumed control of health services in the NT once the military had withdrawn. However, they asserted that they were not responsible for the provision of health services to Aboriginal people, and that they were only responsible for operating the hospitals in Darwin, Katherine, Tennant Creek and Alice Springs. Nor were they responsible for running the Aero Medical Service. The Department of Native Welfare began establishing nursing posts and small hospitals in Aboriginal settlements outside the centres of European settlement<sup>34</sup>. Thus, two health systems tended to develop - one controlled by the Health Department, and restricted to the main white settlements, and the other run by the Native Welfare Branch which employed nurses or subsidised the salaries of nurses

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<sup>33</sup> Both yaws and syphilis are caused by micro-organisms known as spirochaetes because of their corkscrew/ spiral shape. Aboriginal people enjoyed some cross-resistance to syphilis whilst Yaws was common. With the control of Yaws, cross-resistance waned, and syphilis has become common.

employed by missions. By 1968 there were 70 nursing sisters working in bush settings under non-medical supervision. There was no nursing administration in the NT until 1973<sup>35</sup>. The building of hospitals in many communities (for example, Papunya) some of which were never commissioned, is an example of both waste and inappropriate health service development.

Nutrition was of concern by some in the 1950s and before. Cook had been a pre-war critic of the quality of food provided by the missions, but it was probably not much different to that provided in the homes (such as the Bungalow) for which he was responsible. Cook never the less was an advocate for communal feeding on the settlements, which was also supported by Giesse, Director of Welfare. A nutrition survey conducted in 1951 had concluded that the rations provided to Aborigines were deficient in Vitamins C and A, and calcium. Communal kitchens were introduced on government settlements in the late 1950s, but there was little evidence that these provided sound nutrition. Missions resisted this trend, although Hermannsburg Mission did run a similar program. Communal kitchens on government settlements continued until 1973, when Aboriginal people became entitled to welfare payments (unemployment benefits and pensions). Stores became the source of much of people's food supply from then on<sup>36</sup>.

There was no private medicine in the Northern Territory until the early 1950s. Cook had banned private medicine and a free health service was maintained until the Liberal-Country Party Government introduced fees in the early 1950s. The first private pharmacies were opened in Alice Springs and Darwin in 1953<sup>37</sup>.

Whilst Ellen Kettle's account of the development of health services in the NT is full of detailed facts, they are very much from a non-Aboriginal perspective. There is no sense in her writings of Aboriginal people being involved in discussing their situation, in planning what they would do, or being in any sense active agents of their own destiny. They are simply in the background, featuring as passive recipients of limited programs.

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<sup>34</sup> Kettle, E *'Health Services in the Northern Territory - a History 1824-1970.'* ANU, Northern Australia Research Unit, Darwin, 1991, Vol 2, pp1-2.

<sup>35</sup> *Ibid.*, p129.

<sup>36</sup> *Ibid.*, pp129-130.

<sup>37</sup> Kettle, E, Vol 2, *op. cit.*, pp14-15.

In the 1950s and 1960s health service resources outside the main white settlements were scarce. Various medical officers visited Aboriginal communities on an intermittent basis, doing medical surveys and some public health work, notably tuberculosis screening, trachoma surveys, and introducing immunisation programs. As mentioned above, some of the nurses employed at this time were called Survey Sisters. Slowly some work was done developing birth registers, and nursing staff introduced child health programs. Epidemics tended to dominate the health service concerns. There had been a devastating measles epidemic in 1948-49 spreading from Oodnadatta into central Australia killing many people. In the early 1950s a poliomyelitis epidemic hit central Australia. Many people were left with varying degrees of paralysis and muscle wasting. In 1956 some immunisation programs against polio commenced. Tuberculosis was endemic in the 1950s and has continued to be an intermittent problem since then. Screening programs involving Mantoux testing and mobile Xrays were conducted.

A new section of the Alice Springs Hospital was completed in 1961. This became the Ward for white patients, and Aborigines were able to occupy the old wards. The previous 'Aboriginal ward' was used for people with tuberculosis<sup>38</sup>. The separation of patients on the basis of race was the common practise in the hospital, and reflected the practise of separating the races in the general community.

In 1973, the Department of Health took sole responsibility for the nursing services to Aboriginal communities that had previously been run by the Welfare Branch. Education and employment services were also taken over by relevant departments from the Welfare Branch<sup>39</sup>.

However, the health of Aborigines was also the concern of much of the political activity involving Aboriginal people themselves. In the late 1960s heightened Aboriginal activism began to focus more explicitly on their own health needs, and they managed to form alliances with non-Aboriginal health professionals. This activism prompted the health care system to approach Aboriginal health in a fundamentally different way.

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<sup>38</sup> *Ibid.*, p107.

## **A NEW ERA - ABORIGINAL COMMUNITY CONTROLLED HEALTH SERVICES.**

In 1971 a group of Aboriginal activists and non-Aboriginal supporters established the Redfern Aboriginal Medical Service. Concern about Aboriginal people's access to mainstream services which were racist, discriminatory and expensive were the motivating factors behind this development<sup>40</sup>. In Melbourne a similar group established the Victorian Aboriginal Health Service shortly after, and many Aboriginal communities followed these leads. Aboriginal Legal Services were established in this same period.

Black militancy, to some extent inspired by the Black Power movement in the USA (eg Black Panthers), was part of the drive to establish these Aboriginal controlled organisations. There was a link up with the militancy with grass roots community leaders who had been active resources for their communities. The story of Mum Shirl in Redfern is a celebrated example.

On a national level, by 1987 there were 54 Aboriginal community-controlled organisations providing health services, and receiving grants from the DAA totalling \$18.548m. These organisations had formed a peak body in the late 1970s known as the National Aboriginal and Islander Health Organisation (NAIHO). In 1986, the DAA ceased funding NAIHO due to an unsatisfactory audit report. However, the Minister did permit Aboriginal health services to pay a voluntary annual affiliation fee of up to \$3,000 each to NAIHO, so that an administratively restructured NAIHO could undertake national Aboriginal health projects on a contract basis as required<sup>41</sup>. The funding of the peak body, however, remained problematic. Catholic Relief funded the organisation for a year or so, but the crisis also involved dissension within the organisation, and eventually a new body evolved known as the National Aboriginal Community Controlled Health Organisation (NACCHO).

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<sup>39</sup> DAA NT Division 'Annual Report 1972-1973.' AGPS, Canberra, 1975, p1.

<sup>40</sup> Foley, G 'Aboriginal community controlled health services: A short history.' Aboriginal Health Information Bulletin, No 2, 1982, pp13-14.

<sup>41</sup> DAA 'Annual Report 1986-1987.' AGPS, Canberra, 1987, p60-61.

### *Community Control of Health Services*

Community control of health services has been advocated since the late 1960s. In the 1970s a number of groups of women in various centres, but most notably in Sydney (Leichhardt and Liverpool) organised to run their own women's health centres. A number of abortion clinics were also developed along the same lines. A workers' health centre that combined primary health care and occupational health programs was also developed in the industrial western Sydney suburbs. Similar groups were developed in Wollongong, Newcastle, Brisbane, Fremantle, Melbourne and Adelaide. However, preceding all of these developments was the development of Aboriginal community controlled health services.

In all of these situations there have been debates about the nature of community, how the 'community' is represented. From these 'extreme' developments, the public health community more generally has embraced the 'new public health' which has as a central tenet the notion of community control/ participation/ involvement in health service delivery.

In Alma Ata in 1978, the World Health Organisation (WHO) incorporated these principles into their declaration of Primary Health Care. This reflected developments around the world, and especially in some third world countries where community based primary health care programs were developed with little resources except the people of the community in which it developed.

Much of the literature about community control comes from urban and North American experiences<sup>42</sup>. Whilst this is of some interest, it has some obvious irrelevancies to the Aboriginal experience of community control. The most obvious reason relates to the difference between an indigenous people who have been subjugated by foreign invaders compared to people who are part of the dominant society, even if poor and powerless. Further most of these commentaries are by academics or health professionals, who rarely

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<sup>42</sup> Scimgeour, D 'Community Control of Aboriginal Health Services in the Northern Territory.' Menzies Occasional Papers, Darwin, Issue no 2/97, pp5-12.

give credence to the possibility that ordinary community activists might actually take control.

Indeed, in Australia it is true that Women's Health Centres and Workers' Health Centres<sup>43</sup> did involve 'progressive' professionals in their establishment, along with community and workplace activists who would fit Gramsci's notion of 'organic intellectuals'<sup>44</sup> – people who generally had a radical or revolutionary socialist analysis of society and were prepared to engage in new forms of social relationships. In the 1970s (when these services were established) governments established other community health centres, and indeed some were and are little more than extensions of the hospitals, and part of these institutions. In Sydney, feminists who were dissatisfied at the lack of women-friendly services established the Leichhardt and Liverpool Women's Health Centres. Indeed, it is probably fair to say that the development of Aboriginal community controlled health services was a major inspiration behind the development of both women's and workers' health centres.

The overseas commentators quoted by Scimgeour<sup>45</sup> are referring to community health initiatives which have more in common with the women's and workers' health centre positions in Australia at best, and the government controlled community health centres at worst, than the Aboriginal community controlled services. The theme of these commentators is that community control rarely leads to community empowerment, and indeed often led to the entrenchment of the power of professionals<sup>46</sup>. Scimgeour refers to O'Neil's analysis of the Quebec situation<sup>47</sup>:

*'... O'Neil also found that community participation rarely led to genuine empowerment, and more often led to an entrenchment of power of professionals and bureaucrats. He listed four common misconceptions about community participation.*

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43 Bartlett, B '21<sup>st</sup> Anniversary of Workers Health Centre.' Address delivered to meeting October, 1997.

44 Gramsci, A 'The Modern Prince & Other Writings.' International Publishers, New York, 1972, pp 118-123.

45 Scimgeour, D, *op. cit.*, pp6-9.

46 O'Neil, M 'Community Participation in Quebec's Health System: A Strategy to Curtail Community Empowerment.' *International Journal of Health Services*, Vol 22, No 2, 1992, pp287-301.

47 Scimgeour, D, *op. cit.*, p9.

*Firstly, the community as a whole does not participate; only certain individuals and groups do, and their “representativeness” can always be challenged. Secondly, participation does not usually occur spontaneously; it usually requires external motivation and support. Thirdly, participation can be cumbersome and time-consuming. Finally, citizens may not share values of progressive professionals who support participation.*

*‘He also listed elements that can ensure that community participation really means empowerment. Firstly, participating citizens need adequate information on the system in general and the actual operation of the agency. Secondly, they require a strong mandate from the users or the community. Thirdly, a strong personality is required. Finally, there must be mechanisms (such as community organisations) through which representatives can access easily their constituency.’*

In recent years some<sup>48</sup> in the Territory have used Scrimgeour’s paper to claim that community control does not exist in the bush, at least, and that it is the doctors, nurses, or administrators that are actually empowered. However, O’Neil’s commentary needs to be placed in a context. Quebec has been caught up in a political struggle involving that province’s francophone population. O’Neil points out:

*‘At a more macro-social level of analysis, however, the creation of CLSCs<sup>49</sup> was interpreted by some critical analysts as a subtle way for the government to tame and integrate into the mainstream of society a special brand of grassroots organisations which in urban settings (especially in poor neighbourhoods of Montreal and Quebec City), had begun at the end of the 1960s to self-organise various kinds of services, notably in the realm of health. Formal participation on the board of CLSCs is seen by these analysts as a way to curtail situations in which communities had created organisations over which they had total control, and as a more or less deliberate strategy by professionals and technocrats who had gained control over the state health apparatus through the reform to tame this threat to their newly acquired power.’*

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<sup>48</sup> Wakerman, J, Bennett, M, Healy, V, Warchivker, I ‘Review of Northern Territory Government Remote Health Services in Central Australia.’ Menzies School of Health Research, August, 1997, p176.

<sup>49</sup> CLSC is the abbreviation for ‘Centre local de services communautaires’.



These grassroots organisations were known as *People's Health Clinics* or *Cliniques Populaires*. By the end of the 1960s there were about 10 of these organisations across the province. They were totally controlled by citizens from the beginning, and professional power was minimal. They were initiated by what Gramsci called '*organic intellectuals*'. There are strong similarities between these People's Clinics and Aboriginal health services. Whilst health professionals were involved in the development of AMSs, their power was minimal. This issue of power wielded by health professionals, and especially doctors, has been an ongoing issue amongst Aboriginal health services. In the interactions that occur between professional staff employed by AMSs and those employed in the government sector, it is common for those in the government sector to assume that their colleagues employed in the AMSs have the degree of professional power that they enjoy in the government sector. It is as if it is beyond their imagination that community activists could possibly know what were the appropriate decisions because of their lack of professional knowledge. I have had occasion to explain to colleagues in THS decisions made by the management of Congress. In stressing that this was a decision of the Aboriginal Cabinet and management, they have responded by saying '*Yes, but you advise them.*' It is true that I was in that privileged position. But it is not the case that my advice was always accepted. Indeed, it was not always the case that my advice, in retrospect, was correct, although I invariably thought it to be at the time. What I came to appreciate was that the depth of knowledge and understanding of the community dynamics that these Aboriginal leaders had was information that I would never have. Thus my advice was always limited by medical and public health knowledge however I attempted to take into account community and cultural issues. The assumption that the Aboriginal leadership was subservient to my professional wisdom is a major error that has been frequently made. Further it is tinged with racism because it tends to imply that Aboriginal people cannot make such decisions. Thus if they do make a decision, it must be because their non-Aboriginal professional advisers advised that way. Some have suggested that there may also be a process of substituted racism involved in this. It is unacceptable to directly criticise or attack Aboriginal people, but the advisers to Aboriginal leaders are a safe target. Being in the position as a 'white adviser', I have been reluctant to make too much of this. However, aspects of this dynamic are relevant to the development of Aboriginal health professionals, including Aboriginal Health Workers. The difficulty that many non-Aboriginal health professionals have in raising issues and criticisms directly with

Aboriginal people results in a process of paternalism which actually further dis-empowers the Aboriginal people so treated.

#### Consumers and Practitioners

There has always been some degree of confusion in the debates around these developments about who are consumers and who are practitioners. After a period of time a consumer (ie a person without health professional qualifications) who takes on senior management responsibilities in a community controlled health service, does develop health skills and tends to cease to be simply a 'consumer'. In other words the process of consumers taking control of health services inevitably creates a new type of health professional – one that often lacks formal qualifications in the health industry, but who becomes highly qualified in the dynamics of community based primary health care.

The process of establishing a 'community' controlled service (Aboriginal and non-Aboriginal) has always involved threats to the existing service providers. Health Departments have been defensive, and private practitioners have felt that their livelihood might be threatened. All have felt the criticism of their practice implicit in the establishment of alternatives.

This conflict can be beneficial<sup>50</sup>. Everybody lifts their game and services can improve. In other words differences and some degree of conflict can have a creative influence. Certainly, in communities where health status is poor, complacency can be lethal. However, there is also a risk that conflict can become institutionalised – part of the stories institutions tell to those who enter their culture. This can perpetuate unproductive conflict at the expense of better-coordinated delivery of health care. I believe that this continues to be the situation within THS. Recognition of the historical continuities of the colonial relationships which are played out in these conflicts ought to assist health professionals to better manage conflict so that a more productive collaborative relationship can be developed to support Aboriginal people's action to improve health.

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<sup>50</sup> Pederson, AP et al '*Coordinating Healthy Public Policy: An Analytic Literature Review and Bibliography.*' Department of Behavioural Science, University of Toronto, 1988, p 38.

There is also some confusion about the notion of consumers of health services. People with chronic illnesses or women with large numbers of children may fairly readily identify themselves as such. However, most people do not. Early attempts at establishing consumer health organisations in Sydney attempted to include in their constitution that employees of health service providers could not be members of the organisation's executive. This resulted in the ludicrous situation that academic health professionals could be, but cleaners employed by the local hospital couldn't be.

Petersen and Lupton, citing Ife, warn<sup>51</sup>:

*'Participation often amounts to little more than tokenism, where affected people may be consulted to a limited extent but have no real power to affect decisions, and may even be coopted into the power structure that they set out to oppose. This is evident, for example, in those government-sponsored programs going by the name of "community development".'*

Women's health centres in Sydney were established by a mixture of 'organic intellectuals' some of whom were also health professionals. There is little doubt that the establishment of these organisations had a cutting edge impact on the way women's health care was practised. However, the actual model was not duplicated across the country.

Similarities exist with Workers' Health Centres. However, the interventions into workplace safety issues was potentially threatening to the stability of industrial relations. As a consequence of the increased publicity about workplace hazards, largely through the work of the Workers' Health Centre, a new form of legislation was introduced which placed greater emphasis on health and safety committees in workplaces to monitor hazards. At the national level, a tripartite structure, the National Occupational Health and Safety Commission (Worksafe Australia) was established with a Board made up of trade union leaders, employers, and government representatives. The Workers' Health Centre was offered financial support but on condition that it not be involved with workers' education. This was to be controlled by the NSW Trades and Labour Council. Thus the

activities of the Centre were contained in the interest of stability which was seen by sections of the Labour Movement as being in the interests of a Labour Government. It was in the spirit of the Accord. The base of the Workers' Health Centre within the working class of Sydney was not strong enough to resist these pressures. The Centre continues, but without the capacity to play the same social change roles that it was able to play in its early days.

The point of recalling these situations is to illustrate that government and professionals have an interest in asserting control over these sorts of developments. The same pressures have been a recurring feature of Aboriginal health services<sup>52</sup>. The initial reaction of governments was to resist these developments, but increasingly the pressure of government is to incorporate them into a system and control them that way. Currently there are attempts to narrowly use evidence-based medicine to monitor and control Aboriginal medical services. Whilst quality assurance programs are as important to AMSs as they are to other sections of the health industry, the types of standards applied need to be modified to be appropriate to both community controlled primary health care, and to the cultural values of Aboriginal communities, including the practice of traditional Aboriginal medicine. However, AMSs have a strong base within their own community, as well as having their own professional advisers. These factors militate against any simple bureaucratic or professional control being successful.

The difference between the histories of the women's and workers' health movements and the Aboriginal health movement relates to the core issue of the colonial relationship. The government is the government of the colonisers, whereas Aboriginal health services are the organisations of the colonised, the Aboriginal community. Aboriginal society was not party to any agreement about the governance of this country. They were excluded from any say or input into the constitutional arrangements leading to the Federation. Indeed, they have had to fight on the terms of the colonisers (ie on the basis of British law) to have any legal rights established. This colonial relationship helps sustain the different model of AMSs. Whereas, women's health centres and workers' health centres have survived in

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<sup>51</sup> Ife, J *Community Development: Creating Community Alternatives – Vision, Analyses and Practise.* Longman, Melbourne, 1995 cited in Petersen, A & Lupton, D *The New Public Health: Health & Self in the Age of Risk.* Allen & Unwin, Sydney, 1996, p148.

only one or two places, with more appropriate services being incorporated into the mainstream health care system, AMSs have continued to expand outside the mainstream.

### ***The Central Australian Aboriginal Congress***

On 9th June 1973, more than one hundred Aboriginal people from all over central Australia met in Alice Springs to discuss their poor living conditions and health problems in central Australia. This meeting decided that an organisation should be established to fight for improvements, and the Central Australian Aboriginal Congress (Congress) was formed. A board of directors called the Cabinet was elected from this meeting to take responsibility for establishing the organisation. Congress also had as part of its structure a Council that included representatives from all major bush communities. The Cabinet was responsible for the running of the organisation in between Council meetings.

This meeting took place at a time when the national mood was one of social change. The Whitlam reformist ALP government was in power in Canberra. Its victory in December 1972 was on the wave of activism - anti-Vietnam, anti-Apartheid, pro-women and pro-Aboriginal. Land Rights were major parts of the ALP platform, and the electorate broadly supported it.

In central Australia, Congress was the second Aboriginal organisation formed (the first was the Central Australian Aboriginal Legal Aid Service).

Congress was not initially established as a health service but began as an advocacy body and was the voice of Aboriginal people throughout the region. The language used such as *Congress*, and *Cabinet* reflect the intent to establish an explicitly representative political organisation. The Council that had representatives of all communities throughout the region reflected the representative nature of the organisation, and its political intent.

One of the first programs conducted by Congress was a housing project known as the 'Tent Program' which provided tents to Aboriginal people requiring shelter in the town area for a nominal fee of 50 cents per week. This was before the health service began.

Access to health services was a major concern at the time. Aboriginal people had poor living conditions and this was reflected in the illness patterns especially of the children, with infectious diseases being common. As discussed above, the existing health services in central Australia had been authoritarian in relationship to Aboriginal people, and were largely driven by the needs of the coloniser/ settler community. Thus Aboriginal people had limited access to health services, and indeed many Aboriginal people avoided contact with health services until quite late in their illness, and sometimes not at all.

In 1974 Dr Trevor Cutter came to Alice to work for Congress to assist in establishing a medical service. Initially he worked from the back of a motor car, moving around the camps seeing people as necessary, and letting people know that there was a new health service which Aboriginal people had set up. Then premises were found in Hartley Street that became the base for the health service.

Dr Cutter was an imaginative and tireless worker, who constantly worked to provide medical care to people in ways that were acceptable, accessible, and appropriate to them. One of his ideas was to develop a 'hospital without walls' which was essentially a plan to provide people who would normally be hospitalised with care in their homes. Whilst the idea was never fully implemented, it did challenge the conventional views of the health care system and helped shape more appropriate health care delivery for Aboriginal people. It is now the accepted norm at Congress and other Aboriginal health services that people be kept out of hospital as much as possible, and that community based systems of care have been established to achieve optimum care whilst minimising hospitalisation. An example of this is the clinical management of acute pneumonia in small children. An otherwise healthy child of reasonable weight is treated with daily doses of penicillin for 5 days. Diagnosis is on the bases of widely accepted clinical criteria. If after the first dose they remain quite ill, then they are offered X-rays and hospitalisation is encouraged. This results in somewhere around two thirds of children with pneumonia able to avoid hospitalisation without significant compromise to the outcome.

With the Whitlam Government, an era when Aboriginal organisations could be supported by government funds began. This stimulated the development of other organisations in central Australia that was discussed in Chapter 5. Congress played a role in the establishment of most of these organisations.

In 1975, Congress carried out a survey of fringe camps in Alice Springs<sup>53</sup>. Thirteen camps were visited covering a total permanent population of 467, plus between 397-655 visitors. Some one-family or transient camps in the Todd River bed and elsewhere, totalling around 50-100 people, were also visited. The findings which give an indication of the conditions for health at the time, included:

- ♦ Transport: Lack of access to transport was identified as a barrier to Aboriginal people getting timely assistance from the health care system.
- ♦ Water: Only one camp had water to a few house. Another camp had a soak only, and the rest had taps between 50-400 metres from housing.
- ♦ Showers and washing: Two camps had access to hot showers. Another two had cold showers. One camp had one shower for 100 people. The rest had nothing<sup>54</sup>.
- ♦ Toilets: Only 4 camps had toilets. 1 camp had a pan toilet, and 3 camps had septic systems.
- ♦ Rubbish: The Council collection of rubbish was good.
- ♦ Housing: All housing was substandard. However the majority of residents lived in shanty homes, tents, and iron sheds with no indoor facilities.
- ♦ Cooking: Cooking was over open fires, but firewood was in short supply, and transport to collect wood was not available.
- ♦ Food storage: There was none. Only one camp had power connected to support refrigeration.
- ♦ Nutrition: Nutrition was poor consisting predominantly of meat, tinned food and bread, with no fresh fruit or vegetables. Many mothers were bottle-feeding rather than breast-feeding<sup>55</sup>.
- ♦ Social Environment:

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<sup>53</sup> Central Australian Aboriginal Congress *'They've Never had it so Good - NO!'* Aboriginal and Islander Forum, July, 1975.

<sup>54</sup> *Ibid.*, p11.

<sup>55</sup> Central Australian Aboriginal Congress, 1975, *op. cit.*, p12.

- a) Employment: Unemployment levels were high, and access to Social Security payments poor.
- b) Education: It was estimated that around 70% of kids did not attend school.
- c) Alcohol: Alcohol abuse was a serious problem.

The Report Recommended<sup>56</sup>:

- a) That the camps needed land title (to facilitate the development of infrastructure);
- b) More and improved housing;
- c) Improved transport;
- d) Installation of toilets, showers, washing basins, reticulated water, food storage, and rubbish services;
- e) Employment opportunities to be created on the camps;
- f) Improved access to social benefits;

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<sup>56</sup> *Ibid.*, p14.



- g) Improved access to education;
- h) Alcohol rehabilitation programs be developed;
- i) Access to nutritious food;
- j) Continued development of an Aboriginal medical service.

Congress conducted another survey of the Town Camps in 1985 and found that infections and disease were related to inadequate housing and access to water. The health of people at Karnte was particularly bad<sup>57</sup>.

In 1986, Congress conducted a study of Alice Springs Hospital records and showed that town camp kids spent 26 times as many days in hospital as white kids. There was a recognised relationship between water supply, income, housing, overcrowding and the poor health status. Camps with and without showers were compared and showed a marked difference<sup>58</sup>.

In 1987 a comprehensive analysis of morbidity and mortality was conducted. This confirmed the appalling state of health for Aboriginal people in central Australia<sup>59</sup>. This study demonstrated that central Australian Aboriginal people had a slightly worse mortality experience than NT Aboriginal as a whole, and much worse than non-Aboriginal Territorians.

#### Research

Medical student Eduard Beck conducted a further study with Congress' assistance in 1979. Beck accompanied the Congress Town Camp program in its work, and it was this that gave him the opportunity to pursue his study. However, this was not negotiated with Congress. Thus senior people were angry when the results of his study were published<sup>60</sup>. Further no credit was given to Congress, even though the study would not have been

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<sup>57</sup> Tangentyere Council 'Annual Report 1984-85.' Alice Springs, 1985, p11.

<sup>58</sup> *Ibid.*, p2.

<sup>59</sup> Khalidi, N 'Aboriginal Mortality in Central Australia, 1975-77 to 1985-86: A Comparative Analysis and Trends.' NCEPH, Canberra, 1989.

<sup>60</sup> Beck, E, *op. cit.*

possible without Congress' active support. This episode highlights important ethical issues regarding non-Aboriginal people and research involving Aboriginals.

Congress has been involved in conducting a number of other research projects that include:

1. *A study of water supplies* to Aboriginal communities<sup>61</sup>. This study looked at the quality of water available to Aboriginal people and related it to people's health needs.
2. *A Community and Action Oriented Health Service Program* that aimed to achieve a re-definition of the 'Aboriginal health problem' and clarify the process required to improve Aboriginal health in the Centre. This resulted in two publications *Health Business*<sup>62</sup> and *Settle Down Country*<sup>63</sup>
3. *Borning Project*. This was research conducted in 1984-1985 to consult with women in central Australia about matters to do with birthing and women's health<sup>64</sup>. This research resulted in the development of the Alukura that now operates as a birthing centre, women's health centre, and bush service.
4. Research into *Disturbed Behaviour in Central Australia*<sup>65</sup>. This was conducted by Sarah Dunlop for Congress and resulted in the establishment of a community organisation to provide support to people with disturbed behaviour and their families, Disability Services Central Australia (DSCA).
5. An investigation into the *needs of frail aged and disabled Aboriginal people* in Alice Springs<sup>66</sup>. This report prompted the development of support services that are run by Arrernte Council.
6. *Hepatitis B Sero-conversion and cold chain project*<sup>67</sup>. This was conducted by Heather Leatham and Charlie Maher and included various projects including a Hepatitis B

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<sup>61</sup> Camp Scott Furphy Consulting Engineers '*Aboriginal Water Program.*' Central Australian Aboriginal Congress, Alice Springs, 1979.

<sup>62</sup> Natham P & Japanangka DL, 1983 (1), *op. cit.*

<sup>63</sup> Nathan P Japanangka DL '*Settle Down Country – Pmere Arlalteywele*' Kibble Books, Melbourne, 1983.

<sup>64</sup> Carter, B et al '*Borning: Pmere Laltyeke Anwerne Ampe Mpwaretyeke: Congress Alukura by the grandmother's Law.*' Australian Aboriginal Studies, No 1, 1987, p 2-33.

<sup>65</sup> Dunlop, S '*All that Rama Rama Mob: Aboriginal Disturbed Behaviour in Central Australia*' Central Australian Aboriginal Congress, Alice Springs, Vols 1&2, 1988.

<sup>66</sup> Austen B & Tilton E '*Really Missing Out .. A Report on the Home and Community Care Needs of the Aboriginal People of Alice Springs.*' Central Australian Aboriginal Congress, Alice Springs, 1992.

vaccine sero-conversion study, an examination of the cold chain system for immunisations, and a health promotion program involving local Aboriginal people in the production of a television program about health issues.

7. An *alcohol media strategy* for central Australia<sup>68</sup>. This project explored what sort of messages might impact on people and their behaviours about alcohol.
8. Proposals for more effective *administration of Aboriginal health programs*<sup>69</sup>. This project was aimed at analysing current policy and practice of the Commonwealth Governments Aboriginal health programs and to recommend improvements.
9. Perceptions of the *Role of AHWs* in central Australia<sup>70</sup>. This project helped clarify problems faced by AHWs in their work, and why so many AHWs were registered but not working as AHWs.
10. Cultural and social issues involved with *chronic renal failure* in central Australia<sup>71</sup>. This project consulted with Aboriginal people with chronic renal failure and their families. It identified a number of issues and has led to the establishment of a Renal Forum where all stakeholders can coordinate improved service delivery and support to these people.
11. A feasibility study for the development of a community controlled health service and aged care program in the Anmatjere Community Government Council area<sup>72</sup>.

This research program tends to counter the commonly held belief that Congress is opposed to research. It rather shows that Congress is concerned about the quality and process of research. Congress' well known concern about research is based on the histories of anthropologists, medical researchers and others who did research without consent and/ or without appropriate negotiations with Aboriginal people. Most of the above research has

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<sup>67</sup> 'Hepatitis B Immunisation Report.' Central Australian Aboriginal Congress, Alice Springs, 1992.

<sup>68</sup> Tilton E and Maher C 'Health Promotion or Self-Promotion? A Central Australian Aboriginal Alcohol Media Strategy.' Central Australian Aboriginal Congress, 1993.

<sup>69</sup> Bartlett, B & Legge, D 'Beyond the Maze: Proposals for a more Straightforward Approach to the Administration of Health Services for Aboriginal People.' Central Australian Aboriginal Congress and National Centre for Epidemiology & Population Health, 1995.

<sup>70</sup> Tregenza J, Abbott K 'Rhetoric and reality: Perceptions of the roles of Aboriginal Health Workers in Central Australia.' Central Australian Aboriginal Congress, Alice Springs, 1995.

<sup>71</sup> Devitt, J & McMasters, A 'Living on Medicine: Social and Cultural Dimensions of End Stage Renal Disease among Aboriginal People of Central Australia.' IAD, Alice Springs, 1998 (In Print).

<sup>72</sup> Bartlett B & Tilton E 'Development of an Independent Medical Service and an Aged Care Pilot Program based at Ti Tree.' Central Australian Aboriginal Congress, Alice Springs, 1998.

had practical outcomes in terms of improved services, or the development of new services. This illustrates a further concern that research should provided substantial benefits to Aboriginal people.

The Menzies School of Health Research conducted a workshop on Research in Aboriginal health in 1987. As a consequence of Aboriginal interventions at that workshop, the NH&MRC sponsored a project that resulted in the publications of ethical guidelines in Aboriginal health research<sup>73</sup>. Since then formal guidelines have been adopted by the NH&MRC.

#### The Organisation

Congress celebrated its 21<sup>st</sup> anniversary in 1994. The organisation's own perceptions of its work were published in a small leaflet entitled '*21 years – the struggle continues.*':

*'Congress works for the health of Aboriginal people by<sup>74</sup>:*

- *providing effective, efficient, and appropriate primary health care for Aboriginal people*
- *educating Aboriginal Health Workers*
- *assisting other Aboriginal communities to take control of their health matters*
- *being a political advocate for our people, and speaking out on matters affecting our health.'*

As other Aboriginal organisations were established to focus on specific areas of Aboriginal need, health and welfare services, along with political advocacy, increasingly became the core business of Congress. However, Congress continued to play a role in assisting other organisations to become established to deal with a diversity of issues. Often other organisations also worked with Congress to a common objective in the community's interest.

However, by the early 1980s things had changed. The Council ceased functioning in the early 1980s. There were a number of reasons for this. Firstly, the cost of Council meetings

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<sup>73</sup> NH&MRC '*Some Advisory Note on Ethical Matters in Aboriginal Research.*' Canberra, 1988.

was becoming prohibitive. Secondly, as many communities developed their own community organisations (such as community councils, health services) there was less need to maintain the Council. A number of communities had developed their own health services with the assistance of Congress (see below), and many of the people who played important roles in developing these bush health services had been active with Congress, and often members of the Council. Further the impact of the development of community controlled health services led directly to the more appropriate delivery of government controlled health services. However, bush people continue to work with Congress on various issues, and some continue to participate in Congress AGMs. Most continue to use Congress services when in Alice Springs.

Since then Congress has been more town-based in terms of its service delivery. The pressure on the organisation to provide more comprehensive health services has increased. The expectations of Aboriginal people have also increased enormously over the past 20 years or so. Congress estimates that around 40% of its clientele are residents of bush communities or out-stations. The number of consultations have increased steadily over the years, and continue to do so despite the presence in Alice Springs of general practitioners who have worked previously at Congress before establishing their private practice. Some of these practitioners are popular with Aboriginal people, some of whom now use these practitioners as their primary medical advisers. Thus it can be concluded that Aboriginal people have much higher expectations of their service than previously, and indeed more people are accessing health care services than ever before. This has implications for the way PHC services are organised.

The Congress AGM is attended by up to 300 Aboriginal people from around central Australia who elect the thirteen members of Cabinet. The role of the Cabinet is to make decisions about the policy direction of Congress, ensure funds are expended appropriately, and to ensure that Congress remains responsive to community needs.

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<sup>74</sup> Central Australian Aboriginal Congress '21 Years - *The Struggle Continues.*' Pamphlet, Congress, Alice Springs, 1994.

Up until early 1989, the service operated out of a 3-bedroom house, with various modifications and additions. The administration was located in a demountable, as was senior management. The Director, Deputy Director and Senior Medical Officer shared a room about 7'x 15'. There were 3 consulting rooms, and a larger area where doctors, health promotion staff and AHW educators worked. AHW education sessions took place in this same room with others trying to work, talk on telephones and the like. It was a chaotic environment. There were many interruptions, and it is a wonder that things got done at all. But the level of communication was high. Morale was also high.

In the early 1980s, the degree of illness and trauma was extraordinary. Coming from a general practise in Sydney, I could not help but feel the contrast. Many cases of pneumonia were seen each day, compared to one or two a year in relatively healthy Sydney clients. There was too much trauma, and too many late presentations.

In late '88 – early '89 Congress moved into new, purpose-designed premises in Gap Road. It was relatively luxurious, but it was not long before communication problems became evident. Whereas in the old premises you could not help but know what was going on and who was doing what, in the new, relatively spacious environment people did not automatically bump into each other, overhear telephone conversations, etc. This was a major change for the organisation. The organisation also grew into a more bureaucratic organisation than it had been in the old premises.

Congress now employs around one hundred and twenty people, 93% of whom are Aboriginal. Congress has argued for a comprehensive primary health care service, rather than delivering selective programs that have often been the focus of medical and public health professionals. This point continues to be an issue between THS and the Commonwealth and some of the remote services, and Congress. The current programs delivered by Congress are:

- Medical Clinic, including 24-hour emergency care. This clinic employs five doctors, including one public health practitioner. Aboriginal Health Workers play a major role in the delivery of these clinical services in providing basic clinical care, assisting with communication, contributing their community and cultural knowledge, and orienting medical officers to the realities of Aboriginal living.

- ♦ Community Health Program including an out-station service, town camp health program and a school program delivered to Yipirinya School. This program has been under-resourced, but has attempted to keep up with the movement of people from Alice Springs town camps to out-stations within 100 km or so from Alice Springs. The school program attempts to diagnose and treat skin, eye and upper respiratory (especially ear) infections promptly.
- ♦ Under 5s program. This program provides support to the care of children under 5 years of age and includes the immunisation program, and growth promotion. However it attempts to emphasise individually tailored care encouraging parents to take responsibility, rather than usurping those responsibilities which continues to be the hallmark of THS programs. A recent example involves the protocol for weighing children. THS have adopted a protocol where every Aboriginal child is weighed monthly until the age of three. This fails to identify which children are at risk, but rather treats Aboriginality itself as a risk factor. This perpetuates a style of program delivery that does things *to* people rather than forming relationships *with* people.
- ♦ Aboriginal Health Worker Education. Congress has a long tradition in delivering Aboriginal Health Work education. Currently Congress runs an Education Unit which delivers a certificate level course for AHWs.
- ♦ Congress Alukura by the Grandmother's Law, a women's health and birthing centre, which provides local services, and also delivers support to antenatal and other women's health care to PHC services in remote communities.
- ♦ Dental Clinic that includes both an acute dental service and a community based gum disease preventive program.
- ♦ Health Promotion that has tended to focus on nutrition issues.
- ♦ STD/ HIV-AIDS Counselling and Education program. This program continues to operate despite great difficulties given the emotional issues surrounding HIV/ AIDS and the difficulty reaching those with high-risk behaviours.
- ♦ Transport service. Transport continues to be a major problem for many people. The transport service makes regular runs to the camps around Alice Springs, and responds to calls from clients.
- ♦ Childcare Centre. Congress also runs a pre-school Childcare Centre.

Congress' support for community control of health care services might be seen by some as simply the pursuit of self-interest. However, Congress explains why community control is important in these terms<sup>75</sup>:

*'We at Congress know that here are no simple solutions to these problems. But we do know that for our health to improve, Aboriginal people must take responsibility for their own health, by gaining more control over their own lives. Since colonisation, an alien system controlled all aspects of Aboriginal life. The result: our health was amongst the worst in the world, a national disgrace and an international embarrassment.*

*The development of community controlled health services have helped people regain control of their lives.'*

#### Alcohol Programs

Congress has been involved in alcohol programs since the early days. One of the early programs involved a pick up service where people who were drunk were picked up and taken to a safe environment.

In 1986-87 the DAA funded 47 Aboriginal alcohol rehabilitation projects, totalling \$4.54m. The DAA reviewed these alcohol rehabilitation projects in all States, resulting in some projects being restructured to give greater emphasis to prevention and to de-emphasise the residential aspect of their work. The DAA also claimed that funds were being redirected to those able to demonstrate their effectiveness<sup>76</sup>. As part of this review many programs were closed, including the Congress Farm project which provided some relief to drinkers and their co-dependants. The Farm had provided some residential care and food. However the staffing was minimal and did not allow 24-hour supervision. Because of the proximity to town, alcohol was often brought into the facility. However, instead of the review analysing these difficulties and assisting Congress to overcome them the service was simply closed. Thus,

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<sup>75</sup> Central Australian Aboriginal Congress, 1994, *op. cit.*

<sup>76</sup> DAA, 1987, *op. cit.*, p62.



there was only the sobering up shelter, and a small drugs and alcohol unit within THS operating in central Australia. This unit was mainly involved with individual counselling which was predominantly relevant to the non-Aboriginal population.

In 1990 Douglas Abbott, a Southern Arrernte man, and an ex-drinker began to agitate for assistance for Aboriginal drinkers to stop drinking. Abbott was employed by Tangentyere Council, and in 1991 became President of Congress. He organised an Aboriginal Alcoholics Anonymous (AAA) program. However, the Alcoholics Anonymous people in Alice Springs objected to this name, and it was changed to Aboriginal Alcohol Awareness. The AAA stuck. He was charismatic and momentum in AAA quickly developed.

When Congress moved to new premises in 1989, it had to come to terms with a small grocery shop next door which had a take away liquor license. This impacted greatly on Congress, with many people drunk and disorderly. Non-drinkers attending Congress were often harassed by drinkers for money to buy alcohol. Congress Cabinet with Abbott as President decided to buy the shop and the liquor license. The license itself was valued at \$100,000. The vision was to cease selling alcohol and to get the Liquor Commission to buy back the license. There was a great deal of concern at the time that there were far too many take away liquor licenses in Alice Springs, many of which were located in inappropriate enterprises such as corner shops and service stations. The shop would be turned into a grocery and fruit & vegetable shop. There would be an attempt to develop policies in the shop that would encourage people to purchase healthy food. There was an agreement with Tangentyere Council that they would transfer their food voucher system from Woolworths to the Congress Shop.

So in 1990 Congress purchased the shop. At a public opening ceremony thousands of dollars of alcohol were literally poured into the gutter.

However, Congress was unsuccessful in receiving any compensation for the license, and this put a severe financial strain on the organisation. The Liquor Commission on technical grounds, opportunistically revoked the license at the time of building the new shop, making it much more difficult for Congress to benefit from any future buy back scheme.

For a time the shop functioned reasonably well. Congress developed the only retail training program for Aboriginal people in Alice Springs.

However, tension between Tangentyere and Congress, partly due to issues involving the ATSIC Regional Council, focused on the prices at Congress shop as compared with Woolworths, and Tangentyere withdrew its custom. The shop was forced to close.

Congress now leases the premises to an Aboriginal family that run a small café. This has proved to be an enduring arrangement.

In the meantime Doug Abbott and others continued to pursue their AAA activities.

However, the philosophy developed by AAA, which was a mixture of Aboriginal spiritual matters, and an abstinence strategy, clashed with the philosophy pursued by those working in the THS Drug and Alcohol Unit. It is also probably true that they were put out because they lacked any control or influence over Abbott who got his organisational support from Tangentyere Council and Congress. Congress provided facilities for evening meetings, and also assisted in fixing up the old Congress Farm (which had been a residential alcohol rehabilitation facility) for use in a day program for alcoholics.

There was also some clash between the militant program being pursued by Doug Abbott, and the programs that had previously been pursued by Tangentyere. Tangentyere had played a leading role through the work of its Liquor Committee in opposing take away outlets in Alice Springs. Congress has been a strong supporter of this approach. However, Tangentyere had also developed proposals for 4 social clubs that would provide appropriate environments for people to socialise and drink. The reason for seeking 4 such clubs was to allow the dominant language groups to have their own environment.

However, only one club received funding support. The Tyeweretye Club was eventually established and is still operating. However, the militant abstinence lobby accused supporters of the club of being murderers and hypocrites. Tangentyere and Congress developed a multi-faceted strategy at this time. This consisted of:

1. Developing the Congress Farm as a Day Care program for those giving up drinking alcohol, or who were 'co-dependents'.
2. The resourcing of the Central Australian Aboriginal Alcohol Planning Unit (CAAAPU). This Unit was to liaise and consult with Aboriginal communities throughout central Australia, and to develop a comprehensive strategy for dealing with

alcohol problems. This resulted in a report<sup>77</sup> which recommended a residential treatment program (inspired by North American Indian experiences), a continuation of the AAA program based in communities and extended to remote communities so that those who had been through the residential program would have support back in their community, and the development of counselling education programs to strengthen the skills of Aboriginal counsellors.

3. An Aboriginal alcohol media strategy. This resulted in a consultation with Aboriginal communities about media messages relating to alcohol. The report<sup>78</sup> has significance more broadly in the area of health promotion and the media.
4. The Social Behaviour project. This project was aimed at strengthening Aboriginal authority in the community, and developing rules of behaviour in regard to alcohol and other issues. It involved all language groups and worked through the Four Corners Council that was a forum for Aboriginal law men.

Tangentyere took responsibility for CAAAPU and the Social Behaviour projects, whilst Congress managed the Congress Farm Day Care program, and the media strategy.

There was continued resistance by THS about these strategies and arguments tended to revolve around the Commonwealth duplicating programs, and the problems relating to lack of expertise amongst the Aboriginal people involved.

At the same time the Royal Commission into Aboriginal Deaths in Custody was being conducted, and Marcia Langton was employed to look at the underlying issues in the Northern Territory. Her report, *'Too Much Sorry Business.'*<sup>79</sup>, focused predominantly on the issues of alcohol. A number of North American Indians visited central Australia at around this time and forged links with the local alcohol activists. Later a delegation of Aboriginal people visited Canada and the programs operating there. They were impressed. The programmatic demand became for 28 day residential treatment programs. The

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<sup>77</sup> Lyon P, Hill J, Wynter J *'Final Report and Action Plan.'* Central Australian Aboriginal Alcohol Planning Unit, Alice Springs, 1992.

<sup>78</sup> Maher C, Tilton E *'Health Promotion or Self-Promotion? A Central Australian Aboriginal Alcohol Media Strategy.'* Central Australian Aboriginal Congress, Alice Springs, 1994.

<sup>79</sup> Langton. M et al *'Too Much Sorry Business.'* in *'Final Report of the Royal Commission into Aboriginal Deaths in Custody.'* AGPS, Canberra, 1991.

ideological emphasis was that alcoholism was a disease, and therefore it could be treated. This put alcohol issues firmly into a classical medical model, and was inevitably resisted by substance abuse professionals. This became a point of argument amongst the mainstream alcohol treatment industry that saw this as potentially medicalising the problem, and who had sophisticated social and psychological theories to explain alcoholism. The disease theory just didn't fit. The inability of the government employed substance abuse workers to forge relationships with the Aboriginal alcohol activists on their terms probably pushed the activists more than need be to embrace a ready made solution from Canada, rather than grow into their own solutions more gradually. Expensive Indian consultants were playing a fairly central role, although experienced Aboriginal people like Lana Abbott, an experienced AHW manager from Congress, were not without their influence.

CAAAPU now became the Central Australian Aboriginal Programs Unit. It took over the programs run by Congress, IAD (which had received some funds for training counsellors) and Tangentyere and incorporated training of counsellors into the residential treatment program. The trainers were Canadian Indians. There is no doubt that the work of CAAAPU was inspirational, and had significant success. However, in the end there were allegations of mismanagement. The Canadians were sacked in 1994. An Administrator was appointed, and the NT Government withdrew all funding. This was despite a Menzies School of Health Research evaluation<sup>80</sup> which showed that the programs being conducted were significantly more successful than residential programs in the mainstream.

Over the past few years CAAAPU is slowly redeveloping itself. It has lost much of its funding, and is now limiting itself to the provision of day care programs.

#### Congress' Regional Role

For some years Congress has been advocating for a central Australian health planning process that is transparent and inclusive. The discussion of health policy development in

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<sup>80</sup> Miller K, Rowse T 'CAAAPU: An Evaluation.' Menzies School of Health Research, Darwin, Occasional Paper 1/95, 1995.

the next chapter shows how government departments and politicians are prone to making unilateral decisions. This has led to allegation and counter-allegation of duplication of services, and has resulted in entrenched conflict.

As community control of PHC services to Aboriginal people has become embraced as government policy, so the debate about who is the 'community' has come into greater prominence. Thus, THS officers have tended to challenge the legitimacy of Congress (and more broadly, AMSANT) as representative voices of Aboriginal people in bush communities. Thus THS program development has emphasised the 'local' community. Of course the representative nature of the community council, or the Aboriginal Health Workers, or whomever else the bureaucrats chose to talk with can also have their legitimacy challenged. Despite Congress' track record in assisting remote communities with their health service development, THS has tended to ignore Congress in their planning. There have been times that Congress has been invited to participate in a steering committee for a particular project (eg the THS Review) but Congress has declined on the grounds that the parameters of the project have already been set, and they do not wish to simply endorse a predetermined process by their presence. This situation is so entrenched that it is a barrier to improving Aboriginal health.

The question of representativeness is one factor. But there is another factor. The Aboriginal health leadership in the NT is responsible for the delivery of PHC service to Aboriginal people. This is a major reason for involving this leadership in planning processes. There has been a nearly decade long campaign by Congress and others to develop a more collaborative planning process for health service delivery in central Australia.

#### *Central Australian NAIHO*

In the period between the late 1970s and 1990 the central Australian community controlled health services organised a Central Australian NAIHO as a means of identifying common issues and for the purposes of lobbying governments about the needs of community controlled Aboriginal health services.

Attempts at getting resources for a primary health care regional resource facility which would have the capacity to provide a range of regional supports (including in-service training, management support, clearinghouse for clinical and other relevant information) were unsuccessful. Congress applied to the DAA in 1988 for funding of a Central Australia Aboriginal Health Resource Unit, but was unsuccessful. Ad hoc meetings of community controlled health services in central Australia, organised by Congress, continued.

### *The Kerr Review*

In 1989, after a series of incidents leading to allegations of clinical mismanagement on the part of Alice Springs Hospital, a number of community and professional organisations called for a review of health services in central Australia. This included community controlled health services, especially Central Australian Aboriginal Congress and Anyinginyi Congress in Tennant Creek, the Nurses Federation, Miscellaneous Workers Union, Teacher Federation, and the Central Australian Rural Practitioners Association (CARPA). Initially the Minister for Health & Community Services, Steve Hatton, resisted, but eventually appointed Prof Charles Kerr from the University of Sydney to conduct the Review.

The Review<sup>81</sup> recognised that one of the major barriers to improving health was the failure of the Northern Territory Government to formally recognise the work being done by the community controlled health services. He recommended that a Central Australian Health Council be established as a mechanism to develop a collaborative approach to health service delivery and inter-sectoral work. However, the recommendations were never implemented.

The components of a strategic planning process that have been pursued by Congress over the past decade or so are<sup>82</sup>:

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<sup>81</sup> Kerr, C 'Review of Central Australian Health Services.' 1989.

<sup>82</sup> Central Australian Aboriginal Congress 'Towards a Regional Aboriginal Health Strategy in Central Australia.' Alice Springs, 1994.

1. A Central Australian Aboriginal Health Council. This would allow Aboriginal people and their organisations from all over central Australia to meet and work out how best to tackle poor health, in town and out bush.
2. An Indigenous Health Planning Unit. This body is made up of the major players in PHC service delivery in central Australia – Congress, THS and OATSIHS.
3. A Rural Health Training Unit, to address the educational and training needs of practitioners in Aboriginal health. Based in Alice Springs, this would be a place where Aboriginal people can get appropriate training in all aspects of health care, and non-Aboriginal people can learn how to deliver appropriate health care under Aboriginal direction.
4. Aboriginal Health Worker education strategies that meet both the needs of literate health workers to gain qualifications and an appropriate career path, and the community based health workers who have no desire but to remain in and serve their community.
5. A Primary Health Care Network that would nurture an Aboriginal Health Worker Association that can be a voice for AHW interests, and to advocate for industrial and educational needs of AHWs.
6. Adequate funding support for the Congress Alukura by the Grandmother's Law to provide more comprehensive support for antenatal care, women's health and birthing to remote communities.

### *Central Australian Health Planning*

There has been some confusion over the roles and differences of the first two organisations listed above. Indeed the first, the Central Australian Aboriginal Health Council, was promoted in the late 1980s, and was intended to be an Aboriginal body which could oversee developments in Aboriginal health as well as advocate for particular needs. Attempts at getting this funded were unsuccessful.

In the meantime, two things were happening. First, Government services continued to develop new initiatives without consultation. At times these were clearly duplications with initiatives of community organisations. Secondly, those health professionals who had incorporated into their practice the principles of consulting and working with Aboriginal people were making requests to the existing Aboriginal health leadership which were

uncoordinated, and which the leadership were unable to adequately process. Clearly a streamlined approach was required that would assist in developing an appropriate consultative process that could avoid duplication of effort, re-inventing wheels, and where those government departments and health professionals who were want to pursue their own agendas with scant regard for what had gone before, or ethical practice, could be better controlled. Thus the focus became more to do with planning, and a recognition that there indeed was an experienced Aboriginal health leadership that should be included in a strategic approach to Aboriginal health. The issue of the broader issues of involving community members or consumers, and the general issue of representativeness would then be a matter for the planning process to consider.

The Central Australian Indigenous Health Planning Forum had its first meeting in March 1998 with a membership limited to ATSIC, AMSANT, THS and OATSIHS. It is too early to assess its effectiveness.

#### *Central Australian Remote Health Training Unit.*

The Central Australian Remote Health Training Unit was eventually funded in 1995. This resource provides the opportunity to purchase training programs specifically targeted and delivered in the particular community where it is needed. It is managed through a joint management committee involving Congress, Anyinginyi, IAD, THS and OATSIHS. Whilst this Unit has had some teething problems, it has provided a relatively successful experience of collaborative management which no doubt assisted the establishment of the Planning Forum.

#### *Central Australian PHC Network and the AHW Association*

The CA Primary Health Care Network was funded through the Divisions and Projects Grants Program of Commonwealth Health in 1994. During the preceding 18 months there had been a tactical process played out to attract monies designed for Divisions of General Practice to the needs of AHWs in central Australia. When it was known that GP Divisions would be funded, Congress submitted an application to establish a Division of Aboriginal Primary Health Care. This Division would focus on Aboriginal health, and would be multi-disciplinary including all primary health care practitioners in its membership – nurses, AHWs and doctors. This submission had strong support from CARPA and AHWs.



At the time the local GPs in Alice Springs had not made any submission, but when they realised what was happening they vigorously opposed the Congress initiative. Attempts to negotiate with them in terms of their applying for a standard Division of other doctors (all except two worked and resided in Alice Springs) were unsuccessful. However, in this process it became clear to the Commonwealth officers and GPs involved in developing Divisions nationally, that there was a serious incompatibility between the two groups and that there were persuasive arguments about the need for organisational assistance to AHWs. In the end Canberra decided that Divisions could only be for doctors, but that they would fund out of projects funds a Central Australian Primary Health Care Network. The Network organised meetings of AHWs as well as assisting CARPA in its organisational activities. As a consequence of the Network's work a Central Australian and Barkly AHW Association was established. Initially the Association operated out of Congress, but in 1997 moved to its own offices. A Review of the Network was conducted in 1996<sup>83</sup>. Following the Review the funding to the Network was terminated, but OATSIHS have continued funding the Association. The AHW Association is still in its infancy, but has played an important role in developing AHW inputs into issues such as the Aboriginal and Torres Strait Islander Health Worker National Competencies and AHW education needs. However, tensions exist between the Association and community controlled health services over the issue of who best represents Aboriginal health issues. This is a reflection of the broader contest between consumer and professional control of health services. It is a complex issue. AHWs are, as health professionals, often better informed than AMS Boards of Management as to the nature and extent of many health issues. On the other hand AHWs do not necessarily have the appropriate relationship and status within the community. This point is particularly the case in many urbanised areas such as Alice Springs. In remote communities where the communities chose their AHW, they are usually people of some status in the community and the community expects them to play a leading role in health service issues. On the other hand some managers of AMSs and their community elected Board of Management resist the idea that the service should be controlled by health professionals, whether Aboriginal or not.

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<sup>83</sup> Legge, D *Shaping a Healthier Future: A Report on the first year of the Central Australian Primary Health Care Network and the Central Australian and Barkly AHWs Association.* LA Trobe, Melbourne, 1996.

## Congress Alukura by the Grandmothers' Law

In 1983 Congress was successful in getting funding from the Commonwealth Department of Health to conduct an extensive consultation with senior Aboriginal women from all language groups in central Australia about birthing and women's health issues<sup>84</sup>. This followed the research conducted by Congress reported in '*Health Business*'<sup>85</sup>, during which women had expressed their concern about how most women were having their babies in Alice Springs Hospital, and that this was undermining their relationship with country and other cultural matters. It was also thought that it might be an important factor in the high rate of stillbirths experienced by Aboriginal women.

The project involved extensive consultations with all communities in central Australia, with a particular emphasis on talking with senior women, many of whom had little English. Thus the consultative process was conducted in people's own language, recorded, and then translated from tapes. This resulted in a model for a birthing service being developed. The consultation process established that Aboriginal women wished to reclaim their birthing rights, which had been eroded in recent decades by the policy of THS that all women would give birth in Alice Springs Hospital. Whilst this had proved unenforceable, it had resulted in most women complying. However it was also associated with many women avoiding ante-natal care for the fear of being sent to Alice Springs.

There were exceptions to this practice of all women being sent to hospital for birthing. The Urapuntja Health Service accommodated, to some extent, women's desire for giving birth in their country, as did Nganampa Health Council and Pintupi Homelands Health Service. However the extent of these practices varied from time to time depending on the skill and confidence of staff, and there was little support to maintain and improve obstetric skills of health service staff.

The Alukura Council, made up of senior women from all language groups, was established in 1986<sup>86</sup>, and further development of the Alukura involved these women. The service was commenced, but was not resourced to carry out the full extent of that 'model'. In 1987, the DAA provided funding for a pilot project for two years. Initially a women's health program was commenced from the Congress premises in Hartley St. It

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<sup>84</sup> Carter, B. et al, *op. cit.*, pp2-33.

<sup>85</sup> Nathan, P & Japanangka, DL, 1983 (1), *op. cit.*

consisted of one consulting room, and a very small office off the multi-function space incorporating doctors desks, AHW education and health promotion activities. It employed a midwife, an AHW, and a liaison officer. Congress provided a medical officer two days per week. Of course, all staff were women.

In 1988, Aboriginal Hostels Ltd made available an old house in Mueller Street. Supplementary funding was also received from the Australian Council of Churches and the Bicentennial program. This enabled the Alukura to expand their program but the premises were unsuitable for birthing. However, they did provide ante-natal care, and other women's health programs.

THS was initially strongly opposed to the Alukura, especially the plan to commence a birthing service. However, as the work of the Alukura continued it became clear to all that this new service was providing antenatal care to more women than THS had been able to service. An example was that in the first 3 months of operation from Mueller Street, the Alukura had diagnosed 17 cases of gestational diabetes compared to the THS identifying 12 cases in the previous year. This improved antenatal care was so obvious that the opposition to the Alukura moderated. However, a strong view persisted that the Alukura should not develop a birthing service.

In 1989 a Review of the Alukura was conducted as part of the pilot funded by DAA. As a result the funding from DAA was made recurrent, part time positions were turned into full time positions, and the Bicentennial funds were incorporated into recurrent funding from the DAA.

The Alukura had to struggle to get support. It received international acclaim and was invited by the World Health Organisation to present the indigenous 'borning' model to its conferences in Adelaide (1988) where it was supported as a model of *Healthy Public Policy*. The Alukura was also invited to the Sundsvaal conference in 1991 where it was further endorsed as a model of *Providing a Supporting Environment for Health*. The Alukura also received widespread support from women's and public health groups in Australia. However, it was not until 1991 that funding was made available for the

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<sup>86</sup> Congress Alukura *'Arlwekere by the Grandmother's Law: Report of the Congress Alukura.'* Alukura, Alice Springs, Nov 1994.

premises it required to commence birthing. The funding came from NAHS funds via ATSIIC which were for capital expenditure only.

At around this time a new obstetrician commenced work at Alice Springs Hospital. He was less anxious about the Alukura doing birthing, and whilst he was cautious he at least did not actively agitate for it to be blocked, and indeed worked productively with Alukura staff to ensure its safe introduction. The first birth took place at the new premises of the Alukura in September 1993.

The Alukura also provided a women's health outreach program to a limited number of communities focused on improving the information available to women in remote communities about a range of women's health problems, and working with local AHWs on improving their skills in ante-natal care and screening techniques such as PAP smears. During such visits many women were screened for STDs, and cancer. This bush service was not adequately resourced to provide comprehensive coverage to women in remote communities.

Bureaucratic resistance from THS has continued. It has taken two forms. Firstly, there has been the refusal of THS to combine its rural women's health resources with the Alukura to ensure that duplication does not occur. An example was the PAP smear screening program that was funded from the Commonwealth, but through THS who used the resources to strengthen their own program. The other was through the development of the Strong Mothers, Strong Babies program. This program was developed in the Top End, and THS has promoted this as the answer for all communities. Over the past few years they have been trying to impose this program on central Australian communities, rather than recognising that in central Australia, the Alukura *is* the strong mother, strong babies program, and that it would be more efficient and effective to strengthen this program.

The justification for the promotion of this program has rested on an evaluation of the program showing improved birth weights of children born to mothers involved in the program. However, the figures produced by John Condon of THS<sup>87</sup> for all regions in the

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<sup>87</sup> Condon J 'Maternal and Child Health Data.' THS, Darwin, 1998, p39.

Territory show that the best birth weight results are in regions where the Strong Mothers, Strong Babies programs was not operating. The tendency for centralised health bureaucracies to develop programs and then impose them without cognisance of local initiatives is a major issue in Aboriginal health. This is a further illustration of the need for regional planning processes.

Table 3 Birth-weight by THS District 1985 -1995

<b>THS Health District</b>	<b>Approx Birth-weight (Gms)</b>	<b>Comments</b>
Darwin Urban	3,150	Has been around 3,000 from '92 to '94
Darwin Rural	3,000	Declined from 3,050 ('89) to 2,850 ('92), then rose to 3,100 ('93) and has steadily declined to 2,900 ('95)
East Arnhem	2,900	Between '90 and '93 was fairly stable at around 2,800. Improved in '94-'95 to 2,900.
Katherine	3,100	Has been steady at around 3,100 since 1991.
Barkly	3,100	Improved from a low of 2,850 ('89) to 3,200 ('93) and has steadily declined since to 3,000
Alice Springs Urban	3,250	Was at a low of 2,900 in '88 and improved to 3, 250 by '91, improved further to 3,300 in '94 and fell back to 3,250 in '95.
Alice Springs Rural	3,100	From '86 to '88 was 3,100, then fell to around 3,000 where it stayed until '91 and then improved to around 3,100.

This table summarises data in the referenced report.

It is not known what the factors are in the different regions to explain the differences, and the following discussion is purely speculative to illustrate that evaluations of projects can be constructed to support a range of positions. A THS Media Release asserted that the overall improvement of birth weights was due to the Strong Mothers, Strong Babies program. However, the best results were in the Alice Springs Urban region where that program did not operate at all. In the Alice Springs Rural area, the program was only introduced in a few communities in 1995, so any impact would not appear in these figures. So we can say that the two regions where the Strong Mothers, Strong Babies program was operating have the worst birth-weights in the Territory. It would be unfair to blame the Strong Mothers/ Strong Babies program on these poor results, and as the program did not operate in every community, there may be big differences in the communities where the program was operating compared to others. It is possible that a close evaluation of outcomes in the communities where that program did operate would show good birth weights in those communities, whilst not being evident in regional aggregated data.

However, it could be argued that the Alukura and the other crisis-ridden community based primary health care programs that have been operating from Congress in Alice Springs for many years are responsible for that region having the best outcomes. This too would be difficult to substantiate with certainty. Clearly the factors involved in improving birth-weights are many and certainly include culturally appropriate antenatal care, but also nutritional and socio-economic factors.

In central Australia, the development of the Alukura, even though most women are not utilising the birthing service itself, has given a fillip to birthing as Aboriginal women's business. This involves not only more choice of services, but a sense that they have rights, and they can be in control. The alternative has been to simply access the hospital services and the assumptions that birthing and mothering are matters for experts. What the women wanted was to reclaim their birthing rights. That process is multi-faceted, and cannot be simply reduced to birthing outside the hospital. However, only one aspect has been funded - the town based clinic and birthing suite, with limited resources for remote work. The next step is to increase the options for women to have their babies in remote communities. Under the recently established CA Regional Indigenous Health Planning Committee, a Women's Health Working Group has been established to overcome the competition and duplication of resources implicit in THS and Alukura working separately.

### ***Development of Remote Services in Central Australia***

From the beginning, one of the issues for Congress was the delivery of health services to people in the whole of central Australia. The Congress Council was a vehicle for bush people to have their interests represented. In July, 1974, Congress was granted \$18,000 from the Department of Health to conduct a survey of central Australia with the aim of developing a model for health service delivery to central Australian Aboriginal communities<sup>88</sup>. Dr Cutter conducted a survey of the region west of Alice Springs focused on Papunya, and North East of Alice Springs focused on Utopia. This document outlined

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<sup>88</sup> Cutter, T *'Report on Community Health Model: Health by The People.'* Central Australian Aboriginal Congress, Alice Springs, 1976.

a model for health service development, and included inter-sectoral relationships, housing issues and the development of Aboriginal Health Workers as key components of the health service. It took into account the different histories of these two areas, noting that in the eastern area, there were no government settlements such as existed in the west (eg Papunya, Yuendumu). Thus there was less institutionalisation in the Utopia area. It also recognised the importance of Ngangkeroes in the delivery of health care. Some funding was made available for at least a partial implementation of this model.

#### Urapuntja Health Service

As a consequence of the Congress report, funding was made available and in 1977 the Aero Medical Service handed over to Congress the medical records of the people at Utopia<sup>89</sup>. Congress began an outreach health service to Utopia known as the *Angarrpa (Ankerrapw) Health Program* in 1977. Ankerrapw is the name of the place where the Utopia Homestead is located. In 1979, this program was renamed the Urapuntja Health Service when it became independent of Congress and incorporated. Urapuntja is the local name for the Sandover River that runs through the area. The local people had taken control, and the Urapuntja Health Service has been quite autonomous since.

Utopia Station had been handed back to Aboriginal people in 1976. It is interesting to note that, unlike other 'communities' in central Australia which were either missions or government settlements, there is no real centre or town at Utopia. Instead the community is organised into around 17 out-stations or small groups of people of 30 or so in number. The number of groups tends to change as circumstances change. The health service has always been mobile. The health service staff accommodation and a clinic are located in the same area. The store is located in a different area. There had been an ongoing dispute between the people at Utopia and the DAA, with the health service getting involved from time to time, about this dispersed style of living. For the DAA it has been seen as an expensive way of living in terms of the provision of infrastructures. Each out-station needs its own generator for provision of power. Vehicles are expensive, and are needed more

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<sup>89</sup> Review Team '*Urapuntja Health Service: A review of the Urapuntja Health Service, Central Australia undertaken for the Aboriginal & Torres Strait Islander Commission.*' July, 1994, p9.

when people are spread out over a large area. There has been little appreciation by some of the DAA staff of the strength this style of living has for people and their health.

In 1980, the service employed one medical officer and two nursing sisters who serviced around 600 people living in seven different out-stations<sup>90</sup>.

A health survey done in 1990 showed that the health status of people at Utopia tended to be better than generally expected for other Aboriginal communities in central Australia, although direct comparisons could not be made<sup>91</sup>. This was recognised by Minister Tichner in a letter to one of the researchers involved with the survey, Andrew Gault. The 1994 Review of Urapuntja points out<sup>92</sup>:

*‘... the history of relations between the local ATSIC office and UHS over the last several years suggest the policy at the top of the bureaucracy does not necessarily translate into support at the local level. There is little in the present funding and resource levels to indicate that ATSIC does indeed “support the return by Aboriginal communities to dispersed out-station living”<sup>93</sup>.’*

However, by 1990, the service had expanded to cover an increased population living in an increased number of locations. The 1986 census showed that 890 people were living in the area.

In 1991, Richard Downes, the Chairperson of the Arltarlpilta ATSIC Regional Council<sup>94</sup>, also became the Administrator for the Ampilatwatja (Amaroo) Community. He took on the task of establishing a separate health service for this community, which also took over services to a number of northerly out-stations – Irrwelty, Atnwengerrp and Ingkawenyerr. This new service was called the Aherrenge Health Service, but has since changed its name to the Ampilatwatja Health Service.

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<sup>90</sup> Review Team, *op. cit.*, p9.

<sup>91</sup> Urapuntja Health Service ‘*Health Survey.*’ IAD, Alice Springs, 1990.

<sup>92</sup> Review Team, *op. cit.*, p13.

<sup>93</sup> Quoted from letter to Andrew Gault from Minister Tichner, 9<sup>th</sup> August, 1990.



From 1990 to 1992, ATSIC bureaucrats put pressure on the Urapuntja Health Service, and it became administered by the Community Council. This heralded a period of serious instability in terms of non-Aboriginal staff turnover. During this period Congress provided some support through the provision of medical officers.

In 1993 the administrative arrangements of ATSIC changed, with the Arltarlpilta Region being amalgamated with the two other central Australian bush ATSIC Regions to form one large Papunya Regional Council. This gave the health services no direct voice in ATSIC.

In 1993, the Administrator's position was re-established, and the Health Service was again independent of the Community Council. Since that time there has been greater stability in non-Aboriginal staff turnover<sup>95</sup>.

Utopia has also been under pressure from some NT politicians who continue their opposition to Aboriginal people holding title to land because, they claim, Aborigines do not maintain economically viable cattle stations. It is true that when title was given to Aboriginal traditional owners, the cattle on Utopia were mostly eaten, and not replaced. This enabled the bush tucker to grow back. Now, up to 25% of people's diet is from bush tucker that is a major economic activity for the community. Further the health survey estimated that 80% of the population at Utopia did not drink. Certainly alcohol related violence tends to be low. This again is partly due to people living in small and appropriate family groups rather than being mixed up as in the old mission and government settlement communities.

If estimates that the proportion of the diet that is bush tucker is 25% are true, and the population of Utopia is around 1,000 people, then the country is supporting around 250 people in food supply. It is doubtful that the cattle station ever supported so many people from cattle. With cattle, much of the vegetative bush tucker eaten by people is not available.

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<sup>94</sup> The Arltarlpilta Region was abolished in a review of ATSIC Regions in 1993 and was incorporated into the Papunya Region.

<sup>95</sup> Review Team, *op. cit.*, p13.

## Lyappa Congress, Papunya

Following the Congress Report mentioned above, Congress assisted the establishment of a Papunya health service known as the Lyappa Congress. The health service commenced in June, 1978<sup>96</sup> and was run and controlled by the Papunya Community Council, with Congress playing a supportive role only. The Congress Report had pointed out the difference historically between the area west of Alice Springs compared to the area to the East. There were no government settlements to the north east of Alice, whilst to the West there were a number of government settlements, including Papunya and Yuendumu, as well as the Lutheran Mission of Hermannsburg. Thus the degrees of institutionalisation and associated dependencies were greater at Papunya<sup>97</sup>. However, the District Health Committee composed largely of Ngangkeroes proposed in the Congress Report<sup>98</sup> was not implemented. Further, Haasts Bluff was not included, and continued to receive services from the NT Medical Services (now THS).

By 1979, the service employed one doctor, and two nurses, along with a number of Aboriginal staff<sup>99</sup>.

However, around this time divisions developed in the community with the Pintubi people who were brought into Papunya in the 1960s, wanting to return to their homelands. There had been too much alcohol induced fighting at Papunya, and the health service became involved in these issues. The issue of the Pintupi moving away from Papunya had been simmering for some years, and some people had made attempts to move to out-stations<sup>100</sup>. In 1981, the Pintubi people, as a group, left Papunya and settled at Kintore. Initially the health service provided a visiting service to the Pintupi at Kintore, but some other Papunya residents resented this, even though a second doctor had been appointed to help reduce the workload. Shortly after the Lyappa Congress collapsed as a consequence of community divisions, and the lack of support for health service staff from either the

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<sup>96</sup> Scrimgeour, D, *op. cit.*, p31.

<sup>97</sup> Cutter, T, *op. cit.*, p66.

<sup>98</sup> *Ibid.*, p49.

<sup>99</sup> Scrimgeour, D, *op. cit.*, p31.

<sup>100</sup> Cutter, T, *op. cit.*, p10.

Papunya Community Council and responsibility for the provision of health services at Papunya reverted to the Northern Territory Health Department. There were allegations at the time that THS staff was involved in undermining the Lyappa Congress<sup>101</sup>.

*‘There were many problems at Papunya and most seriously there was no assistance by the Department of Aboriginal Affairs to establish a properly incorporated regional health service. Congress was prevented by the same department from giving support and advice, except during crises and finally through the private manoeuvrings by Territory and Federal authorities with support of some Aboriginal people, the service was forced to close in December, 1982.’*

Over the past few years Aboriginal people at Papunya are again making demands about the need for a better health care system at Papunya, and for them to have more control over their health service. Maybe the sentiments expressed by Congress back in 1984 will eventuate:

*‘Lyappa Health Service was “set up” by the Department of Aboriginal Affairs to fail, to prove that Aboriginal people couldn’t run their own affairs.*

*Well they can. Congress proves this, so does Pitjantjatjara, Utopia, and Nganampa, and the hundreds of Aboriginal organisations that are taking over their own services all over the country. Even out of Lyappa a new Aboriginal controlled health service has grown; the Pintupi Homelands Health Service. Perhaps one day the Aboriginal people at Papunya will take over the health service and tell such departments where to go.<sup>102</sup>’*

The collapse of the Lyappa Congress highlights some differences between the ideology of community control often embraced by health professionals, and how Aboriginal people perceive this. It raises issues relating to Aboriginal and non-Aboriginal domains, and

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101 Congress Ten Year Book, 1984.

102 *Ibid.*

where the delivery of health services fit. Myers<sup>103</sup> discusses problems at Papunya and how for many Aboriginal people the delivery of health services is seen as a non-Aboriginal domain – that is it is white fellah business, and thus expectations that they will take over control of day to day aspects of health services is unrealistic. However, that does not necessarily diminish people's desire for ultimate control over the health service that they do exercise when they are unhappy about particular staff or other issues.

#### Pintupi Homelands Health Service

The Pintupi people at Papunya had always been strong supporters of the community controlled health service model, and did not trust either the THS or the DAA. When they moved from Papunya to Kintore in 1981, the Lyappa Congress initially provided health service support. When the Lyappa Congress collapsed in 1982, the Pintupi people at Kintore were unhappy to have their health services provided by THS, and sought support from Congress.

In late 1983, the Walungurru Council at Kintore was keen to establish a health service. Congress provided a medical officer for 3 days a fortnight, assisted with administrative tasks and provided support through the radio schedule run by Congress<sup>104</sup>. Congress and NAIHO lobbied DAA for funding for a Kintore service and in 1984 the Pintupi Homelands Health Service was established<sup>105</sup>.

Kintore's isolation has made the maintenance of the health service difficult at times. Some commentators<sup>106</sup> have made much of this so called instability claiming that it is a product of small, stand alone primary health care services. This view fails to take account of the fact that many government controlled health services have also had periods of instability. Such periods are as much to do with the nature of the communities themselves, and their remoteness than as with who runs them. Whilst Government run services have a

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<sup>103</sup> Myers FR *'Pintupi Country, Pintupi Self: Sentiment, Place and Politics among Western Desert Aborigines.'* University of California Press, Los Angeles, 1991, p276-282.

<sup>104</sup> Congress Ten Year Book, , *op. cit.*

<sup>105</sup> Scrimgeour, D, *op. cit.*, p32.

<sup>106</sup> Wakerman, J, Bennett, M, Healy, V, Warchivker, I *'Review of Northern Territory Government Remote Health Services in Central Australia.'* Menzies School of Health Research, August, 1997, p176.

regionalised administrative structure that enables staff to be relocated relatively quickly to deal with these crises, for community controlled services, Congress has tended to play this role. Indeed, the Health Service has utilised Congress support in a range of matters including assistance with budgeting and negotiations with funding bodies, assisting the resolution of crises involving health service non-Aboriginal staff, and providing medical officer relief. In recent years such support has been less required partly due to the ongoing role of Bill Williams who is the services non-resident Medical Director. This has allowed some continuity to be achieved, and is in line with similar arrangements that Nganampa Health have with Paul Torzillo.

Currently the Pintupi Homelands Health Service can boast<sup>107</sup>:

- ♦ Community control;
- ♦ Salaried Ngangkeraes
- ♦ Permanent, resident medical officers;
- ♦ Experienced, stable nursing staff;
- ♦ Coordinated and comprehensive primary health care;
- ♦ Essential public health programs;
- ♦ Regular chronic conditions review;
- ♦ Transport for health related activities eg sorry business, visiting sick family;
- ♦ Efficient administration and training for local staff; and
- ♦ Financial solvency.

Pitjantjatjara Homelands Health Service (Kalka/ Pipalyatjara)

In the south west area, Docker River was serviced by the NT Medical Service, whilst the more eastern communities such as Ernabella were serviced by the South Australian Health Department. However, this left communities of Pipalyatjara in SA, and Wingellina, Blackstone, Jamieson and Warakurna in WA without health services.

There had been movement of Pitjantjatjara people from Warburton to the east in 1960s and 70s. This had resulted in the last government settlement being established at Docker

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<sup>107</sup> Williams W, Napurrula CR, Tjakamarra EB in letter accompanying '*Pintupi Homelands Health Service, Annual Report, 1996-97.*'

River in 1968. The Pitjantjatjara Council was formed in 1976<sup>108</sup>. Congress had made occasional visits to people in this area and worked with the Council to develop a proposal for a health service based at Kalka, SA for these communities. Congress submitted an application for funding to the DAA in 1977 which was successful and the Pitjantjatjara Health Service was established in 1978. The service was predominantly a mobile one. It was originally planned to locate the service at Pipalyatjara, but this was changed in order to emphasise the mobile nature of the service, and to prevent the service being seen as too closely related to one particular community. Thus the service was located at Kalka, a bore about 10kms from Pipalyatjara<sup>109</sup>.

In 1982 the name of the health service was changed to Pitjantjatjara/ Ngaanyatjarra Health Service. Again, whilst the service was autonomous, Congress continued to provide support where it could, including the daily radio schedule regarding patients, and the provision of relief doctors when required<sup>110</sup>.

#### Ngaanyatjarra Health Service.

The Pitjantjatjara Health Service had difficulties providing a service to all their client communities which were scattered over a large area stretching from the Eastern part of the Pitjantjatjara Lands well into Western Australia. Thus the service was split in 1982 with the establishment of the Ngaanyatjarra Health Service that was run by the Ngaanyatjarra Council. This covered the largely Ngaanyatjarra speaking communities in Western Australia. Most of the people in this area had a history of relating to Kalgoorlie as their major resource centre (including hospital services) rather than Alice Springs. In 1989 the Health Department of WA funded the service to extend their services to the Warburton Community.

Currently the health service maintains an administrative office in Alice Springs. It continues to be run under the auspices of the Ngaanyatjarra Council, and is funded through OATSIHS federally and the WA Health Department.

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<sup>108</sup> Land Rights News, 'A Cultural History of Australia.', Vol 2, No 6, 1988, p29.

<sup>109</sup> Scrimgeour, D, *op. cit.*, p28.

<sup>110</sup> Congress Ten Year Book, *op. cit.*

Nganampa Health Council:

After the Ngaanyatjarra Health Service was established, the Pitjantjatjara Homelands Health Service based at Kalka was now much smaller, with the eastern Pitjantjatjara communities continuing to be serviced by the SA Health Commission. In 1981 Congress (John Liddle and Trevor Cutter) met with Yami Lester (then Director of IAD) and senior people from the Pitjantjatjara Lands at Indulkana, and decided to pursue a proposition to develop a community controlled health service for the whole area<sup>111</sup>. The SA Health Commission had established the Aboriginal Health Organisation in the early 1980s, and this body agreed to fund the Pitjantjatjara Council to conduct a feasibility study<sup>112</sup>. Trevor Cutter and John Tregenza (who had been the first Administrator of the Pitjantjatjara Homelands Health Service) were appointed to conduct the review and recommended the establishment of three community controlled health services at Amata, Ernabella/ Fregon, and Indulkana/ Mimili. Each would have their own Administrator and clinical staff. They would operate under the umbrella of the Nganampa Health Council, which was to be established under the auspices of the Pitjantjatjara Council.

The service began in 1984, but rather than the Council maintaining its original decentralised power structures, it became increasingly centralised and in 1988 the four Administrator positions were abolished<sup>113</sup>. In 1985 the Pitjantjatjara Homelands Health Service at Kalka also became part of the Nganampa. In 1994 the administrative centre for Nganampa moved to Umuwa on the Lands, although an office was also maintained in Alice Springs<sup>114</sup>. Currently, Nganampa Health Council operates the following Community Health Centres<sup>115</sup>:

- ♦ Pukatja Clinic, Ernabella;
- ♦ Mimili Clinic, Mimili ;
- ♦ Kalka/ Pipalyatjara Clinic, Kalka;
- ♦ Amata Clinic, Amata;
- ♦ Aparawatatja Clinic, Fregon;
- ♦ Iwantja Clinic, Indulkana.

As well as three smaller homelands clinics:

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<sup>111</sup> Liddle, J Interview with Ben Bartlett, October, 1997.

<sup>112</sup> Congress Ten Year Book, , *op. cit.*

<sup>113</sup> Scrimgeour, D, *op. cit.*, p30.

<sup>114</sup> Nganampa Health Council 'Annual Report 1994-95', Undated, p3.

<sup>115</sup> *Ibid.*

- ♦ Nyapari Clinic, Nyapari.
- ♦ Yunyarinyi Clinic, Kenmore.
- ♦ Watarru, Clinic, Watarru.

Nganampa is funded through both Commonwealth and South Australian government agencies. Nganampa, as a product of its regional nature, has been able to develop comprehensive primary health care programs (eg the environmental health program, UPK; nutrition programs, STD screening) which smaller stand alone health services have had more difficulty developing. The other significant factor in Nganampa's achievements, apart from their relatively high level of funding, is that the communities of the Pitjantjatjara Lands have legal title to their land, and control of other service delivery (eg housing) as well as health. This provides for greater opportunities to ensure effective inter-sectoral collaboration, as some of the inter-sectoral conflict experienced in other areas with a multitude of agencies involved in service delivery, has been avoided.

#### Mutitjulu & Imanpa

The Mutitjulu Community is the community at Uluru (Ayers Rock) and the numbers in the community have grown since the ownership of the Uluru National Park was handed back to them in 1986. The Imanpa community consists of people who have tended to camp around the roadhouse known as Mt Ebenezer. The community eventually bought this roadhouse. Both communities are of predominantly Pitjantjatjara and Yankunytjatjara people.

In 1985 Mutitjulu asked Congress for help to establish a health service. Congress Director, John Little and Trevor Cutter visited these communities along with those at Kings Canyon and Docker River to discuss health service needs, with the view of establishing a regional service. Congress was met with a hostile reaction from the THS nurse at Docker River and that community decided to remain with the THS service. Initially Mutitjulu and Imanpa agreed to share a health service that was based at Mutitjulu. Imanpa were dissatisfied with this and eventually the two communities developed their own services. Whilst Mutitjulu has maintained reasonable stability in terms of staff and an ongoing



relationship with Congress through the supply of a medical officer, Imanpa has tended to be crisis-ridden.

Medical visits tended to be intermittent from the RFDS doctor based at the tourist resort of Yulara and from Congress.

In 1989 attempts were made by the DAA to stop Congress providing medical services and to hand them to RFDS. During negotiations the main sticking point for Mutitjulu was the refusal of the RFDS to give any say to the community about the choice of doctor.

Congress was able to be more flexible on this point, and the service from Congress was continued. At the same time Imanpa negotiated with THS and now receive regular visits from a THS DMO.

The development of community controlled health services in remote communities involved Congress and all resulted in autonomous health services. It is common for some working for THS to express views that Congress is simply expansionist, imperialist and self-seeking; that the organisation wants to control everything, and attract all funding. Invariably this is put up in terms of resources being concentrated in Alice Springs and the 'poor people' out bush not getting their share. The irony of this argument (rarely put in writing) is that, as can be seen from the above history, Congress has been involved in dramatically increasing the health service resources to remote areas. Whilst THS continue to be responsible for the delivery of primary health care services to a significant number of remote communities, it has yet to employ a single doctor to be resident outside Alice Springs, whilst 6 doctors are employed by community controlled health services in remote communities. Further an examination of the expansion of community controlled health services to remote communities illustrates that Congress has not retained control of these services, but in all cases fostered local community control.

### ***Community Controlled Primary Health Care – Discussion***

The Aboriginal community controlled health services operate in what may appear to an outsider to be a chaotic manner. Aboriginal communities are themselves fairly constantly

in crisis premised on poverty, and dislocation from country and family. This is reflected in the high adult morbidity and mortality partly related to substance abuse and violence. These crises are mirrored in community controlled health services. Aboriginal staff frequently must attend to family and community obligations - such as funerals and sorry business<sup>116</sup>. It is my observation that the greater the degree of Aboriginal control in determining the programs of the service, how they are run and who runs them, the greater programs are caught up in day to day crises that intimately involve some Aboriginal members of staff, as well as placing demands on the services themselves. This frequently is the cause of great anxiety felt by non-Aboriginal health professionals, who are trained to be in control. The crises interfere with planned health program activities.

Another difficulty in understanding the nature of Aboriginal health services is the tendency to resist (or at least neglect) documentation - this resistance is partly related to the unfortunate histories of anthropologists, medical and other researchers in using Aboriginal people as objects of research, without any concern for benefits to the community, without consent, and without feedback. But it is also simply that there are so many other things happening within the crisis-ridden environment, that documentation never manages to appear a priority. Where Aboriginal health services are highly organised and documented, it is often the case that non-Aboriginal professional staff performs the day to day management. These services are still community controlled in the sense that the committee or council can (and does) intervene when they perceive something wrong, and are usually involved in the process of major decisions, negotiations with bureaucrats, and selection of staff. But the service delivery imperatives are left to non-Aboriginal staff.

An example of this is the Menzies-Nganampa-Australian Community Health Association project that attempted to modify the CHASP (Community Health Accreditation and Standards Project) so that it would be more appropriate for Aboriginal health services in remote Australia. Congress was one site of that development, and was the one site where there was a general failure of the whole process despite serious attempts to implement it. This failure was not addressed in the resultant document or in reports of the project. Why did this fail? In the smaller bush services the process was taken up by one of the non-

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<sup>116</sup> Sorry business is the term used to generally describe the customs and ceremonies that take place

Aboriginal staff (usually a nurse) who sat down with the Aboriginal Health Workers and went through the manual systematically. The results of this process became the inputs that formed the basis of the Manual of Standards for Rural and Remote Aboriginal Health Services<sup>117</sup>.

The CHASP process involves both external and internal reviewers, and a systematic working through of the standards over a 3-month period with health service staff. This period involves internal reviewers only with the external reviewer returning at the end of the period to assess the results of the staff work with them and the internal reviewer.

At Congress two Aboriginal Health Workers were nominated to be internal reviewers for this process. They attended a training course with reviewers from other health services that were part of the project. One of these played a role as an external reviewer for one of the other services involved in this project. However, to carry the process within Congress proved impossible. Unfortunately the review of the process overall failed to adequately investigate the Congress experience. My conclusions about this are that it actually was very useful for the doctors at Congress who worked through the standards separately from Aboriginal Health Workers. Going through the standards raised issues such as quality assurance, continuity of care, and client rights that were taken more seriously by doctors after this process. For the health workers, they did not relate to the structure of the process, and could not see the usefulness of it. This is probably a reflection of two factors. One is the level of literacy and intellectual training necessary to participate, and the other may relate to different cultural perceptions of what the health service is about. It may also relate to the role AHWs play in health service delivery that is much less on the mechanistic side of the process and more on the community crisis side. That is, AHWs are part of the community and the problems that face the community, whereas non-Aboriginal professionals are outside that dynamic to various extents, and must construct their own version of what is actually happening. This gives the non-Aboriginal staff a greater motivation to participate and embrace a framework for making sense of what is otherwise difficult to comprehend and operate in.

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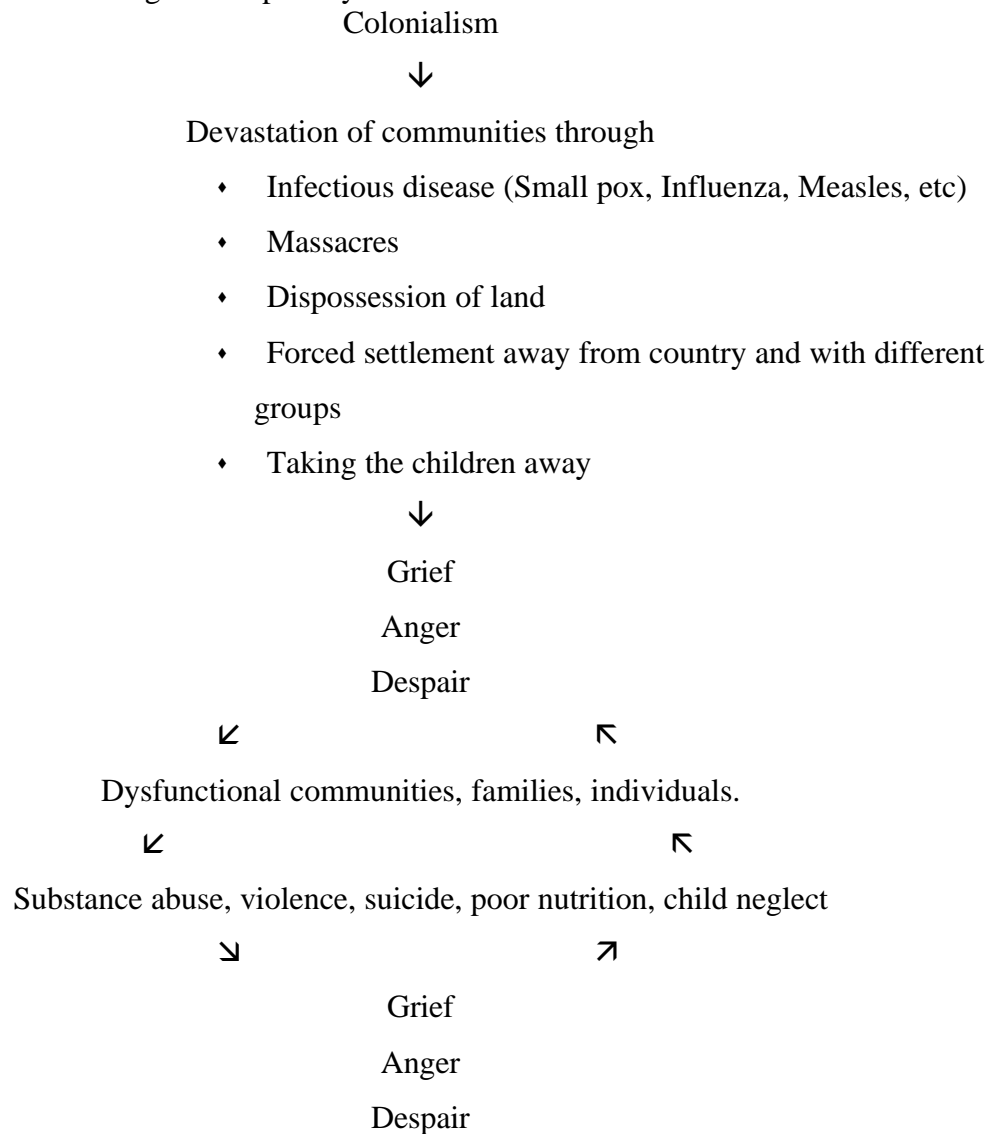
<sup>117</sup> as part of a grieving process after a death.  
Nganampa Health Council 'Manual of Standards for Rural and Remote Aboriginal Health Services.' Nganampa Health Council, 1993.

This example illustrates the clash between Aboriginal and non-Aboriginal processes. This involves cultural aspects which amount to a culturally and historically determined worldview. But this also incorporates aspects that are a product of the colonial relationship, and this to a large extent is related to power. The fundamental parameters of the CHASP process were set in a non-Aboriginal setting – mainstream community health centres. Where non-Aboriginal people were able to take control of the process, the process was deemed successful. Where they could not, the process tended to fail. But this does not indicate that the health outcomes where non-Aboriginal people are more in control are necessarily better. Early recent information examining birth weights of babies born in the Northern Territory (see Table 3) suggest that Aboriginal babies in Alice Springs have the best birth weights, despite the often crisis-ridden programmatic activity. However, the high level of debate and discussions about these issues in the Congress community health program, family support program and the Alukura and the degree of Aboriginalisation and control of these programs may have a lot to do with such outcomes. Such Aboriginal involvement with these issues has an impact throughout the community without specific education programs. The social relationships of Aboriginal health workers and others employed in these programs is capable of spreading the debates and discussions well beyond the walls of a specific health service.

This is not to encourage or condone the lack of documentation of Congress programs. However, the further away from the 'community' health planners and practitioners are, the greater their need for documentation and familiar structural frameworks in order for them to operate. When practitioners are part of the 'target' community, such structural frameworks are not seen as necessary. However, there is little doubt that improved transparent program planning and documentation would improve the outcomes of the programs further.

Health services can narrowly deliver scientifically proven programs including treatment of sick people and various public health measures (immunisations, STD control programs, various screening programs). This style of health service will achieve clear outcomes. Part of the process of developing these programs involves clear documentation of the program parameters, and a process of data collection and analysis that can evaluate the penetration of the program and its effectiveness. Doctors and/ or nurses are employed in both community controlled health services and government services to perform these sorts of functions. However, in health services where the community has identified it as their resource, a more crisis ridden environment results which reflects the crises of the community of which the Aboriginal staff are part. Figure 2 illustrates a way of viewing this crisis-ridden cycle and how it impacts on Aboriginal health.

Figure 2 The Grief - Anger - Despair Cycle.



Within this cycle of grief, anger and despair are community people who metaphorically hold everyone together. They are the resources for the community in times of crisis. Are health services a resource for these people? To some extent, services like Congress are such a resource. But their imperatives frequently clash with the more straight-line imperatives of public health programs and the clinical service. This is a significant tension which operates in community controlled services which are largely Aboriginalised. Strong organisational policies of Aboriginalisation are important in improving people's self esteem (both for the workers and their clients). However, Aboriginal staff are inevitably caught up in the cycle themselves. The high mortality rates, the substance abuse, the suicides all impact on Aboriginal staff. They are immersed in the community and the crises that occur. Inevitably, if the service persists in Aboriginalisation, this will

make the process of achieving the narrow objectives of vertical public health programs more complex. However, the impact of providing organisational support organically to people in crisis has other outcomes that are more difficult to measure than immunisation rates and the like. How many suicides or other violent incidents have been prevented by Aboriginal people having access to resources and support through an Aboriginal organisation that they identify as belonging to them? We do not know.

This emphasises a major challenge to clinicians and public health practitioners. It is possible to deliver a range of public health programs to relatively passive participants, and the narrow objectives of those programs will be achieved. There is a seductive appeal to developing the centralised data bases for immunisations, PAP smears, syphilis serology results, etc. so that we can know that we have good coverage of these programs. But maybe we would achieve much more if we were able to find ways to deliver these programs in ways that also support the key community people who play important roles in the crises that surrounds them.

Congress is one example of a community controlled health service that straddles the colonial relationship. It asserts self-determination and Aboriginal control as a fundamental, it is immersed in the community dynamics, and at the same time delivers clinical and public health programs. It has attempted to break from the colonial relationships which at best treated Aboriginal people as clients of the colonial health services, and created a service which can treat clients, but also attempts to resource the community as agents of improved health.

### ***NAIHO to NACCHO***

The National Aboriginal and Islander Health Organisation (NAIHO) was established by Aboriginal health activists in the mid 1970s. NAIHO played a critical role in assisting Aboriginal communities to establish their own health services, and to advocate to government for appropriate policy development and funding for Aboriginal health.

In 1983 NAIHO was funded to provide advice to government, assistance to communities, and to conduct national health programs<sup>118</sup>. However, funding was withdrawn from December 31st 1986 allegedly because of an unsatisfactory audit report<sup>119</sup>. However, it was also the case that NAIHO clashed with the DAA and the Minister over the direction of funding and planning of Aboriginal health services. Catholic Relief provided assistance to NAIHO for a number of years, which enabled the organisation to continue a watch dog role on Government decisions in Aboriginal health. Splits developed in the organisation, and in 1988 -1989 national meetings of Aboriginal community controlled health services were held as part of the process of developing the National Aboriginal Health Strategy. However, these were held as national meetings of Aboriginal community controlled health services rather than NAIHO.

Eventually a new organisation was established after a meeting in Perth in 1991. This is known as the National Aboriginal Community Controlled Health Organisation (NACCHO). In 1996 funds were made available from the Commonwealth Government and a NACCHO secretariat was established in Canberra.

In a number of regions or states/ territories, local formations of Aboriginal health services have been established. These broadly can be seen as 'branches' of NACCHO, although they all operate autonomously. In the NT the Aboriginal Medical Services Alliance – Northern Territory (AMSANT) was established in 1994. Membership of AMSANT includes:

- ♦ Central Australian Aboriginal Congress (Alice Springs);
- ♦ Danila Dilba (Darwin);
  - ♦ Wurli Wurlinjang (Katherine);
  - ♦ Miwatj Health (East Arnhem Land);
  - ♦ Urapuntja Health Service (Utopia);
  - ♦ Ampilatwatja Health Service (Ammaroo);
  - ♦ Pintupi Homelands Health Service (Kintore);
  - ♦ Mutitjulu Health Service (Uluru);
  - ♦ Imanpa Health Service (Imanpa);

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<sup>118</sup> DAA 'Annual Report 1983-1984.' AGPS, Canberra, 1984, p35.



- ♦ Congress Alukura (Alice Springs); and
- ♦ Nganampa Health Council (Pitjantjatjara Lands).

Anyinginyi Congress (Tennant Creek) has been in some turmoil for the past few years. For various reasons they have decided not to be part of AMSANT at this time.

The next chapters (7 and 8) will examine the development of Aboriginal health policy at the national level.



## CHAPTER 7 – ABORIGINAL HEALTH POLICY BEFORE THE NAHS

As can be seen from other chapters, the colonial relationship began as tentative coexistence, moved to violent pacification, and then to a series of Government policies - protection/ segregation, assimilation, a brief period known as integration and eventually to self-determination.

We have seen in previous chapters that Aboriginal people were not passive, but were active in their struggle for survival, resisted the invasions, and indeed continue to resist.

This chapter looks at the development of Aboriginal health policy from the time of the collapse of the assimilation policy, up until the time of the National Aboriginal Health Strategy and the establishment of ATSIC.

### **Health Policy Development**

#### *National 10 Year Plan for Aboriginal Health*

Until the Whitlam Government took office in 1973, there was no explicit national policy on Aboriginal health. This had been left to the States, although the Commonwealth was responsible for health policy and delivery in the Northern Territory from 1911 until self-government in 1978. In 1973, the Whitlam Government adopted the first national Aboriginal health policy known as the '*National Ten Year Plan for Aboriginal Health*'. However, whilst it was a step in the right direction it had been developed unilaterally without input from Aboriginal people and it did not have wide support from other jurisdictions (that is the States)<sup>1</sup>. The dollars allocated were inadequate, and underlying issues such as unemployment, education standards and living conditions were not adequately addressed.

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<sup>1</sup> Program Effectiveness Review Task Force '*Program Effectiveness Review - Aboriginal Health*' Department of Prime Minister and Cabinet, Canberra, March 1980, pp10-11.

Indeed it was barely more than a statement of intent<sup>2</sup>:

*‘To raise the standard of health of Aboriginals of Australia to the levels enjoyed by their fellow Australians.’*

However, this period did involve a new approach to Aboriginal affairs in general, and Aboriginal health in particular. Funding support from the newly established Department of Aboriginal Affairs (DAA) was provided to a growing number of Aboriginal community controlled organisations, including health services. However, some funding was also provided through the use of doctors working for these services bulk billing Medibank after its introduction in 1975. Other funds for health professionals’ salaries came from Medibank’s Health Program Grants.

### ***House of Representatives Report***

In 1978 the House of Representatives appointed a Standing Committee on Aboriginal Affairs. Previous committees had been appointed in 1973, 1974 and 1976. In December 1976, March 1977 and March 1979, the committee received terms of reference specifically related to Aboriginal health. The Committee’s report *‘Aboriginal Health: Report from the House of Representatives Standing Committee on Aboriginal Affairs’* was presented in 1979. It recommended that high priority be given to environmental factors in Aboriginal communities, with special emphasis on provision of housing in towns away from fringe camps, and support for homelands in remote areas. The responsibility of Commonwealth, state/ territory and local governments was identified as an important issue, as was the need to establish advisory groups of experts in middle level technology. Cultural factors were also identified as important with recommendations focusing on:

- ♦ appropriate design and implementation of health programs;
- ♦ live-in facilities for relatives of hospital patients;
- ♦ in-patient facilities in larger remote settlements;
- ♦ stopping the evacuation of pregnant women;
- ♦ local midwifery services in remote communities;
- ♦ stopping the practise of separating infants from their mothers; and
- ♦ the handing back of bodies to families for appropriate burial.

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<sup>2</sup> NAHS Working Party *‘A National Aboriginal Health Strategy.’* Canberra, 1989, p7.

The report supported the development of out-stations and asserted the need for services to residents of out-stations.

In regard to health programs the report emphasised:

- ♦ preventative programs;
- ♦ independent evaluation following WHO principles;
- ♦ the need to provide a full range of services from which people could chose; and
- ♦ the dangers of funding disease specific task forces.

Generally the report supported self-determination, stressing community control of services and the importance of networking, and was concerned about the need to ensure a community development approach. It was recommended that an inquiry be set up to look at the implementation of self-determination and how it effects community development.

Indeed, the government's health policy included programs to address some of these issues particularly programs aimed at improving Aboriginal living environments, and strengthening the community basis of health services through the promotion of Aboriginal management, and service delivery<sup>3</sup>.

Much of what was in this report remains relevant. The lack of coordinated government effort across jurisdictions was recognised, and indeed the conflict between an 'expert' led strategy (supported by the States and the Commonwealth Department of Health) and a 'community' led approach supported by Aboriginal communities and DAA was highlighted. These conflicts persist.

***NAIHO and the National Black Health Plan:***

In the meantime the Aboriginal community controlled health services had organised a national health organisation, the *National Aboriginal and Islander Health Organisation* (NAIHO). NAIHO had played a role in assisting Aboriginal communities to develop their own health services. A great deal of inspirational strength came from the Redfern AMS.

However, there were many tensions between Aboriginal health services and mainstream services run by the states/ territory. There was not widespread agreement about the value of AMSs on the part of government or private service providers on the ground. Health services felt that they lacked support from the DAA bureaucracy, and were marginalised in the towns and cities where they operated.

In 1977, NAIHO developed a National Black Health Plan that was intended to bring a coordinated and agreed approach by all parties to the task of improving Aboriginal health.

Whilst this plan was never adopted as such by governments, it was a critical document in terms of uniting health services and strengthening their negotiations and input into government policies. It also illustrates the consistency of community controlled health services in seeking collaborative, but equitable relationships with the mainstream health industry.

The fact that governments were unable to seriously consider NAIHO's plan reflects the difficulty the health bureaucracies have had in accepting leadership from Aboriginal initiatives.

### ***Program Effectiveness Review***

In October 1979, the Department of the Prime Minister and Cabinet undertook another review of Aboriginal health that is known as the Program Effectiveness Review (PER). The report was presented to the Department of Prime Minister and Cabinet in March 1980, but was never publicly released. But it leaked to Aboriginal health services all around the country. The report was prepared by officers nominated from the Departments of Prime Minister & Cabinet, Aboriginal Affairs, Finance, Health and Social Security.

This report outlined the disputes between the States and the Commonwealth. The Commonwealth's Aboriginal health policy<sup>4</sup> was to:

- ♦ stimulate, support and coordinate health programs aimed at improving Aboriginal health;
- ♦ progressively strengthen the community basis of health services with emphasis on increasing Aboriginal responsibility and involvement in improving their own health;

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<sup>3</sup> DAA 'Annual Report 1980-1981.' AGPS, Canberra, 1981, p22, 26.

<sup>4</sup> Ministerial Directive on Government Financial Assistance to Aboriginals, 1980-81 - quoted in Program Effectiveness Review Task Force, *op. cit.*, p13.

- ♦ expanded Aboriginal participation in identification of health needs, develop programs and delivery of services in both government and community sectors, and through recognition of traditional practises; and
- ♦ secure satisfactory environmental conditions, especially safe water supplies and sewerage disposal.

However, the states/ territories continued to have a different perspective based on their interpretation of their agreements with the Commonwealth. Their view tended to be that the Commonwealth was responsible for the financing of health programs, and that the states/ territories were responsible for health policy, planning and coordination of health services. They considered that the states general responsibility for health should not be abrogated by the Commonwealth's Aboriginal health policies.

Further the states have tended to avoid being explicit about their attitudes towards policies of self-determination or self-management. According to the PER the states tended to insist that programs should be under the control of professionals. The PER<sup>5</sup> detailed the following points of policy conflict between the Commonwealth and the states/ territories:

- ‘ · *appropriate division of financial responsibility and the role of special supplementary funding;*
- *coordination, policy and planning; and*
- *the emphasis to be given to Aboriginal self-management and the level at which Aboriginals should be involved effectively.’*

At the time funding of Aboriginal health programs rested predominantly with the DAA with some funding for health professional salaries coming from the Commonwealth Department of Health through Medibank's Health Programs Grants. However, the Health Department considered that it should have responsibility for Aboriginal health at the Commonwealth level. Their view was that Aboriginal health could become part of the general health agreements between the states/ territories

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<sup>5</sup> Program Effectiveness Review Task Force, *op. cit.*, p15.

and the Commonwealth if they held that responsibility. However, the PER found that there were differences in interpretation between DAA and the Department of Health on the policy of self-management, the need to modify services, and the degree of cooperation with the states/ territories, with DAA being stronger on adaptation according to cultural and social factors in Aboriginal communities.

Despite the contradictions between state/ territory governments and the Commonwealth in regard to Aboriginal policy generally and Aboriginal health policy in particular, the number of Aboriginal community controlled health services continued to expand between late 1975 and 1983 - the years of the Fraser Liberal-Country Party Government.

In central Australia, Lyappa Congress at Papunya, the Angarapa (later Urapuntja) Health Service at Utopia, Pintupi Homelands Health Service at Kintore, the Pitjantjatjara Health Service at Pipalyatjara, and the Nganampa Health Council providing health service to the Pitjantjatjara Lands were all established, or in the process of being established, during this period. Chapter 6 discussed the details of the establishment of these services.

### ***Continued Territory Government Resistance***

During the years of the Fraser government, Aboriginal health services, as well as Aboriginal organisations in other sectors, tended to grow. However, little progress was made in achieving a more cooperative and collaborative approach with the states and territory governments responsible for the delivery of the mainstream health services.

Indeed there was a general lack of recognition.

An example of this involves the former Chief Medical Officer of the NT Government, Dr Ella Stack. Dr Stack presented a paper entitled '*Implications of Policy and Management Decisions on Services for Australian Aborigines*' to an international conference in Pennsylvania in 1986. In this paper Dr Stack gave an overview of Aboriginal health status, described the health services available to



Aboriginal people (even down to the detail of DMOs<sup>6</sup> and their ‘patches’) and concluded with a strong recognition of the need for more Aboriginal control of health issues.

However, the existence of seven Aboriginal community controlled health services in the NT is not mentioned except as an aside referring to

*‘... several Federal Government-funded general practice-type health services have also been established in a small number of rural and urban Aboriginal communities,’*<sup>7</sup>

Dr Stack’s view of Aboriginal control was limited to strengthening Aboriginal Health Workers working in the Government sector. To describe the community controlled health service as ‘GP-type services’ shows a gross misunderstanding of these services, and their role in Aboriginal health. At the time, community controlled health services had a national organisation which was a vehicle for policy development and lobbying of Government. Congress had produced *‘Health Business’* and *‘Settle Down Country’*. The *‘Rama Rama Report’* was nearing completion after extensive consultation with communities throughout central Australia. The Congress Alukura was being recognised internationally as an innovative model of indigenous women’s health service delivery. As well Congress had been instrumental in the establishment of remote community controlled health services in central Australia. All of these activities stretch far beyond what would generally be understood as ‘GP type’ services.

But perhaps most importantly, such lack of recognition of the achievements of the community controlled health services tends to undermine community efforts and makes the struggle for better health so much harder. It also is illustrative of the capacity of both government departments and health professionals to use the rhetoric of community control or self-determination whilst firmly maintaining control within their own domain.

Another example occurred in a meeting of Aboriginal health services in central Australia with senior staff of the THS in 1988. An Aboriginal health leader asked why the

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<sup>6</sup> District Medical Officers.

<sup>7</sup> Stack, EM *‘Implications of Policy and Management Decisions on Services for Australian Aborigines.’* pp 113-124, in Raffel, MW and NK *‘Perspectives on Health Policy: Australia, New Zealand, United States.’* John Wiley & Sons, Chichester, 1987.

department would not transport Kintore residents who had been flown into Alice Springs from Kintore for routine hospital-based investigations from the airport to the hospital. The Acting Manager of Rural Health in central Australia responded that the department no longer refused to transport such patients, but stressed that they did it *out of the goodness of their heart*. Not because Kintore residents were Territory citizens who had a right to services provided by the health department. The department had previously considered that because Kintore had their own health service they should organise and pay for the transport of their community members requiring hospital services from the airport to the hospital. This is a micro example of the cost shifting that has marred efforts in Aboriginal health for many years.

Of course there are continuities of this attitude with the past. We have seen in Chapter 6 how the AIM Hostel in Alice Springs that provided health care to settlers was not available to Aborigines. When the RFDS was established it was clearly for non-Aboriginal settlers, not for Aboriginal people. Health services initially were not established for Aboriginal people at all. Commonwealth Health, on resuming administrative control of health services after World war 2, asserted that they were not responsible for services to Aboriginal communities and confined their activities to the main towns, leaving the responsibility of health care to Aboriginal people to the Native Welfare Department. As attitudes changed, and the disastrous state of Aboriginal health became a national and international embarrassment, the health services in central Australia became more geared to the needs of Aboriginal communities. However, these efforts were by agencies (the Department of Community Services and Health) which were associated with the general containment of freedoms of Aboriginal people (eg restrictions of movement from one place to another, use of police for treating STDs) as well as the dispossession of Aboriginal people and taking children away from their families. Further, the establishment of Aboriginal health services by Aboriginal people themselves inevitably involved implicit criticisms of existing services. Aboriginal leaders involved with health services were not afraid to make these criticisms explicit. There is, therefore, a strong history of antagonism between government controlled health services, and community controlled health services. This is one of the starkest expressions of the continuation of a colonial relationship. This antagonism and general lack of cooperation, coupled with the states/ territories explicit role in dispossession, led Aboriginal health services to look towards the Commonwealth government for

support (in regard to both policy and funding), and indeed was an impetus for the development of the National Aboriginal Health Strategy.

In 1983 the Hawke led ALP was elected to government. The Aboriginal health policies of the previous government were basically continued under the new government, but there was a degree of stagnation. Few new developments were supported. Anyinginyi Congress in Tennant Creek was opened in 1986. The Congress Alukura (Aboriginal women's health and birthing program) was not adequately supported, and struggled to provide a service with minimal resources.

The Commonwealth was more concerned about the broader Aboriginal politic and specifically issues associated with Land Rights, and housing/ community infrastructure development. The rationale was that Aboriginal health status would improve when people had better housing and adequate environmental health infrastructure. Thus the development of this infrastructure was given priority over health service development.

The Government had a stated commitment to Aboriginal control of health services and programs, and the intent was to expand Aboriginal control over and involvement in all aspects of health service provision including funding, policy and programs<sup>8</sup>. However, there is little evidence to suggest that this was effectively implemented. There has been a continuing significant gap between the policy statements of politicians and bureaucrats and their bureaucratic practice and resources allocated to do the job. Further compounding the failure to implement policy has been the difficulty that bureaucrats have had in applying the principles of self-determination, especially in the face of the sustained investigative focus of Aboriginal affairs by the Senate Estimates Committee. Thus whilst generally stated policies have supported self-determination and specifically community control of health services, the distribution of funds to state/ territory governments and non-Aboriginal controlled programs has continued without any transparent accountability mechanisms.

In December, 1984 new funding arrangements resulted in the DAA assuming responsibility for funding and administration of all the Commonwealth's Aboriginal health programs<sup>9</sup>. The

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<sup>8</sup> DAA 'Annual Report 1983-1984.' AGPS, Canberra, 1984, p34-35.

<sup>9</sup> DAA, 1985, *op. cit.*, p4.

Commonwealth Department of Health which funded professional salaries through Health Program Grants was to retain a broad policy advisory role in regard to Aboriginal health matters, but not in matters relating to funding or administrative policy<sup>10</sup>. This role was poorly resourced and virtually collapsed in the late 1980s.

In January 1987 an advisory panel to provide policy advice and to develop strategies to combat communicable disease within the Aboriginal community was formed. The main concerns of this panel tended to be the risk of HIV/ AIDS and hepatitis B<sup>11</sup>.

Health services, including Congress, expressed concern to Minister Gerry Hand about the lack of any health focus in the Department of Aboriginal Affairs. This meant that it was difficult for health services to explain to DAA bureaucrats their needs for the delivery of health care. There was also evidence at this time of a simplistic interpretation of the processes involved in improving health status. Minister Hand believed that there was a need for accelerated community infrastructure programs and allocated large amounts of funding to particular communities on the basis that this would 'fix up' the problems once and for all. Hand's inspiration for this approach was the Hopetoun community in North Queensland. In trying to convince ADC Commissioners of this approach, he offered to fly them to Hopetoun to see for themselves.

In 1988 Hand allocated \$12.5 million for housing capital expenditure, to be spent over 3 years. Tangentyere Council expressed their need for recurrent support services, as well as the need for housing in bush communities<sup>12</sup>. The Accelerated Town Campers Program was to spend \$30m over 3 years in Town Camps throughout the NT. \$18m was contributed from the NT government and \$12m from the Federal government. There was some support from the NT government on the premise that this might address the problem of people camping in the Todd River bed. At around this time the NT government was encouraging out-station organisations to form peak councils, so they might be assisted as if they were one community<sup>13</sup>. This accelerated community infrastructure program was also applied to selected bush communities such as Kintore.

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<sup>10</sup> DAA 'Annual Report 1986-1987.' AGPS, Canberra, 1987, p60.

<sup>11</sup> *Ibid.*, p61.

<sup>12</sup> Durnan, R *Interview with Fran Coughlan* Alice Springs, Dec. '88.

<sup>13</sup> CAAMA Radio *Interview with Terry McCarthy* 5<sup>th</sup> September, '88.

However, crucial issues need to be addressed if such infrastructure development is to be successful.

These issues include:

- ♦ what types of technology are appropriate to particular communities;
- ♦ what levels of expertise in particular technologies and especially their maintenance exist in the community;
- ♦ what level of dependency particular communities will have on outsiders if particular technologies are introduced;
- ♦ what training programs are appropriate to ensure adequate application and maintenance of introduced technologies; and
- ♦ how appropriate materials supply will be maintained to the community and where the cost will be borne.

These issues have still not been adequately addressed in many communities as Governments continue to insist that maintenance is the responsibility of the people living in the house, or the community utilising the infrastructure without providing the means to achieve that. It needs to be remembered that many communities have little opportunity for economic enterprise, and people are extremely poor.

The overriding issue here is that the solutions to poor health are never related simply to infrastructures such as buildings, water supplies, sewerage, and the like, but to people. It is people who will utilise appropriate technology, and it is people who must maintain them. If people do not have the materials, expertise and knowledge to maintain introduced technologies, they are likely to contribute to poor health status rather than improve it.

The approach outlined above illustrates the difficulty of government (at both political and bureaucratic levels) being able to implement their policies of self-determination, and to nurture a community development approach which has the capacity to build the relationships within communities necessary to sustain improved outcomes.

## **The Hepatitis B Campaign**

In 1988 DAA officers began raising the possibility of a nation-wide Hepatitis B vaccination program for Aboriginal communities. It was evident from discussions that the manufacturers of the Hep B vaccine had lobbied the DAA. The situation in central Australia was that Hepatitis B vaccination had already been incorporated into the childhood vaccination schedule, and that it was just a matter of time before there was good coverage. There were more pressing health problems in Aboriginal communities that were not being addressed through lack of resources.

Despite such opposition, Gerry Hand, the Minister of Aboriginal Affairs at the time, announced a special program called "New Initiatives in Aboriginal Health" for one off health programs. One of the programs funded was for Hepatitis B vaccination. Different types of programs were pursued in different States.

In the Territory, a joint Aboriginal community controlled health service and THS approach was developed including agreement on program parameters and budget. There was broad agreement that conducting a catch up campaign was inappropriate. By the time agreement had been reached, the Aboriginal and Torres Strait Islander Commissions (ATSIC - previously DAA) had only \$450,000 left from the national program budget. All parties agreed that this was inadequate to cover the whole of the Territory, and it was decided that the Congresses in Alice Springs and Tennant Creek would implement the program in central Australia (including the Barkly), and the THS would implement the program in the Top End. However, instead of ATSIC dealing directly with the Congresses, they gave the \$450,000 to NT Health on the condition that \$200,000 went to Anyinginyi Congress and \$200,000 went to Central Australian Aboriginal Congress. Both Congresses objected to this process. The Department kept \$50,000 for 'administration of the funds and negotiations with the Congresses'.

In February 1991, a meeting was held with THS officials, Congress and Anyinginyi. At this meeting there were detailed discussions about the best approach to take with Hepatitis B. There was again general agreement that a catch up vaccination campaign was not sensible. THS asserted that their staff could not be made available for Hepatitis B catch up. Clearly there were inadequate funds to do some more useful things as well as perform a catch up program. There was also general concern at

some evidence of poor sero-conversion rates - was it due to poor cold chain, poor adherence to the vaccination schedule, or something to do with the vaccine itself? It was agreed by all parties as being irresponsible to simply do a vaccination catch up when there were serious questions as to the efficacy of the vaccine. It was therefore agreed by all parties that the thrust of the program should be to improve adherence to the vaccination schedule through supportive visits to health services and clinics (both community controlled and government run) in central Australia, to undertake an expanded sero-conversion study and to strengthen the cold chain system.

As well Congress involved community members in developing a half-hour television program called '*Cuz Congress*', a humorous spoof on super heroes, interspersed with health messages and located in a 'stolen generations' scenario.

Despite the collaborative approach, THS circulated an internal document<sup>14</sup> asking for input as to how the Department could utilise the \$50,000 that remained. It implied that the Congresses had not included bush communities in their work and that the Department did not 'formally' know what the Congresses had done with the funds. This was very disappointing. Part of the funding agreement was that reports would be provided to THS and the DAA. This was done. But more importantly the field workers employed in the program had worked closely with THS staff both in Alice Springs and bush communities on improving the cold chain for vaccines which was thought to be the main problem with the vaccine's efficacy. Other issues addressed in this program were standard immunisations systems for bush clinics, an immunisation data base, a Hep B sero-conversion study, as well as some general issues of an under 5s program such as reviewing the Road to Health Chart (chart used for recording weight, height, and immunisations). The circular proposed a meeting to discuss the issue about how to utilise the \$50,000 but community controlled services were not invited.

On top of all this the NT Minister for Health made public allegations which were printed in the Bulletin about the Hep B program and how the Congresses had wasted taxpayers' money.

This incident is an example of the sort of situations that frequently occur illustrating the lack of collaboration between the Commonwealth, THS and the community controlled health services.

There is little doubt that part of the dynamic behind such stories is political pressure from the NT

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<sup>14</sup> '*Discussion Paper - Hepatitis B*', NT Health, September, '92.

government that has been largely anti-Aboriginal in its electoral campaigning. It has also consistently been opposed to Commonwealth funding going direct to community controlled organisations as this reduces the grants to the NT Government through the Grants Commission process. It further illustrates the lack of resolve of the Commonwealth to provide direct funding to community organisations as a way of simplifying administrative requirements, and strengthening the processes of self-determination at the community level.

The Hepatitis B campaign illustrates some of the double standards that operate. Firstly the program was imposed from Canberra. It was not seen as necessary in the NT context, and much effort was expended by both community controlled health service and THS staff to get the national program shaped to suit local conditions, and fit with the inflexible national guidelines. The process was further complicated by the Commonwealth continuing to channel funds through the NT Government rather than simplifying bureaucratic arrangements by directly funding the services conducting the program. This is contrary to the principles of self-determination. The lack of clarity about the use of the \$50,000 allocated to THS for 'administrative' purposes and the lack of any accountability to DAA for its use highlights a double standard in regard to accountability requirements. Quite stringent financial and program performance indicators were required from the health services, but it appears nothing was required from THS. This is an example of the continuing colonial relationship where, whilst noble policies are espoused, the actual power remains in the hands of the government sector, not the community sector.

Whilst it was these sorts of incidents which led Aboriginal health leaders to push for a collaborative approach to Aboriginal health, with Commonwealth and State/ Territory Governments tied in, in the development of the National Aboriginal Health Strategy (NAHS), such incidents continued to occur.

The pressures on the DAA and the Minister from community organisations resulted in the Health Minister, Dr Neil Blewett and the Aboriginal Affairs Minister, Mr Gerry Hand putting a joint proposition to Federal Cabinet for the allocation of resources to conduct a national consultation to develop a National Aboriginal Health Strategy that could be widely supported by all parties.



The next chapter examines the development and implementation of the National Aboriginal Health Strategy.

# CHAPTER 8 - THE NATIONAL ABORIGINAL HEALTH STRATEGY

## ORIGINS OF THE NAHS

As discussed in Chapter 7 Aboriginal community controlled health services had been concerned for many years about the lack of an agreed, and coordinated approach to addressing Aboriginal health problems. They had advocated a strategic approach since they had developed NAIHO's National Black Health Plan in 1977.

Minister for Health, Dr Neil Blewett had been pursuing the development of a strategic approach to Aboriginal health and indeed reached tentative agreement with Aboriginal Affairs Minister Holding in 1986. This suggested a Task Force approach, but in June 1986 the Australian Aboriginal Affairs Council (AAAC) meeting rejected the idea.

The DAA produced a paper around this time emphasising the improvement of the physical environment as a basis for improving health<sup>1</sup>. This was not acceptable to Aboriginal community controlled health service representatives, because it was mechanistic in concept and did not reflect the holistic approach being developed by Aboriginal health services. However, the attitude that Aboriginal health is dependent on one aspect of living has some popularity still within some Aboriginal organisations and sections of government.

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<sup>1</sup> DAA *'Laying the Foundations for Better Health: Improving the Physical Environment in which Aboriginal People Live.'* Canberra, 1987.

## **THE NATIONAL ABORIGINAL HEALTH STRATEGY WORKING PARTY**

In October 1987 a meeting involving bureaucrats and Aboriginal community controlled health service representatives was held in Canberra in an attempt to reach some agreement on a framework for performance indicators as a means of accountability to government. What was agreed was the importance of a sound and agreed national policy on Aboriginal health<sup>2</sup>. Aboriginal community controlled health services continued to push for a national policy on Aboriginal health and a document, reflecting the views expressed at the Canberra meeting, was circulated in November 1987<sup>3</sup>. Later that same month, Aboriginal Affairs Minister Gerry Hand, and Health Minister Blewett circulated to State Ministers a paper<sup>4</sup> on the development of a national Aboriginal health policy to be discussed at the joint Health and Aboriginal Affairs Ministers meeting in Perth in December 1987. This paper appears to be largely based on the NAIHO paper. The meeting of ministers agreed to the immediate establishment of a Working Party to develop a National Aboriginal Health Strategy.

One million dollars was allocated, and a Working Party was appointed with Ms Naomi Mayers from the Redfern Aboriginal Medical Service at its head. A small full time secretariat was also established and based in Canberra to organise the process. For the next year they received submissions from and consulted with interested individuals and organisations including Aboriginal organisations and communities, government departments, and professional groups across Australia. The Report of the National Aboriginal Health Strategy Working Party was presented to the Joint Ministerial Forum in March 1989.

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<sup>2</sup> *'Ministers Briefing Notes: Development of a National Aboriginal Health Policy.'* 1987.

<sup>3</sup> NAIHO *'Proposal for the Development of a National Aboriginal Health policy.'*, November 3<sup>rd</sup>, 1987.

<sup>4</sup> Anonymous, *'Discussion Paper: Process for Development of a National Policy on Aboriginal Health.'* 20 November, 1987.

### *The NAHS in Central Australia*

There was a view in central Australia that the consultative process was inadequate in that not enough time was allowed to enable community people, especially those in bush communities to understand what the process was about, and to appropriately contribute. Chris George, Director of Anyinginyi Congress, Tennant Creek was the Aboriginal community controlled health service representative from the NT on the NAHS Working Party. With her support, Congress circulated a discussion paper<sup>5</sup> about a national Aboriginal health policy and developed a simple survey<sup>6</sup> designed to stimulate people's thinking about the issues and at the same time informing them of the process. Congress also proposed that a short video be produced to help explain to people what a strategy was. It was thought that an appropriate analogy might be a football game where just as one side started to get the hang of it, the other

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<sup>5</sup> NT Working Group on National Aboriginal Health Policy *'Draft Discussion Paper for NT Communities on National Aboriginal Health Policy.'* Congress, Alice Springs, 1988.

<sup>6</sup> *'Questionnaire for National Aboriginal Health Strategy.'* Congress, Alice Springs, 1988.

side moved the goal posts. Congress did indeed circulate a simple survey to community councils and existing community controlled health services. However, the NAHS Secretariat did not agree to fund a video, and criticised the survey as being 'unscientific'. Of course, the survey was a way of stimulating interest and participation, not to scientifically assess the views of communities. The process was further hampered by the insistence of the Secretariat that they should be present at *all* NAHS consultations. This of course meant that the number of communities visited and the time available in each community was extremely limited, as the number of people on the secretariat was very small. It is difficult to understand the reason for this approach other than a general lack of trust of health services that were in a position to steer a consultative process. This again highlights the contradiction between the stated policies of self-determination and the practice of the bureaucracy that is so steeped in the old colonial relationships.

A number of national meetings were held with representatives from Aboriginal community controlled health services around Australia to discuss the issues and what should be the essential points of a national strategy. The Working Party put in an enormous effort to sift through the many submissions made to it by a wide range of organisations and individuals.

### ***The NAHS Working Group's Report.***

The NAHS Working Group's Report provided useful definitions of health and of primary health care which tend to be poorly understood by governments and health professionals largely due to the relative lack of comprehensive primary health care practice outside Aboriginal health. General practice is often seen as primary health care, whereas it is really confined to medical care, with referral access to some other services.

The Strategy<sup>7</sup> asserted that:

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<sup>7</sup> NAHS Working Party 'A National Aboriginal Health Strategy.' Canberra, March, 1989, p. ix.

*‘Health to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem and of justice. It is not merely a matter of the provision of doctors, hospitals, medicine or the absence of disease and incapacity.’*

It saw health as:

*‘ Not just the physical well-being of the individual, but the social, emotional and cultural well-being of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life.’*

It recognised the basis of traditional Aboriginal social systems as being<sup>8</sup>:

*‘... inter-relationships between people and land, people and creator beings, and between people, which ideally stipulates inter-dependence within and between each set of relationships. Aboriginal spirituality was, and is, essentially land-centred.’*

*‘Aboriginal medicine and practices are a complex system closely linked to land based cultural beliefs. For this reason, Aborigines in contemporary Australia see health as a sovereign issue.’*

Primary health care was defined<sup>9</sup> as:

*‘Essential health care based on practical, scientifically sound, socially and culturally acceptable methods and technology made universally accessible to individuals and families in the communities in which they live through their full participation at every stage of development in the spirit of self-reliance and self-determination.’*

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<sup>8</sup> NAHS Working Party, *op. cit.*, p. ix.

<sup>9</sup> *Ibid.*, p. x.

*‘This contrasts with the view commonly held by the general community that the health of people is the domain of the specific agencies established to provide care. The Health Department, the general practitioner, the specialist and the hospital were seen as the principal means of securing the desired improvements in the health of the community.’*

The report also commented on the political realities where governments responded intermittently and haphazardly to political pressure, and where opportunities for improvements revolved around the search for the quick fix. It recognised that the success of the strategy depended on the political will and commitment of Governments.

The report stressed the need for Aboriginal community control and participation as an important aspect of improving health and that primary health care services should be controlled by the community wherever possible.

The report offered the following as a definition of community control<sup>10</sup>

*‘Community control is the local community having control of issues that directly effect their community.’*

*‘Implicit in this definition is the clear statement that Aboriginal people must determine and control the pace, shape and manner of change, and decision-making at local, regional, state and national levels.’*

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<sup>10</sup> NAHS Working Party, *op. cit.*, pxiv.

Further, it recognised the varying community attitudes to this question, and saw the legitimacy of some communities deciding that they were not able to assert such control at a particular time. However, the report saw community control of Aboriginal health services as the modus operandi most likely to result in improvements in Aboriginal health. It recognised the benefits of community control<sup>11</sup> as promoting responsibility and active participation of the community, rather than the community being passive recipients; allowing the design and structure of services appropriate to the needs and culture of the community, rather than 'fitting' people to the dominant system and ridding the system of paternalism, promoting awareness and raising self-esteem. It further listed the following benefits:

- ‘*• Provides a service acceptable to the people it serves;*
- *Prevents covert and overt racism from doctors, nurses, receptionists and other non-Aboriginal staff working in Aboriginal health;*
- *Prevents unethical behaviour;*
- *Prevents presumptions about lifeways and illnesses which may lead to inaccurate diagnoses;*
- *Has a social and cultural awareness of the people;*
- *Provides appropriate cultural support to patients both pre and post diagnosis;*
- *Has a priority commitment to raising the health status of the people it serves;*
- *Offers training, education and employment to Aboriginal people;*
- *Provides culturally acceptable staff;*
- *Provides flexibility.’*

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<sup>11</sup> *Ibid.*, p xvii.



A strong argument was put for the active transfer of primary health care services to community controlled Aboriginal health services, with state and territory governments retaining responsibility for secondary and other levels of health services. However, the report did not adequately address the question of how this would be achieved. This remains a vexed question for Aboriginal health. Currently the Office of Aboriginal and Torres Strait Islander Health Services (OASTIHS) is reluctant to commit itself to funding new community controlled health services and prefers to continue to channel new resources to the THS for primary health care services. This approach fails to operationalise the policy espoused by OASTIHS that the optimal way of delivering PHC service is through community controlled organisations. Unfortunately the NAHS asserts the principle, but offers no mechanism for implementation.

It was also recommended that minimum standards for existing and future primary health care facilities be developed. This has not been acted on.

The Working Party estimated that \$417 million (in 1989 dollars) was needed over 5 years to enable immediate primary health care service needs to be met.

### **Commonwealth, State/ Territory Government Responsibilities.**

The NAHS recommended<sup>12</sup> that:

1. Aboriginal health funding remain within the portfolio responsibilities of the Minister of Aboriginal Affairs;
2. the Australian Health Ministers Council (AHMC) and the Australian Aboriginal Affairs Council (AAAC) establish a Council of Aboriginal Health as a standing committee to both councils;
3. there be ongoing joint annual meetings of Commonwealth, State and Territory Ministers of Health and Aboriginal Affairs with the purpose of:
  - ♦ reviewing the implementation of the National Aboriginal Health Strategy; and
  - ♦ reviewing regular reports from the Council of Aboriginal Health; and
4. these arrangements be reviewed in 5 years.

### **Structures for Aboriginal Health**

It was recognised that there was a need for a national Aboriginal community controlled health organisation, and that a formal relationship between the national organisation and bodies set up under the NAHS be established and that such relationships should include representatives from community controlled organisations.

The report recommended that the Council of Aboriginal Health be established to:

1. review progress towards implementation of the NAHS, and recommend any necessary changes to the Strategy to the Joint Ministers Forum, paying particular attention to intersectoral collaboration.
2. review annual implementation reports from the various Commonwealth, State and Territory Governments and Aboriginal community organisations involved in health.
3. oversight the development of a national data base of Aboriginal health statistics.

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<sup>12</sup> NAHS Working Party, *op. cit.*, pp37-40.

It also recommended that a permanent Secretariat within the Aboriginal Affairs portfolio be established to service the Council, and that the Council and its Secretariat be jointly funded by the Commonwealth, State and Territory Governments, and that the Commonwealth bear the costs of community representatives on the Council.

The report further recommended the establishment of an Office of Aboriginal Health within ATSIC to:

1. organise and, where appropriate, undertake regular assessments;
2. monitor and evaluate the Commonwealth sector activity in Aboriginal health with regard to the goals of the Strategy;
3. coordinate the implementation of Aboriginal health programs in the Commonwealth sector; and
4. promote intersectoral collaboration in the Commonwealth sector and furnish reports as required by the Council, Commonwealth, State and Territory Governments.

One of the Commissioners to ATSIC was to be designated a Health Commissioner and to be an ex-officio member of the Council of Aboriginal Health.

At the state and territory levels, the report recommended the establishment of Tripartite Forums on Aboriginal health, similar to the Council of Aboriginal Health, in order to examine, promote and resolve issues relating to intersectoral collaboration within the State or Territory.

Intersectoral collaboration recognised the:

*'... dependency that exists between health and all other sectors of a community's activities. In health, intersectoral collaboration recognises the fact that improvements in health cannot be achieved through the efforts of the health sector alone. Vital to the efforts to improve health and well-being are the contributions of a variety of sectors including agriculture, land, animal husbandry, socio-political, cultural, food, industry, education, housing, public works, and communications.'*

And,

*'Intersectoral collaboration is the systematic and planned identification and development of health objectives including the identification of health impact analyses in all health related policies and programs, as integral parts of sectoral policy, through the coordination of specific and workable agreements at all levels for the coordination of health services with other activities contributing to health improvement.'*

It was recommended that mechanisms for intersectoral collaboration anchored to the Aboriginal affairs portfolio, but independent from existing agencies, be established.

Clearly these structures were designed to encourage a collaborative approach between the community controlled services, the Commonwealth and state/ territory health departments. It also recognised the need to develop processes for intersectoral collaboration. Unfortunately the multiple functions of these structures tended to blur the objectives. To include both health service development issues and the broader issues of other sectors such as housing and community infrastructure was to prove unworkable, at least in the Northern Territory.

### **Essential Services**

Essential services such as sewerage, water supply, and communication systems were recognised as integral to effective health system infrastructure. Recommendations were made to improve the effectiveness, adequacy and appropriateness of these essential services. They focused on determining community needs, adequate funding, ensuring ongoing maintenance, and community based training programs.

### **Education and Training.**

Aboriginal Health Workers were recognised as an integral part of the clinical staff of Aboriginal health services and the report recommended that adequate resources, accredited courses, employment and career opportunities and ongoing professional development programs be developed to support Aboriginal Health Workers.

It was also recommended that other medical, nursing and paramedical professional staff have Aboriginal issues (including a primary health care approach) included in their undergraduate education, and that those working in Aboriginal communities be given appropriate orientation to Aboriginal history, culture and health, and that Aboriginal people be involved in the planning and delivery of such courses.

Further it was recognised that employment was important in achieving good health. It was recommended that more attention be given to ensure Aboriginal people had opportunities to become providers of services in the whole range of community life.

However, how these were to be operationalised was not detailed.

### **Specific Health Issues.**

The Report examined the broad range of specific health problems experienced by Aboriginal people, and emphasised the need for preventive strategies as well as curative programs. Poor nutrition was especially recognised as a widespread issue. It was also recognised that Aboriginal poverty had an impact on the implementation of health programs. The report saw the setting of targets for the reduction of disease as problematic, until the full range of health service staff and technology at primary, secondary and tertiary levels was in place.

The report recommended that:

1. funding for preventive strategies be part of the recurrent funding to Aboriginal health services; and
2. strategies be developed and implemented at the local level, addressing local cultural needs, and local priorities.

Alcohol and other substance abuse was also recognised as a major health problem facing Aboriginal people. It was acknowledged that substance abuse is ultimately a symptom of far wider problems, namely dispossession, alienation and discrimination. It was recognised that treatment regimens not designed for Aboriginal people were culturally, socially and traditionally inappropriate and ineffective. The report made a number of recommendations focused on accredited courses for Aboriginal drug and alcohol workers, educational campaigns, visitations to detainees by staff of Aboriginal health services and counsellors from alcohol rehabilitation programs, and sobering-up shelters, detoxification and rehabilitation programs, information networks, availability of alcohol, community policing, and funding issues.

Aboriginal health research was recognised as a priority. The Report restated the concerns of Aboriginal people that research is frequently imposed on Aboriginal communities, with those communities usually having no control or redress. The benefits of research to Aboriginal people was questioned and there was a widely held, strong view that such existing research was of little direct or indirect benefit and was often, indeed, detrimental.

Recommendations focused on ethical guidelines on Aboriginal health research, and funding of research. A list of research topics was also included. However, this list was not prioritised in any way, and thus did not present a thoughtful research strategy for Aboriginal health.

Finally the report addressed the issue of the need for monitoring the implementation of the strategy and evaluation of health programs.

Overall, the Report represented a comprehensive approach to addressing Aboriginal health and included structures designed to ensure the development of collaborative relationships, and the capacity to monitor the strategy. Despite some weaknesses in how particular aspects of the strategy could be operationalised, it was an extraordinary document for two reasons: firstly, its comprehensive approach to the problem; and secondly its apparent support from all governments and the community sector.

### *Aboriginal Health Development Group & the Community Advisory Group*

Despite difficulties, an impressive report was finally presented to the Joint Ministerial Forum meeting in Burnie, Tasmania in March, 1989. This meeting responded by setting up the Aboriginal Health Development Group. This group comprised bureaucrats from state/ territory and Commonwealth government agencies, but with no Aboriginal community representation except the Chair of the NAHS Working Party, Naomi Mayers. The task of the Development Group was to examine the NAHS Working Party report and to develop a strategy for its implementation<sup>13</sup>. However, the method of its establishment and its lack of Aboriginal community representation was already in breach of the spirit of the Strategy, and the Aboriginal community representatives protested vigorously to Ministers Blewett and Hand. Hand responded by establishing a further group made up of Aboriginal community representatives and known as the Community Advisory Group. This group produced its own report in response to the Development Group. However, in the end it was the recommendations of the Development Group that were adopted by the Joint Ministerial Forum meeting in Brisbane in June 1990.

In June, 1989, the national meeting of Aboriginal community-controlled health services in Alice Springs called for the immediate establishment of the Council for Aboriginal Health to oversee the implementation phase of the NAHS Working Party Report. Community representatives to an Interim Council of Aboriginal Health were elected, and they met in July 1989. A representative from the Victorian Minister's office was present, but no other Government representatives were there. This meeting agreed with the following roles and responsibilities<sup>14</sup>:

- a) review progress of the implementation of the National Aboriginal Health Strategy;*
- b) review annual implementation reports from the Commonwealth, State/ Territories and community controlled organisations;*
- c) oversight the development of the national data base;*
- d) oversight intersectoral collaboration action on Aboriginal health;*

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<sup>13</sup> Aboriginal Health Development Group 'Report to Commonwealth, State and Territory Ministers for Aboriginal Affairs and Health.' December, 1989, p3.

<sup>14</sup> Council of Aboriginal Health. First Session - July, 1989, p 3.

- e) ensure that the integration of preventive, curative, and rehabilitative services occurs at all levels.'*

The main concern of this meeting was the role of the Development Group, and the lack of Aboriginal community representation.

#### Aboriginal Health Development Group

The recommendations of the Development Group<sup>15</sup> followed those of the Working Party reasonably closely. However, there were some differences, such as incorporating into the role of the Aboriginal Health Council a liaison function with existing programs - the Better Health Program, the National Women's Health Program and the National Campaign Against Drug Abuse. Despite this, the clash between the mainstream assumptions of these programs and Aboriginal health services continued to be a barrier to better coordination of service delivery.

The Working Party did not specify the make-up of the Council, and the Development Group recommended the following composition:

- ♦ 1 x ATSIC Commissioner;
- ♦ 1 x representative at Senior Executive level from:
  - ♦ Department of Community Services & Health (now Health & Family Services);
  - ♦ ATSIC;
  - ♦ Department of Employment, Education & Training (DEET);
  - ♦ each state/ territory government (8 in total).
  - ♦ 1 Aboriginal/ Torres Strait Islander community representative from each of the 17 ATSIC Zones, to be selected by the Aboriginal or Torres Strait Islander community.

Thus the Development Group recommended 11 government representatives, and 18 Aboriginal community representatives (including 1 ATSIC Commissioner). However, how the 'community' in each ATSIC Zone was to select a representative was not addressed. This issue proved to be of some difficulty. Certainly the community



controlled health services considered that the Working Party's intent for the Council was that it be predominantly made up of Aboriginal people experienced in health service issues. But this was not the view of other players, and they argued that health wasn't just health services, which, of course, is precisely what the Working Party had asserted. We will return later to these controversies.

Overall, the Development Group made 21 recommendations in their report, which are summarised in Table 4, and includes costing where these were made. It should be noted that these recommendations do not cover all of the issues, or the detail, addressed in the NAHS Working Party Report. The Working Group took the view that, rather than producing a comprehensive implementation plan, this should be left to the Council.

Table 4 Recommendations of the Aboriginal Health Development Group.

<b>Recommendation</b>	<b>Comments</b>	<b>One off Cost</b>	<b>Annual Cost</b>
1. Aboriginal Health Council	Plus around \$5,000 / State/ Territory govt. for cost of own representatives.		200,000
2. Tripartite Forum	Cost to be borne by State/ Territory govts.		
3. Office of Aboriginal Health (within ATSIC)	Includes health expertise + secretariat for Council.		280,000
4. National Aboriginal community controlled health service body	Whilst recommending this be implemented, no costing was made.		
5. Environmental health (housing, water, waste disposal, roads, power & communications)	Cost was to be determined by governments within budgetary processes. Guesstimated costs for each area were: Housing: Water: Water disposal: Drainage: Electricity: Airstrips: Roads (external to community) Roads (Internal to communities) Communications  Total	1,580,000,000 350,000,000 100,000,000 25,000,000 150,000,000 25,000,000 220,000,000 40,000,000 <u>10,000,000</u> <u>2,500,000,000</u>	
6. Upgrading Aboriginal	Costs estimated only.	14,000,000	5,000,000

community controlled health services			
7. New community controlled health services		800,000 1 <sup>st</sup> year 2,500,000 2 <sup>nd</sup> year	5,000,000
8. Hospital liaison staff	Estimated costs per location. Cost is to state/ territory governments	80,000 1 <sup>st</sup> year 60,000 thereafter	

Table 4 Recommendations of the Aboriginal Health Development Group (contd.)

<b>Recommendation</b>	<b>Comments</b>	<b>One off Cost</b>	<b>Annual Cost</b>
9. That hospitals serving significant number of indigenous clients have at least 2 indigenous community reps on Hospital Board.	Responsibility of state/ territory government. No particular cost.		
10. Review provision of specialist services.	Responsibility of state/ territory government. Cost will vary with need.		
11. State/ territory government ensures appropriate protocols for dealing with Aboriginal/ Torres Strait Islander people.	No cost.		
12. Rationalise services to Torres Strait.	No costing made.		
13. Consider establishing Task Force on Substance Abuse.	No costing made.		
14. National Campaign Against Drug Abuse give priority to Aboriginal programs.		800,000 1 <sup>st</sup> Year	3,000,000
15 State/ territory substance abuse programs include Aboriginal issues in staff in-service training.	Responsibility of states/ territory. Not costed.		
16. Resources be provided for Link-up programs	Estimated at \$150,000 pa.		1,200,000
17. Alternate psychiatric service be investigated.	No costing made.		
18. Each state/ territory nominates senior official to be responsible for implementation of recs of the 1985 National Taskforce on Aboriginal Health Statistics.	No cost.		
19. Resources be made available to Australian Institute of Health for comprehensive Aboriginal health statistics data collection, analysis and reporting.	No costing made.		
20. Continued discussions re: education & training recommendations of NAHS.	No costing.		

Table 4 Recommendations of the Aboriginal Health Development Group (contd.)

<b>Recommendation</b>	<b>Comments</b>	<b>One off Cost</b>	<b>Annual Cost</b>
21. NH&MRC give priority to Aboriginal controlled research projects.	No costing made.		

The Development Group also discussed issues of funding arrangements for Aboriginal health, and also produced a series of discussion papers on the following topics:

- ♦ Structural Arrangements.
- ♦ Substance Abuse.
- ♦ Environmental Health.
- ♦ Upgrading of Aboriginal Health Worker Training.
- ♦ Mental health.

The Report was presented to the Joint Minister Forum in Brisbane in June 1990. The Forum accepted the recommendations of the Development Group, and this was widely interpreted as acceptance of the principles of the NAHS.

Estimated Cost:

The Development Group made estimates of cost of some of the recommendations (which ones can be seen from the table). In the following calculations, Environmental Health costs that the Development Group guesstimated to be \$2.5 billion, have not been included.

Estimates of cost (over 5 years) relating to Commonwealth expenditure on community based health and substance abuse programs were:

1. One off costs (or first year costs)	18,100,000
2. Cost of establishing structures	2,400,000
3. Recurrent costs (for 5 years)	<u>53,800,000</u>
Total	\$74,300,000

It needs to be recognised that this total figure of \$74.3 million is for new initiatives, and does not include expenditure on health services.

### **THE COMMONWEALTH GOVERNMENT'S RESPONSE.**

In December 1990 the Minister for Aboriginal Affairs, Robert Tickner announced<sup>16</sup> the allocation of an additional \$232 million over 5 years in:

*'... a bid to dramatically lift unacceptable health & infrastructure standards in Aboriginal health and infrastructure standards in Aboriginal communities'.*

These funds were allocated conditionally on contributions being made by state and territory governments. However, the Commonwealth fell short of insisting on equal dollar contributions and settled on some indication of *'increased effort'*. What this actually meant was never defined. Indeed, the Northern Territory Government somehow was able to demonstrate increased effort shortly after closing clinics in two Aboriginal communities (Jay Creek and Amoonguna) in central Australia.

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<sup>16</sup> Tickner, Robert & Howe, Brian *'Major Funding Boost for Aboriginal Health.'* Media Release, 17<sup>th</sup> December, 1990.

Table 5 NAHS Commonwealth Funding 1990-1995<sup>17</sup>.

<b>Program</b>	<b>'90-'91</b>	<b>'91-'92</b>	<b>'92-'93</b>	<b>'93-'94</b>	<b>'94-'95</b>	<b>Total</b>	<b>Estimated</b>
	<b>\$M</b>	<b>\$M</b>	<b>\$M</b>	<b>\$M</b>	<b>\$M</b>	<b>\$M</b>	<b>need \$M</b>
<u>ATSIC</u>							
Environmental Health	2.10	18.38	33.57	58.96	61.00	174.01	2,500.0
Aboriginal Health Services	6.74	9.47	10.36	10.80	11.24	48.61	74.3
ATSIC Health Branch	0.17	0.36	0.38	0.4	0.42	1.73	2.4
<u>DCS&amp;H</u> <sup>18</sup>							
National Campaign Against Drug Abuse	1.33	1.40	1.47	1.54	1.60	7.34	-
Australian Institute of Health	0.10	0.11	0.11	0.12	0.12	0.56	-
<b>TOTAL</b>	<b>10.44</b>	<b>29.72</b>	<b>45.89</b>	<b>71.82</b>	<b>74.38</b>	<b>232.25</b>	<b>2,576.7</b>

Source: ATSIC.

It needs to be emphasised that, at least as far as the funding that ATSIC was responsible for, this represented new funding on top of the existing funding for Aboriginal health services, and the Community Housing and Infrastructure Program (CHIP). However, there were no new funds allocated to NCADA or AIH for their increased role. The Department of Community Services and Health was required to absorb these costs<sup>19</sup>.

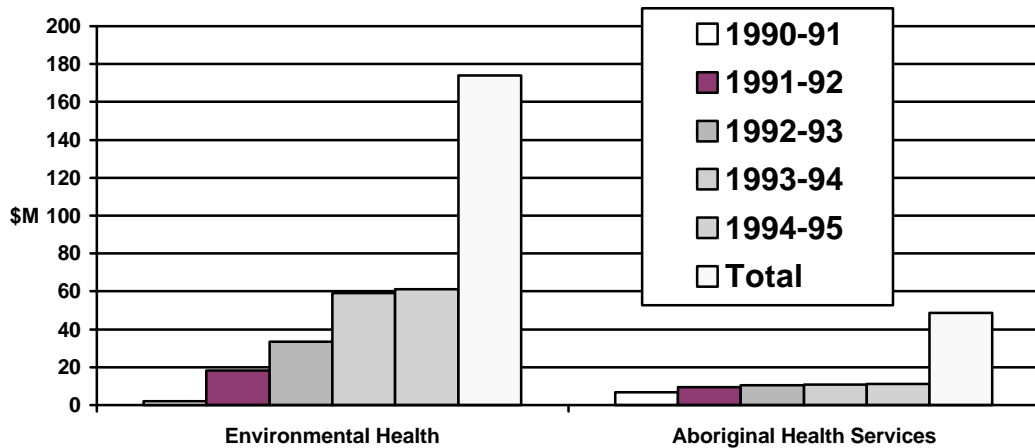
Figure 3 illustrates graphically the allocation of funds over the five year funding period for environmental health programs and health services.

<sup>17</sup> ATSIC Information Package, Attachment B 'Proposed NAHS funding to 1994-95.' Prepared for National Conference Aboriginal Health Services, Melbourne, 12-15 March, 1991.

<sup>18</sup> Department of Community Services and Health.

<sup>19</sup> ATSIC 'Information Package on the National Aboriginal Health Strategy.' July, 1991, Attachment B, p2.

Figure 3 NAHS Funding - Initial 5 Year Commitment  
 - Environmental Health and Aboriginal Health Services



It is obvious, however, that the amount of funding provided was inadequate to meet the enormity of the need. The basis of the Development Group's estimate of need is unclear. As the Development Group said, they had made guesstimates about the environmental need. The Group referred to 'estimates' when talking about health service needs. However, it is almost certain that these too were guesstimates, as no work had been done to determine which communities did not have adequate health services, and what the actual needs of existing services were. Further, there was no agreement about what was a primary health care service - what should be included as core functions, what special needs should be funded, and what sort of facilities should be considered standard.

The Commonwealth Government had the view that state and territory governments should be doing more for Aboriginal people - both in terms of the provision of essential services that they accept responsibility for providing to non-Aboriginal citizens (such as electricity, water, and waste disposal) and in terms of the provision of culturally appropriate health services. Indeed the Minister, and ATSIC both pursued this approach with some vigour. However, it did not have much success. And in the meantime, Aboriginal people were caught in the middle living with inadequate essential service infrastructure and inadequate access to primary health care.

The first round of funding was predominantly allocated to existing Aboriginal health services, and there was very little time allowed to organise funding. As can be seen the funds were only announced in mid December, '90, and the machinery for dealing with NAHS funds was not yet in place. Thus those better organised services had their submissions funded in the rush to get the funds released before the 30<sup>th</sup> June 1991. Some funds were also released for environmental health programs, but again went to areas already identified. Some of the funds in this first round went to recurrent needs that were not permitted in later years.

There was an enormous amount of confusion in this early period about who made the funding decisions, and the role of the various bodies. This confusion was made more complex by the creation of a range of new structures and processes stemming from the establishment of ATSIC and the new structures under the NAHS.

Some funding decisions were made in Canberra, whilst others were made by Regional Councils. There were some expectations that the Tripartite Forum would have some responsibility for funding decisions relating to NAHS funds. In the end the TPF had little say. The State Advisory Committee (SAC) made up of the NT ATSIC Commissioners, representatives of NT ATSIC Regional Councils and government representatives from both Territory and Commonwealth departments, made the final decisions on how the available dollars would be spent. Only projects approved by ATSIC Regional Councils were meant to be funded, but there was concern from some community leaders that some funds had gone to NT Government controlled projects without such approval, or discussion at the TPF. The role of the TPF was marginalised and irrelevant, even though the TPF was meant to provide advice to funding proposals. Certainly, the SAC made decisions without regard to, or knowledge of, the views of the TPF.

ATSIC produced an explanatory document outlining the key processes in the implementation of the NAHS<sup>20</sup>.

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<sup>20</sup> ATSIC, 1991, *op. cit.*, Attachment C.



This involved:

A. Administrative Structure:

1. ATSI Regional Councils:
  - ♦ input into Tripartite Forums and Council of Aboriginal Health; and
  - ♦ overview community & regional opinions on needs, priorities and policy directions.
2. Tripartite Forum:
  - ♦ assist in formalising partnership between the Aboriginal community and governments; and
  - ♦ advise state/ territory governments on the implementation of the strategy.
3. Council for Aboriginal Health:
  - ♦ develop short & medium term strategies to overcome Aboriginal health problems;
  - ♦ advise on ongoing development of Aboriginal health policy strategies; and
  - ♦ assist in reviewing the effectiveness of health services to Aboriginal people, and progress in implementation of the NAHS.
4. Office of Aboriginal Health:
  - ♦ implement the strategy;
  - ♦ assess infrastructure and environmental conditions of Aboriginal communities;
  - ♦ monitor and evaluate Commonwealth sector activities in Aboriginal health; and
  - ♦ provide reports to Council of Aboriginal Health, state/ territory & Commonwealth governments.

B. Negotiations with States and Territories aimed at:

1. gaining agreement with the states/ territories that the NAHS is a budgetary priority; and
2. improving inter-governmental coordination.

C. Determination of Needs, Intended Outcomes and Plans.

This section begins with a statement that ATSIC will expend funds *'both directly and as grants to States and Territories within the framework of an operational plan specifying quantifiable outcomes and performance indicators.'* It claimed that the process of identification was well advanced and pointed to data gained from states and territories and detailed in the NAHS Working Party and Aboriginal Health Development Group Reports. It also pointed to the community development plans and regional plans. Unfortunately, these processes were not well advanced. Many of the community, organisational and regional plans were done in a hurry. They were not available to the work of the Tripartite Forum in the NT. The NAHS and Aboriginal Health Development Group Report did not address anything other than general issues and priorities from a national viewpoint. Neither addressed detailed needs on a regional or community level. Many (probably most) of the community and regional plans did not explicitly deal with health service needs. It is interesting to note that the only body charged with a role relating to health services was the Council of Aboriginal Health. This body met hardly at all and never developed a meaningful role.

It is also interesting to note that the group charged with actually implementing the Strategy was the Office of Aboriginal Health. There is no sense in this information package that that is the communities' strategy and that the role of the Office is to provide a central resource to that process. The NAHS stressed community control of primary health care services alongside the importance of improving the environment through development of community infrastructure (housing, water, waste disposal) and an intersectoral approach that ensured that the non-health sector worked in a way that maximised the health impact of their activities.

A further point of interest is the lack of any mention of the ATSIC Commissioners, or of the State Advisory Committees (SAC) which ended up being the body which made the main funding decisions often regardless of ATSIC Regional Council priorities, though these Councils were represented on SAC, and certainly regardless of the views of the NT Tripartite Forum.

The differences between the vision and intent of the NAHS Working Party Report and the interpretation of this in ATSIIC's development of the administrative processes are stark. They illustrate a continued style reflective of the colonial relationship. Instead of the NAHS presenting new opportunities for a new strategic relationship with the community at its heart, the opportunity was lost, and the conflict central to colonial relationships was in some situations heightened rather than reduced.

### **THE NT TRIPARTITE FORUM.**

The NT Tripartite Forum (TPF) was established in June 1991<sup>21</sup>. As outlined above, the TPF was established as a recommendation of the NAHS at the state/ territory level with the role of overseeing the implementation of the NAHS and to encourage appropriate intersectoral collaboration.

The confusion in process discussed above became a major problem for the TPF. Aboriginal community controlled health services had significant needs that had not been addressed adequately by funding bodies for many years. These services had played a key role in the development of the NAHS and had supported an intersectoral process as a way of improving the health status of people. However, much of the early functions of the TPF were caught in disagreement between NT Government departments and the community representatives. There were also disputes between community representatives. These disputes were about:

1. Government Departments (such as Lands and Housing) claiming NAHS funds for their own programs. There was generally a lack of trust of these Departments' presentation of the 'facts' and were seen by some community representatives as simply a grab for the dollars.

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<sup>21</sup> NT Tripartite Forum *National Aboriginal Health Strategy Information Kit.* Dept. Lands, Housing & Local Government, Dept. of Health, Housing, Local Government & Community Services, and the NT Dept. of Health & Community Services, Darwin, 1992, piii.

2. Community disagreements related to how the dollars would be distributed. There were disagreements between the Top End representatives and those from central Australia. The Top End proposal was for a per capita distribution. This would have resulted in a roughly 60:40 split in favour of the Top End. Central Australian representatives opposed this and argued for a needs based method of distributing resources. Whilst this argument ultimately held sway, there were no real data available to the TPF to enable it to make decisions on this basis.
3. There were also disagreements between some community representatives based on sectoral differences. There was a tendency at times for people to see one area as more important than others. For example water supply was argued as important by some whilst health services were argued by others. Of course, both are important, and the way these things get resolved is through a community development approach where people are able to address their water supply problems along with their health service and other needs. These are difficult issues to resolve at a territory wide and multi-sectoral level, particularly when the resources available are inadequate.

The other issue confronting the TPF related to its size, and consequent cost. It was felt by some that a large TPF of more than 40 people would have difficulty functioning. Many of the community representatives felt that it had to be large in order to ensure adequate representation from the diverse Aboriginal population.

It was eventually decided to operate the TPF with a much smaller Executive, to employ both a secretary and a project/ research officer, and to undertake an independent consultancy on how the TPF could operate.

However, even with a more efficient apparatus with a smaller executive operating, the authority of the TPF was never accepted by NT Government departments, or other bodies such as Batchelor College which had major responsibility for Aboriginal Health Worker education.

Further the TPF proved an inadequate forum even for the sharing of information, and developing joint strategies within the health sector. Some examples follow.

### ***New CRESAP Positions***

In 1992 the NT Government contracted consultants from a private company, CRESAP, to conduct a review of health services. This became known as the CRESAP Review. This review recommended the creation of a number of new Aboriginal Health Worker, Environmental Health Worker and Health Promotion Worker positions. Attempts were made by the community representatives to engage in a planning exercise for the utilisation of these new positions. The attitude of the bureaucrats from THS tended to be that this was just a ploy by the community controlled health services to grab the resources. It is true that these representatives were concerned that community controlled health services should not be excluded from accessing some of these positions. However, the community controlled health services expected there to be a collaborative approach where needs could be worked through. In the end the decisions were made by THS in Darwin with scant regard to the opinions expressed by the community representatives on the Forum, or even the TPF as a whole.

### ***Aboriginal Health Worker Needs***

The TPF had frequently expressed its concern about the continuing crisis faced by Aboriginal Health Workers, and the TPF organised a meeting in Alice Springs specifically to discuss this issue. Central Australian participants expressed their dissatisfaction with their situation since the responsibility for AHW education within THS was transferred from THS (then NT Health) to Batchelor College. Bush AHWs felt they had lost their place<sup>22</sup>. There was also dissatisfaction about the general lack of on-the-job educational opportunities in their home communities, and the consequent need to travel to Alice Springs for education.

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<sup>22</sup> AHW education (both basic and in-service) had taken place in Alice Springs at premises known as the Bloomfield Street Annex. These facilities had been handed over to Batchelor College when they took over responsibility for delivering accredited AHW education. Thus, the premises were no longer available to bush AHWs when they came into Alice Springs. The facilities were only available to enrolled AHW students. Further the premises were used for a range of Batchelor activities, not just AHWs. Another complaint related to student AHWs not being allowed to have their children stay with them at the Annex.

The meeting expressed the strong desire to have responsibility for AHW education in central Australia transferred to the Institute for Aboriginal Development (IAD). Batchelor College opposed this point of view, although a Batchelor College Councillor at that meeting assured central Australian representatives at that meeting that if they wanted IAD to do AHW Education, he thought the Batchelor Council would support them. No action was taken on this issue, and the needs of authoritative, older people who the community sees as the most appropriate people to be their health workers have increasingly not been met. Many of these people have poor literacy that virtually excludes them from accredited courses. The old '*basic skills*' method of education had proved itself very effective in ensuring the development of health worker skills in this group of people with poor literacy. The needs of established institutions continue to be met at the expense of community needs.

### ***Aboriginal Mental Health Training Needs***

In 1993, NT Health commissioned a report on Aboriginal Mental Health Worker Training Needs. The need for this consultancy and how it should be conducted was never raised with the TPF or with Aboriginal community controlled organisations such as Congress.

This again illustrates the difficulty THS had with incorporating the principles of the NAHS into a changed bureaucratic practise, despite their rhetoric.

There are further examples, especially involving the Alukura, the Aboriginal women's health and birthing program.

The point of this discussion is to illustrate the difficulties and frustration experienced during this period, and the ineffectiveness of the TPF as a consequence of relationships between players continuing in the colonial mode. The hopes as expressed by the partnership approach promoted by the NAHS were not realised. Whilst it is fairly pointless to simply try and allocate blame, it is important to appreciate how much of a challenge collaborative work is for government departments. It is not the normal way that they operate, and there has been a strong tendency for decisions to be made at quite a senior level in the central bureaucracy, and then to work to have community organisations work with them on the programs previously decided. The Royal Commission into Aboriginal Deaths in Custody recognised this as a problem:

*‘The perception of many Aboriginal people - and I might add the perception of many public servants with whom I have spoken - is that policies are propounded, programmes put forward, assistance offered in a form which has been largely pre-determined in the bureaucracies of the departments concerned; that there is a process of consultation with relevant Aboriginal bodies or communities but that the parameters of the consultation have been set in advance; that the agenda is being fixed by non-Aboriginal people, not by Aboriginal people.’<sup>23</sup>*

Table 6 summarises the key events in the development of the NAHS.

Table 6 Events in the Development of NAHS

December 1987	Meeting of Commonwealth, State and Territory Ministers of Health and Aboriginal Affairs agree to develop a National Aboriginal Health Strategy. A Working Party is appointed.
February 1989	National Aboriginal Health Strategy Working Party National Conference meets.
March 1989	National Aboriginal Health Strategy Working Party Report delivered to the Joint Ministerial Forum at Burnie, Tasmania. Task of planning the implementation of the Strategy is given to Aboriginal Health Development Group - on which no community representation is included.
June 1989	National meeting of community-controlled Health Services calls for immediate establishment of the Council for Aboriginal Health and

<sup>23</sup> Royal Commission Into Aboriginal Deaths in Custody Report, 1991, Vol4, p20.

	implementation of recommendations of the Working Party Report. Community representatives to an Interim Council of Aboriginal Health are elected.
July 1989	Federal Minister for Aboriginal Affairs, Gerry Hand, establishes the Community Advisory Group to advise him on community views on the implementation of the Strategy.
December 1989	Report of Aboriginal Health Development Group.
February 1990	Report of the Community Advisory Group.
June 1990	Strategy (as represented by the Development Group's Report) endorsed by Joint Ministerial Forum at Brisbane. Approved recommendations are estimated to cost \$2.63 billion over ten years; \$2.5 billion is needed for Aboriginal environmental health.
December 1990	Commonwealth Government allocates \$232m over five years, dependent on 'substantial contributions' from State / Territory governments
March 1991	Commonwealth Ministers for Health (Brian Howe) and Aboriginal Affairs (Robert Tickner) seek agreements from States and Territories on funding arrangements for the implementation of the Strategy.

## **COUNCIL FOR ABORIGINAL HEALTH**

As discussed above, the first meeting of the Aboriginal Health Council was called by the community sector, and was largely ignored by government agencies.

A conference of Aboriginal community controlled health services was held in Melbourne in March 1991. ATSIC funded this meeting and had requested that nominations for the Council come from that meeting. This meeting did consider the Council and how it should be constituted, but did not feel able to make nominations. This was left to processes at the local level to determine. However, ATSIC took the view that these did not meet the Joint Ministerial Forum's decision<sup>24</sup>.

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<sup>24</sup> Codd, M. *Developing a Partnership: A Review of the Council for Aboriginal Health.* March, 1993, p19.



Clearly there was a clash between the Aboriginal community controlled health services and their expectations and understandings of the Council, and ATSIC and its understandings and expectations.

The Council did not officially meet until April 1992. At this meeting concern was expressed at the Commonwealth's approach to the Council, and rejected an ATSIC sponsored draft protocol outlining the relationship between the Council, ATSIC and the Joint Ministerial Forum. The Council met again in June, '92, but the differences were not resolved. After the June meeting, the Department of Industrial Relations advised ATSIC that there were some technical problems with the appointment of the Council that could affect their entitlements (eg workers compensation). ATSIC declined to convene further meetings<sup>25</sup> and recommended to Minister Tickner that a review of the Council be held as ATSIC was of the view that the establishment of ATSIC superseded the role of the Council. The Joint Ministerial Forum had agreed in its June 1990 meeting that the Council should be reviewed after its second year of operation to determine its effectiveness, its relationship with ATSIC, and whether it should continue<sup>26</sup>. In December, 1992 Health Minister and Aboriginal Affairs Minister Tickner agreed to pursue a review of the Council.

Despite the lack of secretariat support from ATSIC, the Council met again on 7th February 1993 in Perth. This coincided with a national Aboriginal community controlled health services meeting. At this meeting, Council members developed a briefing paper for input into the Review of the Council headed by Mike Codd.

### ***The Review of the Council of Aboriginal Health***

The Review of the Council was carried out in March 1993. The Report outlines the submissions made to it by the different parties.

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<sup>25</sup> *Ibid.*, Attachment B, 'Briefing Paper: Council of Aboriginal Health.'

<sup>26</sup> Terms of Reference, Council of Aboriginal Health.

## The CAH Submission

It should be kept in mind that the Council was made up predominantly of Aboriginal health leaders who had played the dominant role in developing the NAHS Working Party Report. The Council tended to be more focused on health service delivery issues, and saw intersectoral collaboration as the means of ensuring that other sectors operated in ways which were cognisant of their health impact. It should also be kept in mind that some of the Aboriginal health leaders involved with the Council had been outspoken critics of ATSIC. The Council's view was that the Council should continue along the lines advocated by the NAHS. This included the Council being a standing committee of both AAAC and the Australian Health Ministers' Council (AHMC), and having an ATSIC Commissioner with health responsibilities being part of the Council. They were of the view that they should remain in a position to provide independent advice.

*'As a Standing Committee to both the Australian Health Ministers' Council (AHMC) and the Australian Aboriginal Affairs Council (AAAC) the Council of Aboriginal Health is not 'owned' by the Commonwealth nor subservient to ATSIC.<sup>27</sup>*

The Council opposed the Review as premature given that they had only met officially twice.

## ATSIC's Submission.

The ATSIC submission outlined some of the history of its involvement with the NAHS, including its prompt funding of the Melbourne meeting of Aboriginal community controlled health services, and its attempts to get concrete nominations from that meeting for the make-up of the Council. It highlighted the Council's rejection of the ATSIC Board protocol that centred on ATSIC participation in the CAH, the need for CAH to inform the Board of its deliberations, and that Ministers seek the Board's view on CAH recommendations. Clearly ATSIC saw the Council as unwilling to take account of the constraints under which ATSIC operated as a statutory body.

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<sup>27</sup> Codd, M, *op. cit.*, Attachment B, *'Briefing Paper: Council of Aboriginal Health.'*

ATSIC put forward a number of options in regard to the future of the Council, but insisted that whatever option was adopted the Review should<sup>28</sup>:

- (i) clarify the role, membership, reporting requirements and relationship to ATSIC of the CAH or similar body;*
- (ii) clearly recognise ATSIC's legislative responsibilities and its primacy as adviser to the Federal Government;*
- (iii) recognise the central role played by Regional Councils in determining local priorities.'*

Clearly underlying ATSIC's concerns were issues related to the power invested in the Council vis a vis ATSIC.

Department of Health, Housing and Community Services' Submission:

This submission focused on the ineffectiveness of the CAH and claimed that, as presently constituted, it was unable to meet its terms of reference. It considered that the CAH was too focused on health service delivery, but recognised that to enlarge the Council to include other sectors would make it too large and unworkable. It put forward two options. One was to set up an advisory group as part of ATSIC and made up of Aboriginal community controlled health services. However, this was not favoured, because the Department felt that such a committee would be unable to provide it with the expert advice it needed. Instead it favoured setting up a Principal Committee of the National Health & Medical Research Council (NH&MRC) with a special role of considering the impact of all government programs on Aboriginal health. The other specific focus that this committee was seen as having related to environmental health issues.

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<sup>28</sup> Codd, M, *op. cit.*, p26.

This, of course, kept it under the wing of this Department. However, this Department has had a surprising consistency in its attitude to Aboriginal health. Earlier investigations (such as the 1979 House of Representatives Report) into Aboriginal health have seen the Department of Health focussing on an 'expert' driven approach. The Department has consistently failed to understand the centrality of the colonial relationship to the poor state of Aboriginal health, and the consequent inability of an expert driven approach alone to achieve better outcomes.

Department of Employment, Education and Training (DEET) Submission  
DEET felt marginalised in the way the Council operated, but wished to remain involved if the Review were able to ensure a more constructive operation.

#### *The Failure of Intersectoral Collaboration*

The NAHS, and the Council, were conscious of the need for intersectoral collaboration, but that the practice of this has been inadequate. One of the lessons may well be that to have effective intersectoral collaboration, there must be strong and developed sectors. To simply create committees or councils with all sectors represented has proved to be counter-productive. This scenario can well lead to different sectors vying for dominance, and for there to be little real focus on the issues and tasks requiring collaboration.

However, a close examination of the different positions of ATSIC and the CAH reveals a concern related to power, particularly in regard to which body had primacy in the advisory role to government. Where was the power located? Clearly, the CAH presented a threat to the Commissioners, and they wanted the Review to clarify relationships and to assert that, whatever structures were set up, CAH:

*'(ii) clearly recognise ATSIC's legislative functions and responsibilities and its primacy as adviser to the Federal Government,'<sup>29</sup>*

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<sup>29</sup> Codd, M, *op. cit.*, p23.

### *The Findings of the Review*

The report embraced the importance of partnership in ensuring the effective implementation of the NAHS. It spent some time exploring the issues at both regional and state/ territory levels, recognising the importance of community organisations, ATSIC Regional Councils, State Advisory Committees and the Tripartite Forums.

The main recommendations<sup>30</sup> of the review were that:

1. the Council should continue under a new name (The National Health Council for Aboriginal & Torres Strait Islander People) and it should report annually to the Joint Ministerial Forum responsible for health and Aboriginal affairs;
2. the function should remain basically the same as originally recommended, but should specifically get regular input from the Tripartite Forums;
3. the TPFs should get more comprehensive information from both Commonwealth and State/ Territory sources about program development and health expenditures;
4. membership of the Council should include some cross membership with the TPFs;
5. membership of the Council should include:
  - ♦ 3 representatives from each of the 8 states/ territories - one nominated by community controlled health services, 1 representative from the state/ territory government, and 1 representative from ATSIC nominated by the State Advisory Committee; and
  - ♦ 1 community representative from the Torres Strait Islands.All were to be members of their respective TPF. The Council should have an independent secretariat; and
6. the Council should form a close relationship with the NH&MRC, the Australian Institute of Health & Welfare and the yet to be formed national organisation of community controlled health services.

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<sup>30</sup> *Ibid.*, p4-7.

The review also made some recommendations relating to better understandings and agreements between the Commonwealth and state/ territory government as a means of improving Aboriginal health.

The recommendations were not implemented and the Council has never met since. In 1995, after the election of the Howard Coalition Government, Minister for Health Wooldridge, established a National Council for Aboriginal Health but not constituted in a way which reflected the Review's recommendations.

### **COAG'S NATIONAL COMMITMENT TO IMPROVED OUTCOMES**

One of the products of ATSIC's and Minister Tickner's efforts to get state and territory governments to do better in addressing the disadvantage of Aboriginal people which underlies their poor health status was the National Commitment endorsed by the Council of Australian Governments (COAG)<sup>31</sup> in December, 1992.

This document defined agreed national objectives under the headings of Land, Culture & Heritage, Economic Development, Social Well-being, and Government services. It reaffirmed the principles of self-determination and self-management, economic independence and equity, maximum community participation, coordination and clarity of roles and responsibilities. It set the framework for the development of bilateral agreements between the states/ territories and the Commonwealth governments. There was agreement that the AAAC review progress annually.

It is unclear what actions were taken in pursuit of this document's objectives.

However, it must be said that essential services to Aboriginal communities in rural and remote regions continue to be inadequate. The Evaluation of the NAHS noted that there had been very little effort or progress towards bilateral agreements that were to be the main vehicles for a national coordinated effort to improve Aboriginal health.

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<sup>31</sup> *'National Commitment to Improved Outcomes in the Delivery of Programs and Services for Aboriginal Peoples and Torres Strait Islanders.'* Council of Australian Governments, Perth, 7<sup>th</sup> December, 1992.

However, by early 1996 Bilateral Agreements with the Commonwealth and states/territories were being enacted, and the new Howard government continued these efforts. They have become known as Framework Agreements, and by 1998 all States/Territories had signed these Agreements with the Commonwealth.

## **THE EVALUATION OF THE NAHS**

In December 1990, when the Commonwealth Government announced its financial commitment to the implementation of the NAHS, it was also announced that a review of the NAHS would take place before the end of the five year funding program<sup>32</sup>.

In late 1993 and into 1994, pressure had been building about the continuing appalling state of Aboriginal health. The AMA had focused on this issue with President Brendan Nelson touring rural and remote Aboriginal communities. The AMA had earlier appointed an indigenous health adviser, Ms Barbara Flick and has maintained its commitment to an indigenous health adviser and to lobbying for funding for Aboriginal health.

Aboriginal health services had begun to call for a change in administrative responsibility for Aboriginal health - that is that the funding of Aboriginal health services be transferred from ATSIC to the Commonwealth Department of Human Services and Health.

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<sup>32</sup> Media Release, '*Major Funding Boost for Aboriginal Health.*' Joint statement by the Minister for Aboriginal Affairs, Robert Tickner and the Minister for Community Services and Health, Brian Howe, 17<sup>th</sup> December, 1990.

The Minister for Health, Graham Richardson, toured Aboriginal communities in North Australia, and received a great deal of publicity, having done an exclusive deal with Kerry Packer's Channel 9 *60 Minutes* program who travelled with him. Richardson proposed that ATSIC keep its full budget allowing existing expenditure on Aboriginal health services to be channelled into housing and community infrastructure development, and that new money be found to fund Aboriginal health services through his department. This would have meant an injection of new resources into Aboriginal affairs, which was, and is, much needed.

However, before the budget, Richardson resigned from the Senate and Carmen Lawrence replaced him as Health Minister. She failed to convince cabinet of Richardson's plan, and instead new dollars were allocated to strengthen the NAHS program under ATSIC. Dr Lawrence went ahead and established in her Department the Office of Aboriginal and Torres Strait Islander Health Services (OATSIHS). It was also decided that an evaluation of the NAHS would occur before any administrative changes would be made. To take account of the calls from the Aboriginal health services, it was decided to establish a Joint Health Planning Committee (JHPC) to advise on the expenditure of the new funds for Primary Health Care services. The JHPC consisted of:

- ♦ 3 ATSIC Commissioners;
- ♦ 1 Commissioner for the Torres Strait Regional Authority;
- ♦ 1 representative from NACCHO;
- ♦ 1 representative from NH&MRC;
- ♦ 1 representative from OATSIHS, Department of Human Services & Health.

#### The Evaluation Committee

The evaluation was conducted in 1994. An Evaluation Committee first met in July 1994. The ATSIC Commissioner responsible for health chaired it, and its other membership consisted of:

1. 5 x ATSIC:
  - ♦ Commissioner for the Torres Strait;
  - ♦ 2 x Chairs, Regional Councils;



- ♦ Deputy Chief Executive Officer;
  - ♦ Director, Office of Evaluation & Audit;
2. 1 x Department of Human Services & Health:
    - ♦ Head, Office of Aboriginal & Torres Strait Islander Health Services;
  3. 1 x Department of Housing & Regional Development;
  4. 1 x Department of Finance;
  5. 2 x National Aboriginal Community Controlled Health Organisation (NACCHO);
  6. 1 x Public Health Association of Australia;
  7. 1 x State/ Territory Government representative:
    - ♦ Deputy Secretary, NT Department of Health & Community Services.

The Committee established two investigative consultancies for the Evaluation focusing on Improving Primary Health Care, and on Improving Environmental Health. As well as widespread consultations were carried out with Aboriginal communities and organisations, and other interested parties around the country. Other information that was to be considered was:

- ♦ Literature and records search;
- ♦ Reports from state/ territory governments;
- ♦ Public submissions;

The Committee also decided that the evaluation specifically should '*show the extent to which the original Working Party recommendations were adopted, and whether their underlying intent had been met.*'<sup>33</sup>

The major findings of the Evaluation were<sup>34</sup>:

1. The NAHS had not been effectively implemented;
2. All governments had grossly under-funded NAHS initiatives in remote & rural areas and thus the objective of environmental equity by the year 2001 could not be attained;

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<sup>33</sup> Minutes of First Evaluation Committee meeting, 4-5 July, 1994, p7.

<sup>34</sup> Evaluation Committee, '*The National Aboriginal Health Strategy: An Evaluation.*' December, 1994, p3-4.

3. There had been a lack of accountability for implementation of the June 1990 NAHS Joint Ministerial resolutions and inadequate program management information where Commonwealth NAHS funds had been applied;
4. ATSIC had been a convenient scapegoat for inaction and the failure of governments to deliver;
5. The National Council of Aboriginal Health which was established to oversee the implementation of NAHS lacked political support from Commonwealth and state/ territory Ministers and ATSIC;
6. However, there had been some encouraging recent developments in line with NAHS taken by a number of governments;
7. If the Commonwealth wanted to achieve environmental equity by the year 2001 there would need to be substantial increases in funding for housing and essential services in remote and rural regions in Australia, including the Torres Strait, over the remainder of the decade;
8. If the Commonwealth responded by making provision for extra funding, priorities could be quickly established in a spirit of cooperation between the major players;
9. The provision of housing and essential services should be accompanied by strategies for improved maintenance of facilities and appropriate education, including health services and promotion, to equip individuals to achieve a lifestyle and level of economic stability which permits healthy choices;
10. Local community involvement and participation as espoused in NAHS was critical not only to improving quality of life but also to the attainment of an experience of health and length of life to be expected in a technologically advanced nation;
11. Public health providers needed to create meaningful coalitions with Aboriginal and Torres Strait Islanders so that communities and individuals could make informed choices regarding health;
12. Health providers need to be focused on outcomes and health gains, and not on the process of health care organisation and financing;

13. The Commonwealth objective of 'gaining equity in access for Aboriginal and Torres Strait Islander peoples to health services and facilities by the year 2001' - if taken to include 'environmental health facilities' (for example housing and essential services) - is unattainable at both current and projected levels of funding; and
14. Health statistics show that Aboriginal and Torres Strait Islander peoples are so far behind the rest of the Australian community, that equity considerations demand national large scale action programs in environmental health.

An analysis of these recommendations reveals the following emphases (allocating one point for each recommendation):

1. General policy implementation and financing - 6
2. Environmental health - 4½
3. Health services - 2½
4. Community - 1

Most of the general policy findings relate to the lack of implementation and the lack of commitment. The rest show a poor analysis of the underlying cause of ill health in Aboriginal communities and the sort of dynamics that are necessary. One of the recommendations relating to health services is a call to mainstream health providers to form relationships with indigenous people, and another is effectively a call for providers to keep out of issues involving the process of health care organisation and financing. This extraordinary situation illustrates the lack of understanding of community development processes that are critical to the re-construction of Aboriginal society. Aboriginal community controlled health services are vehicles of community development and this *process* is a major way in which Aboriginal people can be empowered - to simply focus on health outcomes, assumes that health providers or bureaucrats know how to achieve these outcomes. This is at the crux of the matter.

The Evaluation Committee recommended that<sup>35</sup>:

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<sup>35</sup> The Evaluation Committee, *op. cit.*, p2-3.

1. the Commonwealth reaffirm its commitment to the principles underlying the NAHS including:
  - ♦ acceptance of Aboriginal people's holistic view of health;
  - ♦ recognition of the importance of local Aboriginal community control and participation; and
  - ♦ intersectoral collaboration;
2. that the achievement of equity, by which is meant *equal access to equal care appropriate to need* in comparison with non-Aboriginal Australia remain a major goal;
3. that there be a partnership in pursuit of this goal between the Commonwealth, state and territory governments, ATSIC, and NACCHO at the national, state/territory and regional levels;
4. that a human rights based approach to funding be adopted with major increases for all aspects of Aboriginal health to achieve comparable standards with that of average non-Aboriginal Australia. As much as \$2 billion would be needed in funding just to meet the backlog in housing and essential services in remote and rural communities in Australia, including the Torres Strait; and
5. that the Commonwealth take a leadership position for all Australians by declaring its resolve to achieve health gains.

The Evaluation also presented some organisational options that they asserted should include:

1. a workable, expert National Council for Aboriginal Health involving Commonwealth/ state/ territory governments, ATSIC and NACCHO to provide policy advice at the national level and oversight the implementation and development of the NAHS;
2. agreement between the Commonwealth and state/ territory governments to achieve a common needs assessment and resource allocation process agreement involving ATSIC and relevant Aboriginal organisations including NACCHO at the state/ territory and regional levels instead of continuing to operate independently of each other; and

3. a partnership between state/ territory health providers and Aboriginal health services to achieve an integrated approach to health services delivery to Aboriginal people at the local and regional levels.

The Evaluation also saw a national plan through to the year 2001 as essential to ensuring a strategic approach to implementation and a framework for measuring the impact of interventions, that the COAG National Commitment should be re-asserted and that further allocation of Commonwealth funds to state and territory governments be made contingent upon bilateral agreements developed with the Commonwealth. Such agreements were envisaged as delineating roles and responsibilities of different levels of government, specifying objectives, outcomes, and monitoring and evaluation mechanisms. The agreements were to be developed in consultation with ATSIC, NACCHO, and other relevant Aboriginal organisations, and were to involve local government where relevant.

### **THE TRANSFER OF FUNDING**

Many community controlled health services had become frustrated about the lack of attention to the implementation of the NAHS, the stagnation of the workings of (at least some) Tripartite Forums, and the tendency of ATSIC to focus almost exclusively on the issues of housing and community infrastructure. This left important developments of health services to Aboriginal people largely unaddressed.

In the Northern Territory, these concerns led to the formation of the Aboriginal Medical Services Alliance, NT (AMSANT) whose membership included all of the Aboriginal community controlled health services in the NT (Danila Dilba, Miwatj, Wurli Wurlijang, Anyinginyi, Congress, Ampilatwatja, Urapuntja, Pintupi Homelands, Mutitjulu, and Imanpa) which met to discuss how to push the issue of appropriate administrative and funding support to Aboriginal health services. AMSANT felt that ATSIC had embraced a strategy in regard to health services of making mainstream services appropriate to Aboriginal people as only a minority of Aboriginal people could access community controlled health services. Lois O'Donoghue stressed the point that ATSIC resources were limited and that the states and territories had to take more responsibility through their mainstream services for Aboriginal and Torres Strait Islander health. She describes the ATSIC health program as supplementary funding<sup>36</sup>:

*'ATSIC's health funding is intended to assist in the provision of supplementary programs to help bridge the gap between services provided to indigenous and non-indigenous Australians.'*

However, the way Aboriginal health services see their role is much more central to the delivery of primary health care to Aboriginal communities than just being supplementary. Indeed, the NAHS embraced a strategy intended to have community controlled PHC services established in all communities, and was seen as an important aspect of improving Aboriginal health. Further, many Aboriginal health services funded by ATSIC are the major (an sometimes only) providers of primary health care services to their community.

Previously at a meeting in Cairns in 1994, NACCHO had also supported the transfer, although since then opinions had been mixed with some health services wanting Aboriginal health service funding to remain with ATSIC.

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<sup>36</sup> O'Donoghue, L *'Aboriginal Health: An ATSIC Perspective.'* A Research Section Occasional Paper, AIATSIS, Canberra, No. 1, 1995, p4-5.

Congress published<sup>37</sup> (with the National Centre for Epidemiology and Population Health) a monograph on these issues, and worked with AMSANT to develop a lobbying campaign to highlight the problems with existing practises, and to call for the transfer of administrative and funding responsibilities to the Department of Human Services and Health.

In February 1995 discussions were held with senior Ministers (Health, Employment and Education, Aboriginal Affairs, Housing) where AMSANT put its views. These were reasonably favourably received, except it was clear that Brian Howe, Minister for Housing, was concerned that such a move would undermine ATSIC, and be against the principle of self-determination.

This issue was taken up by some mainstream media, where it was argued that if improving Aboriginal health status required the principle of self-determination to be put aside, then so be it. This reveals a superficial understanding of self-determination. Self-determination does, of course, require a national expression. ATSIC is an attempt to fulfil aspirations at that level. But there are other levels of self-determination - that at the community and family level. AMSANT and others who supported the transfer saw possibilities of strengthening self-determination at the community and family level through the strengthening of community controlled health services as vehicles of community action and development. There were particular concerns about the appalling lack of resources, and the conflict between Aboriginal organisations, all representing genuine community needs, since the advent of ATSIC. These issues were discussed in Chapter 5.

In the Budget brought down in May, 1995 responsibility for the funding of Aboriginal Health Services was transferred to OATSIHS within the Department of Human Services and Health, and a Memorandum of Understanding was drawn up with ATSIC to facilitate the transfer, and to ensure an evaluation after 5 years.

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<sup>37</sup> Bartlett, B & Legge, D *'Beyond the Maze: Proposals for a more Straightforward Approach to the Administration of Health Services for Aboriginal People.'* Central Australian Aboriginal Congress and National Centre for Epidemiology & Population Health, 1995.

It is unfortunate that many of the ATSIIC Commissioners, and ATSIIC Regional Councillors, saw this move as an undermining of their power.

Since that time the OATSIHS have pursued a 're-basing' exercise to determine the needs of existing health services, and the identification of gaps in services. It appears at this stage that productive relationships are developing at least between the Office and Aboriginal health services in the NT. The Bilateral Agreements have become known as Framework Agreements. They have been pursued and appear to provide acceptable concepts of community control and a framework for moving forward. However, in the NT the Country Liberal Party Cabinet delayed signing the Framework agreement because AMSANT was to be a cosignatory. As a consequence Minister Wooldridge delayed announcing new Aboriginal health funding initiatives in the NT. However these initiatives have been funded, but with inadequate consultation with AMSANT. OATSIHS are in the process of reconsidering their consultative processes in regard to funds going to THS. A further concern of OATSIHS strategy is their reluctance to fund new community controlled health services, or to work with state/territory governments on developing a strategy to this end. Instead their focus is on providing increased resources to existing providers, including THS. This approach is contrary to the strategic directions espoused in the NAHS. So hopes of a more collaborative strategic effort in the NT appear to have stalled, although some hope of a new era remains.

## **DISCUSSION**

There are a number of unresolved issues relating to perceptions of 'health' and how these ought to be addressed. Some of this confusion has been fuelled by difficulties relating to a general inadequacy of resources and increased direct competition between community organisations for these limited resources. This has encouraged some fairly simplistic analyses such as *'we'll fix up water this year, and sewerage next.'*

The following issues have been important difficulties in the implementation of the NAHS:



1. The lack of attention to the issues of health service development in Aboriginal communities, and the difference between primary health care and secondary and tertiary health care. ATSIC, rightly, has been concerned to ensure that mainstream services are accessible, and culturally appropriate for Aboriginal people. This is particularly relevant to hospitals, and specialist services, but is less relevant to primary health care services. In the mainstream of Australian society, primary health care services are predominantly delivered by general practice in the private sector, and funded by the Commonwealth through direct fee for service payments to doctors from Medicare. The NAHS made it clear that these primary health care services are best delivered to Aboriginal people via Aboriginal community controlled health services. The efforts of ATSIC to make mainstream services more appropriate and accessible to Aboriginal people were mainly focused at State and Territory governments. The NT Government does indeed control some PHC services in Aboriginal communities, but in non-Aboriginal communities (Darwin, Katherine, Tennant Creek and Alice Springs) this is provided predominantly through the private sector. In Aboriginal communities there are very good reasons why PHC services should be delivered via a community controlled vehicle. Examination of what (potentially) PHC covers illustrates that it is much more than just general practice medical services. In Aboriginal communities (which are mostly new constructs - the products of colonisation) PHC services have the potential of being vehicles of community development. This dynamic is not so readily operative in private general practitioner or secondary and tertiary services. These issues were not well articulated in the debate, and were misunderstood.

2. The emphasis placed by politicians, ATSIC, the Department of Health, the media, and some sections of the public health community on community infrastructure (housing, water and waste disposal) as the key determinant of improved Aboriginal health status. Comments like '*Aboriginal health will not improve until Aborigines have better housing, clean water and proper sewerage*' have been common. However, a more thoughtful analysis tells a different story. Poor physical environments are responsible for infectious disease, and contribute to a community's social and spiritual cohesiveness. Improvement in physical living environments will not, by itself, improve nutrition, self esteem, substance abuse problems and the like. Our tendency to focus on solitary factors as determinants of health status is seriously flawed. The Commonwealth government has tended, at all its levels, to concentrate on this area which actually confronts non-Aboriginal, middle class sensibilities. That is, we, who take for granted a style of accommodation that we see as reasonable, incorporating clean, running water, flush toilets, etc. tend to react to more makeshift facilities. However, a key issue is how much control people have over their environment and the technologies used to shape that environment. This is also influenced by the numbers of people, and their relationship to each other who are living in an area where there is sharing of resources/ facilities. These issues are less of a problem in urban situations where things like water and sewerage are reasonably well developed, although some people may not be able to afford plumbers to fix blockages, etc. In rural and remote areas there are much more widespread and difficult problems relating to these issues. Where people live in small, family groups on their country the degree of control of their environment is often high. The introduction of more standard housing can actually reduce this control and result in the creation of a health hazard. Thus the issue of developing within the group of people living in a particular environment the skills for managing and controlling that environment are key aspects to creating healthy living environments.

The emphasis on housing has too often resulted in the rapid, almost panicky, erection of structures without adequate attention to questions of how people want to live, and what skills might be required to maintain the technology involved in the notion of a house. Nganampa Health Council, with their UPK program<sup>38</sup>, has focused on some of these issues, and has developed the useful concept of health hardware (rather than housing). This enables an analysis of what people require - places for cooking, washing utensils, washing clothes, washing bodies, sleeping, etc. It enables creative approaches as to how to provide these needs in ways which suit how people wish to live, rather than the assumptions that are often made about what a house is. Their program has also been sustained over a period of more than 5 years, and has been implemented with the intimate involvement of community members themselves.

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<sup>38</sup> Nganampa Health Council *'Report of the Uwankara Palyanyku Kanyintjaku: An Environmental and Public Health Review within the Anangu Pitjantjatjara Lands.'* 1987.

3. Intersectoral collaboration was a key aspect of the NAHS and indeed it is part of the concept of comprehensive Primary Health Care<sup>39</sup>. In central Australia attempts were made to implement an intersectoral approach. A range of Aboriginal organisations representing different aspects of community activity which impact on a community's health were encouraged to be involved with both the Central Australian Aboriginal Health Council and the Tripartite Forum. In an environment where there was a shortage of resources, such an approach degenerated into intersectoral conflict. This was also seen at the ATSIC Regional Council. However, including housing associations, land councils and other non-health organisations on bodies like the CA Aboriginal Health Council actually prevented a focus on the development of the health sector itself. Intersectoral means '*between sectors*'. To be effective the various sectors need to be strong in their own right. The Aboriginal health sector did not have the chance to develop and as a consequence there was no focus on the development of health services to sick populations, their development of clinical public health programs or how they could develop support for the community when facing social crises. In other words, the need to identify gaps in the delivery of health services, and to plan and develop better coverage of health services was frustrated by the involvement of parties who had no knowledge or interest in such issues. Rather they were concerned with the equally important areas of housing developments, land rights, land management and the like, which certainly impact on health status. However, the forums that were created in the wake of the NAHS did not allow a focus on sectoral development that is critical to improving health. Too often discussion focused on which sector was more important. *Fix up water this year, and sewerage next* was the approach at times. Indeed a healthy life depends on water this year, alongside waste disposal, shelter, an economic life, appropriate education, good nutrition *and* access to health care when sick. All of these areas require specific developmental foci in their own right. Intersectoral forums need to be focused on specific areas where collaborative action can be pursued with other sectors as necessary and appropriate. How to achieve effective intersectoral collaboration is an important issue that requires further development.

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<sup>39</sup> '*Primary Health Care: Report of the International Conference on Primary Health Care*' Alma-Ata, USSR, 6-12 September, 1978.' World Health Organisation, Geneva, 1978.

4. The public health community has tended to focus on health outcomes. This has included disease control programs such as immunisations, and particular infectious disease control (TB, STDs, Meningococcal Meningitis, etc.). It has also incorporated the use of a goals and targets approach that imagines a measure of health status before and after particular interventions. In the context of mainstream health services, this may be quite appropriate. But only because a health *care* system is in place. Indeed in the mainstream there has often been heated debate in regard to what many see as an unbalanced distribution of resources towards the care of sick people compared to public health programs aimed at preventing people becoming sick. To transpose these arguments and scenarios on to Aboriginal communities which lack adequate health care systems is inappropriate and runs the risk of being seen as a breach of human rights. Adequate health care services are not in place in many parts of Aboriginal Australia, and to limit resources to the Aboriginal health care system based on rigid disease control programs and health outcomes is inappropriate because sickness services are seen in Australia as being a right, and because such services, to some extent, are a measure of what we are as a caring society. The provision of care to a dying person does not easily fit into the notion of health outcomes. This will be measured in the statistics as 1 death. The health promotion professionals who advocate that resources be taken from clinics to health promotion programs in the community are, likewise, transposing their battles with curative dominance in the mainstream on to the unsuspecting, sick and under-serviced Aboriginal communities. Further, that approach has, at times, failed to recognise that clinics and health services in Aboriginal communities have the potential of being more than simply the vehicles for the delivery of medical, curative services. Many are actually community centres - vehicles of community development on a wide range of issues, alas not always fitting into the centrally determined public health priorities. The recommendation of the Evaluation of the NAHS which calls on health providers to

*'...be focused on outcomes and health gains, and not the process of health care organisation and financing.'*

is particularly concerning in this regard, as it tends to threaten the function of health services to *care* for people. It assumes that health care services produce health outcomes. This is quite contradictory to the other attitude expressed in the Evaluation, that it is housing and environmental infrastructure that will improve health status. What it reveals is a lack of appreciation of the role of primary health care services, compared to the 'old' public health which delivered better housing, sewerage and water supplies.

The problems faced by Aboriginal communities in regard to access to health services is a product of the colonial relationship between Aboriginal and non-Aboriginal Australia. The health care system based largely on a system of private GPs, and regional hospitals has developed as part of the occupation of this country and reflects the colonial health care system with roots in Britain. GPs have followed the colonial settlement patterns and provided services to the populations in those settlements. This has not included Aboriginal forced settlements. Hospitals have been developed along these demographic developments and have at times been part of a government strategy to encourage further settlement.

The development of policies and strategies to address Aboriginal ill-health also tend to reflect a continued type of institutionalisation of Aboriginal people. So many of the reports on Aboriginal health discussed in this and the previous chapter have largely come up with similar perceptions of the problem, and a recognition of what needs to be done. However, the failure to implement the recommendations of these reports reveals a lack of political will on the part of politicians, and an inability of bureaucrats to work in a fundamentally different way. The lack of resources allocated to the task is evidence of the former. The selective implementation of the NAHS by bureaucrats (eg the mechanisms established for the distribution of NAHS funds) is evidence of the latter.

The Aboriginal community politic is also problematic. On the one hand the rhetoric about community control is simple and straight forward, but the community is not homogeneous. Basing planning on community representation is somewhat flawed. Community control of health services in particular communities has some meaning. Whilst not all work well, many do and the dynamics within those that do offer outcomes that are not easy to predict or construct. However, when forums are developed on a state/ territory wide or national basis, the issue of community representation presents difficulties. Thus regional approaches are more likely to work because local people are likely to have more confidence in their knowledge about their own region, and what they can represent and what they can't. Planning processes are likely to have more chance of success on this basis. Further, collaborative working relationships are more likely to develop at a regional level where it is possible to operationalise the principles through taking action on particular and familiar problems.

Basing planning processes and the implementation of strategies on the existing governmental jurisdictions again reflects the continuities of the colonial relationship impacting on health.

The next chapter will examine the details of health service provision to the Aboriginal population of central Australia.







## **CHAPTER 9 - FRAMEWORK FOR IMPROVED PHC TO ABORIGINAL COMMUNITIES**

This chapter proposes a model of health service delivery to Aboriginal communities in central Australia that attempts to break from the continuities of the colonial relationship evident in government delivery of PHC. This builds on the community controlled health services that broke from the continuities of the past to a significant extent by providing services outside the government structures, and being driven by the community itself. Of course the funding provided by government continues to influence what programs are developed and which are not. In developing a model of health service delivery, there is a need to balance two potentially contradictory stances. One is that the community itself should be in control of what services are provided. The other is the responsibility of health bureaucrats and providers to ensure that primary health care services are accessible to all. Clearly not all communities wish to take full control of their own health services. The proposals in this chapter attempt to straddle these principles so that the opportunities for people to take control of aspects of their health service are optimised, whilst the system ensures good coverage of services regardless of the degree of control asserted by the community.

This chapter<sup>1</sup> examines the concept of comprehensive primary health care, and proposes a mechanism for ensuring the development of such service through an operationalised notion of core functions of PHC. A collaborative planning process is explored, and some basic principles of health planning in central Australia presented. These proposals attempt to provide the basis for breaking with the negative aspects of the colonial relationship argued in this thesis, and particularly to break with the damaging institutionalised conflict that has dogged developments in the past.

As can be seen from the previous chapter, there has been a gap between the policies of government and their implementation. A key recommendation of Aboriginal health policies over the years has been the need for community controlled primary health care.

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<sup>1</sup> Much of the information in this chapter was presented in Bartlett, B et al '*Central Australian Health Planning Study: Final Report.*' OASTISHS as part of the Central Australian Health Planning Study, 1997.

However, primary health care in the mainstream is hardly comprehensive. It depends on, mostly, private medical practitioners arbitrarily distributed with referral links to a range of specialist and allied health services. Since the 1970s community health centres have been added to this referral list, but these are very varied in their role and the programs delivered. Aboriginal health services have at least aspired to a more truly comprehensive approach, although this has not been well defined. International debates have focused on the issue of comprehensive versus selective primary health care. Criticisms have been made about the tendency to target diseases (eg diarrhoea) and impose programs narrowly on these diseases. In the case of diarrhoea, this has included the marketing of oral rehydration salts rather than more widely available materials in communities, thus increasing the dependency of communities on outside resources<sup>2</sup>.

So what is primary health care. The Alma Ata Declaration of PHC<sup>3</sup> defined it as:

*'Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process.'*

It goes on to say that PHC should address the main health problems in the community, providing promotive, preventive, curative and rehabilitative services and should include education concerning the prevention and control of prevailing health problems, the

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<sup>2</sup> Werner D, Sanders D 'Questioning the Solution: The Politics of Primary Health Care and Child Survival with and in-depth criticism of Oral Rehydration Therapy.' HealthWrights, California, 1997.

<sup>3</sup> 'Primary Health Care: Report of the International Conference on Primary Health Care, Alma Ata, USSR, 6-12 September, 1978.' WHO, Geneva, 1978, p 3-4.

promotion of food supply and proper nutrition, adequate supply of safe water and basic sanitation, maternal and child health care, including family planning, immunisation against the major infectious diseases, prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries, and the provision of essential drugs.

This remains a sound definition of comprehensive primary health care and includes health care, provision of treatment, and the provision of preventive and public health measures. It is very much in line with the definitions of holistic health care as adopted by NAIHO in the 1970s and the National Aboriginal Health Strategy in 1989.

### **Core Functions of Primary Health Care**

The implementation of a strategy to ensure that comprehensive PHC services are available to Aboriginal people have been inadequate. Community controlled health services have been proposing to government for some years that a core functions approach be adopted as a standard of service provision in terms of both existing community controlled health services and the establishment of new services. Attempts were made to include such an approach in the recent Framework Agreements between the Commonwealth and the states/ territories, but was unsuccessful. However without agreed functions, PHC services to Aboriginal communities are likely to remain patchy, with some communities continuing to have poor access, and there being no way of measuring government effort.

PHC services are the key strategic point of access for communities to the broader health care system. This must be a central understanding in any attempt to turn around the poor health status of Aboriginal people.

The notion of core functions of PHC has been around since at least early 1994 when Commonwealth Health sponsored a meeting of representatives of community controlled health services and a number of health bureaucrats in Sydney. This meeting was called in anticipation of Commonwealth Health gaining responsibility of the funding of AMSs. This in fact did not happen until 1995. However, the community controlled health services were keen to have some notion of core

functions included in the Health Departments arrangements for funding so that there would be a clarity of what Aboriginal health services were.

Later, there were moves to ensure that core functions of PHC were included in the Framework Agreements between the State/ Territories and the Commonwealth on how Aboriginal health issues would be pursued. Whilst this was not accepted, AHMAC sent the issue back to the states/ territories for further consideration and development. Thus the Northern Territory, at least, has a process under way focused on this issue.

When Minister Wooldridge established the National Aboriginal and Torres Strait Islander Health Council, there were three sub-committees established by the Council – Workforce Issues Sub-Committee, Substance Abuse Issues Sub-Committee, and Remote Area Issues Sub-Committee. The Remote Area Issues Sub-Committee took on the task of developing a definition of core functions.

The core functions of PHC according to a circulated paper<sup>4</sup> restricted the notion of core functions to the provision of sick care and the medically derived preventive/ public health measures such as immunisations, and various screenings. Whilst recognising the wider functions of comprehensive PHC, it did not see these functions as ‘core’.

Such a limited notion of core functions does not fit well with Aboriginal notions of ‘health’ nor with the dominant causes of mortality in the Aboriginal community. It is predictable that such a notion would result in the limited funds available for Aboriginal health being totally consumed by medical programs, with programs aimed at addressing social issues involved in substance abuse, youth suicide, domestic violence, and the like, not attracting resources because they are not considered ‘core’. A primary health care service that only provides sick care from a medical and public health point of view fits better the definitions of selective PHC rather than comprehensive PHC as discussed above. On the other hand, attempts to define core functions in detail for the non-medical health activities assumes that outcomes can be achieved in a way that mirrors the medical. That is the determination of strategies outside the community politic/ dynamic and followed by implementation strategies which are imposed on the ‘target’ community. This is not the case. Whilst

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<sup>4</sup> *‘Health Service Delivery for Remote Aboriginal Communities: Position paper of the Remote Areas Issues Sub-Committee of the Aboriginal and Torres Strait Islander Health Council.’ April, 1997.*

medical care and public health interventions of the medical type can successfully deliver specific (but narrow) outcomes to passive recipients, this does not apply to other issues such as nutrition (heart diseases, diabetes), substance abuse, violence, and the like. Attempts to specify detail about what these programs should be fails to take account of the common factor that holds them together. That is, they all require community initiative and action for there to be any chance of change.

The debates around these strategic questions again reflect the colonial relationships. The battles that occur in the mainstream between sickness services and public health, and in more recent decades between these interests and health promotion, as well as the professional jealousies embedded in those relationships, are imposed on the strategies for better Aboriginal health. This dynamic tends to push PHC towards a selective rather than comprehensive approach. A move towards agreed core functions of PHC for community controlled health services would help prevent this tendency of fragmentation of PHC towards selective programs.

A further purpose of a core functions approach is to provide a template for funding bodies so that their funding lines are clear and have a reasonable chance of supporting the development of effective and comprehensive community PHC. It would help identify gaps that particular services have in achieving a comprehensive approach, and allow for a measure of government performance.

The history of conflict between government and community run PHC services can be lessened if governments are able to move away from defining their primary role as a deliverer of PHC towards a role of support for PHC. This could become the key focus for a collaborative partnership approach between the government and community sectors.

***Table 7 Core Functions of Primary Health Care.***

<b>Core Function</b>	<b>Programs</b>
Clinical Services	Sick care services Screening programs Public Health Programs (eg immunisations)
PHC Support	Management Education and training Specialist/ Allied health support
Special Programs	Preventive programs requiring community 'agency' (eg substance abuse, youth suicide, domestic violence)

*Source: Central Australian Health Planning Study, 1997.*

## *1. Clinical Services.*

These services include sick care services and medical public health or preventive services. The staff required to deliver these services are AHWs, nursing staff and doctors. In small out-stations without resident health service staff, access will depend on the following:

- A. Visiting services – AHWs, nurse, and/ or doctor visits organised from neighbouring communities or from Regional Centres such as Alice Springs. This will require a re-orientation of PHC services to servicing out-stations in their area rather than just the community in which they reside. The timing, frequency and length of visits should be negotiated with each out-station or community.
  
- B. Provision of medicine kits, supported by a regionally organised supply and training program. Medicine kits should be provided at a level determined by the qualifications and experience of the holder. Some basic medicines such as paracetamol, Ascabiol, antiseptics, methyl-salicylate (rubbin' medicine) and oral re-hydration salts ought to be readily available. Others such as antibiotics, narcotic analgesia and other more uncommon drugs should only be available where a qualified AHW is resident. Specific drugs for people with particular medical conditions could be provided through this scheme via dosette boxes. The list of drugs provided would need to be modified according to the availability of refrigeration.

The Health Care Agents Subsidy Scheme is a currently operating program in the NT where unqualified persons on pastoralist properties are designated as health care agents. In practise these are almost always the wife of the pastoralist who mostly has no health qualifications or experience. They are provided with a graded subsidy of up to \$20,468 per annum depending on the number of people in the area (See Table 8). This scheme is a further example of the continuities of the colonial relationships that have influenced the development of health services. However, this program could be modified to support individuals in small communities/ out-stations without access to resident health facilities, to play a primary health care function. Small subsidies could be tied to people's participation in regionally organised training support programs.

The medicine kit holders scheme would require regional support that would:

- ♦ organise provision of medicine kits with a regional pharmaceutical distribution service;
- ♦ maintain supplies to medicine kits through the pharmaceutical distribution service;
- ♦ liaise with designated PHC services to ensure coordination with health service staff visits; and
- ♦ organise regular training support.

**Table 8 Health Care Agents Subsidy Scheme.**

<b>Size of Community</b>	<b>Percentage of Subsidy (%)</b>	<b>Amount of Subsidy (\$)</b>
200	100	20,468.00
160-199	80	16,374.40
120-159	60	12,280.80
80-119	40	8,187.20
40-79	20	4,093.60

Source: Territory Health Services

C. Telephone health care advice service requiring access to telephone or radio.

This will allow contact to be made with health staff both for emergencies, and advice about more minor problems, such as scabies.

## **2. Support Services**

In order to ensure high quality clinical services in remote communities, adequate support for PHC must be provided. Some of this needs to be provided at the community level and should focus on administration and maintenance of equipment, buildings, and vehicles. However, other types of support need to be organised regionally.

### **Local Administrative Support**

Each Health Service should have an Administrator as part of its base funding. The role of the Administrator is to ensure that non-clinical aspects of PHC service delivery are done. Such things include maintenance of vehicles, buildings and other equipment, and ensuring funding accountabilities are maintained.



The THS Review<sup>5</sup> and the Central Australian Health Planning Study<sup>6</sup> recommended that central Australia be divided into health service zones. The THS Review also recommended that each zone have an area manager. This was seen by some critics within THS and by the community controlled health services as an extension of the regional bureaucracy of THS into remote communities. This could be understood as a strategy to continue government control of PHC rather than allowing the local community influences to have greater opportunities to impact on PHC service delivery. It also allows the continuing colonial relationships to remain dominant. If PHC is best delivered through a 'team' approach, then an approach which encourages an hierarchy of power is inappropriate. In most of these remote services the numbers of staff are going to be small. A devolved management structure still firmly set in hierarchy is likely to be disruptive to health service delivery.

### **Regional Support**

One of the lessons to be learned from PHC service development in central Australia, with the development of autonomous primary health care services in a number of communities, is the difficulty that these services have with a number of functions ranging from management, to program development and in service education for staff.

Regional support programs require particular emphasis in order to develop arrangements that free up community based resources to concentrate on PHC service delivery. These supports should be developed within a collaborative framework which helps ensure the support of all agencies with major responsibilities for Aboriginal health service development (THS, OATSIHS and AMSANT), and ensures that the roles and responsibilities of different agencies are clear. The mechanism for this is through the Central Australian Indigenous Health Planning Committee (see below).

### ***MANAGEMENT***

Management can be divided into two types. The first is administrative management, and the second is health program development. The reason for separating these is that they are fundamentally different in their objectives and underpinning philosophies.

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<sup>5</sup> Wakerman J, et al 'Review of Northern Territory Government Remote Health Services in Central Australia.' Menzies School of Health Research, Alice Springs, August, 1997.

<sup>6</sup> Bartlett B, et al 'Central Australian Health Planning Study.', OATSIHS, Canberra, July 1997.

## *Administrative*

Regional management support is important so that those in the community can concentrate on community issues. The following areas lend themselves to regional approaches:

- ♦ Recruitment of Staff. It is likely that financial savings are to be made from a regional approach. Whilst a small health service may need to recruit a nurse every 2 years, say, on a regional level nurses will be recruited at much more frequent intervals. Recruitment processes get lost in the PHC service, but can be more efficiently maintained at a regional level. A previous attempt to develop a regional recruitment service some years ago was developed unilaterally by individuals, and did not receive the support from key agencies. It should be stressed that this function is not to decide who will be employed, but rather to assist the client service to develop job descriptions, selection criteria and processes with the PHC staff or community members. The regional role should assist to advertise the job, check any police record, check previous employers, short list applicants, organise interviews with selection panel, and inform applicants of the result. This task should also include organising the relocation of successful applicants, and the development of clear terms of employment. The regional recruitment service could also assist with the packaging of salaries. For this to work, funding bodies should consider insisting that funded services avail themselves of such a facility.
- ♦ Financial management. Regional support in financial management, including how to access funds, accountability requirements, and how to utilise resources to achieve outcomes are issues that have proved difficult in the past. If health councils or other community groups are to play a role in determining the direction of health programs, then they need to be able to access guidelines about financial management. Such guidelines could be developed at a regional level, and modified at the local level as appropriate.
- ♦ Industrial relations – protocols for hiring and firing staff, award wages, leave entitlements, overtime, time in lieu, and other entitlements need to be developed. Such policies can be modified at the community level to suit local needs, but will need to comply with legislative requirements.
- ♦ Maintenance of assets eg. vehicles, office and medical equipment – asset registers, maintenance protocols, depreciation protocols. Guidelines and computerised systems could be developed at a regional level.

- ♦ Insurance – fire/ burglary, workers compensation, public liability, and professional indemnity insurance.
- ♦ Workers' health and safety matters – such as workers compensation procedures, workplace health and safety policies and medical waste disposal arrangements.
- ♦ Other administrative policies and procedures – drivers/ vehicles policy, confidentiality, complaints procedures, consumer rights, smoking, alcohol, and staff grievance procedures.

Many of these matters can be facilitated from a regional management support unit. It should be stressed that this unit would not set the policies, but would ensure that policies sit within legal responsibilities, and would provide draft policies that community PHC services could modify as desired.

Many of these areas of management have proved difficult for small stand alone health services. Larger services have developed some of these policies, as have THS. Further, CHASP<sup>7</sup> provides a framework for considering policy issues in terms of the objectives of the service. They have also produced a manual<sup>8</sup> for small rural and remote PHC services and, with Nganampa Health Council and Menzies School of Health Research, developed a manual<sup>9</sup> modified for use in Aboriginal health services. A regional approach could build on work already done, and draft policies made available to smaller health services. There is an education and training component to these issues that could be part of in servicing for health service administrators and managers.

People elected to Boards of Management of community controlled health services frequently do not realise their rights and responsibilities that go with the position. The development of straightforward guidelines of legal and other requirements would assist a better understanding of the roles and responsibilities of these Boards.

### ***Health Program Support***

Public health programs such as immunisations, STD and other communicable disease

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<sup>7</sup> CHASP (Community Health Accreditation & Standards Program) *'Manual of Standards for Community and Other Primary Health Care Services.'* Australian Community Health Association, Sydney, 1993.

<sup>8</sup> CHASP Manual of Standards for Remote/ Rural Community and Other Primary Health Care Services.' Australian Community Health Association, Sydney, 1994.

<sup>9</sup> CHASP, Nganampa, Menzies 'Manual of Standards for Rural and Remote Aboriginal Health Services.' 1993.

control, as well as well women's programs, chronic disease and child health programs require systems to be put in place so that health service staff can efficiently follow people up to achieve appropriate health outcomes. The mobility of people makes it difficult for health service staff to get current information about what action is required. A regional approach that allows staff to efficiently access the information they require about people who may not normally be part of their client population would assist the effectiveness of these programs. Assistance with the establishment of local PHC information systems would facilitate greater efficiency in these matters. The CARPA Standard Treatment Manual<sup>10</sup> and the Women's Business Manual<sup>11</sup> are examples of regionally developed resources that are widely used throughout PHC services in central Australia.

Other aspects of PHC support that could be facilitated from regional support includes:

- ♦ Program development – facilitating local staff with the setting of objectives, the means of reaching them, and how they can be evaluated.
- ♦ Referral agencies – regional support mechanisms should ensure that there is regularly updated information to community based PHC service staff about what allied health, and specialist services are available, and their referral guidelines.
- ♦ Resource management – how to mobilise available resources to achieve the objectives of the program.
- ♦ Delivery, monitoring and evaluation – aspects of this need to involve regional resources. Evaluation requires some external input to assist local staff to better set their objectives, and their program activities, as well as the criteria they will use in judging their progress.
- ♦ Community participation issues/ consumer input – this relates to specific program issues such as involvement of carers of children in growth promotion programs, rather than health service control issues per se.

## **Staff Development Education & Training**

Continuing education of staff is critical to the maintenance of high standards of health service delivery. This must include orientation of new staff to ensure that already

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<sup>10</sup> CARPA 'CARPA Standard Treatment Manual.' Central Australian Rural Practitioners Association, Alice Springs, 2<sup>nd</sup> Ed, 1994.

<sup>11</sup> Congress Alukura, Nganampa Health Council 'Minymaku Kutju Tjukurpa: Women's Business Manual.' Alukura/ Nganampa, Alice Springs, 1994.

developed systems for various health programs are built on, rather than duplicated. In-service education (staff development) and orientation programs could be delivered by collaboration between employer organisations and the Central Australian Remote Health Training Units (CARHTU), and (for doctors) the Divisions of General Practice and the Rural Incentives Program (RIP). In central Australia, the CARPA Conference has been held twice a year for over 10 years. This established forum should be utilised as part of continuing education for PHC staff. Similarly the CARPA newsletter provides an important forum for the discussion of PHC issues.

Orientation of Staff. New staff, whether Aboriginal or non-Aboriginal require orientation to their new work. For local Aboriginal staff, orientation will need to be more focused on how the health care system works, and what their expected role in it is. For others, there will need to be orientation about the region generally, including general cultural issues, the nature of Aboriginal organisations and communities, and the specifics of the health care system. Much of this can be organised at the regional level. The Aboriginal Cultural Awareness Program (ACAP) needs to be supported so that employees of all services can access their program. Local orientation will also be required, and ACAP or the CARHTU could assist the development of a local orientation program for each health service.

Management. Some of these issues have been discussed under the heading of management. However, there is also an education component. At present there is virtually no support for PHC service managers, apart from a general management course conducted by IAD. A number of professional organisations exist for health service managers in the mainstream health system, but these seem to have had little impact on Aboriginal PHC. Again, the CARHTU and IAD could play a significant role by organising in-service sessions for managers and administrators that would enable improvements in their work, as well as the sharing of experiences and the development of networks. IAD already delivers a course for managers of Aboriginal organisations.

Health Service Boards of Management. Community members elected to Boards of Management often have poorly developed ideas about legal and representative roles and responsibilities of their position. Well-timed workshops (eg early in the elected term) would assist Board members to understand their roles and responsibilities and strengthen their role in representing their community's

interest in health service development. This process should involve more experienced health service board members both in the particular community and those from other services. Otherwise, there will be a risk that health service providers will train Board Members to simply conform to provider agendas.

### **Evaluation and Support**

All of these programs will require evaluation and support. Regional evaluation mechanisms need to be identified and applied to ensure that people generally have access to the core functions identified at a high level of quality. David Scrimgeour, Komla Tsey and others of the Menzies School of Health Research have provided this type of support to a range of health services and community development programs. Some public health monitoring processes (eg such as have been developed by Congress in their clinical Quality Assurance program, or Nganampa in their STD program) could be applied to other smaller health services which lack the capacity to develop such systems themselves.

### ***3. Special Health Prevention Programs***

In developing health care programs, a distinction has been made between those services that are clinical, and those that are non-clinical. The purpose of this distinction is:

- i. to relieve clinical staff of the often self imposed expectations that they have to deliver non-clinical preventive programs. This is quite unrealistic, and can actually result in a decline in quality of clinical services.
- ii. to recognise that, whilst clinical services can be delivered to passive recipients, this is not the case for the non-clinical special health prevention programs. This has been discussed above.
- iii. to develop funding guidelines for these programs that are appropriate to their nature.
- iv. to ensure a maintenance of balance between clinical and non-clinical aspects of comprehensive PHC so as to develop a strategic approach to improving Aboriginal health.

The key issues for these types of programs is the necessity of community agency in their delivery. Without that, such programs are unlikely to work, or be of limited sustainability.

The framework for the development of PHC services to Aboriginal communities outlined above risks, like all such frameworks, making assumptions which lock in past practices which limit the opportunity of breaking from the premises embedded in the colonial relationships. To some extent this is unavoidable. Health services and other programs inevitably will reflect this relationship as it is impossible to operate outside it. However, the above framework attempts to break from the past entrenched and competitive positions that have marked PHC service delivery, at least in central Australia. It is based on the principles of Aboriginal community controlled PHC as detailed in the National Aboriginal Health Strategy, and is designed to optimise opportunities for communities to assert control. It also provides government with a new role. Rather than defining their role as providers of PHC, their predominant function would be to provide strategic support to PHC delivery, and to ensure specialist and allied health support through PHC services. In order to optimise this break from the old colonial relationship, planning of health services needs to be based on the current realities of Aboriginal living – where they live, their mobility, and the resources available to them.

### **Central Australian Indigenous Health Planning Committee.**

In order to ensure sound planning processes for PHC it is necessary to overcome the entrenched conflict that is a product of the colonial relationship between Aboriginal communities and organisations and government. The core functions of PHC outlined above provides a framework for improved service delivery to Aboriginal communities. However, in order for this to be implemented in a culturally appropriate way, it is necessary to develop a collaborative forum in which community and government agencies can oversee developments. Such a forum has been advocated in central Australia by community health services, as well as various inquiries, such as the Kerr Review, since the late 1980s. In April, 1998 the first meeting of the Central Australian Indigenous Health Planning Committee was held. Participants included AMSANT, Congress, THS, OATSIHS and ATSIC. It is too early to assess the effectiveness of this approach. The discussion below focuses on how such a body could function to ensure better service provision.

Regional planning is important in order to ensure the efficient, effective and equitable mobilisation and distribution of available resources with the objective of improving Aboriginal health.

This should include those organisations responsible for health service delivery to Aboriginal people in central Australia. Lessons from the Tripartite Forum suggest that such a body should be small so that it is workable, and that it be focused specifically on health service issues. Participants should be limited to THS, OATSIHS, ATSIC and AMSANT with this group being able to coopt other organisations and individuals for specific purposes, possibly through limited term working parties to investigate and inform the body on specific health service issues. Issues requiring intersectoral action, can be addressed as necessary, and should include ATSIC.

The current way in which both NT and Commonwealth agencies (eg ATSIC) are organised tends to create competition between town and bush. This builds on the historical racist attitudes about '*half castes*' and '*full bloods*' or '*traditional*' and '*non-traditional*', rather than on an understanding that Alice Springs is the resource centre for the whole region and that families and communities straddle the whole region. By administratively separating town and bush, it makes it much harder to organise resources in a way which both maximises services available to people in the bush as well as ensuring appropriate regional support, and the provision of secondary and tertiary services when they are needed. A regional planning process is designed to help overcome this.

Health planning is necessary in central Australia to:

1. allow consideration of needs across the whole Region to ensure a degree of equity of access to health care services for all;
2. allow changes to occur in health service delivery to reflect changing demographic patterns such as the movement of people to out-stations;
3. identify changing needs in terms of illness patterns, and available specialist and other services;
4. provide coordinated effort in disease control programs that are unsustainable by small PHC services alone; and
5. identify gaps in services, and to prioritise the expenditure of new resources as they become available.

These should occur in ways that are cognisant of the needs for developing increased consumer input into health service development processes, both at community and regional levels. This should



ensure that there is a process at these levels to increase the capacity of communities to be involved with their health care services.

### **An Integrated Approach**

As professionals and health bureaucracies have become more aware of the need to involve Aboriginal people in their work, there have been an increasing number of invitations either to AMSANT or to individual health services like Congress to join project steering committees, reference groups or to endorse particular projects (often developed as submissions for funding). Whilst this confirms the recognition of the leadership responsibilities of these players, it has also been impossible for AMSANT or the individual health services to adequately assess and contribute to these processes.

The proposed model provides integration between information flows, research projects, and service delivery. The current inadequacies of basic PHC service in communities makes an integrated approach a primary concern. The analysis of routinely collected data (eg hospital separations) and results of research programs need to inform the development of more adequate and appropriate PHC service delivery.

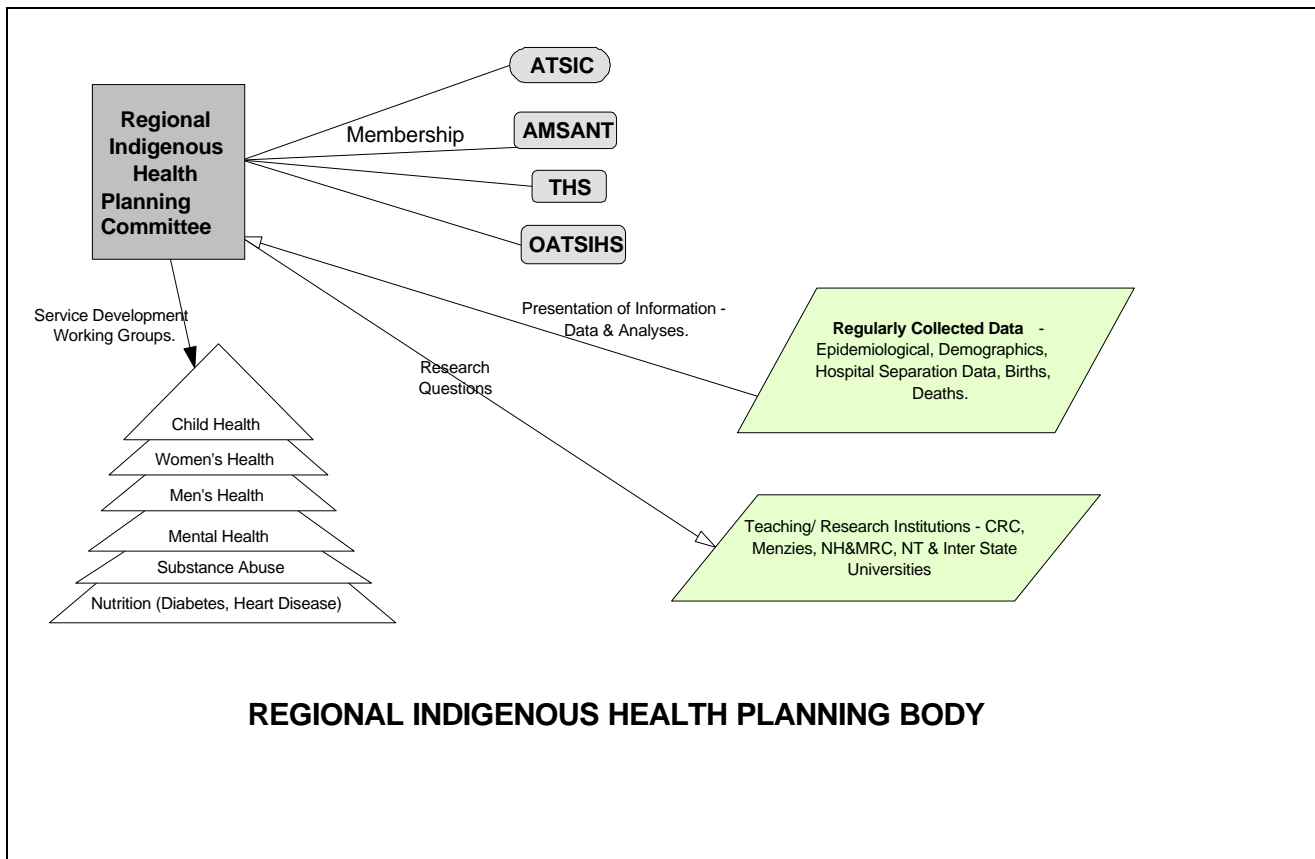
The Working Groups/ Task Force idea is flexible. How many groups and what they should focus on are matters for the planning body to decide. However it is important that:

- ♦ the number of working groups be kept fairly small;
- ♦ they be driven by specific short term objectives (rather than establishing permanent committees) and that clear time frames are set and monitored by the planning body;
- ♦ they be made up of those people who have the responsibility for working in this area, whether paid or voluntarily. This should apply to all regardless of race. Care should be made not to take people away from their communities where they are doing important work just so they can sit on a committee.

In this model existing resources are more integrated to serve a collaborative planning process.

The issue of the development of consumer input into health service delivery is an issue that the planning body itself should address. Resources may be required to conduct bush meetings, or other agreed processes. It needs to be stressed that the interim make-up of the planning body does not include consumer representatives, even though leaders of community controlled health services can claim this mantle at least as far as their own communities are concerned.

**Figure 4 Collaborative PHC Planning Structure**



FROM: CENTRAL AUSTRALIAN HEALTH PLANNING STUDY, 1997.

**POSSIBLE AGENDAS FOR WORKING GROUPS**

The sorts of agendas that might be appropriate for the working groups are:

1. PHC programs at community level;
  - ♦ Clinical services – particularly defining which services people should have access to;
  - ♦ Community care of people with disabilities and the aged;
  - ♦ Child growth promotion strategies.
  - ♦ AHW education and support.

## 2. Regional support for:

- ♦ Program development.
- ♦ Follow up systems.
- ♦ Quality Assurance.
- ♦ Data flows.
- ♦ Staff development, orientation, and in-service training.
- ♦ Specialist and Allied Health Services.
- ♦ Transport.
- ♦ AHWs.
- ♦ Consumer input.

This proposed model has been largely adopted by the new Indigenous Health Planning Committee. Time will tell whether this body reaches its theoretical potential.

However, such collaborative forums are premised on a recognition of the colonial relationships between Aboriginal and non-Aboriginal Australia, and the need for negotiation in the efforts to improve Aboriginal health.

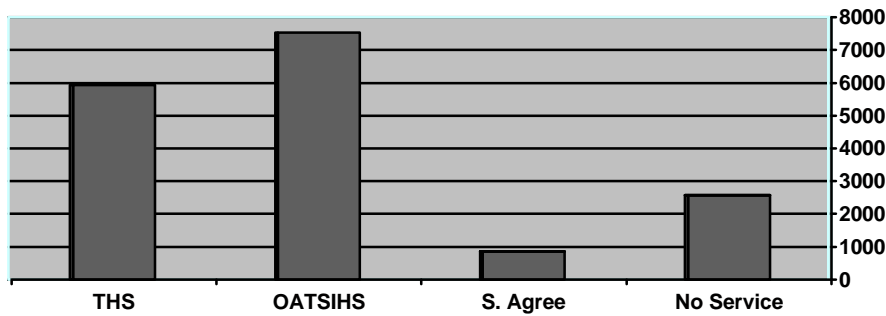
### **Current Models of PHC in Central Australia**

How health services are currently delivered further illustrates their origins in the colonial histories and continuing relationships. In central Australia, Government services have failed to provide adequate access of Aboriginal people to PHC services outside Alice Springs. Negotiations are now being pursued to provide resident medical services to Yuendumu, but over the past decade many people have left such communities to establish out-stations.

Primary health care to the Aboriginal communities in central Australia is currently delivered by THS, through THS Service Agreements with Community Councils, and through OATSIHS funded community controlled health services. The development of community controlled services was discussed in Chapter 6.

Figure 5 and Table 9 illustrate the approximate populations currently serviced by the different models. It can be seen that around 2,500 people have no organised access to health care. This is a reflection of how health services have been developed as part of the colonisation process and lag behind the movement of Aboriginal people through their re-occupation of country known as the out-station movement. It is extraordinary that primary health care service development has not been based on basic demographic data as a starting point for identifying needs. A Central Australian Health Planning Study<sup>12</sup> (funded by OATSIHS) was conducted in 1997, and plans are being made to conduct a similar study in the Top End of the Northern Territory.

Figure 5 Aboriginal Access to PHC Services



Source: Central Australian Health Planning Study, 1997.

**Table 9 Populations Serviced Through Different PHC Models.**

	<i>THS</i>	<i>OATSIHS</i>	<i>Service Agreement</i>	<i>No Service</i>
Population Serviced	5,925 (35%)	7,525 (45%)	860 (5%)	2,575 (15%)

Source: Central Australian Health Planning Study, 1997.

Thus existing health services have been based on historical patterns of delivery from the, largely, non-Aboriginal population centres of Darwin, Katherine, Tennant Creek and Alice Springs. This again illustrates how health services reflect the colonial relationships and histories.

<sup>12</sup> Bartlett B, 1997, *op. cit.*

### *THS Delivered PHC Services and THS Service Agreement Health Services*

THS has had a continuity with Commonwealth health services that operated before self government for the NT in 1978. Briefly services to Aboriginal communities are based on small clinics in those communities staffed by nurses and Aboriginal Health Workers with medical officers based in Alice Springs visiting weekly – monthly depending on the community.

As policy pressure mounted about the importance of community control of services, and the fact that where such services existed a higher standard of service was provided, THS developed what was initially known as Grant-in-Aid Services. The name was later changed to Service Agreement Services. This was the NT Government version of community control. Agreements were reached with a community council and funds made available to employ nurses and AHWs, as well as for vehicles, pharmaceuticals and other supplies. Usually the THS employed medical officers have continued to provide medical visits. There are no resources provided for management and administration, for relief staff to enable permanent staff access to in-service training, or for preventive programs.

There has been an on-going conflict between the community controlled health services (as expressed through the peak body AMSANT) and THS about the status and adequacy of these services. AMSANT has disputed the claim that these are community controlled on the basis that there is no health council as such, and that the Community Council has no real input into these services – largely because of the weight of other issues such as community infrastructure which the Councils are primarily responsible for.

The development of this model is an example of how THS has adopted the policy of community control of primary health care, and then developed its own model through which it actually retains a good deal of control but without the day to day responsibility. It is a reflection again of the colonial relationships. In developing the model THS has excluded Aboriginal health leaders. Thus the model developed was offered to communities as a package, but did not facilitate the exploration of other possibilities which may have been more suited to the community's particular circumstance. The absence of resources for management and the absence of health councils has resulted in there being

little capacity in these services for advocacy on health issues, accessing resources for preventive programs, or participation in regional health forums.

The advent of Aboriginal community controlled health services in the 1970s provided a break with the colonial continuities of government services. However, that development has not provided coverage to all communities.

Community controlled services have been better able to provide services to out-stations than government services which have lagged behind the changing demographics of their client populations.

The proposals below are premised on the principles of equity of access to primary health care, and the need to develop regional collaborative relationships as a means of achieving a greater degree of community control of PHC.

### **Central Australian Health Service Zones**

The establishment of Health Service Zones provides an improved framework in which to plan PHC service delivery in the context of many remote Aboriginal communities in central Australia rather than the previous model which tended to focus on the major concentrations of people outside Alice Springs and Tennant Creek. Organising demographic data in this way, provides manageable information to be considered by the collaborative planning body. Without such information it will remain exceedingly difficult to advance.

The proposed Zones are based on:

- ♦ language groups and cultural relationships;
- ♦ knowledge of relationships;
- ♦ geographic proximity and other logistical considerations.

Organising data in this way it is possible to see something of the distribution of the population in the region.

**Table 10 Population Distribution by Health Service Zone**

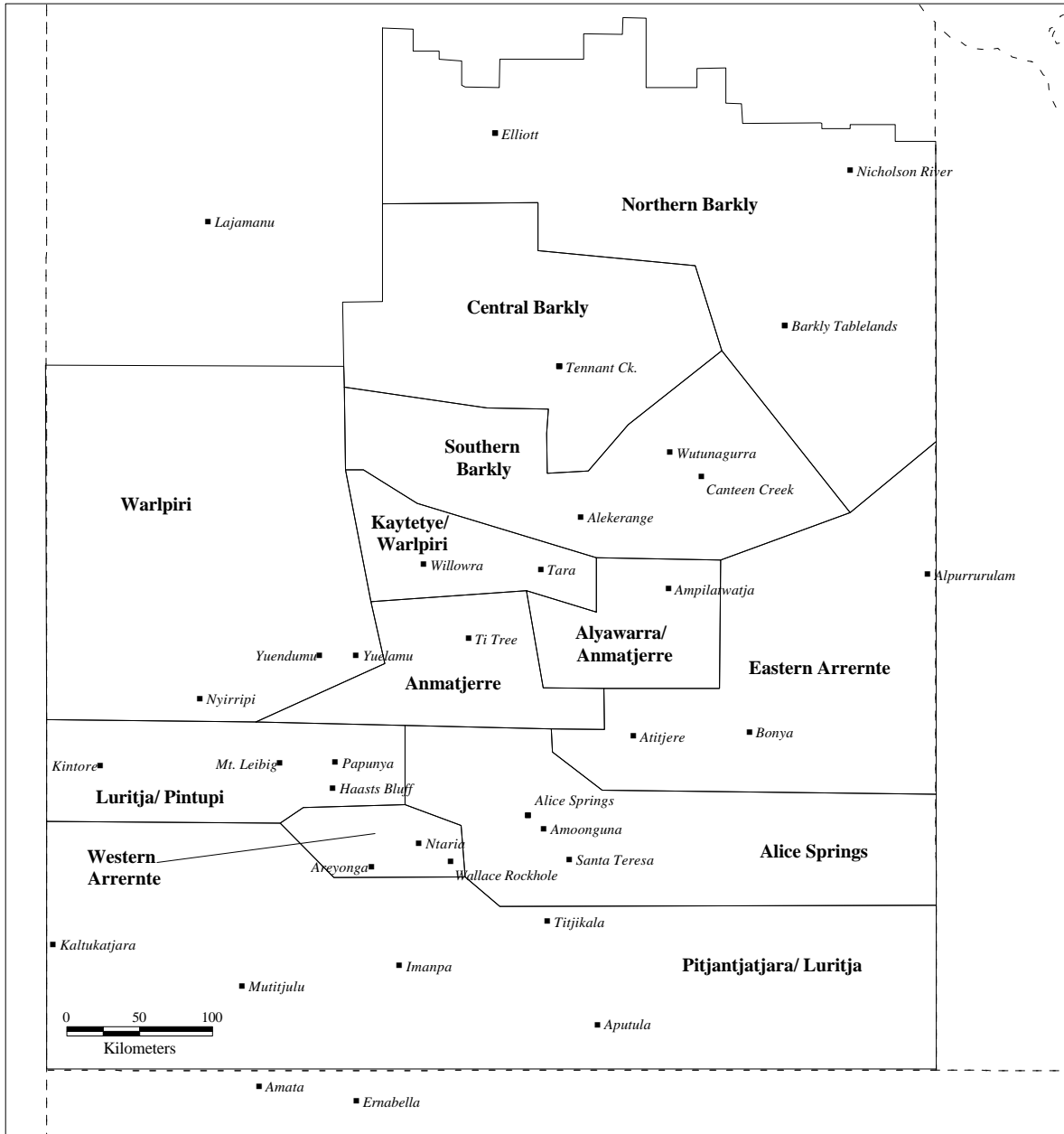
<b>HEALTH SERVICE ZONES</b>	<b>No of Places</b>	<b>Pop</b>	<b>&gt; 800</b>	<b>400-799</b>	<b>250-399</b>	<b>75-249</b>	<b>&lt; 75</b>
<b>1. Northern Barkly</b>	29	865	-	1 = 500	-	-	16 = 365
<b>2. Central Barkly</b>	46	1,190	1 = 930	-	-	-	14 = 260
<b>3. Southern Barkly</b>	14	660	-	-	1 = 300	2 = 265	5 = 95
<b>4. Warlpiri-Kaytetye</b>	7	450	-	-	1 = 300	1 = 100	4 = 50
<b>5. Alyawarra – Anmatjere</b>	27	1,240	-	-	1 = 250	3 = 230	19 = 760
<b>6. Eastern Arrernte– Alyawarra</b>	19	805	-	1 = 400	-	1 = 120	15 = 285
<b>7. Anmatjere</b>	17	1,125	-	-	1 = 300	4 = 590	9 = 235
<b>8. Warlpiri</b>	28	1,290	-	1 = 700	1 = 270	1 = 180	7 = 140
<b>9. Luritja – Pintupi</b>	35	1,215	-	1 = 400	1 = 300	1 = 200	20 = 315
<b>10. Western Arrernte</b>	47	1,255	-	1 = 450	-	2 = 350	26 = 455
<b>11. Alice Springs</b>	69	5,280	1 = 3,710	1 = 540	-	1 = 230	40 = 800
<b>12. Pitjantjatjara – Luritja</b>	77	1,510	-	-	2 = 570	3 = 560	34 = 380
<b>TOTAL</b>	415	16,885	2 = 4,640	6 = 2,990	8 = 2,290	19 = 2,825	209 = 4,140

Source: Central Australian Health Planning Study, 1997.

Table 10 shows the proposed Health Service Zones with their approximate population. The last 5 columns show the number of communities of various population sizes in each Zone. This illustrates something of the population density and distribution within these Zones. The *Number of Places* column shows the total number of out-stations and communities in the Zone. It can be assumed that this figure, less the number of out-stations/ communities with populations in that row, represents the numbers of out-stations probably not occupied at this time. However, many are likely to be occupied in the future. The non-Aboriginal population has not been included in the estimates for Tennant Creek and Alice Springs because there are other services in these towns that are largely used by the non-Aboriginal population. However, in other communities (such as Elliott) the total population is included regardless of Aboriginality, because all will be utilising the same health service.

The boundaries of the proposed Zones are shown in the Map in Figure 6.

**Figure 6 Map of Central Australian Health Service Zones.**



Source: Central Australian Health Planning Study, 1997.

None of these areas necessarily have strong community backing. Indeed, there are significant divisions between communities in many of these areas. People’s identity is bound up with a complexity of factors and administrative areas have not become part of the way people think about issues.



The question of community governance has been a point of dispute between some communities, Land Councils, community councils, as well as Territory and Commonwealth Governments. The significance of this for health service development within these Zones is that it will continue to be necessary to identify resources that belong to particular communities.

Access to PHC within these Zones is not even. It is beyond the scope of this thesis to go into detail, but details of each Zone, and methods of measuring and comparing health service access have been included in Appendix 1.

These arrangements have the capacity to reorient health service providers to a new way of operating, with various players having a clearer demarcation of agreed roles and responsibilities whilst allowing critical decisions to be made as close to the community dynamic as possible. This optimises the opportunities for self-determination at the family and community level to express itself.

## CHAPTER 10 - CONCLUSION

The colonial relationships that persist between Aboriginal and non-Aboriginal societies in Australia have been illustrated by:

1. The histories of colonial conflict.
2. The institutionalisation of Aboriginal people through forced settlements, restriction of movement and taking children away from their families.

This has been demonstrated in the examination of the colonisation of central Australia in Chapter 3.

The development of health services has clearly had little to do with providing health care, or improving the health status of Aboriginal people until very recent times, and that has been due in large part to the protracted struggle of Aboriginal community controlled health services.

The continuities between the origins of health services that were clearly to assist white settlement and the dispossession of Aboriginal people that went with that, and the current government health services can be seen from the institutionalised conflict that besets their relationships with Aboriginal community controlled health services. Some examples have been presented involving HALT, the Alukura, and others.

Chapter 2 explored underlying attitudes that are an integral part of the colonial relationship, and how they have been, and continue to be, influenced by racist attitudes of white superiority. They are also fuelled by the lack of relationship that most non-Aboriginal people have with Aboriginal Australia, and the often unspoken stories of our forefathers' relationship with the above histories.

In examining the Aboriginal health policy development it is clear that government agendas have frequently been dominant despite different Aboriginal priorities, and despite the rhetoric about Aboriginal self-determination and self-management in recent decades. The lack of political will to implement the widely supported NAHS is a particularly damning part of recent history.

The history of health services also demonstrates how health services did things to people with little respect for their rights, and again there are continuities with current public health practices.

So conflict has been a major feature of health services in central Australia since the founding by the Aboriginal community of the Central Australian Aboriginal Congress. In examining the policy developments, it can also be seen that states and territories have been particularly vehement opponents to the development of the community controlled health sector. They have argued that Aboriginal people do not have the expertise, and they have been mostly supported in this view by the Commonwealth Department of Health, even as recently as the Codd review of the National Aboriginal Health Council. The DAA, and more recently, ATSIC, have had a different perspective on the complexities that underlie poor Aboriginal health status, but have too often discounted the importance of health services to sick people themselves, and the opportunities that community control of health services presents for community development/ reconstruction..

So why are people sick? In Chapter 2 the population decimation of Aboriginal Australia was explored. It showed that, on conservative estimates, there was close to a 75% decline of the Aboriginal population in the first 150 years of colonisation. On top of this the population was dispossessed and thrown into poverty. The colonial authorities then set about to contain people in institutions so that they were unable to pursue traditional practices and economic activities such as hunting and gathering of food and medicines.

The continued mortality rates translate into frequent episodes of grief. The dislocation of family and community that is implicit in these histories has caused deep emotional trauma. The anger gets turned toward family and self, rather than the invaders who have conquered. These emotional factors, coupled with poverty are the main reasons people are sick. Central to that is the colonial relationship.

And yet, the attempts to address Aboriginal disadvantage and poor health status continue to be hampered by the imposition of existing powerful paradigms within the mainstream which frequently clash with the agendas of the Aboriginal community.

The Anger-Grief-Despair Cycle shows something of the dynamic that operates in many Aboriginal families and communities.

The conflict between the mainstream health system imperatives and the community imperatives is related to this. The crisis-ridden community controlled health services discussed in Chapter 6 are also part of this dynamic.

Thus it can be argued that people are sick because of the histories that have devastated their families, community, country and economies. This is the colonial relationship, and poor health status is due to the injuries of colonisation. Of course this includes the poor physical environments in which many live, inadequate nutrition, infectious disease, etc. These are all related to the marginalisation of Aboriginal society and the poverty that that entails.

The implementation of public health programs can be done as a top down program driven by expertise, or it can involve a process where expertise becomes a resource for the community leaders who are struggling with the crises of their community. The first option is the one that most practitioners are used to when it comes to public health. However, in many Aboriginal communities it is predictable that such attempts will be met with resistance. No doubt, in the short term practitioners will find Aboriginal individuals who will cooperate with them. The HALT experience shows, however, that depending on individuals to carry the program without support of the community politic is not viable in the longer term.

Lack of resources to Aboriginal health is also recognised as a problem. However, unless the colonial relationship is understood, it is likely that dollars will continue to be allocated inappropriately from a community perspective. That is that the powerful paradigms of the dominant society will prevail over the needs identified by the community. The neglect of AHW education and wage justice over the past 5 years are contrasted with remote doctors now earning in the vicinity of \$120,000 per year. There is an obscenity involved with this. It is an obscenity that is difficult to know how to avoid. Aboriginal people need and want doctors and clinical services because

they are sick. To attract doctors requires that salaries be offered that have some parity in the medical market place. But the obscenity of the situation remains.

In looking at the contemporary Aboriginal population in central Australia, it has been seen that there is a continuing movement away from towns (including missions and settlements) to out-stations, and that mainstream health services lag behind the population movement in offering appropriate PHC. Again this reflects continuity with the old colonial way health services were delivered. This out-station movement reflects people's own determination to re-establish a more appropriate living arrangement on their land. As has been discussed, this has many health benefits, but services are still required.

In Chapter 9 a proposed model of PHC service delivery was presented. However, earlier in Chapter 5 the complex issues of Mabo, Wik and reconciliation were discussed. These issues that are involved in questions of sovereignty and social justice cannot be separated from the processes necessary for improved health outcomes. Focusing narrowly on health services whilst continuing the historical process of dispossession further reduce people to passive clients. Thus the development of health services needs to occur in ways which strengthen the communities' own responses to their problems. Public health interventions have more potential to achieve this than does the delivery of clinical services to sick people. This is a challenge to the public health community. How to implement programs in ways that can achieve this is best done in a collaborative relationship with the Aboriginal health politic.

Health services themselves can be sterile environments where people go when they are sick, or they can be vehicles for the community to utilise to further its own agenda for improving health.

The productive aspects of a crisis-ridden health service were discussed in Chapter 6. However, often people see such environments as being disorganised and a barrier to achieving health outcomes. But a crisis-ridden environment can reflect the community in action on its own terms, rather than the service being run according to the mainstream imperatives. Within a crisis-ridden environment it is still possible to conduct public health programs, but they need to be modified and put into a broader

perspective that takes into account the main issues that might be driving community action. The Special Programs advocated in the core functions of a PHC framework have the capacity to provide support to such community action. The role of health professionals is to act as a resource to that action.

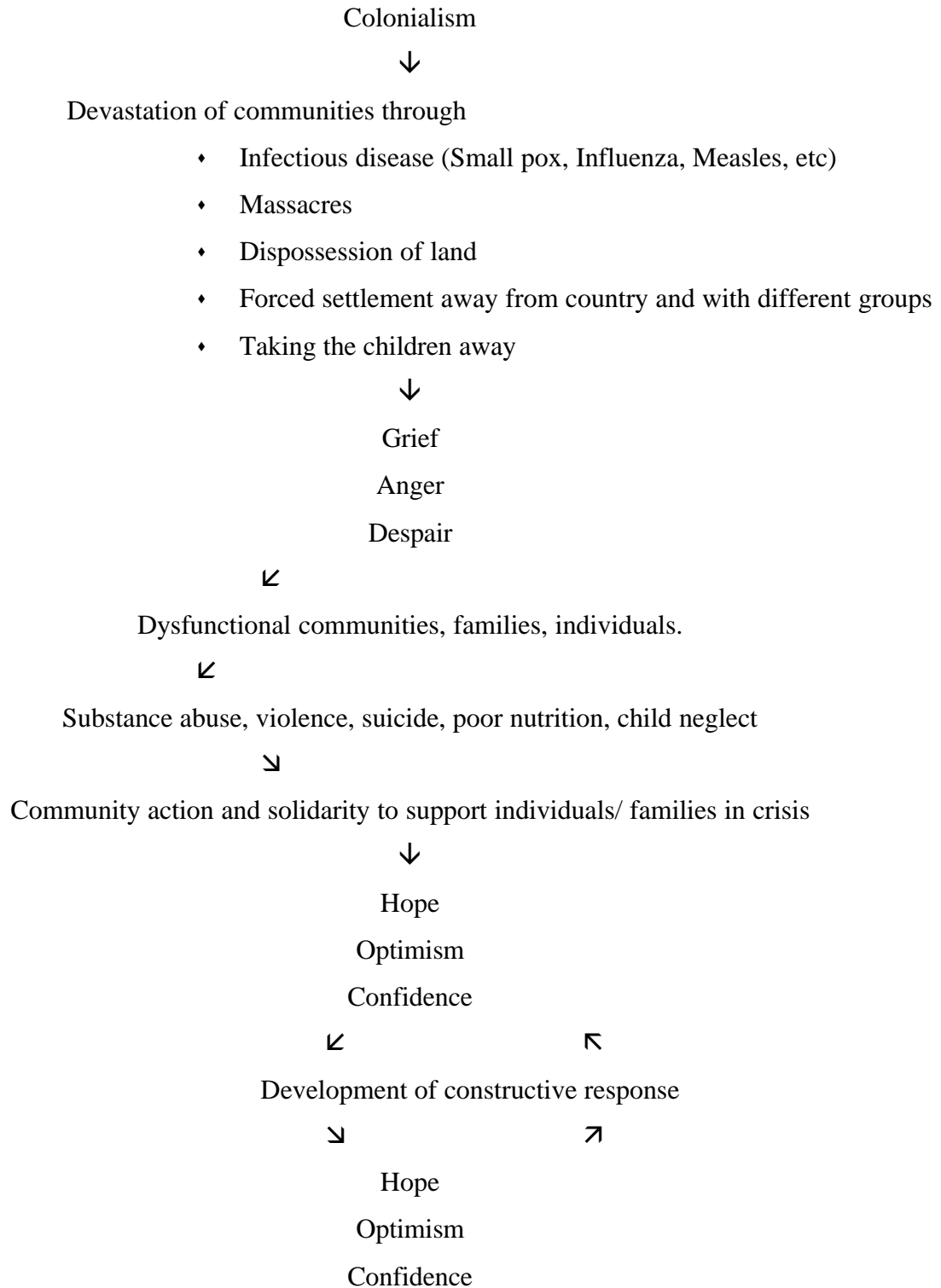
So there is an onus on health practitioners working in Aboriginal health, whether in a community controlled organisations or elsewhere, to accept leadership from the Aboriginal health politic and to become a useful resource to that politic. This is the consequence of understanding the colonial relations perspective impacting on Aboriginal health.

The other critical structural matter involves pursuing the development of integrated collaborative regional forums in which Aboriginal health leaders and activists, and health practitioners and bureaucrats can better work together on the project of improving Aboriginal health. Because of the complexities of issues like Aboriginality and the notion of community, these are best organised at a regional level. Whilst the central government authorities need to be involved with this, particularly in terms of ensuring appropriate national policy implementation, there needs to be a recognition that programs will not be implemented in the same way in all regions.

Further, health programs need to be delivered in ways which address immediate problems and deliver effective public health interventions but in ways that strengthen the community to re-establish itself and to overcome the generational trauma and grief that is so prominent.

Within the Grief-Anger-Despair Cycle operating in many families and communities are strong individuals who act to support others. These people are key to the development of processes which can allow people to break out of the negative cycle. Community controlled health services have the capacity to provide resource support to these people. An alternative cycle that health services can support could be represented as the Hope-Optimism-Confidence cycle. It represents a break with the Grief-Anger-Despair cycle and the destructive behaviours that result, and encourages a reconstruction of Aboriginal families and communities.

Figure 7 The Hope- Optimism- Confidence Cycle.



How health services deliver programs can work either to perpetuate the grief-anger-despair cycle, or to break with that and develop the hope-optimism-confidence cycle of reconstruction. It challenges health providers to break from the colonial relationship and allow Aboriginal agency to be a key force for change.





## GLOSSARY

AAA	Aboriginal Alcohol Awareness
AAAC	Australian Aboriginal Affairs Council
AAPA	Australian Aboriginal Progressive Association
ACAP	Aboriginal Cultural Awareness Program
ADC	Aboriginal Development Commission
AEDP	Aboriginal Employment Development Policy
AHW	Aboriginal Health Worker
AIAS	Australian Institute of Aboriginal Studies
AIDS	Auto Immune Deficiency Syndrome
AIH	Australian Institute of Health
AIM	Australian Inland Mission
ALP	Australian Labour Party
AMS	Aboriginal Medical Service
AMSANT	Aboriginal Medical Services Alliance – Northern Territory
AOT	Aboriginal Organisations Training
ASTC	Alice Springs Town Council
ATSIC	Aboriginal and Torres Strait Islander Commission
CAAAPU	Central Australian Aboriginal Alcohol Programs Unit
CARHTU	Central Australian Remote Health Training Unit
CARPA	Central Australian Rural Practitioners Association
CDEP	Community Development Employment Program
CHASP	Community Health Accreditation and Standards Program
CHIP	Community Housing and Infrastructure Program
CIA	Central Intelligence Agency
CLC	Central Land Council
COAG	Council of Australian Governments
DAA	Department of Aboriginal Affairs
DEIR	Department of Employment and Industrial Relations
DMO	District Medical Officer
FCAATSI	Federal Council for the Advancement of Aborigines and Torres Strait Islanders

GP	General Practitioner
HIV	Human Immunodeficiency Virus
IAD	Institute for Aboriginal Development
NAC	National Aboriginal Conference
NACC	National Aboriginal Consultative Committee
NACCHO	National Aboriginal Community Controlled Health Organisation
NAEDC	National Aboriginal Employment Development Committee
NAHS	National Aboriginal Health Strategy
NAIHO	National Aboriginal and Islander Health Organisation
NAILM	National Aboriginal and Islander Liberation Movement
NCADA	National Campaign Against Drug Abuse
NESA	National Employment Strategy for Aboriginals
NH&MRC	National Health and Medical Research Council
NLC	Northern Land Council
NSW	New South Wales
NT	Northern Territory
OATSIHS	Office of Aboriginal & Torres Strait Islander Health Services
PER	Program Effectiveness Review
PHC	Primary Health Care
PHHS	Pintupi Homelands Health Service
RIP	Rural Incentives Program
SA	South Australia
STD	Sexually Transmitted Disease
TB	Tuberculosis
THS	Territory Health Services
TMB	Town Management Board
UHS	Urapuntja Health Service
UPK	Uwankara Palyanyku Kanyintjaku
US	United States
WA	Western Australia
WHO	World Health Organisation



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