THE REPORT OF THE COMMITTEE OF REVIEW INTO ABORIGINAL HEALTH IN SOUTH AUSTRALIA

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CHAIRPERSON

May 1984

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? NAIHO position is education not training,

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INTRODUCTION

The Review of Aboriginal Health Services in South Australia was commissioned in November 1983 by the South Australian Minister for Health, The Hon. Dr. John C. Cornwall MLC after a visit to the Aboriginal communities in the Pitjantjatjara Homelands on which he was accompanied by the Director of the South Australian Aboriginal Health Organisation (AHO), Mr. Elliot McAdam and the then Secretary of the National Aboriginal and Islanders Health Organisation (NAIHO), Mr. Gary Foley. As a result of his concern that the current health system did not seem to be operating effectively for Aboriginal people, Dr. Cornwall commissioned the review and appointed Mr. Foley as Chairperson. Other members of the Review Committee were Mr.E. McAdam, Ms. Mary-Anne Binsalik of the Aboriginal Task Force in South Australia, Mr. Tim Agius, Chairperson of the Aboriginal Health Organisation, Dr. Gavin Hart of the South Australian Health Commission, Mr. Kerry Wisdom of the Commonwealth Department of Aboriginal Affairs, and Mr. Ian Procter of the South Australian Treasury Department.

The review began its work in early November 1983, and decided that consultation would be held in all major Aboriginal communities in South Australia with the exception of the Pitjantjatjara Homelands. It was felt that because the new Nganampa Health Service would begin operating its own independent, Community-controlled health service in the homelands on 1 December 1983, it would be appropriate that Nganampa Health Council be invited to present a submission to the Review stating their needs, desires and aspirations in terms of health care programs in their area. The Review Committee then established three sub-committees to visit all other regions of South Australia and held consultations with Aboriginal communities and relevant local, State and Federal authorities.

The terms of reference for the Review Committee were as follows:

To investigate and make recommendations on -

a) The effectiveness of existing organisational and structural arrangements in respect of Aboriginal Health in South Australia

b) Commonwealth and State funding arrangements

? Foley was Publicity Officer not Secretary.

* Ab. Com. controlled & based health service.

c) Training needs

d) Measures which would ensure greater Aboriginal control over health resources, including variations to existing arrangements.

During the field trips and consultations, the Review Committee visited and held public meetings in the following communities; Metropolitan Adelaide, Po Augusta, Whyalla, Port Lincoln, Ceduna, Koonibba, Yalata, Coober Pedy, Oodnadatta, Nepabunna, Point Pearce, Point McLeay, Murray Bridge, Gerard, Kingston, Berri, Meningie, Penola, Naracoorte, Mt. Gambier, Bordertown, Taile Bend and Maitland. Additionally, advertisements were placed in city and regional newspapers, inviting submissions from any interested partys.

When it came to evaluating the results of these consultations with the wide variety of people and organisations, the Review Committee was forced to conclude that major changes are required if the state of health of South Australia's Aboriginal people is to improve and that Aboriginal people in South Australia have suffered a history of material, social and cultural deprivation since the arrival of the British colonists almost 200 years ago. There is no doubt in the eyes of the Review Committee that this continuing deprivation can be directly attributed to the original dispossession of Aboriginal people of their traditional lands.

In South Australia, a small part of this historical injustice has been redressed with the Pitjantjatjara Homelands being returned to the traditional owners, but the majority of Aboriginal people in South Australia remain dispossessed and subject to a vicious cycle of poor health, poor educational attainment, poverty, unemployment, malnutrition, inadequate and over crowded housing, poor and unsafe water supplies, and disproportionate representation in the prison system.

Indeed, even in the Pitjantjatjara Homelands, where a start has been made to establish Aboriginal-designed and controlled programs to alleviate specific problems, there remain serious social/health problems (e.g. juvenile petrol sniffing) which are difficult to overcome because of the Pitjantjatjara people's lack of control over European culturally-oriented and controlled programs (e.g. the education system) that have a strong influence in the community.

Consequently, the Review Committee regards as vital the general concept of Aboriginal Community-control over all social welfare, health, education and economic development programs which exist in their communities and which are supposedly there for the benefit of Aboriginals themselves.

While this report is concerned with the special needs of Aboriginals and their priority, the Review Committee strongly affirms the need to ensure that Aboriginals benefit from the general services available to the whole South Australian population. It is not intended that implementation of the recommendations of this report relieve general programs of the responsibility to provide appropriate services to Aboriginals as citizens of the State. In fact, a major theme in this report is the urgent need to co-ordinate such service delivery better, so that it is more responsive to Aboriginal needs.

The recommendations of this report are a reflection of this fundamental need and desire on the part of Aboriginal people, and we hope that other relevant agencies (both government and otherwise) are prepared to realise the importance of this principle and at some stage in the near future adjust their programs accordingly. If this were not to occur, the ability of Aboriginal people to overcome their interrelated problems would be seriously impaired.

Any attempt to improve the delivery of health care to the Aboriginal people of South Australia must be made in conjunction with dramatic and fundamental changes to all the services affecting Aboriginal people. This must occur if any real improvement is to be expected in the state of Aboriginal spiritual, mental and physical health.

There is a serious lack of co-ordination and integration of service delivery to Aboriginal people from a multitude of agencies. This is illustrated by the fact that during the period of the Review, the facilities and personnel involved in the Review were constantly requested to resolve crisis issues in the Aboriginal community of South Australia

There were repeated requests for assistance and support in such areas as child welfare, fostering, housing, land rights, prisoner support, medical and dental services, legal aid, welfare and counselling, financial and social services.

A team of Aboriginal people was required (in a voluntary capacity) to assist the Review team to attempt to resolve some of these crises for the better health of the Aboriginal people themselves and the community in general.

While these activities may not be perceived to be properly within the parameters of the Review Team's appointed task, the requests could not be ignored. In some communities, the situation borders on chaos. The fact that people sought the services of the Review, when it could be argued that there are already in existence agencies to provide these services, only further emphasises the seriously disorganised situation of general service delivery to Aboriginal people in the State.

The existing service agencies are either not addressing themselves to the real problems in the community or are inadequately designed and funded to deliver these services, or are not doing their work effectively, efficiently or competently.

Therefore it should be noted that while the Review has been delayed in the presentation of its Report it has, during its brief existence, been performing an additional and obviously much needed service to the Aboriginal community.

By way of conclusion, it is important to point out that the Review could not have achieved its task in the short time it had, without the co-operation and support of the South Australian Aboriginal community. This co-operation and support is a reflection of the widespread desire for change and both the Commonwealth and the State Governments need to be conscious of the fact that Aboriginal expectations have been heightened by the communities' participation in the Review Committee.

It is also important to acknowledge the individuals who supported the Review in the exhaustive "hack work" which was necessary for us to complete our task. These people include Mr. John Tregenza, Ms. Ruby Hammond, Ms. Eva Johnson, Mr. Cliff Coultard, Ms. Shelly Monkland and Ms. Faith Thomas who comprised the basic secretariat and resource people. Also of invaluable assistance were Mr. Henry Croft, Mr. Alec Wilson, Mr. Tom Walsh, Ms. Christine Giles, Mrs. Betty Dohnt, Mrs. Muriel Olsen, Mr. John Williams, Mr. John Zadow, Mr. Gokula Chandran and all Aboriginal community organisers who assisted in each individual community.

Last, but not least, special mention must be made of the South Australian Health Minister, Dr. Cornwall who displayed the courage of his convictions in establishing the Review, and without whose continuing encouragement, support and highly principled approach, this Report could not have been achieved.

It is the Review Committee's sincere hope that it's recommendations will be implemented by both State and Federal agencies as a matter of urgency. If this is done, the Aboriginal people of South Australia should have a real chance of immediately alleviating and ultimately overcoming, the tragic and unnecessary health problems which continue to afflict their community.

Chapter One: RECOMMENDATIONS

* The NAIHO Regionalisation & Specialisation process or can take care of all functions described in that (2) clause. There can be no fall back position dealing with the States as any comp[illegible] weakens the NAIHO.

MAJOR RECOMMENDATIONS

1. That the South Australian Government adopt the health model as proposed in this report. The principal features of this model are on pgs. 8 and 9.

This clause is NOT necessary. It appeases & imposes further the status

2. That the Aboriginal Health Organisation should become a statutory body to be called the Aboriginal Health Council of South Australia and that its major functions are to be: Administration and Coordination of services, Health Education and Training, Research and Policy Development.

3. That the present network of Community-controlled health services be extended to facilitate a more intensive and improved service delivery at community level.

As in 2. this clause caters to the status quo & not to the decisions of the community. This clause is NOT necessary. Those State positions are a State responsibility not of the communities OR NAIHO.

4. That all existing Aboriginal Health Organisation staff positions be transferred to the proposed Aboriginal Health Council of South Australia and, where appropriate, Aboriginal Health Worker and Community Health Nurse positions be transferred to the control of the local Aboriginal Health Services and/or Committees.

   It is further recommended that, where appropriate, the South Australian Health Commission employ those staff who wish not to be transferred, without any cost to the local committees.

[illegible] this is [illegible] necessary but is [illegible] to state [illegible] the status quo & its existing programs.

5. That the Aboriginal Health Council have, as a high priority, a policy of Aboriginalisation of staff and that a significantly expanded effort be made by the South Australian Health Commission to employ Aboriginal people in meaningful positions in the areas of general services such as Hospital Liaison, Alcohol and Drug Addiction, Mental Health and Dental Services.

6. That the South Australian Government take action to ensure that the health needs of Aboriginal people are more effectively met by the services provided for the general community by the South Australian Health Commission.

7. That the South Australian and Commonwealth Governments substantially increase present financial commitments to health services that meet the needs of Aboriginal people in this State.

8. That firm action be taken by the South Australian Government to provide effective coordination of community services (especially Health, Welfare, Education and Housing) to Aboriginal people. In particular that the State Minister for Health, as a matter of priority, initiate discussions with the Minister of Community Welfare on the issue of coordination and integration of Health and Welfare Services to Aboriginal people.

9. That a significantly expended effort be made to provide Education and Training for all personnel in health and health-related services affecting Aboriginal people. Particular attention should be given to enabling Aboriginal people to enter a full range of occupations in the health area.

Conflicts with NAIHO

10. That as a matter of priority, the State Government takes immediate action to develop comprehensive data collection on the health status of Aboriginal people in South Australia. A minimum requirement for this system would be statewide data on Aboriginal Births and deaths through the vital statistics system and Aboriginal births, deaths and morbidity data through the hospital inpatient statistics system.

11. That both State and Commonwealth Government Agencies take immediate action to deal, in a coordinated way with the serious and widespread problem of petrol sniffing. Any action in this area must be taken in full consultation with Aboriginal communities.

This is against Abi Com. Controlled & based Health Services
These data can be held @ local levels & secured by that local community.

DETAILED RECOMMENDATIONS

A. Organisational and structural arrangements emphasizing increased Aboriginal control:

12. That the structure, functions and responsibilities of the Statutory Aboriginal Health Council of South Australia be as follows:

i) the Health Council is to consist, initially of one nominee of each of the existing or recommended Community Controlled Health Services and/or Committees and one from each of the following specialist services: WOMA, A.S.G., NAIHO

ii) the nominees to the Health Council are to be selected and advised by their respective Community-controlled Health Committees.

iii) the Health Council is to meet regularly to coordinate the delivery of health care for Aboriginal people across the State; to conduct research into Aboriginal health needs; to be involved in the development of programs for the education and training of Aboriginal and non Aboriginal health personnel and to provide policy advice to Governments on Aboriginal health matters.

iv) the Health Council is to assist Community-controlled Health Services and/or Committees to recruit professional staff, if requested and, more importantly, to design and run orientation courses for professionals on Aboriginal health matters concentrating on the politics of health.

v) the Health Council is to advise the Minister on matters of Aboriginal Health in South Australia, and to give the Minister an Annual Report of its operations.

vi) the Health Council is to provide assistance and support to local Community-controlled Services only upon request.

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13. That the Aboriginal Health Council be served by a Secretariat which will have the following functions:-

    i. Administration and co-ordination

    This unit is to fulfill general administrative matters for the Health Council; co-ordinate the Council's programs in relation to support services such as visiting specialist services; carry out a lobbying role in relation to general issues or in support of individual community Health Services' demands for assistance; disseminate information to these Health Services; monitor developments in health matters and report to the Health Council; to perform other duties as directed by the Council

    ii Research and Information

    This unit is, as directed, to coordinate research programs, gather and collate appropriate statistical information; participate in specific health programs and to supply technical and medical information to Community-controlled Services.

    iii Education and Training

    This unit is to devise and deliver courses of Education and Training for Aboriginal and non Aboriginal personnel in the Aboriginal health area; liaise with resource Agencies and Educational Institutions to provide support for Aboriginal people undergoing formal training; liaise with communities on training needs; develop Health Education resources for use by communities; negotiate with Educational Institutions and Authorities for course accreditation, where appropriate.

14. That the local Community-controlled Health Services and Health Committees be established, initially in the following communities and that the level and types of resources be provided as recommended in Chapter seven.

i) Adelaide
ii) Port Augusta
iii) Yalata/Maralinga
iv) Ceduna/Koonibba
v) Coober Pedy/Oodnadatta
vi) Nepabunna/Flinders Ranges
vii) South East
viii) Riverland
ix) Lower Murray
x) Yorke Peninsula
xi) Whyalla
xii) Port Lincoln

15. That the primary functions of the local Community-controlled Aboriginal Health Services and Committees be to:-

- deliver comprehensive primary (curative and preventative) health care services to the local Aboriginal community
- liaise with the Aboriginal Health Council to inform it of support services required from the general State Health system
- select community nominees to Health Authorities and Agencies
- initiate program proposals to meet local community health needs
- stimulate and assist local coordination of all service resources available to the local Aboriginal community

16. That the South Australian Government take particular action to:-

- employ Aboriginal Hospital Liaison Officers in hospitals admitting a significant number of Aboriginal people
- appoint Aboriginal people, where appropriate, to the Boards of Management of Hospitals that have high Aboriginal admissions
- provide an effective Health Surveying service to Aboriginal Communities.
- increase the number of Aboriginal people in all health professions.

17. That dental services should be more readily available to the Aboriginal community. This should take the form of dentists being employed on a sessional/salaried basis under local Community-control as well as regular and emergency services using, for example, the existing fee-for-service Scheme.

18. That Mental Health services be provided in a similar manner to those recommended for Dental Health, with appropriate practitioners being employed under local Community-control on a sessional or salaried basis. In particular consideration should be given to placing a psychiatrist in Port Augusta to service the Aboriginal communities in the remote areas of South Australia.

19. That greater financial support and recognition be given to community based, Community-controlled Alcohol Rehabilitation Programs. In particular, that the proposed Aboriginal Health Council and the South Australian Alcohol and Drug Addicts Treatment Board support programs for Aborigines with alcohol dependency problems.

20. That specific educational programs be implemented into schools both primary and secondary where large numbers of Aboriginal children attend and that these programs should be conducted by trained Aboriginal alcohol educators.

21. That an alcohol and drug education program aimed at youth in the general community and the Aboriginal community be developed utilizing prominent Aboriginal personalities and involving the South Australia Drug and Alcohol Board, Department of Sports and Recreation and the Department of Community Welfare and the program be administered by the regionally-based Aboriginal Community Controlled Health Services.

22. That the Research function of the proposed Aboriginal Health Council include the development of Statewide statistical systems. The very important and useful Renal Survey should be continued and expanded under the aegis of this Council.

23. That an urgent review be conducted on the role of the Public Buildings Department in the design and oversight of projects on behalf of the Department of Aboriginal Affairs under the Aboriginal Public Health Improvement Program with a view to ensuring:

    - a greater degree of consultation with and control by the Aboriginal communities and

    - providing opportunities for Aboriginal people to develop skills by participating in the projects.

24. That as a matter of priority the State Government immediately set up a task force incorporating those government departments involved in the delivery of health and welfare, housing and education services to Aboriginal communities. The Task Force should deliberate with full co-operation and participation of Aboriginal communities.

B. Education and Training

25. That the South Australian Health Commission and the Department of Aboriginal Affairs continue to fund the existing Aboriginal Health Worker Training Program and that any future development of the Program be carried out in full consultation with Aboriginal communities and this whole area is to be reviewed by the Aboriginal Health Council, once established.

26. That there be continuing research into Health Worker education needs together with continuing evaluation of whether those needs are being met by programs

27. That in order to satisfy community needs as well as accreditation criteria, flexibility of content, teaching and assessment methods be retained within the structure required for accreditation (see Chapter six, page 60).

28. That, in consultantion with local communities, there be continual follow-up by Aboriginal Health Council training staff of trainee and trained Health Workers in the field. This follow-up would be to give them support and ensure that, within their training and experience, they are fulfilling the needs of their Aboriginal community.

29. That the Aboriginal Health Council become an enclave for Aboriginal students and trainees entering health professions, whether through nursing or academic channels.

30. That Aboriginal Health Workers be awarded appropriate scholarships to further their education in Tertiary Institutions.

31. That bridging courses be run within the enclave in order that Aboriginal people can gain entry into the Health Professions.

32. That other Aboriginal workers whose fields of work and education overlap with those of Health Workers be encouraged to join the training course.

33. That an Orientation Unit be developed by the Aboriginal Health Council for non-Aboriginal persons and professionals who will in some capacity be working for or alongside Aboriginal people. The politics of health is to be an important component of this Unit. This Unit could be offered for incorporation into professional courses held at Tertiary Institution e.g. Medical courses, nursing courses, social work courses etc.

34. That a policy of positive discrimination by the South Australia Government be adopted to enable Aborigines to undertake enrolled and registered nurse training.

35. That all Health Workers employed by Aboriginal communities, hospitals, health centres and other Institutions must undertake a Health Worker Education Program.

36. That there should be an evaluation of Health Worker training in other states to look for consistency in philosphy approach, awards and standards.

37. That the required numbers of fulltime and parttime education staff positions in the proposed Aboriginal Health Council secretariat to be phased in over three years. The Committee considers that a model of staffing structure could be, in order of priorities, as follows:-

Co-ordinator of the Educational and Research program
Co-ordinator of the enclave function
Co-ordinator of the academic function
A clinical educator
Student counsellor
Three field training officers
Two tutors, one in literacy
Two research officers
Part-time secondary teaching
Part-time tertiary lecturing

In all cases Aboriginal applicants should be encouraged to apply for these positions and where it is not possible to find suitable Aboriginal Professionals then non-Aboriginal Professionals could be employed on a contract basis with built-in provision for Aboriginal trainees.

C. Finance

38. That all local Community controlled Health Services and Committees be funded directly by the Commonwealth Government (through the Department of Aboriginal Affairs, the Department of Health and other relevant agencies).

39. That the functions of the Aboriginal Health Council and its Secretariat be funded by the Commonwealth Government (a minority view by the representative of the Department of Aboriginal Affairs was that this should be a financial responsibility of the State Government-see page 53).

40. That the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) be expanded to provide better and more extensive access by Aboriginal people to both transport and accommodation assistance.

41. That the State Government have financial responsiblity for the provision of support services from within the present health system to the local Community-controlled Health Services. In particular that the State Government finance, firstly the appointment of Aboriginal Liaison Officers in hospitals admitting significant numbers of Aboriginal people, and secondly, the provision of Health surveying services to Aboriginal communities (See page 53 for dissenting view).

42. That funding for the proposed Aboriginal Health Council's Health worker education programs be sought from appropriate State and Commonwealth Education authorities.

Chapter Two: CURRENT HEALTH SERVICES

Background

Health services provided for the general community have long been recognised as inadequate for Aboriginal people's needs. Apart from the socio-cultural differences between Aboriginal communities and the general community, the very concept of well-being and healing hold differing meanings in the two communities. The magnitude of these differences has still not been fully recognised.

I. Aboriginal Health Services

Health services directed specifically for Aboriginal people's needs came into operation in South Australia in the early 1970's. As a result of the ten-year plan announced by the then Federal Minister of Health in 1973, the South Australian Department of Health initiated the Aboriginal Health Unit with the appointment of Aboriginal Health Workers and Community Health Nurses in the metropolitan, country and tribal communities of the State.

1. The Aboriginal Health Organisation of South Australia

In 1981, the South Australia Health Commission took steps to separately incorporate the Aboriginal Health Unit to form the Aboriginal Health Organisation of South Australia with a ten member Board of Management. The Department of Aboriginal Affairs, through its State grants programs funds most of its administrative, Health Programme and other costs. The South Australian Health Commission funds the remaining administrative and other costs (see p 42). The Aboriginal Health Organisation employs staff and administers programs throughout the State except in the Pitjantjatjara communities who now have their Community-controlled Nganampa Health Service.

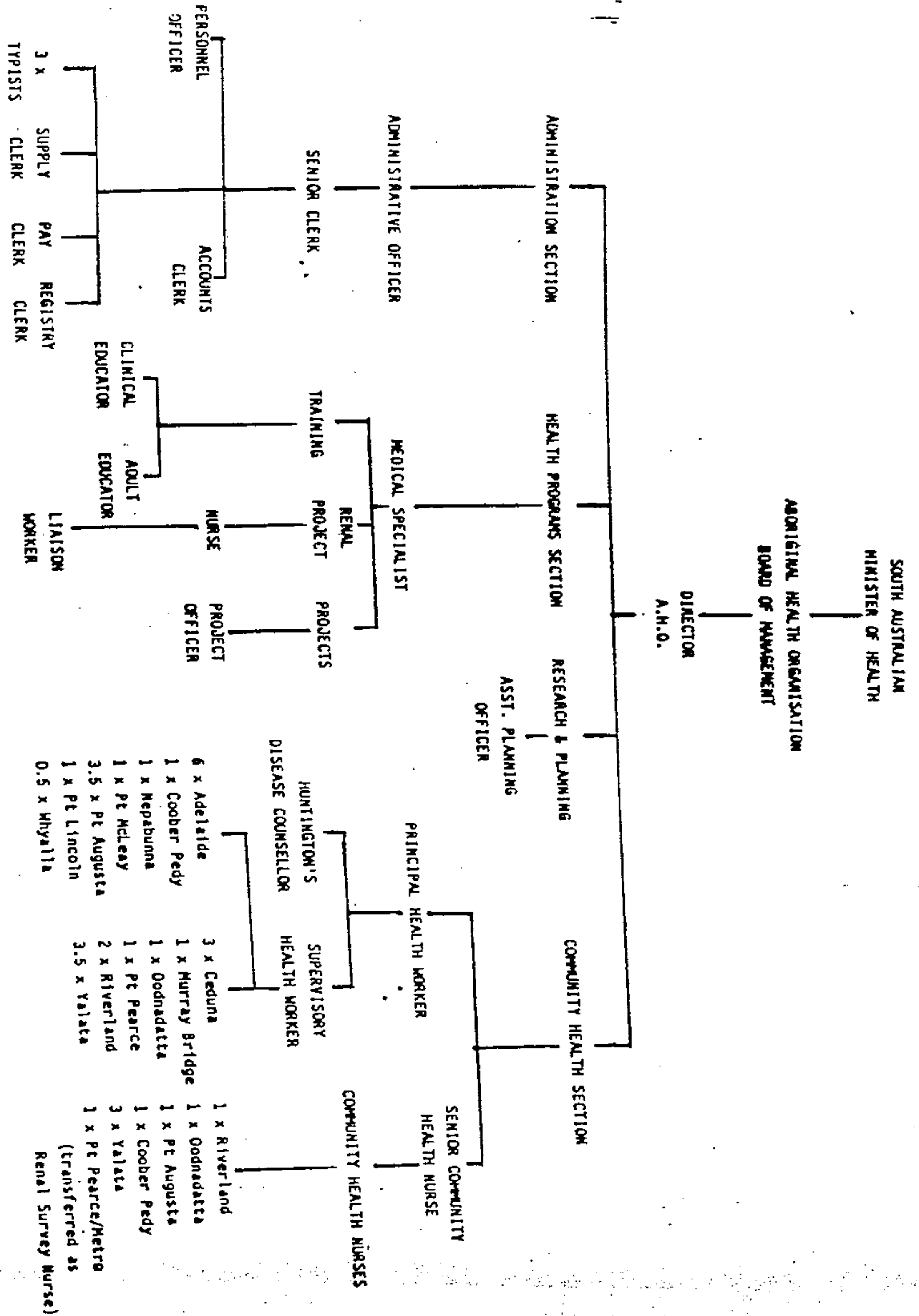
Aboriginal Health Organisation (Staff establishment)

1 Director
1 Administrative Officer
1 Senior Clerk
1 Personnel Officer
4 Clerical Officers
3 Typist/Receptionists
1 Research Officer
1 Medical Specialist
1 Senior Community Health Nurse
1 Adult Educator
1 Clinical Educator
1 Project Officer (temporary)
1 Huntington's Disease Counsellor
1 Principal Health Worker
1 Supervisory Health Worker
2 Renal Survey Sisters (1 temporary).

The Organisation employs field staff in fourteen different communities including Adelaide.

Communities	Ab. Population *(1981 Census figures)	AHO Field Staff Establishment
Adelaide	3283	6 Health Workers 2 Hospital Liaison Officers
Ceduna	312	3 Health Workers
Coober Pedy	70*	1 Community Health Nurse 2 Health Workers
Murray Bridge	178*	1 Health Worker
Nepabunna	92	1 Health Worker
Oodnadatta	100	1 Community Health Nurse 1 Health Worker
Pt. McLeay	98	1 Health Worker
Pt. Pearce	214	1 Health Worker
Pt. Augusta and Davenport	1120	1 Community Health Nurse 3 Health Workers 0.5 Hospital Liaison Officer
Pt. Lincoln	348*	2 Health Workers
Riverland		1 Community Health Nurse
Gerard	125	1 Health Worker
Renmark	31	1 Health Worker
Whyalla	320	0.5 Health Worker
Yalata and Maralinga	281 (Yalata only)	3 Community Health Nurses 3.5 Health Workers

* population figures collected by Health Workers are in excess of the 1981 Census Figures (see pg. 29).



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ABORIGINAL HEALTH ORGANISATION
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ACCOUNTS CLERK
3 x TYPISTS
SUPPLY CLERK
PAY CLERK
REGISTRY CLERK
MEDICAL SPECIALIST
TRAINING
RENAL PROJECT
PROJECTS
CLINICAL EDUCATOR
ADULT EDUCATOR
NURSE
LIAISON WORKER
PROJECT OFFICER
ASST. PLANNING OFFICER
PRINCIPAL HEALTH WORKER
HUNTINGTON'S DISEASE COUNSELLOR
SUPERVISORY HEALTH WORKER
6 x Adelaide
1 x Coober Pedy
1 x Nepabunna
1 x Pt McLeay
3.5 x Pt Augusta
1 x Pt Lincoln
0.5 x Whyalla
3 x Ceduna
1 x Murray Bridge
1 x Oodnadatta
1 x Pt Pearce
2 x Riverland
3.5 x Yalata
SENIOR COMMUNITY HEALTH NURSE
COMMUNITY HEALTH NURSES
1 x Riverland
1 x Oodnadatta
1 x Pt Augusta
1 x Coober Pedy
3 x Yalata
1 x Pt Pearce/Metro (transferred as Renal Survey Nurse)

In the financial year 1982/83, the following occasions of service were provided by the Aboriginal Health Organisation:

A. Services for the West and North-West Communities

1. In-patient clinical services
   a. Total number of patients = 125
   b. Total occupied bed days = 162
      Average length of stay = 1.3 days
2. Out-patient clinical services
   a. Total occasions of service = 433
   b. Total occasions of Health Promotion Service = 1439

B. Services for the metropolitan and country communities

1. Health Promotion Services
   a. Total occasions of service (metropolitan) = 2553
   b. Total occasions of service (non metropolitan) = 11628

The services provided by the Organisation are largely orientated towards disease prevention, health education and promotion. The main thrust of services has been towards promoting the greater utilization of all health services by Aborigines through educating Aboriginal communities and through sensitising service providers towards the needs, attitudes and perception of Aboriginal people.

2. The Aboriginal Medical Services

The Aboriginal Medical Service arose out of a community concern for a lack of a doctor/clinic service that the Aboriginal people could use confidently and have an input.

In South Australia, there are now two such clinics, one in Davenport Community, Pt. Augusta and one in Adelaide - and both of them operate independently of the Aboriginal Health Organisation. The Aboriginal Medical Service Clinics provide a much needed clinical service and are almost entirely funded by the Department of Aboriginal Affairs. The remaining funds are mainly from the Commonwealth Department of Health.

Due to lack of funding by both the Federal and State Governments, the Medical Services operate on a strictly limited basis.

Preventative health programs, including Child Health and nutrition clinics have been conducted on a short term basis at the Davenport Medical Service. However, programs of this type are largely dependent upon the attitude of the Doctor and the amount of funds available. Both these factors currently act as significant barriers to the development of much needed preventative health programs by the Medical Services within their communities.

Davenport Aboriginal Medical Service (Staff Establishment)

1.5 Doctors
1 Nurse
1 Administrative Officer
1 Field Worker
1 Homemaker

Adelaide Aboriginal Medical Services (Staff Establishment)

1.5 Doctors
1 Nurse
1 Receptionist/Typist
(1 Dentist incorporating fee-for-service)

Aboriginal Medical Services, where they exist, would form the most viable basis for Community-controlled Health Services.

3. Specialist Services

a. Alcohol Rehabilitation

Alcohol rehabilitation programs for Aborigines are provided by WOMA and the Aboriginal Sobriety Group, both funded by the Commonwealth Department of Aboriginal Affairs. The Adelaide Central Mission, which operates a drop-in centre and provides Aboriginal Alcohol counsellors, is also partly funded by the Department of Aboriginal Affairs.

The Statewide program of WOMA has local committies in Pt Augusta, Pt Lincoln, Ceduna, Yalata, Coober Pedy, Murray Bridge and Gerard. Some WOMA programs are funded directly, others are funded through their local Aboriginal Community Councils.

A State WOMA Committee, comprising representatives from regional areas, develops policy and disseminates information through its Secretariat in Adelaide. Major changes are currently being considered to the WOMA Secretariat by the Department of Aboriginal Affairs based on a Research Study carried out in 1983.

The Aboriginal Sobriety Group is also based in Adelaide and provides counselling and rehabilitation programs in the metropolitan area. It is managed by an independent committee, and has close liaison with the WOMA programs, both at the State and local WOMA Committee levels.

Established in 1973, the Aboriginal Sobriety Group is funded by the Department of Aboriginal Affairs and by the Aboriginal Hostels Ltd, on a third party basis. The limited and restrictive funding by the Department of Aboriginal affairs is reflected in the Group servicing the metropolitan Adelaide and operating three hostels (an overnight shelter, a women's shelter and a half-way house) - all funded by Aboriginal Hostels - with an Administrator, one field officer and a temporary, part time receptionist/typist. Church groups (Catholic Relief Fund and the Anglican Church in Adelaide) have been providing relief funds and equipment.

Given the extent of the alcohol problem in Adelaide, this Group has been providing a very effective service and yet its needs have been grossly neglected by the funding agencies.

Aboriginal Sobriety Group (Staff Establishment)

1 Administrator
1 Field Officer and 1 NESA Trainee
0.5 Receptionist/Typist (temporary)
3 Hostel Managers

b. National Trachoma and Eye Health Programme

Prior to 1982, the only Trachoma program administered by the Aboriginal Health Unit was that of a visiting Ophthalmologist who, on a voluntary basis, visited the Pitjantjatjara communities about 2 to 3 times a year. The Aboriginal Health Organisation re-imbursed the travel and associated costs.

Between 1976 and 1979 the Commonwealth Government provided financial support for the National Trachoma and Eye Health program of the Royal Australian College of Opthamologists to carry out a comprehensive survey and treatment program in the rural areas of Australia where Aboriginal people comprised the major part of the population.

The National Trachoma and Eye Health program found, among other things, that more than half the Aboriginal people screened were suffering from trachoma, there being a particularly high prevalence among children. A close correlation was found between prevalence of trachoma and poor environmental conditions including climate, nutrition, housing and water supplies.

The National Trachoma and Eye Health program Report indicated the need for ongoing surveillance in areas where the prevalence of trachoma was high. Thus, in 1982, a decision was made to reactivate the program Australia-wide through the establishment by the Royal Australian College of Ophthamologists of State and Northern Territory trachoma committees having majority Aboriginal representation.

As a result, a Statewide, Aboriginal Community-controlled, South Australian Aboriginal Trachoma and Eye Health Committee was formed with a full time Project Co-ordinator appointed to co-ordinate Ophthamologist screening and treatment programs throughout the Aboriginal communities of South Australia.

c. Huntington's Disease Program

Until late 1982 the Huntington's Disease Counsellor position for Aborigines was based in the Department of Community Welfare. The funds and the physical location of the position has since been transferred to the Aboriginal Health Organisation, as the most suitable location.

It is vital that this position, with its close links to all Aboriginal field and health workers and to Specialist Hospital establishments that care for this specific disease, continues to exist.

II General Health Services:

The majority of Aboriginal communities throughout South Australia have access to a wide range of Health Services including hospitals, community health centres, general practitioners, dentists and visiting specialists. The extent to which these Services are used by Aboriginal clients varies throughout the locations. The majority of these Health Services are administered by the South Australian Health Commission and have been designed to meet the needs of the white community and does not cater for the needs of Aboriginies, despite the fact that the rate of admissions to hospitals among Aborigines is more than two times that of the non-Aborigines (in one age category, it is more than six times - See Table 6)

The Review Committee was repeatedly advised that Aborigines were not effectively utilizing the existing services. The reasons are many but the most important are the following:

a) lack of understanding by staff within hospitals in respect to social, cultural, traditional and spiritual beliefs of Aborigines
b) attitudes of Aboriginals who perceive existing Services with suspicion, mainly due to point a above
c) inaccessibility of Services (Oodnadatta, Cattle Stations)
d) Services not designed to meet Aboriginal needs.

Whilst there has been a general improvement mainly due to the effectiveness of Aboriginal Health Workers and a more enlightened attitude, of late, by the South Australian Health Commission, it is not likely to reach acceptable levels until such time as the respective Services provide employment for Aborigines right throughout the Health Service structures. The Review Committee strongly believes that remedial action should occur as a matter of urgency to alleviate this present imbalance.

1. Dental Health Services

The current delivery of dental services to Aboriginal people is totally unsatisfactory, and the general level of Dental health appalling. Except in Adelaide where there is a part-time fee-for-services Dentist available at the Aboriginal Community Centre Aboriginal people have to utilize existing, where they do exist, Dental Services throughout the State. This has many problems for Aboriginal people and consequently dental care is minimal and usually of an emergency nature.

General Dental services, such as the School Dental Scheme, do provide some services to some Aboriginals. However, the only service specifically for Aboriginals, funded by the Commonwealth, is the fee-for-service Scheme which has strict eligibility criteria. Fee for service is clearly cost inefficient, and the Review Committee has found a high level of dental ill-health among Aboriginals. (See Tables 7 & 8).

2. Alcohol and Drug Addicts Treatment and Mental Health Services

The South Australian Alcohol and Drug Addicts Treatment Board, the State Drug and Alcohol authority and the Mental Health Services provide treatment and rehabilitation in cases of alcohol, drug-dependency and mental health problems.

The Review Committee understands that the clinics and hospitals operated by these Services are frequented by Aboriginal people - although there are no figures available from records kept by these bodies to validate this. While these Services (especially the detoxification clinic) are essential, and crucial to the rehabilitation programs established by Aboriginal groups, they have consistently overlooked requests by these Aboriginal groups to employ Aboriginal liaison personnel within the clinics and hospitals to ensure that the Aboriginal people requiring treatment there complete its full course.

3. Hospital Services

Throughout the State one of the major problems facing Aboriginal people has been their reluctance or inability to interact and utilize effectively the hospital services available. This is due to the alien and intimidating cultural organisation of the hospitals themselves, and to the frequent racial intolerance and abusive behaviour by the hospital staff. Hospital admissions by Aborigines are thus avoided until the patient's situation becomes unbearable, and even then the patients invariably discharge themselves and go home before their treatment is completed, resulting in future readmissions due to medical relapses.

The Review Committee regrets that the high quality of equipment and staff available in the hospitals of this State are not being fully utilised by the most needy of its consumers. It is especially regrettable when the main barrier causing this under-utilisation is in the prejudicial and stereotyping nature of a few.

4. Public Health Services

Health Surveying

The South Australian Health Commission provides Public Health Survey services (funded by Department of Aboriginal Affairs) to all Aboriginal communities throughout South Australia on a regular basis. This involves visiting communities, approximately every six weeks, dispensing advice and following up mainly on general environmental health issues.

The approach is quite fragmented given the disastrous environmental health condition which prevails in many Aboriginal communities and fringe camps. It is generally accepted in Aboriginal communities that Health Surveyors play an important role at a local level particularly when support is sought by the communities to augment their submission to the Department of Aboriginal Affairs for improved water, electrical, sanitation and other environmental health needs for funding. It is the Review Committee's view however that very little discussion and

consultation occurs at the Organisational level between the Health Surveyor Section of the South Australian Health Commission and the Department of Aboriginal Affairs who administers the Aboriginal Public Health Improvement Program, which is designed, supposedly, to improve the environmental conditions of Aboriginal communities. The Review Committee is especially concerned that the Public Health Surveyor based in Ceduna and servicing Ceduna and Yalata has been withdrawn from the area. Given that the Health Surveyor makes frequent visits to Yalata and has established a good rapport with the community there, it is imperative that a Health Surveyor be immediately placed in Ceduna.

The Committee considers that a more consistent and coordinated service would result from the assumption by the South Australian Health Commission of the full responsibility for providing Health Surveying services to Aboriginal communities. This would constitute one of the areas of the present health system in which the State Government could take action to ensure that Aboriginal health needs are met more effectively.

NAIHO Regionalisation & Specialisation Covers more adequately

Aboriginal Public Health Improvement Program

This program is entirely funded by the Commonwealth Government. The Public Buildings Department however, in almost all instances, is required to design and oversight projects on behalf of the Department of Aboriginal Affairs. This particular aspect of the program regarding construction, servicing and maintenance in Aboriginal communities requires immediate review because of the inflexibility of the Public Buildings Department to design and implement technology appropriate to the community.

The required complex repair and maintenance is rarely available within the local Aboriginal community, and in most cases, experts need to be flown in at high cost. The Review Committee considers that more locally-based training programs should be provided for local Aboriginal people to repair and maintain buildings and equipment thereby increasing the possibility of employment and ensuring regular ongoing maintenance.

It is also the Review Committee's view that it is far more appropriate to design and install technology in consultation with the local communities using local resources, material and labour thereby increasing the awareness and involvement of the community in matters pertaining to their environment and providing opportunities for development of work skills. Some Aboriginal communities in South Australia (e.g. Davenport, Yalata, Nepabunna) experience far worse environmental conditions than many third world countries. This is an indictment of the present system.

Chapter Three: CURRENT HEALTH STATUS

Background

The Review Committee's work has confirmed the lack of comprehensive data on the health of Aboriginal people in South Australia. This was a source of continual frustration to this Committee in its efforts to assess the effectiveness of existing health Services for Aboriginal people and is undoubtedly a major constraint on planning programs for Aborigines.

1. Aboriginal Health Statistics

A minimum requirement for routine monitoring of Aboriginal health is a detailed State-wide statistics system on Aboriginal births and deaths through the vital statistics system, and on Aboriginal births and deaths through the hospital inpatient statistics system. A welcome recent development is the availability of statistics on Aboriginal confinements through the Health Commission's obstetric data collection. However, no State-wide death statistics are available, and there appear to be problems with the adequacy of identification of Aborigines in the hospital collection. A similar deficiency applies to Aboriginal cancer statistics.

Efforts must be made to ensure that Aborigines are adequately identified in those statistical collections where provision is made to do so, so that high quality statistics can be made available in published form.

It is critically important that Aboriginal births and deaths be identified in the State's vital statistics system as a matter of priority.

An important indicator of Aboriginal health status that is still not available is that derived from drug and alcohol related illnesses. The State Drug and Alcohol Authority operates detoxification and rehabilitation centres and the Mental Health Services operates Alcohol rehabilitation wards within their hospitals.

While verbal and statistical evidence from the Aboriginal Sobriety Group, Woma and others support the notion that the affliction of alcoholism and drug addictions within the Aboriginal community is highly prevalent, the Review Committee notes with dismay that the State Government Drug and Alcohol Authorities, do not accommodate the collection of any statistics on their Aboriginal clients.

For detailed surveillance of Aboriginal health, special statistics collections need to be established, and the Committee is pleased to note various developments along these lines, such as the State-wide renal survey, and the data collection system recently developed for the Aboriginal Health Organisation for use in its clinics. Two points need to be emphasized, however. To be useful, such collections need extensive analysis, and periodic, detailed technical reports are essential. Where possible, information should be collected about the whole State, not only remote communities.

The recent Renal Survey (see pg 32) provides reasonable prevalence data on chronic conditions such as diabetes, hypertension and obesity but is not useful in indicating the importance of episodic diseases such as infections and trauma. The hospital morbidity system provides information on more serious episodes of disease but does not provide information on the incidence and prevalence of these diseases. Nevertheless the Renal Survey aims to survey the entire Aboriginal population of the State and information from such surveys are highly valuable.

A recent population count in some Aboriginal Communities conducted by the Aboriginal Health Workers in preparation for their renal survey confirmed an oft-repeated criticism of census figures - that they are inaccurate for Aboriginal communities. The table below shows the comparison obtained for some of the communities.

Total Aboriginal population by

Community	Census figures (1981)	Health Worker Count (1983)
Barmera	31	43
Berri	45	73
Coober Pedy	70	248
Meningie	46	56
Murray Bridge	178	303
Port Lincoln	348	492
Tailem Bend	46	50

Inaccuracies and deficiencies therefore exist not only in Aboriginal health statistics but also in obtaining basic population figures on Aborigines.

An Aboriginal Health Research Unit should be developed within the structure of the proposed new Aboriginal Health Council (see chapter 6). The work of this unit should include the development of Statewide statistical systems which enable the following indicators to be derived for Aboriginal communities:

1) Birth rate
2) Infant mortality rate and age specific death rates
3) Growth patterns of Aboriginal children
4) Immunisation status of Aboriginal communities
5) Longitudinal assessment of growth patterns, hearing and vision loss in Aboriginals
6) Pattern of diabetes onset in Aboriginal communities
7) Incidence of treponemal and other significant diseases
8) Pattern of contraceptive use and natural fertility within Aboriginal communities
9) Pattern of anetnatal care delivered to Aboriginal communities
10) Variation of the foregoing information between communities and over time
11) The types of problems and management encountered in primary care which can be used as a guide to staff training.

2. Aboriginal Health Problems in South Australia

Despite data deficiencies which preclude precise quantification, the major types of health problems among Aboriginals can be enumerated. These include:

- Respiratory infection
- Obesity (which predisposes to hypertension and diabetes)
- Diabetes
- Alcohol abuse and its sequelae
- Suppurative Otitis Media
- Diseases related to infection: whooping cough, measles, scabies, impetigo, abscesses, carbuncles and skin infection
- Gastroenteritis
- Abdominal/pelvic symptons - probably related to pelvic inflammatory disease

Tables 1 and 2 in the Appendix indicate the major health problems as evidenced in the hospital morbidity data.

There is also evidence that morbidity is very unevenly distributed among the total Aboriginal population, both between general geographic areas and within individual communities. Thus over 40% of preschool hospital users in Pt. Augusta and Meningie have multiple admissions in one year whereas this proportion is only 25% in Pt. Lincoln. In Pt. Augusta in 1981 there were 12 preschool children who were admitted to hospital 5-10 times and two were admitted over 10 times! (See Table 5) Consequently considerable improvement in population morbidity may be achieved by intensive intervention with a small proportion of the population.

a. Hospital Data

Table 3 indicates the total number of Aboriginals admitted to recognized hospitals Table 4 indicates the numbers of children (0-14 years old) admitted in some of these hospitals.

Pt. Augusta dominates children's admissions. This hospital accounted for 27.7% of Aboriginal children admissions in South Australia in 1981, a marked increase in both absolute terms (from 241 to 466) and proportion (19.1% to 27.7%) from 1979. Other areas with significant number of these admissions include:

Adelaide (Adelaide Childrens Hospital)	(19.0%)
Ceduna	(10.2%)
Maitland	(10.0%)
Barmera	(5.5%)
Whyalla	(3.9%)
Pt. Lincoln	(3.2%)

The large contribution by children in hospital admissions indicates the need for extensive co-ordination of services to cater for ill-health among Aboriginal children.

Table 5 shows the impact of multiple admissions in various South Australian hospitals in 1981. Multiple admissions play a dominant role in many hospitals, the most marked effect occurring at Pt. Augusta. Thus for 0-4 year olds 43% of patients were admitted more than once and these admissions accounted for 74% of all occupied bed days in this age group. The 14 patients who had 5 or more admissions are clearly targets for intensive health and social service support.

Table 6 shows the rate of hospitalization of Aborigines by age and the relative rate when compared to admissions of non-Aboriginals.

Petrol Sniffing

The Committee is concerned here to specifically mention this major health problem that is not reflected in available data.

The problem of petrol sniffing amongst young Aboriginal people has reached extemely serious proportions especially in the north and west of South Australia. Petrol sniffing is, in an immediate sense, a health problem but the community considers that it is symptomatic of broader social problems and raises very clearly the issue of coordination of action by the various agencies involved in providing community services for Aboriginal people.

Accordingly, while the Committee wishes to draw attention here to petrol sniffing as a (largely undocumented) health problem it is discussed in greater detail in page 50 when dealing with the need for coordination of community Services.

b. Renal Survey Data

The Renal Survey initiated by the Aboriginal Health Organisation and currently in progress, has produced information not only on the prevalence of Renal disease and Diabetes but also on more basic factors like height, weight and blood pressure. This study is significant in that, firstly it aims to cover the whole Aboriginal population of the State and secondly it is useful as a health audit of the total Aboriginal population of the State.

It is of the greatest importance that this Study has been an Aboriginal initiative and was carried out in a non-coercive fashion. It matters very much, therefore, that it's findings are reported back, both collectively and individually, to those whose co-operation has made it possible - a step which has disgracefully, been neglected in many previous similar studies. It is thus the responsibility of those in authority to ensure that the means both to treat and prevent the illnesses that have been here defined are to hand. This has major implications, both for the health administrators and practitioners, and also the Aboriginal people themselves.

Summary of the findings, so far:-

Study population	1,078
Areas	Suburban, rural, tribal
Sex	Males 45.5% : Females 54.4%
Age Distribution of the Survey	5-80 years

50% of the surveyed population were aged 20 or under.

Renal Disease:-

Haematuria/Proteinura - 13%
Proteinuria alone - 10%

Significantly more renal disease was observed in the tribal areas.

Renal Failure - 12 cases
Estimated excess prevalence of renal disease (compared with white Australians) x 10-13
Estimated excess prevalence of renal failure (compared with white Australians) x 10-30

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Blood Pressure and Hypertension:-

Blood pressure is correlated with age in Aborigines irrespective of location.

Blood pressure is correlated with body mass index in Aborigines.

Aboriginal salt consumption is of "european" proportions.

Hypertension (Diastolic BP 95 mmHg) has a greater prevalence in Aboriginal women than white Australian women in all ages. For males there is an excess prevalence in Aboriginals under the age of 40.

"Diastolic hypertension" is typical of the Aborigine population.

Height, Weight, Body Mass Index:-

52% of Aboriginal men between the ages 25-64 years are overweight.

69% of Aboriginal women between the ages 25-64 years are overweight.

Aborigines with the greatest obesity tend to reside in suburban areas.

Renal disease, diabetes, and hypertension are correlated with obesity.

Diabetes Mellitus:-

Juvenile (Type 1) diabetes was not observed. The prevalence of diabetes correlates with both age and body weight.

Age specific prevalence data show a 15-18 fold excess of diabetes in Aborigines between the ages of 20-60, compared with the results of the Busselton survey of a European population in 1964.

<u>50% of Aborigines with diabetes are undiagnosed; 50% of Aboriginal diabetic subjects have renal disease</u>.

The data currently available from the Renal Survey are convincing, but is incomplete firstly because it would be strengthened by the inclusion of the greater number of elder subjects and secondly because the metropolitan population, whose characteristics may be quite different, has not yet been assessed.

The Committee strongly supports the continuation of this study.

Good health is not bought cheaply - both in terms of money and endeavour. This survey suggests, although it cannot prove, that excessive premature mortality is occurring amongst Aboriginals, and not only in the perinatal period. This is clearly accompanied by an overwhelming amount of morbidity.

The general thrust of the Study is that it has served to focus on one of the more glaring problems of our time - the poor state of Aboriginal health. The Aboriginal population, struggling to overcome the burden of chronic ill health imposed by alienation ie. poverty, epidemic infection, malnutrition, etc., has now been further assailed by the equally unpleasant diseases of civilisation - diabetes, renal failure, cardiovascular degeneration etc.

Chapter Four: EDUCATION AND TRAINING

Against NAIHO

Background

A central objective of the Review Committee's report is to increase the extent of Aboriginal control of, and involvement in, the design and delivery of Health Services to the Aboriginal community. Effective education and training programs for Aboriginal (and non Aboriginal) people involved in dealing with Aboriginal health needs must be in the Review Committee's view, a vital part of any efforts to do so.

Because there are very few Aboriginal health professionals, Aboriginals not only have to rely on service delivery by non-Aboriginal professionals but they are also frequently forced to rely on "expert" decisions by these professionals. This often has the result of taking away from Aboriginal people, individuals and communities, their personal autonomy.

Aboriginal students and trainees are now welcome into most health professions. However, entry into relevant courses is dependent on certain educational pre-requisites for which only a minority of Aboriginal students have been adequately prepared in the present secondary school system.

Most educational authorities now agree that it is time for affirmative action to compensate for past neglect and disaffection in the general education system.

There are many examples throughout Australia and four in South Australia, of such affirmative action. They are the Aboriginal Task Force, Aboriginal Studies and Teaching Education Centre, Aboriginal Community College and the Department of Technical and Further Education's Aboriginal Unit. In these examples an enclave environment and specialised teaching, has resulted in successful education and qualifications for most students.

However, this kind of affirmative action has not been attempted in the Health field in South Australia. The Aboriginal Health Organisation has a training course for Aboriginal Health Workers but it has no award value outside of the Organisation. * NAIHO has accreditation! for education NOT training.

The Aboriginal Health Organisation's main functions have been, health promotion and disease prevention with activities directed at developing skills that can assist the Aboriginal communities to adopt practices which promote health. This vital role played by the Aboriginal Health Worker has always been stressed but the policies of recent State Governments have affirmed that the passing of additional responsibilities to Aboriginal people for the planning and delivery of their own health services was to be actively promoted.

The proposed Aboriginal Health Council (see Chapter Six) would be ideally placed not only to improve the training provided for Aboriginal Health Workers but also to expand into other productive areas of education and training so as to prepare them for the assumption of these additional responsibilities.

1. THE ABORIGINAL HEALTH WORKER TRAINING PROGRAMME

The formal Health Worker training program of the Aboriginal Health Organisation which commenced in February 1981 was designed to upgrade the skills of Health Workers and develop their confidence so that they can successfully meet the health requirements of the Aboriginal population of South Australia.

The curriculum covered the following topics:

Clinical Care
Emergency Care
Socio-cultural and Mental Health
Prevention of Disease
Communication and Interpersonal Relations
Environmental Health
Health and Related Systems
Growth and Development
Personal and Professional Development
Administration and Management
Health Promotion

Because of the cross-cultural nature of the teaching situation, the knowledge of the health worker was used and built upon and attempts were made to integrate the topics for teaching purposes. Attempts were also made to relate teaching methods to the educational and life experience of the students. This involved practical as well as theoretical teaching.

Currently the second training course has commenced. Meanwhile, a Project Officer has been employed to

- research the educational and training needs of both trained and trainee Health Workers
- research the needs of Aboriginal communities in the area of Health Worker training i.e. what skills they would like their health workers to learn and what knowledge they would expect them to possess
- research the possibilities of accreditation of the course so that the certificate would be of value outside of the Aboriginal Health Organisation e.g. in communities, hospitals, interstate Organisations etc.
- research access for Aboriginal people into the health professions and other forms of health education;
- co-ordinate the rewriting of the curriculum so that it fulfils the criteria of accreditation as well as fulfilling the needs of the Aboriginal communities and the Aboriginal Health Workers.

The present curriculum does not meet accreditation criteria. Information from the communities suggest that the Training program is neither adequate not highly respected. However, Health Workers themselves feel that they have learned a lot and gained a great deal from their training although several of them consider that there were some omissions in the course that could be remedied.

Thus the information gathered suggests that upgrading of the existing course is definitely required both in suitability and in status.

As an interim action, based on the research of the Project Officer, a more detailed statement of the philosophy, strategy and policy of the Aboriginal Health Worker Training program is being written. Several of the units within the curriculum is being rewritten in the structural form required for accreditation and incorporates in the content requests and suggestions of communities and Health Workers.

NAIHO Experience of Research has been that of researchers abusing information gleaned from communities to further their own career often at the detriment of those communities. Thus we have an Informatio

Although the structure of the course is unlikely to change, the actual content is flexible and will change according to continuing research and evaluation. Community needs will differ according to local conditions and may well change over time. Accreditation of the course according to the Tertiary Education Authority Act, 1979, is being pursued through several possible channels and practical access to health professions such as Nursing and Health Education is being investigated.

Plans for a bridging course as a substitute for present entry requirements into Enrolled Nursing are underway together with plans for an enclave support system for Aboriginal people accepted into an Enrolled Nursing course.

With all these developments in the training section of the Aboriginal Health Organisation, the Committee considers that it is an ideal time to strengthen and widen the education and training powers of the proposed Health Council to begin to fill what is becoming widely recognised as a sorely felt gap in Aboriginal Education.

Chapter Five: FINANCING ABORIGINAL HEALTH SERVICES IN SOUTH AUSTRALIA

Background

The socio-economic disadvantages (and related poor health status) of Aboriginal people in South Australia, as in other parts of Australia, mean that the public sector is the source of Health Services for Aborigines to a far greater degree than is the case for non-Aboriginal people. The financial support of Governments for health services is, as a result, a much more significant determinant of the availability of health care for Aboriginal people than is the case for the non-Aboriginal community. The Review Committee wishes to emphasise its view that the effectiveness of health services for Aborigines is a function of both the level of financial support available from the Government and the suitability of the health services provided by Governments.

1. Current Funding Sources

The funding for Aboriginal health services in South Australia is provided by both the Commonwealth and State Governments. It is important to recognise that both levels of Government are involved and that Government funding is provided both directly and indirectly. The Commonwealth Government (primarily through the Department of Aboriginal Affairs and the Department of Health) directly finances Services through both the States Grants (Aboriginal Assistance) program and the programs of assistance from both Departments to Aboriginal Medical Services and other community bodies. The State Government directly finances Aboriginal Health Services through its support for the programs provided through the Aboriginal Health Organisation and more recently, through its financial support for the Nganampa Health Service.

Both levels of Government finance a range of medical, hospital and allied services which indirectly meet some of the health needs of Aboriginal people as members of the South Australian community. The Commonwealth and State have, from 1975 until the introduction of Medicare in 1984, shared equally the costs of providing hospital services to Aboriginal people. Under Medicare arrangements both Governments will continue to finance the provision of hospital services,

The Commonwealth under arrangements prior to Medicare has financed the bulkbilling arrangements under which so called "disadvantaged" people have received medical services and the Commonwealth will continue to do so though, under Medicare, in the context of a universal health scheme.

Both levels of Government indirectly fund other health Services which provide assistance to Aboriginal people.

The Financial Framework

The Committee has (as far as possible) used financial data for 1983-84 as a means of providing a picture of current financial arrangements.

Direct funding of Aboriginal health Services in South Australia in 1983-84 may be summarised as follows:

COMMONWEALTH	($)mill.	STATE	($)mill.
1. Department of Aboriginal Affairs		1. Aboriginal Health Organisation	0.398
. State Grants(1)	1.530		
. Grants-in-Aid(1)	2.618		
2. Department of Health		2. South Australian Health Commission	
. Health program Grants	0.912	. Nganampa Health Service	0.175
. Nganampa Health Service	0.100		
	5.160		0.573

N.B.
Data have been adjusted for the financial effect of the commencement of the Nganampa Health Service from 1st December, 1983.

The main elements of the programs financed directly in 1983-84 by both levels of Government are as follows:

	Commonwealth ($'000)	State ($'000)
1. ABORIGINAL MEDICAL SERVICES		
. Adelaide	71	-
. Pt. Augusta	120	10
. Nganampa	1,206	185
2. WOMA	770	-
3. ALCOHOL AND DRUG AUTHORITY	11	-
4. ABORIGINAL HEALTH ORGANISATION		
. Employment of Aboriginal Health Workers & Community Health Nurses	660	-
. Training for Aboriginal Health Workers	40	77
. Dental Program	120	-
. Health Surveying	108	-
. Patient Travel	30	-
. Administration	310	155
. Research	-	28
. Other	52	118
5. ABORIGINAL PUBLIC HEALTH IMPROVEMENT PROGRAMME	1,662	-
	5,160	573

The extent to which Commonwealth and State Governments indirectly finance Health Services for Aboriginal people is difficult to assess because of a paucity of both utilization and financial data. The dominant item of expenditure in the South Australian Health Commission Budget is that of hospital Services. Data on the utilization of public hospitals by Aboriginal people is available for 1981. This suggests that, on the basis of average bed day costs, hospital Services for Aborigines in 1982-83 would have required expenditure of about $8 million. This cost was shared equally by Commonwealth and State Governments.

In 1982-83 the Commonwealth spent $6.3 million in South Australia on the costs of bulk billing for medical services provided for the so-called "disadvantaged". There are about 78,000 Health Care Card holders in South Australia with special needs of whom about 1,000 are Aborigines. A 'pro rata' costing would mean that the Commonwealth outlayed $80,000 in this way on medical services for Aborigines though it is likely that this figure would be higher because of the relative health needs of Aboriginal people.

Commonwealth and State funding also supports other elements of the overall health system which provides services for Aborigines.

3. Issues in the present financial arrangements

It is clear from the discussion of the present financial arrangements that both levels of Government finance a range of Aboriginal Health Services through a number of mechanisms.

These arrangements have evolved over the period since the late 1960's when the Commonwealth first became involved in a substantial way in Aboriginal Affairs. The Commonwealth now funds Aboriginal Health Services in South Australia both directly and indirectly; the latter including assistance provided under the States Grants (Aboriginal Assistance) program the arrangements for which were established in the mid 1970's. The South Australian Government now also directly and indirectly finances Health Services for Aborigines.

In the Committee's view there are two principal deficiencies in the present arrangements.

First - there is (and has been for some years) a lack of clarity in the arrangements regarding the respective financial responsibilities of the Commonwealth and the State Government.

Second - the present approach is characterised by fragmented service delivery and by a lack of effective co-ordination.

The Committee is aware that these problems are characteristic of funding arrangements in a number of areas of Aboriginal Affairs and that the Commonwealth and the State Governments have made a number of attempts in recent years to establish a better set of arrangements.

The Committee's terms of reference refer explicitly to Commonwealth/State funding arrangements and the Committee believes that the Review offers the opportunity to tackle the issues as they affect Aborigines in the health field.

4. Commonwealth/State Financial Responsibilities

The approach of the former Commonwealth Government to this important issue was based on the concepts of "normal" and "special" services. The State's responsibilities under this approach were to ensure that Aborigines as citizens of the State would receive general community services ("normal services") provided by the State out of its own resources including Commonwealth sub-ventions (e.g.) hospitals. Further, like other disadvantaged groups, Aborigines should be eligible to benefit from such community services on the basis of "need". The Commonwealth's responsibility was to apply the "needs" principle to its programs where prvided directly to the community and to utilize the State Grants Program to supplement State resources to make "normal" services accessible to Aborigines and improve or accelerate their provision and also to enable the State to provide selective services to Aborigines to meet their "special" needs.

In conceptual terms the delineation of respective Commonwealth and State responsibilities would appear clear cut under this appoach. Indeed, it was the view of the former Commonwealth Government that, according to this approach to the issue, the States, generally speaking, were not meeting their responsibilities. However, the States disputed this assertion and respond that the Commonwealth was only attempting to transfer its responsibilities to the States.

In the area of Aboriginal health in South Australia these broad differences of view between Governments have been manifested in recurring disagreements over budgets and uncertainty in funding arrangements with consequent disruption to the planning and delivery of services to the Aboriginal people. There are real conceptual and practical difficulties in seeking to resolve this issue. It is not the Committee's intention, however, to go over these issues again but the Committee is concerned that the financial arrangements are changed in a way that clarifies the respective responsibilities of the Commonwealth and the State.

5. Co-ordination

The diverse range of funding sources and mechanisms has been discussed above. The practical effect of such diversity has been to fragment the delivery of health services to Aboriginal people. There is a lack of effective co-ordination in the present funding arrangements both at a State level and also at the local community level. The establishment of the Aboriginal Health organisation has assisted in providing a greater measure of co-ordination at the State level and the Committee is aware that co-operative working relationships between the Aboriginal Health Organisation, the Aboriginal Medical Services and WOMA have begun to develop. The Aboriginal Health Organisation has also played a useful role in co-ordinating services delivered by the South Australian Health Commission and its incorporated Health Units. There is a need, however, to further develop these arrangements.

At the local community level, Health Services which assist Aboriginal people are funded in a variety of ways and it is the view of the Committee that these activities have not been effectively co-ordinated. It seems likely that funds will continue to come from a range of sources and if so then the Committee's view is that there is a real need for effective co-ordination at the local level of the agencies involved in providing services to Aboriginal people.

In summary the Committee feels that communities should exercise direct control over the provision of the delivery of health services to which Aboriginal people need access. The direct funding of local Aboriginal community organisations has been a major characteristic of the Commonwealth Government's financing to Aboriginal health programs, mainly through the Department of Aboriginal Affairs. The Communities and organisations are familiar with its personnel and its financial procedures, and there would be real benefit in building on this base in the future.

In South Australia, the State Government has responsibility for the provision of those Health Services which are beyond the resources of individual groups or communities. The most visible of these Services is the hospital system, but other less visible Services such as preventive programs and public health programs are also administered by the State. This Committee has found that health programs in general will be more effective, especially among Aboriginal people, if there is a co-ordinated delivery under local Community-control of basic primary

health care, both curative and preventive. The resources for preventive health programs currently administered by the State using Commonwealth funds would therefore be more effectively utilized if they were passed directly to the control of the communities.

Commonwealth funds should therefore be provided as direct grants to communities for the provision of primary health care. This will enable a better co-ordination of Services at the community level, and an extension of those services in those communities with high priority needs. The funds provided by the Commonwealth Department of Health for clinical salary costs of the Pt. Augusta Medical Service should be expanded to meet the additional needs in this area, and the eligibility of other Aboriginal Medical Services to receive such grants should be established as a matter of urgency.

Similarly, the access of Aboriginals to transport and accommodation assistance should be developed by expanding the scope of the relevant scheme (IPTAAS) and simplifying its administrative requirements.

This Committee has also found that there are high priority needs for better access by Aboriginals to the Health Services currently provided by the State, especially the hospital system, improved co-ordination of the health care system and greater community input into the policy and administration of those services.

These improvements will require an expansion of the resources available and their financing by the State would be consistent with its current responsibilities.

In summary, the principal problems in the present financial arrangements are identified as being;

- the lack of clarity with regard to the respective financial responsibilities of the Commonwealth and State Governments;

- the lack of effective co-ordination of State and local levels of health agencies funded by both levels of Government through a variety of programs.

Chapter Six: PROPOSAL FOR CHANGE:

Background

In the metropolitan and other areas throughout the State, Aboriginal people are attempting to survive in an oppressive and alien system. Many people are in situations characterized by large single parent families in which lack of income, no or over-crowded housing, alcohol and drug dependence, isolation from family and other Aboriginal support systems, family breakdown and juvenile crime are all common aspects.

The fact that Aboriginal people sought the services of the Review Committee to resolve some of these issues when, there are already in existence agencies to supply these services, only further emphasises the chaotic state of general service delivery to Aboriginal people in this State.

General Change

1. Aboriginal Health Council of South Australia

It is the opinion of the Review Committee that the first step toward improvement of the supply and delivery of services to Aboriginal people lies in the Community-control process. The knowledge that the design, control and delivery of services must be in the hands of those who receive the services - the Aboriginal community - requires recognition by all funding agencies, most importantly the Federal and State Governments. In addition, it is a fact that the Community-control process is the most efficient and cost effective process; it must be supported by Governments through the supply of sufficient funds and resources to the Aboriginal communities of South Australia to manage their own services - independent of Government influences and interference.

In the health area, this means that the delivery of health services under Aboriginal control must be achieved at all levels. To enable this to occur, it is recommended that a Statutory body be established by the South Australian Government called the Aboriginal Health Council of South Australia. This Council must have a clearly defined legal status and function and its relationship with the Minister of Health and relevant agencies, particularly in the health field, must be specified.

Operates against Ab. Comm controlled based Health / The cart before the horse / Supports Status quo

The Aboriginal Health Council and its structure must, however, be established with a flexible and responsive frame-work to ensure that it reflects and reacts to the Aboriginal communities' needs.

The following model is proposed:

A. i) the Aboriginal Health Council of South Australia is to consist, initially of one nominee of each of the existing or recommended Community Controlled Health Services and/or Committees and one from each of the following specialist services: WOMA, A.S.G., NAIHO.

ii) the nominees to the Health Council are to be selected and advised by their respective Community-controlled Health Committees.

iii) the Health Council is to meet regularly to coordinate the delivery of health care for Aboriginal people across the State; to conduct research into Aboriginal health needs; to be involved in the development of programs for the education and training of Aboriginal and non Aboriginal health personnel and to provide policy advice to Governments on Aboriginal health matters.

iv) the Health Council is to assist Community-controlled Health Services and/or Committees to recruit professional staff, if requested and, more importantly, to design and run orientation courses for professionals on Aboriginal health matters concentrating on the politics of health.

v) the Health Council is to advise the Minister on matters of Aboriginal Health in South Australia, and to give the Minister an Annual Report of its operations.

vi) the Health Council is to provide assistance and support to local controlled community Services only upon request.

B. The Aboriginal Health Council is to be served by a Secretariat which would carry out three major functions.

i. Administration and co-ordination

This unit is to fulfill general administrative matters for the Health Council; co-ordinate the Council's programs in relation to support services such as visiting specialist services; carry out a lobbying role in relation to general issues or in support of individual Community Health Services' demands for assistance; disseminate information to these Health Services; monitor developments in health matters and report to the Health Council; to perform other duties as directed by the Council

ii Research and Information

This unit is as directed, to coordinate research programs, gather and collate appropriate statistical information; participate in specific health programs and to supply technical and medical information to Community-controlled Services.

iii) Education and Training

This unit is to devise and deliver courses of Education and Training for Aboriginal and non Aboriginal personnel in the Aboriginal health area; liaise with resource Agencies and Educational Institutions to provide support for Aboriginal people undergoing formal training; liaise with communities on training needs; develop Health Education resources for use by communities; negotiate with Educational Institutions and Authorities for course accreditation, where appropriate.

NAIHO has accreditation.

All staff within the Secretariat are to be employed by the Aboriginal Health Council.

What's different?

The Aboriginal Health Council must have as its highest priority the policy of Aboriginalisation of staff.

This is a cover to detract from NAIHO Experience of Ab Controlled & based health Serv

2. Co-ordination with other Community Services

In the course of the Review, the Committee received comments from Aboriginal communities in South Australia about the roles of all the different Agencies and Organisations involved in community service delivery. Clearly, health problems and services cannot be isolated from other areas of Aboriginal welfare.

The Review Committee members were often approached by Aboriginal people on matters of concern in the areas of housing, employment and social welfare. It was evident that Aborigines lacked adequate contact with Departments and that there is a lack of co-ordination between the Departments in the delivery of community services to Aborigines.

In the Committee's view, an important factor in explaining the difficulties experienced by Aboriginal people in other areas, as with health, is the lack of a significant degree of Aboriginal control of, and involvement in, the design and delivery of community services.

In the case of Community Welfare services, which is an area of special need in the case of Aboriginal people, the Committee formed the impression that the Aboriginal community in our State views the present "crisis intervention" approach to service delivery as being ineffective, uncaring and insignificant in terms of its impact on the resolution of Aboriginal problems.

Petrol Sniffing

A matter of particular concern to the Committee is that of the problems of petrol sniffing. In the north and the west of South Australia petrol sniffing amongst Aboriginal juveniles, and some young adults, is chronic. In some communities, well over 50% of children from the ages 5 and 6 years to 20 years are regular, daily petrol sniffers.

A whole generation of Pitjantjatjara and Yankunyatjara children are growing up on petrol fumes!

The magnitude of this problem cannot be overstressed. Hundreds of Aboriginal children in these communities are affected. The police at Oodnadatta stated to this Review Committee that if it were not for petrol sniffing, the need for their presence in the north-west Aboriginal communities would be minimal and that approximately 90% of their work is a direct result of the activities of the petrol sniffing groups in the communities.

In the Aboriginal communities visited by the Review Committee, the people expressed an urgent need for youth programs run by themselves to begin to cope with the situation confronting their youth. The on-going oppression by non-Aboriginal society resulting in increased alienation between the generations has led to high levels of alcohol and drug abuse amongst the young and often to a cyclic participation in the legal/penal system. The extremely high levels of unemployment amongst Aboriginal youth further exacerbates this problem.

Aboriginal people are aware of the problem and have been seeking support from the various Government Departments, in particular the Department for Community Welfare, for years. They are aware that the phenomenon is symptomatic of general social problems and the alienation of their youth due to the presence of the dominant white culture. The Aboriginal people have been proposing possible ways of dealing with this problem but they do not have the resources to put them into practise.

The Review Committee wants to emphasise the situation with respect to petrol sniffing not only because of the seriousness of the problem, but also because it serves to illustrate two other aspects of the Committee's general views.

Firstly, petrol sniffing is, in an immediate sense, a health problem. Being symptomatic of broad social problems, it underlines the particular difficulty of separating health and welfare issues. Secondly, it illustrates the great need for, and the present inadequacies in, co-ordination between departments, especially the Community Welfare Department and the South

Australian Health Commission in dealing with the problems of the Aboriginal community.

Accordingly, the Review Committee believes it important that the Minister of Health approach the Minister of Community Welfare on the question of a more co-ordinated and integrated health and welfare service for Aborigines in South Australia and that priority be given to concerted action on the problem of petrol sniffing.

3. Financial Arrangements

The principal feature of the health care model recommended by the Committee are: NAIHO is the only authority.

an Aboriginal Community-controlled health authority with Statewide responsibilities; Against NAIHO Regionalisation & Specialisation p

a number of local Aboriginal Community-controlled health services delivering basic primary (curative and preventive) health care;

services provided by the South Australian Health Commission and incorporated Health Units.

It is the Committee's view that there are a number of areas in which th State should have the responsibility to ensure that present health Services provided by the South Australian Health Commission and Health Units are made more sensitive to the needs of Aboriginal people. An important new element of this should be the provision of Aboriginal Liaison Officers in order to facilitate the utilization by Aboriginal people of the hospital services provided across the State. In a number of cases this may involve the employment of those Aboriginal Liaison Officers by local Aboriginal controlled Health Services with funding provided by the State Government. Another aspect of present service delivery that the State should assume responsibility for, is that of th funding of Health Surveyor Services for Aboriginal communities.

The Committee has concluded that Health Services for Aboriginal people will be more effective if there is a co-ordinated delivery under local Community-control, of basic primary (curative and preventive) health care. It is the Committee's view that the estabishment and operations of these locally controlled Health Services should appropriately be financed by the Commonwealth Government.

The Committee's view is that such a model will ensure an overall effective system of health care for Aborigines.

An important advantage of this model will be the opportunity provided for the co-ordination of programmes of health care assistance to Aborigines.

The Aboriginal Health Council will be primarily involved in broad policy development, research and co-ordination, and education and training for health personnel.

The full Committee had difficulty in prescribing responsiblity for funding the establishment and operation of this Council to one or both of either the State or Commonwealth Governments.

A Minority View

While other members of the Committee do not concur, it is the view of the representative of the Commonwealth Department of Aboriginal Affairs that the broad division of responsibilities recommended in this report readily permits a complementary division of responsibility for funding between the Commonwealth and the State Governments. Thus, the statutory Health Council recommended to be established by the State and its State-wide responsibility for the co-ordination or provision of support resources for local Aboriginal organizations are appropriately State funding responsibilities. The Commonwealth, which has established a funding system of direct grants to local Aboriginal Organizations which this report recommends be considerably expanded, is the appropriate funding source for those local Organizations.

The Department of Aboriginal Affairs' representative notes that this will involve the transfer to local Aboriginal Organizations of funds presently allocated by the Commonwealth to the State for the State's Aboriginal Health Program. It is acknowledged that this will entail an additional financial commitment by the State. This would make the Commonwealth and State share of direct funding of programs $5.2 million and $1.9 million respectively. Taking indirect funding of programs into account, the Commonwealth

share would be about $9.2 million and the State share $5.9 million. It is expected that the gap between the respective contributions will widen in 1984/85 when full-year costs of the Nganampa Health Service program in the North-West Reserves have to be met.

The Department of Aboriginal Affairs representative's view is that such a division of funding responsibility is reasonably appropriate, and that the division of functional responsibilities on which it is based is administratively efficient. As well as financing a more effective total health care system for Aboriginal people. such arrangements would avoid the confusion and delay that characterise the present arrangements for responsibilities and funding.

The Majority View

With the exception of the representative of the Department of Aboriginal Affairs, however, the Committee arrived at the view that the financial responsibility for the Aboriginal Health Council should rest with the Commonwealth.

This was based on a consideration of the Council's nature and functions. The proposed Aboriginal Health Council would be an Aboriginal Community-controlled health authority responsible, in an overall sense, for the effective local delivery of health services for Aboriginal people in South Australia. It is the view of the majority of the Committee therefore that it would be appropriately a Commonwealth responsibility to fund the operations of the proposed Aboriginal Health Council.

The role of such a central Council is unique to South Australia and the Committee considered that the Commonwealth approach to funding should be sufficiently flexible to accommodate its role as a broadly based Aboriginal Community-controlled Health Organisation.

The Committee noted that the implementation of the proposals in this report would entail additional financial commitments for both the Commonwealth and the State Governments.

While the Committee's primary concern was not with the source of whatever funds are required for the provision of quality health care for Aboriginal people, the Committee however noted that, in the case of the Commonwealth, the approach proposed by the representative of the Department of Aboriginal Affairs to funding would initially consist only of a transfer of funds ($1.3 million) already provided to the State Government to local Community-controlled health services. In the case of the State Government, there would be a requirement both to replace the resources so transferred and to finance the additional services (primarily Aboriginal Liaison Officers in hospitals) recommended in the report. The Committee considered that there is no ideal share of Commonwealth and State funding to meet respective responsibilities in Aboriginal health.

The Committee noted, however, that the level of State Government funding for specific Aboriginal health initiatives has increased substantially in South Australia in recent years (with additional funds already committed to the Nganampa Health Service in 1984-85).

The overall financial impact of the implementation of the Committee's recommendations would be to require of the South Australian Government a per capita (numbers of Aboriginal people) expenditure well in excess of that which would result from the implementation of the recommendations of recent similar reports in New South Wales and Victoria.

That is, the practical effect of this would be to financially penalize a State Government that has sought, in the past, to utilize Commonwealth funds to provide health services to meet the obvious health needs of the Aboriginal population in that State. The extent of that 'penalty' would be exacerbated by adopting the approach advocated by the Department of Aboriginal Affairs representative.

The Committee considered that the implementation of the model in the manner suggested in the majority view would bring considerably more clarity and certainty to the financial arrangements for Aboriginal health services and that this would be a significant improvement in those arrangements.

Social Security payments

Relevant Government Departments should note that in several rural communities, the operations of the Social Security services are based in local non-Aboriginal businesses.

Recently there were some successful legal actions taken in Coober Pedy against a local business abusing the system-but it continues. The Committee believes that action is required to remove all such probabilities from the system.

The overriding characteristic of Aboriginal health services, which impairs their effectiveness is the lack of co-ordination of Government Agencies.

The Review Committee found examples of projects remaining half completed, or failing to meet their objectives due to the apparent inability of agencies to work together. Not only is the effectiveness of the programs jeopordised but more importantly, the Aboriginal communities lose out in these circumstances and it is the view of the Committee that this can no longer be tolerated.

II Specific Change:

1. Dental Services

Dental Services should be more readily available at the community level in the form of Salaried dentists under local Community-control, as well as regular and emergency services, using for example, the existing fee-for-service scheme. The funding of clinics seems appropriate. The State could assist these community clinics by provision of supplies and equipment. If such expanded services were funded, some supplementary funding of Aboriginal health and health-related organisations in local communities for genuine emergency care on a fee-for-service basis would be justified.

Regardless of who the employer is, the responsibility for funding the Aboriginal Hospital Liaison Workers belongs to the State Government, whilst the selection of the Worker remains a community process.

ii) The election and/or appointment of Aboriginal people to the hospital Boards of Management of the country and city hospitals where appropriate. Where the use of hospital services by Aboriginal people is a significantly large percentage of total use, more than one Aboriginal Board member should be appointed.

iii) To assist hospital staff and Doctors in cross-cultural interaction with their Aboriginal patients, Aboriginal Health and General Studies must become part of the required nurse training, especially in the country hospitals. Orientation courses and on-going in-service education of staff on Aboriginal Affairs must be instituted by the hospitals and supervised by the local Aboriginal Community-controlled Service and/or Committee. One of the functions of the Aboriginal Health Council also covers this need in its orientation courses for health professionals.

4. Education and Training

The Review Committee noted that the current Aboriginal Health Organisation has compiled a set of specific proposals for future Aboriginal health worker education. Whilst these proposals are discussed in the following pages, the Committee strongly emphasises that before any final decisions are made on future training and education programs, there must be full consultation with local communities and with the proposed Aboriginal Health Council. The nature and extent of any future programs in this area must be ultimately decided by the Aboriginal Health Council.

Furthermore, the Committee strongly believes that if future Aboriginal Health Worker Education programs are to succeed, there needs to be a significant increase in funding for such projects. Despite the fact that preventive programs, such as Health Worker Education, are a vital element in achieving greater Aboriginal control (and thus alleviating specific health problems), Governments in the past have provided only minimal financial support.

The following are specific ideas for future change by the Aboriginal Health Organisation.

a. Health Worker Training

The Aboriginal Health Organisation considers that a primary objective here should be the further revision and upgrading of the Health Worker Training program. This upgrading should include using available resources in such areas as Health Promotion, Environmental Health, Drugs and Society etc. on a part time basis.

The actual training would be decentralized with training blocks of 2 - 3 weeks occurring in various country and community centres. This will give trainees the opportunity of fitting their learning to local needs, and the opportunity to train in communities and country towns other than their own. This will allow them to compare and contrast the needs of different groups, a wish expressed by several trainees.

b. Accreditation NAIHO has accreditation.

Accreditation of a two-level certificate is being considered.

i) A Health Work Certificate taught and assessed at a sub-tertiary standard. However, flexibility of content is anticipated with the possibility of alternative methods of teaching and assessment that ensure progress to the same standard of education.

ii) An Advanced Health Work Certificate which, as well as teaching the basic subjects as in a) above will include choices of topics taught at a tertiary level. These options could include "Mental Health", "Renal Problems", "Social Research Methods", "Community Development and Social Change" etc.

The basic course will include the following topics:

Aboriginal Society and Culture
Communication subjects (includes personal and professional development)
Health and Society (includes disease prevention, growth and development)
Drugs and Society
Mental Health
Emergency and Clinical Treatment
Health Promotion
Environmental Health
Community Development
Administration
Plus a unit on techniques and programs for change - a practical unit which brings together information from Communication, Community Development, and Drugs and Society

Part III of Section 18(2) of the Tertiary Education Act 1979 prescribes several ways of achieving accrediatation for a course of study. The most promising approach would be for the Tertiary Education Authority of South Australia to approve the proposed Aboriginal Health Council as an Educational Institution. This is likely if the proposed Aboriginal Health Council were a statutory body with permanent funding with suitable staff and sufficiently diversified courses.

The Committee has been advised that members of the Tertiary Education Authority of South Australia is aware of the lack of opportunity for Aboriginal people in the health professions and would look carefully and sympathetically at the above approach.

c. Ongoing Education of Health Workers

Many Health Workers have expressed a need for refresher courses and further ongoing training. ? If accreditation of the Aboriginal Health Workers Certificate is achieved, it is possible that these trained, ? certificated Health Workers may have to study further options, to have their certificate retrospectively accredited. Similarly, if any of the trained Health Workers intend attaining higher qualifications, then the Aboriginal Health Council could provide programs in the form of bridging units to give them the necessary pre-requisites for tertiary study.

d. Further Education

If the Aboriginal Health Council were an approved Educational body it would be possible to mount further courses and have them accredited at the Associate Diploma level and higher.

Presently the Aboriginal Health Organisation is investigating use of the Health Worker Certificate as an entry into tertiary education. For this reason the Advanced Health Worker Certificate would contain tertiary level options. If suitable options were chosen, not only entry but status in the Associate Diploma of Aboriginal Studies at Underdale Campus of the College of Advanced Education is possible.

? "You train animals we Educate our people. NAIHO.

There is a specific curriculum that is being considered for accreditation, at the Sturt College of Advanced Education for the Bachelor of Applied Science (Health Studies).

Studying the health units from this degree course would have the advantage that if students who have already obtained the Associate Diploma in Aboriginal Studies (Health) wished to go on and get the Bachelor of Applied Science (Health Studies) they will already have gained between 20 and 32 points towards this qualification.

e. Scholarships

It is appropriate that at least one year after completion of the Health Worker Training course, Health Workers who wish to further their education, be awarded scholarships with appropriate benefits and allowances for study in tertiary institutions so that they can finish their education fulltime over 3 years.

Bridging courses

While Aboriginal people are welcome into courses in Enrolled Nursing and Registered Nursing there are usually only a few applicants. As a consequence of this the Aboriginal Health Organisation has applied to the Nurses Board of South Australia, to examine the possibility of changing entry requirements to the Enrolled Nursing course.

Within the next few months the Aboriginal Health Organisation has intentions of setting up a bridging course similar to the one set up within Technical and Further Education in Pt. Augusta, to provide pre-vocational training to Aboriginal people who wish to apply for the Enrolled Nurses course. Communication between the Aboriginal Health Organisation and the Royal Adelaide Hospital is continuing.

Enclave

Together with mounting a bridging course, the Aboriginal Health Organisation is planning a small enclave for those applicants who successfully gain entrance into the Enrolled Nursing course. The aim of the enclave would be to support the students over the 12 months of the course with counselling, extra tuition where requested and library and research facilities.

f. Education for non-Aboriginal Professionals

Another area of education that would be served by the proposed Aboriginal Health Council is that of the education of Non-Aboriginal Professionals. The lack of awareness and understanding of Aboriginal culture, society and values, on the part of non-Aboriginal medical and nursing staff, was identified by many Aboriginal communities as being a serious problem.

Orientation programs would look at Aboriginal and non-Aboriginal cultural differences, values of traditional Aboriginal health methods and remedies and encourage communication between non-Aboriginal and Aboriginal experts in health matters. One example of this would be communication between psychiatrists and ngangkaris, the spiritual, physical and emotional advisers who still operate in some Aboriginal communities.

g. Other Possible Users of the Health Worker Training Course

The Aboriginal Sobriety Group has indicated interest in some aspects of the existing Training course but needs additional and more specialised skills on alcohol and drug dependency and treatment.

WOMA is at present undergoing restructuring and has yet to make a final decision on their training needs. They are looking at options that include training with the Aboriginal Health Organisation, the South Australian Alcohol and Drug Addicts Treatment Board and developing a training program of their own. The Committee considers that whichever of these options Woma decide upon, it seems useful to note that Aboriginal Health Organisation does in fact offer courses very much in line with expressed needs of WOMA workers.

The Aboriginal Medical Service in Adelaide does not employ any field workers but it is likely that this Training course would be beneficial, if not completely suited to their needs.

h. The Aboriginal Health Organisation as an Educational and Research Unit

The Aboriginal Health Organisation has an opportunity to fill what has been up until now, a large gap in the South Australian Aboriginal Education.

Community Studies, Social Work, Business Studies, Law, Anthropology and some other Arts subjects have been taught, tutored or supported in some other way by the Aboriginal Task Force (A.T.F.). Teacher Training and Aboriginal Studies have been successfully taught and supported by the Aboriginal Teacher Education Program and the Aboriginal Studies Department, now combined to form the Aboriginal Studies and Teacher Education Centre (ASTEC).

Living skills, pre-apprenticeship training, post-secondary trade and technicians educational topics have been dealt with by the Aboriginal Community College and by the Aboriginal Unit of Tertiary and Further Education.

However, there is no officially recognised ecucational establishment whose specific purpose is to teach and support Aboriginal people who wish to make careers for themselves in the health professions.

While many of these health professions are willing to open their doors to people of Aboriginal descent, they are all demanding certain pre-requisite subjects at levels not usually well served by secondary schools to Aboriginal students.

As more Aboriginal Communities take on the responsibility for their own health care there will be a greater demand for Aboriginal professionals. The proposed Aboriginal Health Council will need to address itself to this demand.

i. Future Staffing Needs for an Educational Unit within the Aboriginal Health Council

Although a co-ordinator would be needed for both the enclave situation and the academic function, overseas and Australian experiences suggests that it is unwise to separate these two functions. Consequently an over-all co-ordinator is necessary to ensure full interaction between the two groups.

A student counsellor would be essential for the enclave function together with a remedial/literacy tutor.

Three field training officers would be needed for follow-up purposes. A clerical educator and an academic tutor would be required for the academic function.

Two Research Officers would serve either function as necessary. This gives a total of twelve full-time staff several of whom would need further qualifications.

Appropriate clerical and administrative staff will also be required.

Conclusion

The Committee believes strongly that if Aboriginal people in South Australia are to achieve greater control over health service delivery in their own communities, it is obvious that a more significant effort needs to be made in the area of Aboriginal health worker education programs. In other States there has been considerable debate on the merits and otherwise of a variety of approaches to this problem. In some cases (e.g. NSW Health Commission) there has been a strong emphasis on formal training in a recognised education institution with accreditationbeing perceived as a major issue among Aboriginal trainees themselves. In other cases (e.g. Victorian Aboriginal Health Service program at Koori Kollig) accrediation is seen as of secondary importance to the rapid gaining of a wide range of para-medical and community organisational skills.

In South Australia, the Committee therefore believes that such major, fundamental differing philosphies need to be discussed at length and decided upon both locally by Aboriginal communities, and in the context of the Aboriginal Health Council. Existing Education programs of the Aboriginal Health Organization should continue in the short term, but its further development should be subject to review by communities and the Aboriginal Health Council when it is established.

This would ensure that whatever type of Health worker education programs were conducted by the Aboriginal Health Council they would reflect the specific desires, needs and aspirations of South Australian Aboriginal people. NOT NECESSARILY

Chapter Seven: HEALTH NEEDS IN SPECIFIC ABORIGINAL COMMUNITIES

Introduction

This chapter briefly outlines the background to the major Aboriginal communities in South Australian and the current health and health-related services that exist in these communities.

The Review Committee acknowledges that the issues raised in this chapter and the recommendations made from it are neither complete nor final. They represent the outstanding deficiencies in the current services, where they do exist, that has caused the state of Aboriginal ill-health to remain unchanged. The Aboriginal Health Council of South Australia and local Aboriginal Health Committees, once established will be charged with the final responsibility to rationalise existing services and deliver comprehensive health care to their respective communities.

* When is it complete & final?

ADELAIDE

The Aboriginal community in Adelaide is served by the health services that have been described in Chapter Two. The Aboriginal Medical Service in Adelaide is presently providing only a basic medical and dental service. It should be funded to incorporate the preventative and promotional health services currently provided by the Aboriginal Health Organisation of South Australia. In addition, this Adelaide Aboriginal Health Service should provide outreach services and assistance to the suburbs of Adelaide with high concentration of Aboriginal population and to the nearby Aboriginal communities.

Recommendations

1. That a separately incorporated, Community-controlled Aboriginal Health Committee be established in Adelaide distinct from the Aboriginal Community Centre Council of South Australia (Adelaide).

   That an Adelaide Aboriginal Health Service be established to provide comprehensive medical and dental health care to the metropolitan and surrounding Aboriginal communities, under the auspices of this Health Committee.

2. That the staffing level of this Health Service include, at least the following personnel:

   Health Services Coordinator x 1
   Medical Practitioners x 2
   Aboriginal Health Workers x 6
   Supervisory Health Worker x 1
   Hospital Liaison Officer x 2
   Community Health Nurse/Educator x 1
   Administrative Officer x 1
   Project/Research Officer x 1
   Typist x 2
   Receptionist x 1

3. That this Health Service provide outreach services to the suburbs of Adelaide with a high Aboriginal population and provide medical and administrative support to the surrounding Aboriginal communities (Murray Bridge, Gerard, Pt McLeay, Pt. Pearce).

4. That Hospital Liaison Officers be employed in the major metropolitan hospitals in Adelaide and in other hospitals with high Aboriginal admissions (Flinders Medical Centre, The Queen Elizabeth Hospital, Royal Adelaide Hospital, Queen Victoria Hospital, Lyell McEwin Hospital, Modbury Hospital, Adelaide Childrens Hospital).

5. That Aboriginal members be appointed, where appropriate, to the Boards of Management of these major hospitals.

YALATA

Background

The Yalata community is the Pitjanjatjara/Yankunyatjara people living far from their traditional homelands. The forced re-location of these people in the 1950s from their traditional lands to the north of Ooldea to make way for the testing of Atomic weapons at Maralinga and other locations, is the single most important factor contributing to the drastic ill-health of the people.

The dispossesion, alienation and social disintegration caused by this move and the consequent alien life-style imposed by Christian mission administration has left this community in an appallingly bad spiritual, social, mental and physical state of health. It is a tribute to the cohesive power of traditional spiritual values of the people that they have survived at all.

However, to overcome the major health, social and economic problems at Yalata, the community need special assistance from all relevant organisations and Government Departments. The health situation at Yalata is dominated by heavy abuse of alcohol by the adults, chronic petrol sniffing amongst the juveniles and aggravated by poor living conditions, bad diet and abject poverty.

The community at Yalata has, for years consisted of two separate groups. One group lives in and around the community at Yalata. The other, often referred to as 'Big Camp' has been a mobile group living between 5 and 200 km from Yalata. The latter group has consisted of many people attempting to avoid the social destruction and alcohol abuse at Yalata itself and has formed the core of those intending to return to their traditional lands in the Maralinga/Lake Dey Dey area.

It should be stressed that the granting of freehold Land Title to the Yalata community, and ensuring that the people have the resources to return to live on their lands on their own terms are most important issues. The South Australian and Commonwealth Governments must ensure that this occurs.

Current Health Care

The Aboriginal Health Organisation have three permanent nursing positions at Yalata, but for the past few months until the end of May, two of these positions are being filled on a relief basis. There are three Aboriginal Health Workers employed, one of whom is highly experienced and has completed the Aboriginal Health Worker training program.

The delivery of health care has been, and still is, clinic based. The staff work from the clinic during the day (8.30am to 5.00pm) and operate a rostered duty system for after hours and emergencies. In addition, the nursing staff are responsible for the operation of the ambulance which is stationed at Yalata. This includes answering general response to traffic accidents etc. on the highway as well as evacuations of Yalata residents to Ceduna.

The nursing staff also carryout visits once a week to the group living at Ooldea, Maralinga or wherever they may be. This often necessitates a trip of several hundred kilometres over rough roads. This places additional strain on the nursing staff and additional work-load of those remaining at Yalata.

Doctors' visits to Yalata are made by a private medical practitioner from Ceduna. The Doctor, visits Yalata once a fortnight and also consults Yalata residents who are evacuated to Ceduna when necessary. Whilst this service may be better than no service, it is extremely limited. In addition, there are on an average, 3 to 5 road evacuations each week to Ceduna, each of which necessitates a 400km round trip by one of the staff, with the consequent loss of this resource to the community. In addition there are, on an average, 2 - 3 evacuations per week for diagnostic or other tests to Adelaide or Whyalla.

The present facilities are totally inadequate. The Aboriginal Health Organisation have a submission to the Federal Government for funds for a new health centre and this should be actively pursued. Any new facility must include a general clinic area, separate male and female examination rooms, in-patient facilities for adults and children with supporting ablution and kitchen facilities, staff rooms with provision for Health Worker education facilities, a dental clinic and support facilities, storage space and an administration centre including medical radio equipment.

Aboriginal patients attending Ceduna hospital complain of the 'rough' treatment by staff whose lack of understanding of Aboriginal people and their special needs, together with the general alien and threatening environment isolates them from their people and social support system. As a result many patients discharge themselves before their treatment is complete, and as a consequence are either re-admitted, or evacuated to Adelaide in a more serious condition.

The provision of dental care to the Yalata community is on an ad-hoc basis. A private dentist visits from Ceduna once a fortnight to carry out routine checks and treatment. This service is limited given the poor state of dental health in the community.

The Aboriginal Health Organisation of South Australia have provided a mobile dental unit. This needs to be fully utilised and arrangements should be made with the Port Augusta and Davenport Aboriginal Health Service to provide ongoing and regular preventative treatment programs.

Specialist vists to the Yalata community are irregular and infrequent. As a result, many patients are evacuated to Whyalla and Adelaide incurring unnecessary expense and social dislocation. It is the option of the Review Committee that immediate steps be taken to rectify this anomaly through the existing channels (Aboriginal Health Organisation, South Australian Health Commission) and that in the long term appropriate arrangements be negotiated with the proposed Yalata Aboriginal Health Service.

During the Review Committee's deliberation, the South Australian Health Commission withdrew the services of the Health Surveyor based at Ceduna. It is this committee's view that this action was extremely short sighted and does not take into consideration the drastic environmental conditions existing in the Yalata community. The South Australian Health Commission should immediately take action to restoring Health surveying services to this region.

Recommendations

1. That a local Health Committee be established in Yalata to represent the Yalata, Maralinga and the surrounding homeland Aboriginal communities.

2. That a comprehensive Aboriginal Community-controlled Health Service be established at Yalata, to service the Yalata and surrounding homeland communities and a unit of this service be established at Maralinga/Ooldea. This health service should be similar in organisation and structure to one of the separate units of the Nganampa Health Service. It shall operate under the control of the local Health Committee that employs its own staff, has control of its own resources and develops its own program with the support and assistance of the proposed Aboriginal Health Council of South Australia.

3. That the staffing level should include at least the following personnel to service the Yalata and surrounding homeland communities:

   Yalata:

   Health Coordinator x 1
   Medical Practitioners x 1
   Aboriginal Health Workers x 4
   Community Health Nurse/Educators x 2
   Office Administrator x 1
   Typist/Receptionist x 1

   Maralinga/Ooldea:

   Community Health Nurse/Educators x 2
   Aboriginal Health Worker x 3

   It is further recommended that the Maralinga/Ooldea unit be supported by the Doctor and staff at Yalata and that suitable accommodation and facilities be provided. This should include the following:

   Staff Accommodation
   Mobile Health Clinic
   Radio Communications
   Vehicles (4 W.D.)

4. That a new Community Health Centre be constructed at Yalata as proposed by the Aboriginal Health Organisation. Where feasible this project should use local materials, resources and personnel.

5. That the current evacuation system be rationalized when a doctor is employed at Yalata. Routine evacuations to general practitioners in Ceduna should be eliminated, and the resident doctor should then be able to evacuate patients direct from Yalata to whichever hospital is most appropriate (e.g. Ceduna, Adelaide or Whyalla) for the patient. The same system should also apply to the unit of the Yalata Health Service at Maralinga/Ooldea.

6. That the Yalata Health Service, with the support and assistance of the Aboriginal Health Council, design and deliver appropriate environmental health programs.

7. That particular attention initially be given to needs for programs dealing with nutrition, sex education and family planning, alcohol use, petrol sniffing, general community health and hygiene.

8. That the Port Augusta and Davenport Aboriginal Health Service provide preventative dental care and treatment to the Yalata and surrounding communities and that the School Dental Service commence providing a service to the Yalata school children.

9. That the South Australian Health Commission immediately place a Health Surveyor at Ceduna to service the Yalata and surrounding homeland communities.

10. That specialist visits (E.N.T., Skin, Ophthamologist etc). to Yalata and homeland communities be updated and coordinated as a matter of high priority.

11. That the local WOMA organization be provided with funds and resources to enable it to operate a more effective, positive, full-time program at Yalata.

12. That a Community-controlled Youth program be established with funds and resources to enable it to run a effective, positive and on-going programs for both male and female youths at Yalata particularly those affected by petrol and drug abuse. As well, assistance to establish a Youth Camp away from Yalata incorporating appropriate treatment and rehabilitation programs.

13. That the Yalata Health Service, with support and assistance from the Aboriginal Health Council deliver an Aboriginal Health Worker Education program.

CEDUNA/KOONIBBA

Background

Ceduna is the largest town on the upper Eyre Peninsula and has an Aboriginal population of about 350 people at Ceduna and Thevenard. There is also a group of people living at Half-way Camp just west of the Ceduna township consisting of approximately 30 permanent residents and a varying number of itinerant people. There are approximately 110-120 people living at Koonibba 30 km to the West of Ceduna.

The health needs of these people are served by the Aboriginal Health Organisation with 3 Aboriginal Health Workers based in the Health and Welfare Centre next to the Murat Bay District Hospital in Ceduna. Two local Medical Private Practices provide services to Ceduna and Thevenard community.

The Aboriginal Health Workers have responsibility for carrying out the AHO program for the whole area including Koonibba. Their work also involves making arrangements for patients from Yalata to be sent into Murat Bay District Hospital, for their repatriation and care after discharge and arranging for further specialist treatment in Adelaide or Whyalla. In addition, the Health Workers' time is frequently occupied assisting clients with welfare matters (eg. counselling, social security administration, budgeting and financial matters etc.).

Although Aboriginal people have a choice of Doctors in Ceduna/Thevenard, many do not present until they are very ill because of the alienating nature of the system with which they must contend.

Alcohol abuse and related problems are seen by the Community to be the major health problem, or cause of health problems, in the area. Of particular concern to all is the increasing use of alcohol and drugs by youth. This is not only symptomatic of the state of the community and the high unemployment in the area, but also emphasises the lack of facilities for young people generally. Youth programs have been poorly supported with resources and have not been permanent. Many people have attempted various schemes but these have generally collapsed due to lack of support in terms of funding, vehicles, accommodation and equipment. The only permanent program is one for juvenile offenders, run by the Department for Community Welfare. The irony in this is that, to gain access to this programs, the youth are obliged to have had committed offences and be convicted.

WOMA operates a Centre in Ceduna but do not have sufficient funding and resources to carry-out the necessary programs. In particular they do not have any accommodation for a residential Alcohol rehabilitation program. The nearest rehabilitation Centres are at Baroota, south of Pt. Augusta and in Adelaide. Many clients are unwilling to be away from their home and family and consequently have to miss out on this service. There is an urgent need for a rehabilitation centre at Ceduna. The Far West Aboriginal Progress Association have land available near Ceduna for such a centre but cannot obtain the funds to establish it. The recent development of the Poverty Flat garden project is seen as important in relation to an alcohol rehabilitation program (see also pg. 94).

There is also a desperate need for a hostel-type accommodation for patients discharged from Ceduna Hospital awaiting return, particularly to Yalata. Presently the Yari Miller Hostel is forced to accommodate these people, whenever possible, though not designed to carry-out this task. However there is a suitable building next to the Far West Aboriginal Progress Association. These premises have been used in the past as accommodation for discharged patients, but is currently being used by the Department of Community Welfare for their youth offenders program. The building is used, principally to store equipment used in the program.

Futhermore, as with most country communities there is no accommodation for the aged people at Ceduna. Elderly people who require special care and accommodation have to go to Pt. Augusta's Wami Kata Hostel. Many are unwilling to spend their old age away from their families, and consequently have no suitable place to live. In addition, Wami Kata does not have facilities nor staff for geriatric care (See Pt. Augusta Interim Report in Appendix).

The isolation and lack of resources and facilities in the health related areas also exist in the medical area. There are no specialists in Ceduna, which necessitates frequent evacuations or referrals to Adelaide or Whyalla. Trips to Whyalla, the regional hospital for Eyre Peninsula, pose many difficulties as there is no direct public transport available. There are currently patients in Adelaide from the Ceduna/Yalata area receiving dialysis treatment for Renal disease. There are no facilities outside of Adelaide for treatment of this kind. One patient requiring dialysis treatment in Adelaide in 1983 preferred to stay in Ceduna and die rather than experience the social and cultural isolation of survival in Adelaide.

The Renal Unit at the Royal Adelaide Hospital informed the Review Committee that Aboriginal people from isolated areas requiring dialysis treatment were faced with two choices: to go to Adelaide and die from lack of social support or stay home and die from lack of specialist facilities. This state of affairs, particularly in view of the extremely high level of renal disease amongst Aborigines in South Australia requires urgent attention.

Koonibba

There are no health or medical facilities at Koonibba. Anyone requiring medical treatment must travel to Ceduna on the community bus in the morning for an appointment with the Doctor, and return in the afternoon. In the case of emergencies, the people must find some-one with a vehicle to transport them to Ceduna. The Community Council has a vehicle but this is used for general community work and is not always available for medical use. Furthermore, Doctors in Ceduna do not consult after hours nor make home visits. This, obviously is not always convenient nor appropriate for people from Koonibba.

The Aboriginal Health Workers from Ceduna visit Koonibba once a week, but not on a regular basis because of the pressures of the work-load in Ceduna. This is totally inadequate and the cause of some concern amongst the Koonibba people.

One matter requiring urgent attention is the need to upgrade the supply of water to the Koonibba community. With only a single 5000 gallon tank at Koonibba and an inadequate pipeline between Koonibba and Calambie, the Department of Aboriginal Affairs (Aboriginal Public Health Improvement Program) should take immediate action to rectify this situation.

There is a need to establish a health centre in Koonibba. At present there are community premises available which only require minor renovation and equipment to be operational.

Recommendations

1. That a local Aboriginal Health Committee be established in this area consisting of representatives from the Ceduna and Koonibba Aboriginal Communities.

2. That a comprehensive Community-controlled Health Service be established at Ceduna to serve the Aboriginal communities at Ceduna and Koonibba.

3. That the staffing levels for this Service should include at the least the following:-

   Ceduna:

Health Coordinator	x 1
Medical Practitioner	x 1
Aboriginal Health Worker	x 4
Community Health Educator	x 1
Office Administrator	x 1
Typist/Receptionist	x 1

   Koonibba:

Aboriginal Health Worker	x 1

   It is further recommended that the Koonibba Unit be supported by the Doctor and staff at Ceduna and that suitable facilities be provided for this Unit. This should include, at least the following:

   - Health Centre
   - Vehicle

4. That the Department of Community Welfare be approached in relation to transferring the building located next to the Far West Aboriginal Progress Association over to the local Aboriginal community - to be used as a Community Health Centre/hostel.

5. That an Aboriginal person be appointed to the Board of Management of the Murat Bay District Hospital.

6. That two Aboriginal Hospital Liaison Officers be employed at Murat Bay District Hospital and that at least one have Pitjantjatjara language skills.

7. That the Department of Aboriginal Affairs immediately provide adequate funds to upgrade the water supply to Koonibba.

8. That immediate consideration be given to adequately fund the Poverty Flat project at Ceduna.

9. That a home for the aged with geriatric care facilities be established at Ceduna.

10. That the Port Augusta and Davenport Aboriginal Health Service provide preventative dental care and treatment to the Ceduna and Koonibba Aboriginal Communities and that the School Dental Service continue its existing program.

11. That the Department of Aboriginal Affairs expand the operations of the existing Woma program to include a rehabilitation farm in conjunction with the Poverty Flat project.

COOBER PEDY/OODNADATTA

Coober Pedy

The Aboriginal population of Coober Pedy is approximately 250. This includes many itinerant groups passing through the town.

The delivery of health services in Coober pedy is through the local hospital which retains a doctor operating a private clinic; and the Aboriginal Health Organisation which employs a Community Health Nurse and two part time Aboriginal Health Workers. In addition the Royal Flying Doctor Service (Pt Augusta) provides transportation for visiting specialists, Dentists and evacuations, when necessary.

The local Aboriginal Community is represented by their Umoona Community Council which was established in 1974. The Council is responsible for the local Woma programs, Homemaker services, Housing program and a commercial enterprise (Umoona Opal Mine). In attempting to further address the local problems, the Council has several submissions before various Government Departments.

Alcohol abuse is a major problem of the total Coober Pedy Community. The Woma program at Coober Pedy is seriously hampered by a lack of funds and resources - for example; their vehicle is in a dangerous state of repair. Furthermore, there is no rehabilitation area for Woma to operate a long-term program.

Adequate accommodation is urgently needed for many Aboriginal residents - as is some form of hostel accommodation for itinerant people. There are many complaints of little or no maintenance on existing dwellings. There is no accommodation for the aged in Coober Pedy. The elderly have the option of going to Alice Springs or Port Augusta (which does not provide Geriatric care) or staying in Coober Pedy in difficult circumstances.

Coober Pedy has no office of Social Security nor a Commonwealth Employment Service. Given the Department of Community Welfare's limited resources, the Aboriginal Community has little access to general welfare services. Some local businesses operate credit systems based on anticipating receipt of social security cheques, so that the Aboriginal customer has little control of his income. (see pg. 56)

Oodnadatta

Oodnadatta, situated in the far North of South Australia is a unique town in that its Aboriginal population comprises 85% of the total population (80 aboriginal and 30 non aboriginal)

This has been brought about by the realignment of the railway line to Alice Springs and the subsequent decrease of Australian National Railways staff in this area, and to the development of a new town, Marla, some 250 kilometres to the East.

As a result of these developments the Aboriginal Community have purchased the local Hotel and other property from Australian National Railways and these actions have formed the basis for potentially the most exciting concept in Aboriginal self management and community development in South Australia.

These actions include building programs, commercial enterprises and restoration of the Railway Station.

Despite these facts some of the worst instances of racial abuse and maltreatment by the non Aboriginal health care providers were reported to the Review Committee. Some of these matters are subject to legal proceedings and no further comment can be made.

The principal health service available to the people in Oodnadatta is the local hospital which serves the town and surrounding pastoral properties and is managed by Frontier Services (Sydney), a division of the Uniting Church. The hospital was established by Rev. J. Flynn approximately 75 years ago, and is deficit funded by the South Australian Health Commission (Western Sector, Adelaide). The hospital employs two community health nurses.

The medical supervision of the Oodnadatta Hospital is via the Royal Flying Doctor Service (Port Augusta). The Royal Flying Doctor Service also provides evacuation when necessary. Access to Doctors, Dentists and other visiting specialists is determined by the nurses at the hospital.

The local Aboriginal people are reluctant to avail themselves of the existing hospital services due to a lack of commitment by the nurses employed by Frontier Services. There is also an increasing trend for the non Aboriginal people to bypass the hospital for these same reasons. This is further exacerbated by a high turnover of staff and by the continuing archaic policy of the Uniting Church in combining spiritual and health care rather than addressing the real health needs of the community.

The Aboriginal Health Organisation employs a Community Health Nurse and an Aboriginal Health Worker who are mainly involved in health promotion and prevention programs in the community, quite seperate from the hospital services.

The relationship between these two services is totally dependent upon the goodwill of the staff involved. There needs to be a complete rationalisation of all health and health related services in Oodnadatta so as to ensure comprehensive health care for the total community.

Recommendations

1. That a local Aboriginal Health Committee be formed with representatives from Coober Pedy and Oodnadatta communities.

2. That a comprehensive regional Aboriginal Community-controlled Health Service be established at Coober Pedy to service the Coober Pedy, Oodnadatta and surrounding Aboriginal communities.

3. That the staffing levels should include, at least the following personnel to service the Coober Pedy, Oodnadatta and surrounding communities:

   Coober Pedy

   - Health Coordinator x 1
   - Medical Practitioner x 1
   - Aboriginal Health Worker x 3
   - Community Health Nurse/Educator x 1
   - Office Administrator x 1
   - Typist/Receptionist x 1

   Oodnadatta

   - Community Health Nurse/Educator x 2
   - Aboriginal Health Worker x 2
   - Clerical Assistant x 1

4. That negotiations occur between the South Australian Health Commission and the proposed Coober Pedy/Oodnadatta Health Committee in respect to securing the old hospital complex as an administration centre for the regional Coober Pedy/Oodnadatta Health Service.

6. That an Aboriginal person be appointed to the Board of Management of the Coober Pedy Hospital.

7. That an Aboriginal Hospital Liaison Officer with appropriate language skills be employed at the Coober Pedy Hospital.

8. That the Department of Aboriginal Affairs evaluate the WOMA program at Coober Pedy with a view to upgrading and expanding existing facilities.

9. That the South Australian and Commonwealth Governments give consideration to the establishment of a Sport and Recreation Centre at Coober Pedy.

10. That the Department of Social Security give consideration to the establishment of a child care centre for the Aboriginal community with appropriate backup support and services.

11. That the South Australian Minister of Health should commence negotiations with the representatives of the Uniting Church in respect to the transfer of the Oodnadatta Hospital, equipment and funds (presently being provided by the South Australian Health Commission) to the Aboriginal community at Oodnadatta.

NEPABUNNA/FLINDERS RANGES

This region includes the Andjamathna community at Nepabunna and the people living in the Flinders Ranges towns of Blinman, Copley, Lindhurst, Hawker, Quorn, also Leigh Creek and Marree. The recent history of the area has been a sorry chronicle of neglect and inappropriate, programs resulting in a situation today of poor health and environmental conditions,-inadequate housing, too few community facilities and little support for the people in general.

It is the Review Committee's opinion that Nepabunna is undoubtedly one of the most neglected Aboriginal Community in South Australia. Both Commonwealth and State governments which have provided services over a great many years have failed to meet the needs and aspirations of these people.

General living and environmental health conditions at Nepabunna are appalling. There has been a long history of poor water supply, both in quality and quantity. Apart from the effect this has had directly on the community's health, it has also meant that the plumbing and sewerage systems have rarely worked efficiently. The long-term solution to this problem lies in the construction of a local dam. The houses in Nepabunna are in a very poor state of repair and maintenance is almost non-existent. In addition there is chronic over-crowding.

The provision of Health Care Services to the Nepabunna Community is almost non existant with the exception of twice weekly visits by the Aboriginal Health Worker based at Leigh Creek and the monthly visits by the Royal Flying Doctor Service from Broken Hill. Spasmodic visits are also made by a private Dentist and the Child and Family Health Service.

The Leigh Creek Hospital, approximately 80 kilometres from Nepubunna has full inpatient care facilities. A private General Practitioner consults on a daily basis at the hospital.

There is an urgent need to upgrade the Health Centre at Nepabunna with basic clinical facilities. This centre should be staffed by a community health nurse/educator and at least 2 Aboriginal Health Workers. The Medical and administrative support and assistance should be provided by the Port Augusta and Davenport Aboriginal Health Service.

Recommendations

1. That an Aboriginal Community controlled Health Committee, representing the Nepubunna and Flinders Ranges Aboriginal communities, be established at Nepubunna.

2. That the Health Centre at Nepabunna be upgraded to include basic clinic facilities.

3. That the staffing level at the Centre include at least the following:-

   Community Health Nurse/Educator x 1
   Aboriginal Health Worker x 2

4. That the Port Augusta and Davenport Health Service provide administrative support and coordinate medical, dental and other specialist visits to this region.

5. That an Aboriginal person be appointed to the Boards of Management of the following hospitals in the region: Leigh Creek; Hawker and Quorn.

6. That an Aboriginal Hospital Liaison Officer be employed at the Leigh Creek and Hawker Hospitals.

7. That the Department of Aboriginal Affairs fully investigate the feasibility of constructing a dam at Nepabunna to ensure adequate water supply to the community.

8. That the main thoroughfare through the township of Nepabunna be sealed or re-routed.

9. That the Commonwealth Department of Aboriginal Affairs and State Office of Aboriginal Affairs in consultation with the local communities, investigate the long term needs and aspirations of the Nepabunna community particularly in relation to employment, housing, social and welfare needs.

Aboriginal Health Committees

Each one of the following regions is not considered to be in a position to operate its own Community-controlled health service immediately, although they are all in desperate need to improve the delivery of health services to their respective communities.

Each of these areas shall establish local Aboriginal Health Committes and be represented as full members of the proposed Aboriginal Health Council of South Australia. In areas that cover more than one Aboriginal community, agreement will have to be reached to ensure proportional representation of the whole area on the local Health Committee.

One or more of these Health Committees may eventually establish fully independent Community-controlled Aboriginal health services. The structure and organisation of each health service will depend on the local situation.

It is vitally important that the Aboriginal Health Council, when established. provide special support and assistance to those communities.

The South Eastern region of South Australia covers the area from Kingston and Bordertown to Mt. Gambier. It includes the townships of Naracoorte, Millicent and Penola. The Aboriginal people here live in scattered family groups and must utilize existing services for health care needs. There is no input by the Aboriginal Health Organisation in this area at present. Consequently, some of the people feel that their special needs have been neglected.

The Riverland region covers the Aboriginal population of the riverland towns of Waikerie, Barmera, Berri, Renmark, etc. (population 300-400 people), and the community at Gerard (approximately 120 people). Currently the people must use the existing health services and private general practitioners in the respective towns. The Aboriginal Health Organisation retain two Aboriginal Health Workers in the area.

The people experience difficulties and frustration in dealing with a conglomeration of services; and the health worker's job is hampered by the necessity for them to assist people with a whole range of health and welfare issues. There is no visiting doctor service available, not even to the community at Gerard, and apart from having to interact with the often unsympathetic medical staff, transport to these services is also a problem.

Whyalla has an Aboriginal population of approximately 450 with a large floating population. Since the downturn in BHP operations the unemployment situation has worsened, but the population has increased with single parent families moving in due to availability of housing. There is a high number of single parent families in the city.

The Aboriginal community has no facilities or resources available to them except what is available to the general community. Unlike other towns and cities with significant populations, there is no Community Centre or contact point for the people. The Community has the temporary use of a school building whilst awaiting a response for funding from Department of Aboriginal Affairs.

There is only one part-time Aboriginal Health Worker to service all the needs of the population in Whyalla. This is totally inadequate, because, apart from the duties as demanded by the Aboriginal Health Organisation, the Health Worker is also caught up in the whole range of legal, social, alcohol problems, for which there is no adequate service delivery. Woma and The Aboriginal Legal Rights Movement have their nearest offices in Pt. Augusta whose resources are already stretched. Consequently, Whyalla people are without effective and positive services of all kinds.

The Port Lincoln Aboriginal community numbers approximately 500 people. The population has been steadily growing over the past few years due to an infux of people from Eyre Peninsula and Western Australia. The most significant developments in the community is the establishment of the Mallee Park Sports Club and Community Centre incorporated under the Port Lincoln Aboriginal Organisation. This club has its own sports grounds, social and administrative centre, and acts as a general focus point for community activities. The Review was impressed by the Club, the Port Lincoln Aboriginal Organisation and the impact of their achievements on the health of the community.

Recommendations

SOUTH EAST

1. That a Community-controlled Health Committee be formed in Mt Gambier representing the various communities in the region.

2. That this Health Committee be responsible for the formulation of policy, employment, coordination and delivery of health services in this region. They shall liaise with the Aboriginal Health Council in respect to the delivery of health care in its communities.

3. That this Health Committee be funded to employ at least 2 Aboriginal Health Workers and appoint Hospital Liaison Workers where appropriate. That adequate funding for vehicle, administrative and operating costs also be provided.

4. That where appropriate, Aboriginal people be appointed to the Boards of Management of hospitals in the region.

5. That negotiations commence with the Adelaide Aboriginal Health Service with respect to medical and administrative support.

6. That the Aboriginal Health Committee aim to integrate health and welfar services to the Aboriginal communities in this region.

GERARD AND RIVERLAND

1. That a Community-controlled Health Committee be formed to represent the various communities in the region.

2. That this Health Committee be responsible for the formulation of policy employment, coordination and delivery of health services in this region. They shall liaise with the Aboriginal Health Council in respec to the delivery of health care in its communities.

3. That this Health Committee be funded to employ at least 4 Aboriginal Health Workers (at least 2 for Gerard).

4. That Aboriginal Hospital Liaison Workers be employed at the Barmera anc Berri Hospitals.

5. That an Aboriginal person be appointed to the Boards of Management of hospitals at Barmera and Berri.

6. That negotiations commence between the Aborginal Health Committee and local general practitioners in respect to provision of regular consultations at Gerard.

7. That, in the interim, negotiations commence with the Adelaide Aborigin Health Service with respect to medical and administrative support.

8. That the Aboriginal Health Committee aim to integrate health and welfa services to the Aboriginal communities in this region.

PT. MCLEAY AND MURRAY BRIDGE

1. That a Community-controlled Health Committee be formed in Murray Bridge to represent the various communities in the region. The Health Committee shall establish a clinic and health centre in Murray Bridge with the further aim of employing professional medical staff in the near future.

2. That this Health Committee be responsible for the formulation of policy, employment, coordination and delivery of health services in this region. They shall liaise with the Aboriginal Health Council in respect to the delivery of health care in its communities.

3. That this Health Committee be funded to employ at least 2 Aboriginal Health Workers each at Murray Bridge and Pt. McLeay and one Aboriginal Health Worker/Liaison Officer each at Tailem Bend and at Meningie.

4. That Aboriginal members be appointed to the Boards of Management of hospitals at Murray Bridge, Meningie and Tailem Bend.

5. That the need for a major dental health program in the area be urgently investigated.

6. That an Aboriginal hostel/home for the aged be established in the area.

7. That the Health Committee and the local Woma program negotiate for the integration of their services and operations or otherwise establish closer cooperation.

8. That negotiations commence with the Adelaide Aboriginal Health Service with respect to medical and administrative support.

9. That the Aboriginal Health Committee aim to integrate health and welfare services to the Aboriginal communities in this region.

YORKE PENINSULA

1. That a Community-controlled Health Committee be formed in Pt. Pearce to represent the various communities in the region.

2. That this Health Committee be responsible for the formulation of policy, employment, coordination and delivery of health services in this region. They shall liaise with the Aboriginal Health Council in respect to the delivery of health care in its communities.

3. That this Health Committee be funded to employ at least 2 Aboriginal Health Workers at Pt. Pearce

4. That an Aboriginal person be appointed to the Board of Management of the Maitland Hospital.

5. That negotiations commence between the Aborginal Health Committee and local general practitioners in respect to provision of regular consultations at Pt. Pearce.

6. That the Aboriginal Health Committee aim to integrate health and welfare services to the Aboriginal communities in this region.

WHYALLA

1. That a Community-controlled Health Committee be formed at Whyalla to represent its Aboriginal community.

2. That this Health Committee be responsible for the formulation of policy, employment, coordination and delivery of health services in this region. This Committee shall negotiate with the Port Augusta and Davenport Aboriginal Health Service for administrative, medical and Health Worker training support.

3. That this Health Committee be funded to employ at least 2 Aboriginal Health Workers.

4. That an Aboriginal Hospital Liaison Officer be employed at the Whyalla Hospital.

5. That an Aboriginal person be appointed to the Board of Management of the Whyalla Hospital.

6. That the Commonwealth Department of Aboriginal Affairs fund the establishment of an Aboriginal Community Centre incorporating a youth drop-in centre, health clinic, women and children centre, half-way house and WOMA programs.

7. That the Aboriginal Health Committee aim to integrate health and welfare services to the Aboriginal community in this region.

PORT LINCOLN

1. That a Community-controlled Health Committee be formed at Port Lincoln to represent its Aboriginal community.

2. That this Health Committee be responsible for the formulation of policy, employment, coordination and delivery of health services in this region.

3. That this Health Committee be funded to employ at least 3 Aboriginal Health Workers.

4. That an Aboriginal Hospital Liaison Officer be employed at the Port Lincoln Hospital.

5. That an Aboriginal person be appointed to the Board of Management of the Port Lincoln Hospital.

6. That the Aboriginal Health Committee aim to integrate health and welfar services to the Aboriginal community in this region.

Chapter Eight: CONCLUSION

The Review Committee, with limited resources and time available to it, was not able to examine in detail, every possible aspect of the Aboriginal health care system in South Australia. Nevertheless, we believe we were able to identify the major weaknesses and shortcomings of the current system, and the recommendations made by the Committee should create a new direction which will be greatly beneficial to the South Australian Aboriginal community.

The Review Committee, in its attempt to evaluate the effectiveness and cost efficiency of the current Aboriginal health care delivery system in South Australia, was aware of the fact that in other parts of Australia the most successful programs are those which are controlled by, and largely delivered by, Aboriginal people themselves. Indeed, over fifty Aboriginal communities throughout Australia are currently operating their own Community-controlled health services which, in most instances have proven to be highly successful in overcoming many serious community health problems.

The fact that the Committee found evidence of continuing serious health problems in the South Australian Aboriginal community, clearly indicated that the present philosophy and approach by South Australian health care providers has essentially failed. The inescapable conclusion by the Committee was that there needs to be greater Aboriginal input and, ideally, control over, the design and delivery of their own health care system.

Over the past ten years nationally, there has been an increasing realisation on the part of government funding agencies and health care providers that previous policies of encouraging or "educating" Aboriginal people to utilise existing general community health services have largely been a failure. At the same time, many Aboriginal organisations and communities have taken the initiative and established their own Community-controlled health care delivery services.

The major difference between services designed and operated by non-Aboriginal agencies, and those designed and run by Aborigines themselves, is that the Aboriginal models emphasise a combined curative and preventive approach. Programmes initiated by non-Aborigines inevitably tend to emphasise preventive aspects only, and seek to "encourage" Aborigines to attend general community services, which is alienating to even many non-Aboriginal people.

The Committee found extensive evidence that Aboriginal people in South Australia desire to control their own health care delivery. Furthermore, there is ample evidence to suggest that Aboriginal Community control of a health service creates a program more relevant to community needs; and because the people perceive such a service as "theirs", there is increased attendance which increases the possibility of overcoming community health problems. There is also a corresponding community committment to the service which is often translated into an extension and improvement of services offered.

The lack of real Aboriginal control and participation was seen to be the greatest weakness in the current system in South Australia, although the Committee was encouraged to note that South Australia has, over the past ten years, developed a more progressive and positive approach to this issue than any other state. Yet despite this more enlightened attitude within government and health care providers, the key element of Aboriginal control has not been established or developed.

Consequently, the major recommendations of this report are designed to substantially change this situation. The proposed local Community-controlled health services and committees should give Aboriginal people in all significant South Australian Aboriginal Communities, extensive say in, and control over, virtually all aspects of their own health care delivery. This in turn should ensure programs of greater relevance to community needs, and future directions which more closely reflect the desires and aspirations of South Australian Aboriginal people.

The proposed Aboriginal Health Council should extend the concept of community control into the major, central co-ordinating body. It will also give the Aboriginal people maximum input and control over the vitally important areas of policy development, health worker education, research and data collection.

If the major recommendations of this report are speedily and efficiently implemented, South Australia could well become the State with the most progressive approach to Aboriginal health, but more importantly, the serious health problems confronting the South Australian Aboriginal community could be alleviated relatively quickly and cost-efficiently.

It is therefore vital to the success of the model the Committee has proposed, that the relevant Commonwealth and State funding authorities urgently resolve potential differences regarding perceived funding responsibilities.

Of all major health problems identified by the Committee, without doubt, one of the most serious and potentially disastrous in terms of its destructive effect on individuals and communities, is petrol sniffing among children and juveniles. This tragic problem is so extensive that an entire generation of young Aboriginal people is in danger of being overwhelmed by it. The Committee was appalled by the extent of the problem, and the apparent lack of any significant programs or even resources to deal with it. It consequently feels that urgent action should be taken to, firstly, have full consultation with relevant Aboriginal communities and then to initiate Community-controlled programs to overcome it.

Other major health problems identified include the wide range of serious diseases revealed by the Renal Survey. The fact that many of these diseases went undetected before the Survey, leads to the suspicion that other serious problems remain undetected. If therefore concerned the Committee to learn that the future of the Renal Survey could be in doubt.

The Committee strongly believes that the Renal Survey needs to be extended to include every significant community of Aboriginal people in South Australia, and that further comprehensive health surveys need to be conducted as soon as possible.

The Committee has made specific recommendations on the issue of statistical data in Aboriginal health. For too long Governments have agreed on the desirability of a comprehensive statistical collection for Aboriginal health, but little action has been taken to create such a collection. The fact that data isn't generally available from present sources only serves to emphasise the need for the Renal Survey to be continued and expanded.

Another major problem confronting the South Australian Aboriginal community is the apparent lack of consultation and co-ordination between government agencies operating in Aboriginal communities. The Committee has drawn attention to examples of community-based action not only to illustrate the importance of that as an approach to Aboriginal health problems, but also to underline the interrelated nature of the elements of deprivation suffered by Aboriginal people. In South Australia, Aboriginal communities are, by and large, disadvantaged in the areas of housing, employment, education, health and yet others.

The Committee has drawn attention in the report to the great lack of co-ordination among Government agencies in the design and implementation of social programs that are intended to help Aboriginal people. This lack of co-ordination and consultation on the part of government agencies (particularly the Departments of Community Welfare and Education) cause a great deal of unnecessary tension and suffering for Aboriginal people, and the Committee considers that this is an area in which action is urgently required if the overall efforts by Governments is to be effective in achieving objectives apparently set for such programs.

The Committee has made specific recommendations in this area as it considers it a basic requirement for overall efforts to assist Aboriginal people in dealing with health and other problems.

Nevertheless, not all aspects of the general Aboriginal health situation investigated by the Committee proved to be negative. In Ceduna, the Committee had the pleasure of visiting the Poverty Flat organic market garden which was established in 1983 by a group of unemployed Aboriginal people, and which today produces more than 45 different varieties of fruit, vegetables and flowers. The garden not only provides fresh fruit and vegetables to the Aboriginal community, but also to the entire community in Ceduna, and this is a potential commercially viable operation. The Poverty Flat Market Garden is one of the most interesting and exciting experiments in Australia today, in that similar projects in most South Australian Aboriginal communities could possibly stimulate a major improvement of not only the nutritional well being of Aboriginal people, but also have a dramatic effect on the self-esteem, pride and dignity of many Aboriginal communities. The Committee commends the Poverty Flat project as a possible answer to some of the nutritional health problems confronting many Aboriginal communities.

Finally, it must be stated again that ultimately the most significant step toward the overall and long term improvement of health and other problems of Aboriginal people would be the granting of Land Rights and/or Compensation for lands alienated. Land Rights would give Aboriginal people security and an economic base which would enable them to become economically independent of non-Aboriginal Australia. This, in turn would give Aboriginal people the chance to solve their own problems, on their own terms and in their own way. Whilst the Committee notes that the South Australian government has a more enlightened approach, with a better record than any other government in regard to Land Rights, it hopes that progress will continue to be made until all South Australian Aboriginal people are compensated for the historical injustices perpetrated against them.

Until such time as all Aboriginal people in South Australia have received Land Rights and/or Compensation, it will be necessary for Commonwealth and State authorities to continue providing resources to alleviate specific problems. The model that the Committee of Review has proposed for South Australia, has proven in other parts of Australia to be the most effective and cost-efficient means of health care delivery to Aboriginal communities. The Committee believes that a better health service for South Australian Aboriginal people is desperately needed and long overdue, but it believes that in using the proposed model as a foundation it should be possible, in a relatively short time, to substantially ease the continuing, unnecessary, ill health and deprivation suffered by the South Australian Aboriginal community.

TABLE 1 & TABLE 2: Overrepresented diagnoses among Aboriginals (compared with Non-Aboriginal)

DIAGNOSIS	1979				1980				1981			
	Seps	% seps % b.Seps	Av LOS	N/Ab. Av LOS	Seps	% seps % N/Ab.Seps	Av LOS	N/Ab. Av LOS	Seps	% seps % N/Ab.Seps	Av LOS	N/Ab. Av LOS
Pulmonary TB (11-11.9)	2	2.32	48.0	54.85	11	19.58	67.18	47.08	8	12.52	45.00	38.27
Whooping Cough (33-.9)	-		-	6.43	1		18.00	6.69	10	5.50	7.90	8.32
Measles (55-.9)	27	6.80	5.11	3.55	-	-	-	2.83	21	4.72	7.19	3.44
Scabies (133-.9)	9	81.61	10.14	6.67	13	120.36	9.00	4.40	20	203.53	7.10	7.75
Alcohol Psychosis (291-.9)	14	7.85	2.64	8.11	11	4.63	3.91	8.81	15	4.42	7.87	19.90
Alcohol Dep Synd (303-.9)	46	5.54	2.41	6.58	67	7.75	3.34	7.38	52	5.95	5.62	7.62
Non-Dep Drug Abuse (305-.9)	12	5.10	1.67	1.48	12	4.44	1.92	1.48	32	8.98	2.13	1.82
Conjunctivitis (372-.9)	10	4.25	4.8	2.97	16	5.74	6:50	3.53	2.	5.29	7.4	2.97
Supp Otitis Media (382-.9)	91	3.63	6.84	2.86	117	4.00	6.02	2.51	135	4.65	6.58	2.46
Other Ear Disorders (388-.9)	4	3.30	4.25	3.79	12	7.82	64.75	3.13	7	4.67	7.43	2.89
Rheumatic Fever (390-.9)	8	20.73	22.00	9.29	5	8.90	15.60	10.00	9	15.93	5.78	10.26
Acute Urti (465-.9)	92	5.86	6.1	3.6	130	6.82	4.80	3.93	149	6.19	6.01	3.91
Ac. Bronchitis (466-.9)	27	1.74	7.74	5.92	63	2.81	5.22	4.65	70	3.25	7.27	5.21
Pneumoc. Pneumonia (481-.9)	27	2.32	8.78	7.9	33	2.53	7.09	8.94	42	2.92	6.50	8.71
Pneumonia (486-.9)	53	4.27	7.64	22.60	40	2.78	7.20	16.40	43	3.04	7.37	19.72

TABLE 1 & TABLE 2: Cont.

DIAGNOSIS	1979				1980				1981			
	Seps	% seps / % N/Ab.Seps	Av LOS	N/Ab. Av LOS	Seps	% seps / % N/Ab.Seps	Av LOS	N/Ab. Av LOS	Seps	% seps / % N/Ab.Seps	Av LOS	N/Ab. Av LOS
Chronic Bronchitis (490-.9)	85	3.78	6.33	6.01	98	4.14	5.85	6.08	159	5.99	6.26	8.44
Other Respiratory (519-.9)	76	6.36	6.87	6.19	51	3.78	6.22	6.13	83	4.83	22.41	6.26
Chronic Liver Dis (571-.9)	14	2.27	7.21	11.79	13	2.15	7.85	10.95	15	2.59	10.87	12.71
Carbuncle (680-.9)	10	12.95	6.30	5.83	11	16.43	7.00	3.74	18	17.04	5.61	4.26
Abscess (682-.9)	36	2.95	5.94	7.47	69	4.18	5.58	6.38	100	5.44	6.47	6.47
Impetigo (684-.9)	9	14.84	7.89	4.21	17	35.77	6.29	6.41	23	33.44	5.48	6.54
Skin Infection (686-.9)	20	4.77	7.85	7.65	19	4.68	6.53	6.71	27	5.78	8.30	6.92
Open Head Wound (873-.9)	29	2.37	2.97	2.52	35	2.40	2.63	2.78	51	3.02	1.75	2.39
Other Open Wound (879-.9)	10	3.73	7.70	2.50	10	3.89	4.10	4.68	11	3.32	2.82	4.53
Open Arm Wound (881-.9)	10	2.24	2.20	4.43	12	2.88	6.00	4.13	14	2.66	2.71	5.24
Open Hand Wound (882-.9)	8	1.71	6.88	2.52	5	1.05	3.20	2.90	13	2.34	1.77	3.33
Contusion Eye (921-.9)	4	1.08	2.50	4.88	9	1.93	4.11	4.63	13	2.76	3.46	4.57
Burns (Trunk) (942 - 942.9)	3	1.57	6.33	10.53	3	1.10	19.67	9.61	12	4.40	16.17	9.50

TABLE 3: Aboriginal Patient Admissions by Hospital (minimum of 10 patients in 1981)

HOSPITAL	1979 SEPS	%	OBDS	%	1980 SEPS	%	OBDS	%	1981 SEPS	%	OBDS	%
RAH	225	6.4	3419	14.8	269	6.3	3850	14.3	292	6.0	4212	13.4
QEH	364	10.4	1154	5.0	576	13.4	1496	5.6	621	12.8	1744	5.6
FMC	49	1.4	450	2.0	42	1.0	280	1.0	59	1.2	459	1.5
Modbury	18	0.5	100	0.4	32	0.7	121	0.5	25	0.5	178	0.6
ACH	348	10.0	3697	16.0	328	7.6	3355	12.5	331	6.8	3347	10.7
Lyell McEwin	52	1.5	400	1.7	62	1.4	305	1.1	84	1.7	346	1.1
Berri	7	-	14	0.1	5	-	12	-	12	0.2	39	0.1
Cent Eyre Pen	11	0.3	27	0.1	2	-	6	-	10	0.2	22	0.1
Cleve	1	-	1	-	2	-	26	0.1	10	0.2	29	0.1
Great Northern	17	0.5	59	0.3	32	0.7	1722	6.4	28	0.6	1654	5.3
Kingston	10	0.3	43	0.2	5	-	92	0.3	15	0.3	92	0.3
Mannum	20	0.6	42	0.2	13	0.3	33	0.1	21	0.4	58	0.2
Millicent	15	0.4	53	0.2	11	0.3	22	0.1	19	0.4	62	0.2
Murat Bay	393	11.2	2027	8.8	405	9.4	1703	6.3	479	9.8	3320	10.6
Murray Bridge	116	3.3	458	2.0	111	2.6	448	1.7	131	2.7	442	1.4
Renmark	10	0.3	33	0.1	4	-	14	0.1	18	0.4	89	0.3
Lower Murray	39	1.1	317	1.4	28	0.6	109	0.4	37	0.8	143	0.5
Meningie	293	8.4	1982	8.6	206	4.8	1231	4.6	137	2.8	686	2.2
Barmera	235	6.7	1384	6.0	219	5.1	1647	6.1	241	5.0	1204	3.8
Mount Gambier	15	0.4	53	0.2	12	0.3	97	0.4	22	0.5	71	0.2
Port Augusta	648	18.5	3817	16.5	926	21.5	5143	19.1	1030	21.2	5983	19.1
Port Pirie	24	0.7	142	0.6	37	0.9	258	1.0	31	0.6	201	0.6
Wallaroo	6	-	24	0.1	7	-	20	0.1	12	0.2	35	0.1
Whyalla	172	4.9	1229	5.3	212	4.9	1323	4.9	240	4.9	1497	4.8
Port Lincoln	118	3.4	429	1.9	125	2.9	720	2.7	136	2.8	1300	4.1
Naracoorte	9	-	20	0.1	16	0.4	63	0.2	12	0.2	27	0.1
Quorn	48	1.4	385	1.7	73	1.7	445	1.7	65	1.3	345	1.1
Queen Victoria	23	0.7	112	0.5	54	1.3	329	1.2	78	1.6	370	1.2
Maitland	53	1.5	381	1.7	144	3.3	711	2.6	326	6.7	1977	6.3
Leigh Creek	40	1.1	210	0.9	68	1.6	299	1.1	66	1.4	187	0.6
Aust Inland Miss	9	-	5	-	30	0.7	26	0.1	27	0.6	14	-
RDNS Marree	5	-	3	-	20	0.5	3	-	14	0.3	4	-
Coober Pedy	-	-	-	-	116	2.7	432	1.6	159	3.3	786	2.5
TOTAL	3393	95.9	22461	97.4	4192	96.9	26341	97.9	4788	98.4	30933	98.7
TOT ALL HOSPS	3496	100%	23065	100%	4302	100%	26858	100%	4868	100%	31355	100%

TABLE 4: Aboriginal Children (0-14 years) Admission by Hospital (minimum of 10 patients in 1981)

HOSPITAL	1979 SEPS	%	OBDS	%	1980 SEPS	%	OBDS	%	1981 SEPS	%	OBDS	%
Queen Elizabeth	10	0.8	112	1.2	15	1.0	246	2.5	17	1.0	186	1.7
FMC	9	0.7	153	1.7	6	0.4	29	0.3	10	0.6	70	0.7
ACH	333	26.3	3533	38.9	317	21.9	3261	33.2	320	19.0	3286	30.8
Lyell McEwin	4	0.3	46	0.5	14	0.1	64	0.7	17	1.0	41	0.4
Great Northern	8	0.6	22	0.2	15	1.0	95	1.0	12	0.7	124	1.2
Murat Bay	167	13.2	868	9.6	114	7.9	432	4.4	172	10.2	745	7.0
Murray Bridge	27	2.1	128	1.4	18	1.2	49	0.5	27	1.6	137	1.3
Meningie	123	9.7	1022	11.3	80	5.5	548	5.6	50	3.0	288	2.7
Barmera	83	6.6	349	3.8	75	5.2	1021	10.4	92	5.5	394	3.7
Pt Augusta	241	19.1	1525	16.8	377	26.1	2161	22.0	466	27.7	2522	23.6
Pt Pirie	12	0.9	78	0.9	16	1.1	119	1.2	14	0.8	104	1.0
Whyalla	65	5.1	342	3.8	86	5.9	491	5.0	66	3.9	392	3.7
Pt Lincoln	35	2.8	136	1.5	55	3.8	271	2.8	54	3.2	290	2.7
Quorn	15	1.2	60	0.7	24	1.7	121	1.2	25	1.5	104	1.0
Maitland	27	2.1	189	2.1	76	5.3	375	3.8	169	10.0	1106	10.4
Leigh Creek	16	1.3	122	1.3	28	1.9	69	0.7	33	2.0	87	0.8
Coober Pedy	-	-	-	-	46	3.2	177	1.8	40	2.4	139	1.3
TOTAL	1175	92.8	8685	95.7	1362	94.1	9529	97.1	1584	94.1	10015	94.0
TOT ALL HOSPS	1264	100%	9076	100%	1447	100%	9829	100%	1682	100%	10664	100%

[illegible]requency of admiss[illegible] for Aboriginal patients (0-4 yrs.) in various South Australian hospitals in 1981

			ADMISSIONS 1 PATS	1 OBDS	2 PATS	2 OBDS	3 PATS	3 OBDS	4 PATS	4 OBDS	5-10 PATS	5-10 OBDS	Over 10 PATS	Over 10 OBDS	Total PATS	Total OBDS
ACH	0-4	No.	132	1229	25	727	8	135	2	75	-	-	-	-	167	2166
		%	79.0	56.7												
	Total	No.	205	1927	37	998	11	201	2	75	1	89	1	66	257	3356
		%	79.8	57.4												
RAH	0-4	No.	1	1											1	1
		%														
	Total	No.	208	3058	24	1116	5	70	2	40	3	145	-	-	242	4429
		%	86.0	69.0												
Barmera	0-4	No.	20	97	4	49	6	90	1	28	-	-	-	-	31	264
		%	64.5	36.7												
	Total	No.	103	415	19	264	15	233	2	46	3	188	2	59	144	1205
		%	71.5	34.4												
Meningie	0-4	No.	11	87	4	31	2	37	2	58					19	213
		%	57.9	40.8												
	Total	No.	57	317	16	133	7	111	2	58	3	72			85	691
		%	67.1	45.9												
Murat Bay	0-4	No.	46	180	16	121	7	97	2	50	3	126			74	574
		%	62.2	31.4												
	Total	No.	221	2220	48	411	27	346	6	149	7	183	1	15	310	3324
		%	71.3	66.8												
Pt Augusta	0-4	No.	98	552	37	328	12	255	11	284	12	533	2	161	172	2113
		%	57.0	26.1												
	Total	No.	443	2213	115	1504	38	795	21	414	22	930	2	161	641	6017
		%	69.1	36.8												
Pt Lincoln	0-4	No.	26	182	8	68	-	-	1	12					35	262
		%	74.3	69.5												
	Total	No.	78	1072	19	164	3	42	3	22					103	1300
		%	75.7	82.5												
Whyalla	0-4	No.	19	88	4	52	2	57	2	58	1	35			28	290
		%	67.9	30.3												
	Total	No.	152	1000	30	310	[illegible]	[illegible]	[illegible]	[illegible]						

TABLE 6: Aboriginal Hospitalisation rates (per 1000 population) and relative rate (compared with Non-Aboriginals) by age - 1982

Age	Non-Aboriginals		Urban Aboriginals		Rural Aboriginals	
	Rate	Rel. Rate	Rate	Rel. Rate	Rate	Rel. Rate
0-1	418	1	852	2.0	2763	6.6
1-4	197	1	189	1.0	760	3.9
5-14	98	1	84	0.9	229	2.3
15-19	139	1	178	1.28	400	2.88
20-49	195	1	300	1.54	578	2.96
50+	263	1	350	1.33	934	3.55
TOTAL	195	1	226	1.16	518	2.66

TABLE 7: ABORIGINAL DENTAL PROGRAMME PER 100 EXAMINATIONS

Fee-for-Service Programme

ITEM	CITY/METRO	COUNTRY	TOTAL
Examinations	100	100	100
Dental Health Education	0.6	12.2	7.7
Topical Fluoride	6.8	1.9	3.8
Prophy, Scale and Clean	71.8	26.2	43.9
Amalgam Filling	135.7	113.4	122.1
Composite Resin Filling	67.5	40.4	50.9
Complex Conservative	2.3	3.5	3.0
Endodontics	6.8	3.9	5.0
Radiographs	74.7	63.7	68.0
Extractions (L.A.)	41.9	97.1	75.7
Surgical Extraction (oral surgery)	14.0	68.7	47.4
Extractions (G.A.)	1.6	1.4	1.5
Relief of Pain	10.1	20.2	16.3
Full Dentures (Units)	6.2	10.7	10.2
Part Dentures	9.4	6.4	7.6
Immediate Dentures	1.0	1.2	1.1
Repairs	11.4	15.5	13.9
Orthodontics	0.3	-	0.1
Misc. Op.	55.5	77.9	69.2