

Aboriginal health

Sir—Your March 14 editorial on aboriginal health¹ is timely. To find solutions, however, is not easy.

When I took up the chair of child health in Sydney in 1960, I found more pressing problems on my doorstep. At the Royal Alexandra Hospital for Children an official instruction to the nurses was that all children in low-sided cots up to the age of 6 years and in high-sided cots up to the age of 4 years had to be in restrainers. Such matters had to be coped with, and I decided that the problems of aboriginal health were in the too difficult basket.

Every few years, medical students would ask if I could help obtain admission to the medical school for some aboriginal students at a lower educational level than that required for white students. We would discuss this, and they soon realised the problems. Could the aboriginal students continue to be given conditional passes, and what evidence was there that an aboriginal medical graduate would want to work amongst his own people rather than join a lucrative practice on Sydney's North Shore?

When Gough Whitlam became prime minister; we had a government that truly desired to improve the health of the aboriginal population. He appointed a delightful, bumbling, kindly man with a big heart as the minister responsible, Gordon Bryant. An aborigine should get the same pay for the same work as a white man. Aborigines worked well as stockmen in the Northern Territory but they would periodically go "walk-about" for some weeks. The properties were mostly American managed and they lost their jobs. Aborigines should make their own decisions about what they eat and drink—so the consumption of beer rose. Child allowances should be the same; in no time families were so large and allowances so great that to take employment would be foolish. So the effects of the minister's well meaning moves were all bad.

There was an outcry at the infant mortality amongst aboriginal children in Alice Springs. The government built a new hospital, with white labour flown in. Not an hour of aboriginal labour was used despite over 90% unemployment. Furthermore, the hospital might have been suitable for whites but it was wholly unacceptable to aborigines. In Darwin, a new children's ward was opened. Many of the children admitted because of diarrhoea and malnutrition turned over and died after they had been resuscitated. Not, I believe, because of

unrecognised potassium deficiency but because they woke up in an environment so alien that they could not cope with it.

Some dedicated doctors have set up appropriate, user-friendly clinics in the depressed aboriginal reserves outside towns but these are almost impossible to maintain on a permanent basis.

So, the problems are not easy to solve. I am, however, optimistic for there has been a sea-change in the attitudes of most young Australians and the first professor of aboriginal health (Michael Gracey) has been appointed, at the University of Western Australia, Perth.

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1 Editorial. Aboriginal health, a missing dimension. *Lancet* 1998; **351**: 765.

Sir—We would like to comment on some of the issues you raise in your editorial¹ after working for 6 years in remote North West Queensland, where 20% of the population of 36 000 are indigenous people. The pattern of disease found in aboriginal people is different from that in other Australians. Life expectancy for aboriginal Australians falls short of fellow Australians by almost 20 years. Comparison with other indigenous groups such as native Americans or Maoris in New Zealand shows that aboriginal Australians have catastrophically poor health outcomes. The high incidence of disorders such as rheumatic fever, diabetes, ischaemic heart disease, and hypertension may reflect not only the present cultural and material destitution of many aboriginal people, but also a legacy begun in utero (maternal malnutrition compromising fetal pancreatic β -cell development, fetal alcohol syndrome).

To recruit aboriginal health professionals is laudable, and forms a necessary step towards the goal of autonomy for health services in aboriginal communities. However, progress has been slow and it may take 20 or 30 years to show results. Many aboriginal people are reluctant to travel to centres of traditional education—ie, metropolitan universities and colleges—and a consistent demand is for locally delivered education and training. Important progress towards locally based health worker training for aboriginal students is being made in Mount Isa, with local delivery of health education material supported by new distance education technologies. It is critical that this training, as well as providing a goal in itself, promises aboriginal health workers a mechanism

to enter mainstream health education, whether nursing, medical, or allied health.

Other goals should be improved access to health services (overcoming both cultural and geographic barriers) and enhanced communication (helping people to understand that their health may be affected by their lifestyle). However, when a group of people in a society is concerned with the most basic aspects of life (obtaining food, water, and shelter), health becomes a luxury that is rapidly dispensed with. Poverty is perhaps the unifying theme, defining aboriginal health and disease. To argue for equity is insufficient when aboriginal people have been left so far behind in so many respects. A concerted government approach will be needed to improve substantially health outcomes for this group of Australians. Recognising native title to traditional lands is fundamental to any process of healing and reconciliation.

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1 Editorial. Aboriginal health, a missing dimension. *Lancet* 1998; **351**: 765.

Sexual ill-health among blacks in the UK

Sir—Your editorial on aboriginal health¹ revisits race, ethnicity, and ill-health objectively. The example you provide, of a high incidence of sexually transmitted diseases (STD) initially blamed on promiscuity but shown to be associated with inadequate access to services—and thus pointing to the need for cultural appropriate care rather than behaviour modification—to sexual ill-health in those of African descent in the UK.²

At a seminar on STDs organised by the African Caribbean Medical Society on March 14, 1998, I outlined the anthropological principles underlying the definition of race and ethnicity. Anthropology has two basic divisions: physical anthropology deals with differences in human physical characteristics (race) and cultural anthropology looks at language, behaviour, and beliefs (ethnicity). The danger when race and ethnicity are used by researchers in the analysis of STD data is illustrated by the Tuskegee syphilis study. Both distinctions, the racial and the ethnic, deal with minor differences among the human race, who belong to a single species for whom sex, recreational or for procreation, carries the risk of STD. Sexual transmission of an infection requires the agent to be present in one partner, the other partner to be