

Epidemiology and Health Information Branch

Information Circular No. 10

ABORIGINAL HEALTH COMMENTS


1. There has been a dramatic improvement in the health of aboriginal children over the last 15 years (Figure). Basically infant mortality rates have been more than halved in that time and the ratio of aboriginal to non-aboriginal mortality in infancy and early childhood has been reduced from 8-10 to 2-3. The current level of infant mortality in Aborigines though high by Australian Standards, is on a par with parts of South America and Eastern Europe.
2. These improvements in infant mortality have been brought about largely through health services - which have been somewhat heavy handed at times, but have nonetheless been highly successful.
3. Survival of children varies directly with birth weight and the improvements in infant mortality have been achieved without bringing about any improvement in the general circumstances of Aborigines and this is reflected by the lack of change in Aboriginal birth weights. This is a matter of continuing concern, indicating issues of maternal nutrition and consumption of tobacco and alcohol.
4. Despite the improvements in infant mortality, there are major continuing concerns with the health of Aboriginal children. Growth of Aboriginal children in many communities falls off after 6 months - a pattern found in many developing countries. About a third of Aboriginal children are anaemic and this interferes with learning ability. The nutritional problems in children are not only important in themselves, but may contribute significantly to the health problems of Aboriginal adults.
5. By contrast with the improvements in health of Aboriginal children, **there has been no improvement at all in the mortality of Aboriginal adults over the last 15 years**, while the total adult Queensland population adult mortality rates have dropped by about 40% during the same period.

As a consequence, inequalities between aboriginal mortality and total mortality rates in adults are getting worse. In middle age the excess in adult mortality **reaches a peak of 12 times the general population rate in females and 9 times in males (see Figure)**. There are few countries for which reliable statistics are available, which have as high a level of adult mortality as do Australian Aborigines.

6. The fact that adult mortality rates are very high and Aboriginal/non-Aboriginal inequalities are increasing, is quite different from say the situation in New Zealand Maoris where adult mortality rates for Maoris are dropping at a faster rate than for the non-Maori population (see Figure).
7. The expectation of life for Aborigines today is about the level that was experienced by Maoris and North American Indians in the 1950's. **Current expectations of life for Aborigines are about 10 years less than for Maoris and North American Indians** (see Table). This is a staggering difference and indicates the total failure in dealing with the problem of Aboriginal adults. (The infant mortality of Aborigines in Queensland is on a par with the rates for Maoris and Canadian Indians.) However it also indicates the tremendous improvement in Aboriginal Health that is possible.
8. The excess in adult mortality for Aborigines is due in the main to heart disease, diabetes, hypertension, respiratory disease and injuries - all conditions which are susceptible to a variety of treatment and prevention strategies.
9. Health programs to date have largely concentrated on the health of children and a systematic approach to the above health problems of Aboriginal adults has yet to be developed.
10. The main need now is to develop a variety of social, economic and health strategies that are appropriate for the issues in Aboriginal Health. The necessary knowledge has been around for decades and has been used successfully in other parts of the world.
11. **It is realistic to aim at a 50% reduction in adult mortality over the next 15 years but improvements will only come if the necessary resources, and appropriate health programs are provided together with a wider set of social and economic changes.** The message from a health point of view is that major improvement in Aboriginal Health is not only possible but failure to achieve it will indicate a failure of will and/or a failure to provide the necessary resources and/or a failure to develop and implement appropriate treatment and prevention strategies for each of the major health issues.

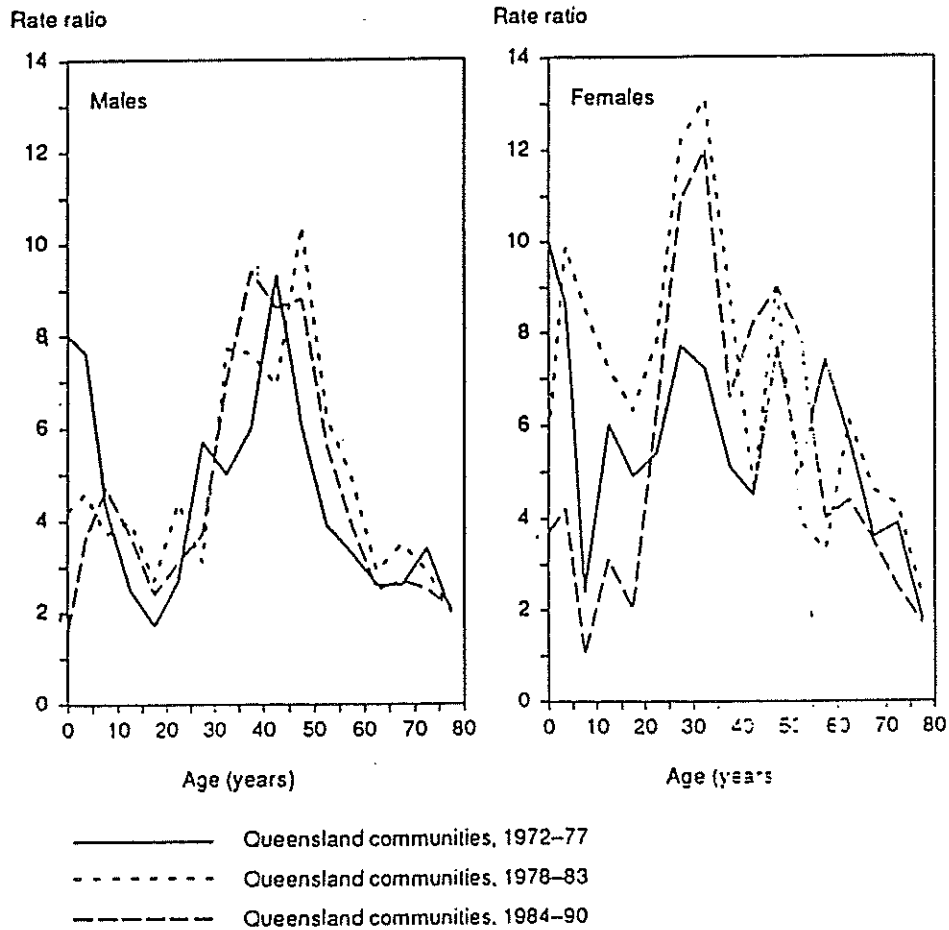
Other issues

Threat of AIDS.



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Figure 5: Age-specific death rate ratios for the Queensland Aboriginal communities, by sex and various years.



Note: A ratio of the observed Aboriginal rate to the total Australian population rate in 1986.

Source: Australian Institute of Health, unpublished, data provided by the Queensland Department of Health

Source: Hogg, R and Thomson, N, Australian Institute of Health and Welfare

Figure 6: Deaths from all causes, ages 25-44, by ethnic origin and sex, 1970-1988

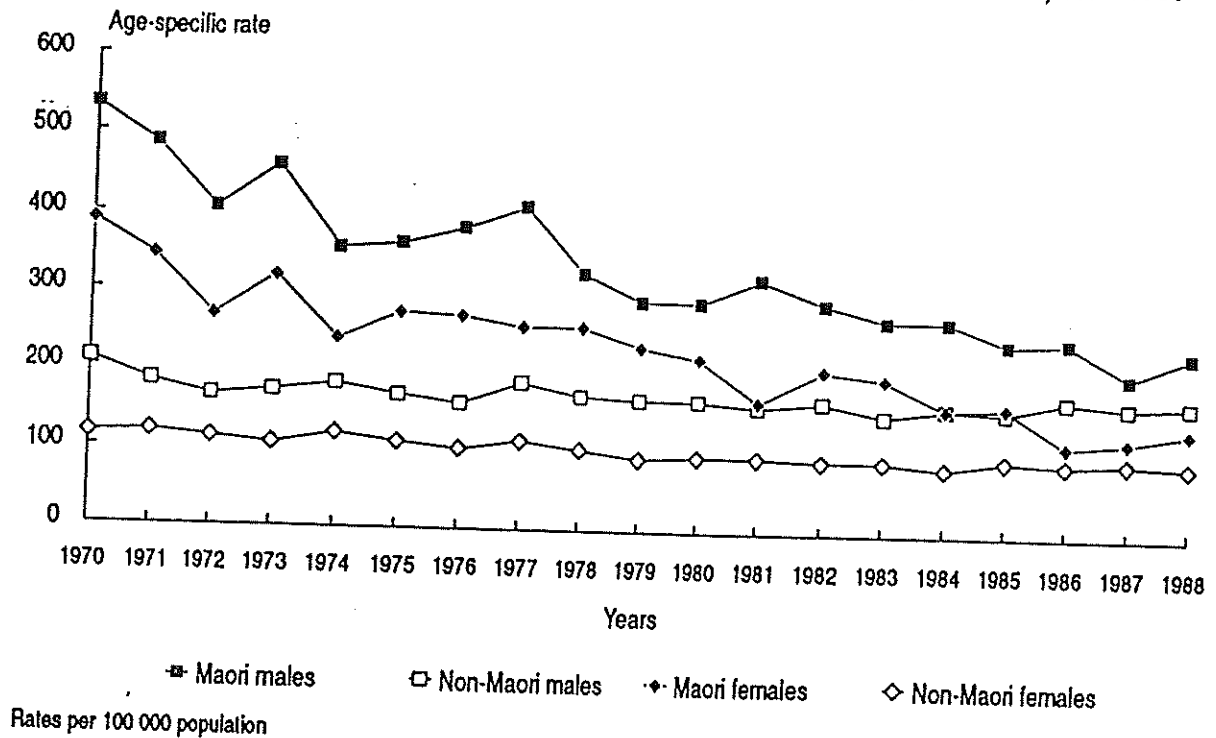


Figure 7: Deaths from all causes, ages 45-64, by ethnic origin and sex, 1970-1988

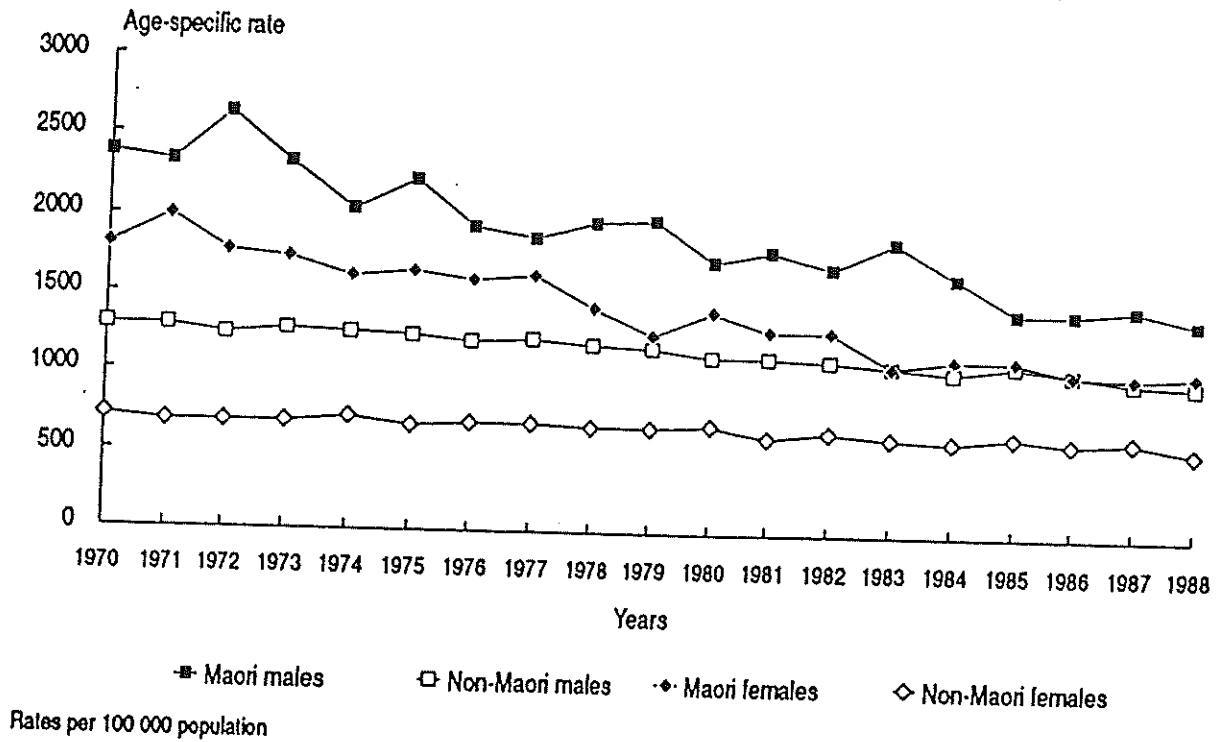


TABLE 1 Life expectancy at birth, four indigenous populations, 1920s-1980s

Decade	Maoris ^a		US Indians ^b		Canadian Indians ^c		Aborigines ^d	
	Male	Female	Male	Female	Male	Female	Male	Female
1920s	47	45	NA	NA	NA	NA	NA	NA
1930s	46	46	NA	NA	NA	NA	NA	NA
1940s	48	54	51.3	51.9	NA	NA	NA	NA
1950s	57	58	58.1	62.2	NA	NA	NA	NA
1960s	61	65	60	65.7	59.6	63.5		50 ^f
1970s	63	67	60.7	71.2	57.8 ^e	60.3 ^e	NA	NA
1980s	65	68	67.1	75.1	64	72.8	54	61.6

NA = not available.

^a Pool (1985: 231); data are for a single year within each decade.

^b Indian Health Service (1989: 41); data are for the census year (1940, 1950, etc.).

^c Millar (1982: Tables 7 and 8); data are for 1974-78. Ministry of National Health and Welfare (1988: 14-15); data for 1982-85. Medical Services. Department of National Health and Welfare (n.d.); data for 1960-64. The registered Indian population of Alberta is about 12-13 percent of all registered Indians.

^d Thomson (1989: 39); Gray (1989: 11).

^e Alberta only.

^f Northern Territory only.

Source: Kunitz, S, Population and Development Review 16 No. 21.