

## **CHAPTER 5**

### **IMPROVING THE HEALTH AND FUTURE OF ABORIGINAL CHILDREN**

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## CHAPTER 5

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Key findings about the physical health of Aboriginal children are reviewed in this chapter. Despite Aboriginal health being an important priority issue for governments, progress in improving Aboriginal health status has been poor. There is currently no national policy framework specific to the health of Aboriginal children. The current focus of Aboriginal health policy is directed to alleviating the principal causes of premature adult mortality and chronic disease. The significant findings from the Survey provide the first representative population data to underpin the development of policy and allocation of resources to improve the health and future of Aboriginal children.

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The findings reported in this first volume of results largely concern key modifiable health risks that Aboriginal children, young people and their carers are exposed to, set amid striking geographic diversity and social disadvantage and in the presence of inadequate health services and barriers to their access. These findings may be summarised as follows:

### MODIFIABLE HEALTH RISKS

- *High sustained rates of breastfeeding during infancy and early childhood.*  
The mothers of Aboriginal children, particularly those living in more isolated areas, were both more likely to initiate breastfeeding and to breast feed for longer, than mothers in the general population. This offers a positive basis from which to build health promotion programs in the post-natal period.
- *High rates of maternal tobacco use.*  
Despite a decade or more of intensive health promotion campaigns in the general population, the persistence of tobacco use by virtually half of all women giving birth to Aboriginal children remains unacceptably high and in urgent need of attention. These rates are uniform across all ATSI regions and all levels of relative isolation.
- *High rates of early teenage pregnancy.*  
The high rate of early teenage pregnancy in Aboriginal women is a significant cause for concern. Early pregnancy imposes substantial biological and social risks to the infant and in very young mothers impairs her own growth and interrupts her schooling. Importantly, the care of children born to early teenaged mothers was more likely to be transferred, and to be transferred earlier, to a person other than the birth mother, which may pose long term risks for poorer outcomes later in life.
- *High rates of premature birth and low birth weight were confirmed.*  
The rate of low birth weight (<2500g) was almost double that of the total population, the result of higher rates of both premature birth and poor intrauterine growth.
- *Inadequate consumption of fresh vegetables throughout the State.*  
Of the four indicators of dietary quality, fresh vegetable intake was particularly deficient. This deficit occurred at *all* levels of relative isolation and was highest



for children 12–17 years. Within individual families, meeting the indicators of dietary quality was inconsistent, suggesting that food choices are seldom directed by a knowledge and desire for a healthy diet.

- *High rates of recurrent infections.*  
There was substantial co-morbidity of recurrent skin, ear, chest and gastrointestinal infection, particularly in areas of extreme isolation. The co-existence of different types of recurrent infections was associated with financial strain. Recurrent and discharging ear infections, which affected one in eight Aboriginal children, had a very significant impact on rates of hearing loss and rates of speech, language and learning problems.
- *Low prevalence of asthma in children living in extremely isolated localities.*  
The four-fold reduction in the prevalence of asthma in extremely isolated Aboriginal children confirms other reports observing this effect. The basis for this reduction, if better understood, may suggest strategies for prevention of this burdensome condition.

## DEMOGRAPHIC DIVERSITY AND SOCIAL DISADVANTAGE

- In a population of about 66,000 Western Australian Aboriginal people, the median age for males is about 20 years and about 21 years for females and life expectancy 55 years and 63 years respectively.<sup>1</sup> In practical terms the impact of death, separation and divorce on the lives of Aboriginal children is striking: About 6 per cent of Aboriginal children under the age of three years are being cared for by someone other than their original parent(s) compared with 20 per cent for children aged between 12–17 years.
- Striking variations occur in the distribution of household family composition and in the care arrangements of children within these households across levels of relative isolation as well as age groups of Survey children.
- Within Western Australian ATSI regions there are substantial variations in levels of isolation. This makes broad generalisations about Aboriginal families based on regional location hazardous without taking into account level of relative isolation.
- There are high levels of socioeconomic disadvantage within families as measured by carer education, employment, occupational skill level, and income. This is present across all family types whether sole parent, two parent or intergenerational extended families.
- The use of traditional Aboriginal languages is one marker of cultural preservation. The rates of inter-generational language loss appear to be in the order of 20 per cent in areas of moderate to extreme isolation. Rates of language loss appeared particularly high in areas of moderate isolation. This suggests that unless continued efforts are made to preserve, document, teach and encourage the use of Aboriginal languages, in a relatively short period this heritage will be lost to Aboriginal people and the world.

## ACCESS AND BARRIERS TO HEALTH SERVICES

- Aboriginal children generally receive emergency health services if they need them. While there are variations in the immediacy of emergency service provision, this is an important confirmation that this aspect of service provision is broadly effective, considering the vastness of Western Australia.



- The overall rate of reported contact with doctors over a six month period is 10 per cent lower for Aboriginal children when compared with their non-Aboriginal counterparts in the Perth metropolitan area and 20 per cent lower in areas of high and extreme isolation.
- Isolation, carer education and carer Indigenous status are important, and *independent* predictors of a child's contact with a doctor. Compared with Aboriginal children living in Perth, Aboriginal children living in areas of high and extreme isolation are 66 per cent less likely to have had contact with a doctor in the previous six months. Carers with a higher level of education are more likely to have taken their child to see a doctor in the previous six months. Finally, Aboriginal children of non-Indigenous carers (85 per cent of whom were the birth mothers) were more likely to have had contact with a doctor in the last six months. No association was found between measures of financial strain and the likelihood of having contact with a doctor.
- The pattern of contact with dentists generally matched contact with doctors. Non-Indigenous carers and carers with higher levels of education were more likely to have taken their children to see a dentist in the previous six months. Children have access to dental services most commonly in areas of high (but not extreme) relative isolation and access to a vehicle was significantly associated with the likelihood of dental visits.
- As isolation increases, and the availability and access to doctors decreases, contact with nurses and Aboriginal Health Workers increases substantially. Children are more likely to be seen by nurses where their primary carer is Aboriginal, where there is no reported access to a vehicle, and where they are living in areas of increased socio-economic disadvantage. Contact with Aboriginal Health Workers followed this pattern and was also associated with high levels of family financial strain.

## MAKING PROGRESS IN ABORIGINAL CHILD HEALTH POLICY

Many of the levels of morbidity and mortality in indigenous people of other nations are not as poor as those observed in Australia despite similar histories of colonisation.<sup>2</sup> For example, approximately thirty years ago indigenous peoples in Canada, New Zealand and the USA suffered similar high infant mortality rates to those observed in Australia. However, these countries have significantly reduced their rates of indigenous infant mortality relative to those in the Australian Aboriginal population and now the picture is different.

In Canada, the 1999 infant mortality rate in First Nations people was 8.0 per 1,000 live births – about 1.4 times higher than the total Canadian population. In the USA, these figures for American Indian and Alaskan Native populations are 9.3 per 1,000 live births, or about 1.2 times higher than the total USA population. In contrast, the infant mortality rate in Australian Aboriginal population was 13.0 per 1,000 live births or 4.6 times higher than the total Australian population.<sup>3</sup>

Although by no means on a par with the mainstream population, the health of populations of indigenous people in other countries similar to Australia has advanced for several reasons. For example, North American governments have a longer history of specialised health services for indigenous people, have spent more per capita, established better traditions of partnerships and involvement of indigenous people, and made genuine advances in recognising the past history of colonisation and dispossession. None of this has been perfect and much of it has occurred unnecessarily late. Much of this progress has been made over more



extended post-colonial periods – Australian Aboriginal populations have, in relative terms, been colonised ‘recently’.

In Australia then, how should information about Aboriginal child health be translated into policies relevant to the future health and the health of the next generation of Aboriginal children? To address this question, data, the burden of its collection and policy environments that currently provide what is known about Aboriginal child health are discussed in this section along with models of health expenditure in light of the need for coordinated efforts by other sectors.

## THE PROVISION OF BETTER AND MORE RELEVANT DATA ON ABORIGINAL HEALTH

Stemming from the 1991 recommendations of the Royal Commission into Aboriginal Deaths in Custody<sup>4</sup>, it has now been a decade since the publication of the first national survey of Aboriginal and Torres Strait Islander people in 1994.<sup>5-8</sup> These data were notable for the inclusion of questions on a diversity of topics, including health. Since this first survey there has been an increasing effort to improve the quantity, timeliness and quality of information on Australia’s Aboriginal population.<sup>9-11</sup> Milestones in these efforts include the Indigenous components of the 1995 and 2001 National Health Surveys as well as the biennial reports on the health and welfare of Australia’s Aboriginal and Torres Strait Islander Peoples.<sup>12-17</sup>

## THE BURDEN OF DATA COLLECTION

Amid developments in the provision of timely and better quality information, it remains the case that Australia’s Aboriginal and Torres Strait Islander people bear a disproportionately large burden of research and data collection relative to the non-Aboriginal population. Coupled with evidence of slow or negligible progress in achieving health outcomes that match those of the non-Aboriginal population, Aboriginal people have understandably questioned the value of both data collection efforts and, particularly, the efforts of researchers.<sup>18</sup> Tangible returns from data collection and research are either not seen or, when they are forthcoming, are seen to be unrelated to the initial data collection and research efforts.

In addressing this concern, government agencies have formulated policies governing health and medical research of Aboriginal Australians.<sup>19, 20</sup> These policies set out criteria for:

- the level and manner of engagement of Aboriginal individuals, communities and organisations in the creation, conduct and dissemination of research findings
- the demonstration of eventual benefits of the research
- the sustainability and transferability of the findings
- the proposed mechanisms that build Aboriginal capabilities through the conduct of and participation in the research
- the way in which the proposed research address priorities and significant health issues identified by Aboriginal people and their communities.<sup>19</sup>

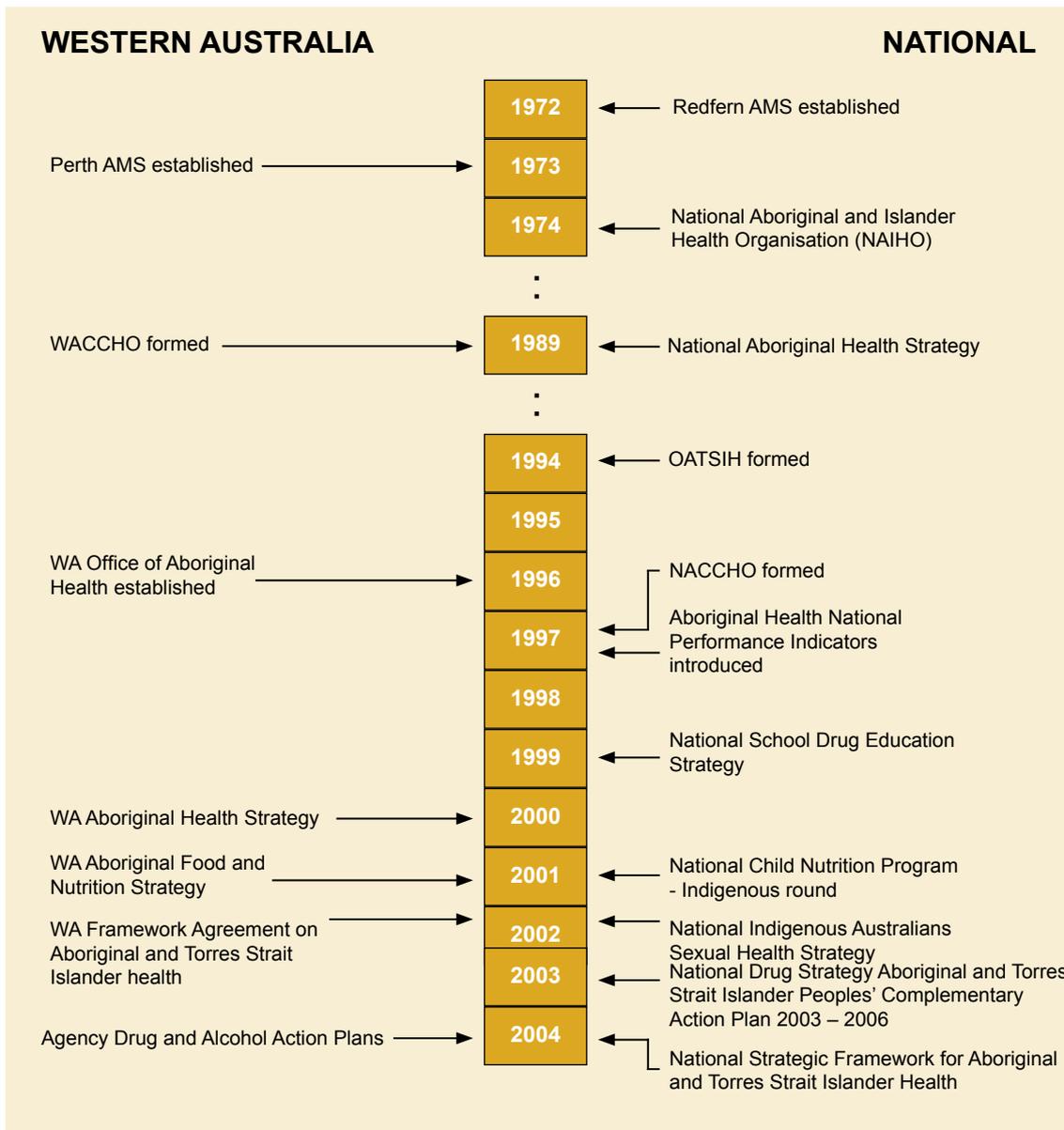
With respect to the significance of any intended research, a strategic plan has been developed entailing appropriate leadership by, consultation with, and input from Aboriginal researchers, communities and leaders. This strategic research plan sets out a ‘roadmap’ of priorities to advance Indigenous research deemed relevant to Aboriginal and Torres Strait Islander peoples.<sup>21</sup>



POLICY FRAMEWORKS FOR ABORIGINAL CHILDREN

At present there is no national policy framework *specific* to Aboriginal child and adolescent health (see Appendix E). The Office for Aboriginal and Torres Strait Islander Health (OATSIH) is currently developing an Aboriginal and Torres Strait Islander Child and Maternal Health Policy in response to priority areas derived from the National Strategic Framework for Aboriginal and Torres Strait Islander Health. Currently, Aboriginal child and adolescent health strategies are covered under a number of generic frameworks developed by both Federal, and State and Territory jurisdictions (see Figure 5.1).

**FIGURE 5.1: TIMELINE OF ABORIGINAL HEALTH FRAMEWORKS**



Priority areas derived from the National Strategic Framework for Aboriginal and Torres Strait Islander Health are important because this framework represents the first systematic effort to address many of the factors that have prevented previous policies from achieving intended health gains.<sup>22</sup>



A key element of the National Strategic framework is the Primary Health Care Access Program (PHCAP). Because the Commonwealth, State and Territory Governments share responsibility for the provision of primary health care services, PHCAP was established as a mechanism for overcoming structural impediments in the equitable delivery of comprehensive primary health care for Aboriginal people. This has critical implications for child health because primary health care is the principal form of care that children receive and is the foundation on which prevention is built. The shortfall in health care service utilisation and access documented in the Western Australian Aboriginal Child Health Survey is one important indicator of why progress in prevention remains slow.

For most Aboriginal people, particularly those living in rural and remote areas, primary health care has traditionally been provided through Aboriginal Medical Services or through State public hospitals. Where the State Government has provided these services, it has generally been done in the absence of general practitioners and other private or community based providers. State hospitals are geared to provide acute and in-frequent episodes of care. They do not have the capacity and systems of care to ensure follow-up, ongoing monitoring for chronic disease management, protocols for opportunistic screening, and active recall to deliver comprehensive primary health care.

The Primary Health Care Access Program (PHCAP) is being progressively implemented in States and Territories in selected regions where regional planning forums have jointly completed a comprehensive primary health care plan, and in the four former Aboriginal Coordinated Care Trial Sites. Since the program was announced in the 1999–00 federal budget, its total annual recurrent funding has increased to \$54.8 million in 2003–04. The PHCAP program was established in Western Australia through an Australian/State Government memorandum of understanding and is currently being implemented in two sites in the Kimberley region to address the following objectives:

- Increasing the availability of appropriate primary health care services where they are currently inadequate
- Reforming the local health care system to better meet the needs of Aboriginal people
- Empowering individuals and communities to take greater responsibility for their own health.

Finally, the National Strategic Framework is supported by two recent policy initiatives: 1) the NHMRC '*A Healthy Start to Life*' Policy Framework for Aboriginal and Torres Strait Islander Research<sup>23</sup>, and 2) the report to the Council of Australian Governments (COAG) *Overcoming Indigenous Disadvantage: Key Indicators 2003*.<sup>24</sup> These initiatives share a common focus on the need for concerted action both across and beyond the health sector to address the complex and inter-related factors that contribute to the causes and persistence of health problems amongst Aboriginal and Torres Strait Islander Peoples.

## HEALTH EXPENDITURE AND ABORIGINAL CHILD HEALTH

The most recent Indigenous health expenditure data estimated that in 1998-99 for each dollar spent on health services for other Australians, \$1.22 was spent on Aboriginal and Torres Strait Islander people.<sup>25</sup> During 1998–99 an estimated total of \$1,245 million was spent on health services used by Aboriginal and Torres Strait Islander peoples. This was 2.6 percent of the total expenditure on health



by the Commonwealth, State and Local governments and private sources during the same period. A breakdown of this total funding for Aboriginal health showed that State Governments provided 48 per cent, Commonwealth funding to States provided a further 25 per cent, other Commonwealth programs provided 21.5 per cent and Local Governments provided 0.5 per cent. The remaining 5 per cent came from private funding sources including out-of-pocket payments by patients, health insurance funding and workers compensation through various State Commonwealth, Local Government and private sector programs.

Funding allocations by the WA State Government, to both mainstream and community controlled health services, have not been based on population and geographic cost factors. This poses a major impediment to progress in Aboriginal health. Furthermore, allocations for mainstream and community controlled services have been independently planned. These disconnected processes have resulted in allocations that are not based on relative need and have increased duplication of services and the risks of inadequate provision for those in greatest need.<sup>26</sup>

Significant funding inefficiencies do arise because of differences in the capacity of the community-controlled sector and State health services to charge Medicare for patients using primary health care services. State services are unable to make charges on Medicare where patients attend hospital outpatient services without referral or where the State provides community health services in remote communities.<sup>27</sup> It has been suggested that State and Commonwealth funds should form a single pool of resources allocated according to a model that reflects the Aboriginal population and their needs, geographic and other cost factors, and is linked to joint planning processes.<sup>26</sup>

A variety of weighted capitation formulae have been proposed which attach weights to Aboriginal and Torres Strait Islander and other populations with relatively poor health outcomes.<sup>28, 29</sup> However, putting this into practice has been difficult for two reasons. First, there is a critical lack of good population data on the distribution of Aboriginal and Torres Strait health needs within and between States and Territories; and second there are difficulties in determining the appropriate adjusting weights that respect the views and values of Indigenous and non-Indigenous Australians.

An innovative weighted capitation approach to Aboriginal and Torres Strait health resource allocation has recently been proposed and tested for future distributions to ATSI regions within Western Australia.<sup>30, 31</sup> This model by Houston (2003) addresses a number of the recommendations of the 2001 Commonwealth Grants Commission Report on Indigenous Funding. Most particularly it provides a methodology that includes the participation of Aboriginal and Torres Strait Islander people in decisions affecting funding distribution and service delivery. It has a particular focus on outcomes, recognises the importance of capacity building within Indigenous communities and ensures a long-term perspective to the design and implementation of programs and services. Thus it provides a secure context for setting goals. It has demonstrated relevance and applicability and could be extended to take account of the specific provision for child health services needed to increase capacity to benefit in the longer-term. It could also be modified to take advantage of the developments of the Level Relative Isolation index (LORI) developed in the WA Aboriginal Child Health Survey.

#### RESOURCE ALLOCATION METHOD FOR ABORIGINAL HEALTH (2003)

Four components are weighted and aggregated to allow for the preference of Aboriginal Peoples to determine what is to be achieved and the good which is being sought with respect to expenditures in health.<sup>30</sup>



#### RESOURCE ALLOCATION METHOD FOR ABORIGINAL HEALTH (2003) (Continued)

- The first component is an efficiency measure that estimates the potential benefit that additional resources will provide i.e. the capacity to benefit (CTB).
- The second is an equity component that involves a weighting of CTB to reflect the fact that not all nominally equal benefits will be valued the same (and independently of the relative disadvantage) by all recipients. Weighting is achieved by considering local disease prevalence and environmental health data to establish three indices: an environmental and morbidity index (EMMI), a social mortality and morbidity index (SMMI), and a lifestyle mortality and morbidity index (LMMI).
- The third component then addresses the fact that some communities have more developed infrastructure (including management, economic, social and human resources) that gives them greater community capacity to benefit from additional resources.
- The fourth component is a weighting adjustment to reduce inequities in access arising through both geographic remoteness and cultural barriers to accessing health services. These include weightings based on SEIFA indicators of relative disadvantage, the costs associated with remoteness as measured by ARIA, primary care costs and hospital costs for Aboriginal and Torres Strait Islander people in different geographic regions, a regional price index based on the town index developed by the Department of Commerce and Trade and a travel cost index based on established travel costs for medical treatment.

#### RESOURCE DOMAINS FOR ABORIGINAL CHILD HEALTH AND DEVELOPMENT – THEIR CREATION AND MAINTENANCE

Aboriginal child health is inextricably tied to processes of human development and growth. Moving from better quality information to relevant and achievable Aboriginal child health policies demands understanding and commitment to this. As a result, any policy framework for Aboriginal child health (indeed, the health of all children) needs to influence several principal resource domains for child development:

- the physical environment (ie housing, clean water, sanitation and nutrition) to meet the basic necessities of living
- the levels of family income available to support the development of children
- the creation of human and psychological capital available to support child development
- the social capital available to individuals living in the community and wider society.

Findings in this current volume inform some, but not all, of these areas.

#### ADEQUACY OF THE PHYSICAL ENVIRONMENT

All Australians should have access to satisfactory living conditions. These conditions include appropriately maintained and safe housing, clean air and drinking water, suitable food preparation and storage facilities, heating and cooling, effective sewerage, safe removal of waste and control of pests. Within this volume the data show that significant levels of over-crowding exist, especially for families living in isolated areas. This and other aspects of housing and community infrastructure and their relationship to the health and well being of Aboriginal children and families will be detailed in future volumes of the Survey findings.



## FAMILY INCOME TO SUPPORT THE DEVELOPMENT OF CHILDREN

Aboriginal people earn on average \$221 per week less than their non-Aboriginal counterparts (\$364 vs \$585)<sup>32</sup> and Aboriginal children are more likely to be raised amid significant levels of financial strain relative to non-Aboriginal children.

Data from the Aboriginal Child Health Survey show only weak associations between measures of income and the health status of children. There are stronger associations between carer education and health status of children, consistent with other findings documenting the generally weak relationship between income and physical health.<sup>33</sup> However, some aspects of this relationship at a population level require further comment.

First, children born in low-income families are far more likely to grow up at increased risk for a range of poor developmental outcomes including chronic physical illnesses. Poor health is indisputably linked with absolute poverty and deprivation<sup>34</sup> and the WA Aboriginal Child Health Survey show considerable levels of poverty within Aboriginal households. Empirical evidence, however, also shows this relationship to be complex. Low income has more profound effects early in a child's development than later – particularly as this concerns access to and purchase of material goods and services used specifically for child development. This is underscored by observations that caregiver education, work experience, and parenting skills (i.e. human capital) show a stronger predictive relationship to child development and health than does income per se.<sup>35</sup> These observations underscore the importance of human capital and its relationship to child health and development (see below).

Second, there is a broader relationship between the income inequality experienced by Aboriginal families as it is set within the total population of Australia. The relationship between income inequality and health has been extensively investigated.<sup>36-39</sup> Income inequality is associated with higher population rates of mortality, infant mortality, death from cardiovascular disease and homicide. Exactly why this should be so remains uncertain. However recent research has shown income inequality is more likely to occur where there is low social capital.<sup>37,38</sup> This again is a dynamic relevant to Aboriginal children in their families in their communities and to the broader Australian society.

## THE CREATION OF HUMAN CAPITAL AVAILABLE TO SUPPORT CHILD DEVELOPMENT

A long life, individual physical capacity and health, education and acquired skills, experience and practical knowledge and parenting skills comprise what is commonly referred to as human capital.<sup>40,41</sup> Stocks of human capital are measured in a variety of ways and are significantly related to child development.<sup>42</sup> There are critical differences in levels of human capital built in mainstream families and in Aboriginal families:

- *Life expectancy.* All resource domains are affected by premature death. Resources for child development in the mainstream Australian population have been built within the context of a steadily increasing lifespan.<sup>32</sup> It is difficult to underestimate the impact of early death particularly on the creation, sustainability and transmission of human capital within and between families. Australian life expectancy for a boy and girl born in 2001 is 77 and 83 years respectively – an increase since 1991 of three and two years. In contrast, at the beginning of the new millennium it is not possible, with any agreed precision, to state the life expectancy of Aboriginal Australians.<sup>32</sup> The estimate of the gap between the total life expectancy of the population and the Aboriginal population is not known precisely. However, there is no doubt that life expectancy for Aboriginal people is



significantly shorter relative to life expectancy in the total population. Aboriginal death rates are higher than for the total population in all age groups, and highest, by a factor of five relative to the total population, in the age group 35–54.<sup>32</sup>

- *Infant mortality.* Infant mortality in the Australian population between 1999–2001 was estimated at 6 deaths per thousand. In this same period Aboriginal infant mortality was 16 deaths per thousand – a rate similar to that of the Australian population over thirty years ago.<sup>32</sup>
- *Adult chronic health.* Over half of all Aboriginal people over 30 years of age already have chronic disease or one of the precursors to chronic disease, such as hypertension, impaired renal function or glucose intolerance. Three quarters of Western Australian Aboriginal deaths are accounted for by five conditions: circulatory disease (30 per cent), cancer (11 per cent), respiratory disease (10 per cent), injury and poisoning (15 per cent) and diabetes (8 per cent) and similar statistics are evident nationally.<sup>26</sup> The incidence of deaths from these diseases is significantly higher (6–8 times) than the rates for non-Aboriginal people.<sup>43</sup>
- *Education.* Education is a critical component of human capital for its role in enabling access to employment and income – particularly as modern economies move to emphasising the need for specialist knowledge and skills in technology and in industry. However, human capital also plays a role within the family and community. For example, higher education is associated with better parenting skills (particularly mothers) and better academic and mental health outcomes. Better knowledge and the use of income to improve the material circumstances relevant to a child’s development (particularly language, cognitive and intellectual capacities) are significant benefits derived from human capital building.<sup>35</sup> About 48 per cent of Aboriginal people aged 15–19 years are not attending formal education. This compares with about 24 per cent of non-Aboriginal people.<sup>32</sup>
- *Health impacts on child rearing.* The health of adults is critically linked to the health and well being of their children. For Aboriginal children, available population data as well as data from this survey show that their carers are more likely to be young, to develop chronic diseases or experience injury and to succumb to an early death. For example, in the Western Australian Aboriginal Child Health Survey a total of 47 (2 per cent) birthmothers had died by the end of 2002. Additionally, in the approximately eighteen-month period after data collection for the Survey, fourteen primary carers and eleven secondary carers of the Survey children had died. In practical terms the direct impact of death, separation and divorce on the lives of Aboriginal children is striking: About 6 per cent of Aboriginal children under the age of three years and 20 per cent of children aged between 12–17 years are being cared for by carers other than their original parent(s).

Human capital resources and their role in the health of Aboriginal children are only partially described in this first volume. The interplay of carer human capital resources – particularly parenting, carer physical health and education – as well as the mental health status of carers and children (ie psychological capital) are components of potentially important developmental pathway to be explored in subsequent volumes.

## SOCIAL CAPITAL

By social capital we mean the integrity of social structures that engender community safety, trust, reciprocity, and inclusion.<sup>39, 44</sup> Cultural traditions, practices and the networks also comprise part of social capital. Social capital operates at the



community, regional and national level. As Lomas (1998, p.1181) pointed out, ‘... the way we organise our society, the extent to which we encourage interaction among the citizenry and the degree to which we trust and associate with each other in caring communities is probably the most important determinant of our health’.

Despite their history and the extent and speed of change following colonisation, cultural heritage and traditions have imparted significant resiliency to some aspects of social capital for Aboriginal people. However there are significant threats and barriers to the creation of new social capital within and between Aboriginal and non-Aboriginal Australians.

Data from the WA Aboriginal Child Health Survey show marked variations in the preservation of cultural heritage – particularly when measured by traditional language preservation. There is an almost total cessation of the use of traditional Aboriginal languages in all but the more isolated areas. The intergenerational loss of traditional language use is marked, particularly in transition zones of moderate isolation – although even the most isolated areas show some decline in traditional Aboriginal language use. If traditional language use is considered as a measure of cultural integrity, and if cultural integrity is a critical component of the stocks of social capital available to Aboriginal people, then there is an urgent need to reverse this loss, and to restore and preserve Aboriginal cultural heritage through language.

A primary barrier to the creation of social capital is the level of violence some Aboriginal people experience within their families, within their own communities, and through contact with non-Aboriginal society. This fundamental barrier precludes the establishment of safety, trust, reciprocity, and inclusion. Beyond violence are the social and structural barriers that deny Aboriginal people full economic and social participation in Australian society. Some of this is apparent in the WA Aboriginal Child Health Survey data showing differential access to health services by Aboriginal and non-Aboriginal carers of Aboriginal children. These differences are not associated with education or location *per se*.

Finally there are symbolic barriers to the creation of social capital. This includes the recognition of the impact of colonisation and the lived experience of Aboriginal people in this history. It has been suggested that past colonial paternalism, an official policy of assimilation, and the lack of formal recognition through treaties have acted to create and reinforce a sense of powerlessness in Australian Aboriginal people to a greater extent than is seen in indigenous groups in other countries.<sup>2</sup> Ring and Firman point out that treaties offer a powerful means of affirming two important determinants of health which are linked to disadvantage: the collective sense of control that people have over their lives and the sense of hope that this creates.<sup>45</sup> These are fundamental to the creation of social capital.

## SUMMARY

Mainstream policies have operated well to produce measurable advances in many of the key indicators of Australia’s progress.<sup>32</sup> Policies governing access to safe and healthy housing, mandated education, equitable access to jobs and material benefits, ownership of land and housing, a stable and nutritious food supply, law and order, and access to and delivery of health services have led to real increases in resource domains for the development of children. At a population level, Australia has secured a safe and stable society with healthy, educated families in which to rear children and through which more (rather than less) developmental resources for children may be mobilised on their behalf. This has allowed developmental ‘bootstrapping’ from generation to generation.



Currently, such benefits are not being realised for Aboriginal children or, where they are, progress is too slow relative to the urgency of the need. Relationships among income, employment and education on one hand, and health outcomes on the other, show either negligible or modest associations. This is not to say that these social circumstances are unrelated to Aboriginal health, but instead reflects 1) the low average level of these resources and their low level of variability (i.e. ‘spread’) in measures such as income, and 2) circumstances in the social and physical environment that disrupt these associations for large segments of the Aboriginal population. Many of these latter aspects will be the focus of the next volume of findings.

## SETTING POLICY DIRECTIONS

Breaking the cycle of Aboriginal poor health and disadvantage requires a strategic national focus on the importance of early child health and development. As Young notes, the reasons for this go beyond humanitarian concerns for those least able to look after themselves.<sup>46</sup> New insights from neuroscience, evidence from longitudinal studies and large scale intervention trials clearly demonstrate the benefits accruing from nurturing the health and development of children in their earliest years. Internationally, this is now recognised as possibly the single most effective strategy currently available to governments and communities for reducing the worst effects of poverty and breaking the cycle of inter-generational disadvantage.

Three issues have posed significant barriers to achieving gains in the population health of Aboriginal and Torres Strait Islander people. These include:

- deficiencies in Aboriginal health policy, planning and system coordination
- inadequate funding for Aboriginal health and inadequate accountability arrangements for delivering health progress at the national, state and regional levels
- too few, inadequate and un-coordinated levels of appropriate mainstream and community controlled services for Aboriginal people.

Over-arching all of these issues, is the slow progress in overcoming Indigenous disadvantage. This volume of findings from the Western Australian Aboriginal Child Health Survey shows the impact of this disadvantage on the human capital resources of Aboriginal people and their communities. Levels of disadvantage limit the change that can be expected from interventions seeking individual behaviour change without broader cultural, socio-political and other change *beyond the health system* to reduce Indigenous disadvantage.<sup>47</sup>

Policy makers frequently examine research findings and ask, ‘What should we do?’ Certainly the Survey findings describe important health goals to achieve better Aboriginal child health. These include: lowering the rate of early teenage pregnancy, improving maternal health and well being, lowering the rate of preterm and low birth weight infants, lowering rates of alcohol and tobacco use – particularly in pregnant women, reducing infection rates, improving nutritional knowledge and access to nutritious food – particularly fresh vegetables, and improving rates of contact of Aboriginal families and children with health services – particularly comprehensive primary health care services.

More importantly however, policy makers wishing to improve Aboriginal child health must ask ‘How should we take action and with whom?’ In the absence of an integrated Aboriginal child health policy based on sound theories of human development and measured against the population burden of disease, policy development and implementation will remain piecemeal and reactive.



Child health and development is a responsibility and obligation that is shared across the Australian population. The child health problems documented here are burdensome. They compromise not only the current generation of Aboriginal children and their entitlements to grow up well, but pose significant barriers to future generations of Aboriginal children and their families. Self-determination in how these problems are addressed is an essential step in their solution. However, recognising the importance of self-determination does not preclude opportunities for partnerships across the Australian health system and across the Australian community. The key is to focus on the interests of children, their families and communities and place these interests at the centre of initiatives required for progress to be achieved.

The Survey confirms many of the directions taken by the Council of Australian Governments' strategy for overcoming Indigenous disadvantage.<sup>24</sup> The findings show why no single government agency can be responsible for creating the policies and programs that will make for overall improvements. This means that where the health system takes action, it will need to do so with sectors other than health. This includes developing health policy for children.

With this in mind, actions are now required to:

- Develop and implement an evidence-based Aboriginal child health policy which targets early child development, identifies strategic areas for action.
- Acknowledge Aboriginal leadership and self determination in the long term planning, funding and implementation of this policy.
- Develop partnership arrangements between and within Aboriginal and mainstream communities based on mutual trust, respect and commitment.
- Increase primary health care services to address the documented shortfall in service provision to Aboriginal children.
- Implement prevention interventions that reflect the relationship between maternal and early child development, adult health and levels of human and social capital.
- Negotiate joint accountability across government departments for achieving policy based objectives.
- Develop funding models weighted both in proportion to the burden of illness and accounting for the costs of service delivery.
- Establish a culture of measuring and reporting progress against mutually defined objectives, benchmarks and indicators of performance.

## CONCLUDING COMMENTS

Findings from the WA Aboriginal Child Health Survey present a comprehensive picture of the population prevalence of key health conditions and disabilities affecting children, their associated modifiable risk factors, along with rates of service use and barriers to their access. Importantly, these are observed in the context of new descriptions of the demographic diversity and social disadvantage that characterises the contemporary circumstances of Aboriginal children and young people living within urban to extremely isolated settings.



It is well recognised that underlying the main diseases affecting Aboriginal people is the history of colonisation and its inexorable destruction of Aboriginal people, their culture, and their society.<sup>48</sup> Introduced diseases, termination of ownership and removal from traditional lands and food sources and, for some, removal from families of origin, fuelled a consequent collapse of Aboriginal societies and economies. These forces are not simply a matter of past history but, in reality, they remain active in the current causal pathways to present day Aboriginal mortality and morbidity. This is seen clearly in assessing some of the critical resources for child development.

The population perspective that emerges through these data illustrates why health systems and health services alone cannot provide the traction for progress. The principal determinants of Aboriginal health, and Aboriginal child health specifically, lie outside the immediate influence of the health system. They are linked to the fundamental factors underpinning human development. This highlights why progress in Aboriginal health is critically dependent upon engagement of Aboriginal communities along with concerted, coordinated actions across governments and sectors to develop and implement policies that reflect this fundamental reality.

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