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Northern Territory intervention

A “third-world” health catastrophe

Part 3

A WSWS reporting team
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World Socialist Web Site *journalists Susan Allan and Richard Phillips and freelance photographer John Hulme recently visited central Australia to report on the social and political impact of the federal government’s Northern Territory Emergency Response or police/military intervention into Aboriginal communities. This is the third in a series of articles, interviews and videos. Parts one, two, four, five, six and seven were posted on June 21, June 26, July 15, July 24, August 6 and August 25 respectively. Video clips can be watched here.*

In mid-April, Northern Territory newspapers reported on an inquest into the death, almost two years ago, of Julama Limbunya, a 78-year-old Aboriginal man.

On August 21, 2006, Limbunya was flown home to Kalkaringi-Wave Hill, a small Aboriginal community about 750 kilometres south west of Darwin, after receiving treatment for pneumonia at Katherine hospital.

Although Limbunya had recovered from his illness, he was blind, could not walk unaided, spoke little English and had early signs of dementia. Nevertheless, the elderly man was provided with no escort on the specially chartered flight, nor were his relatives or the local community told when he would be arriving.

While guidelines for transporting remote patients to Darwin or Katherine stipulate that anyone frail, aged or chronically ill must be escorted on medical evacuation flights, permission must first be obtained by the outlying clinic from a District Medical Officer (DMO) in Darwin.

Requests for a medical escort for Limbunya, however, were rejected by a Darwin DMO and so the old man was dispatched alone to Kalkaringi. The pilot dropped him off at the dusty unmanned airstrip, where the temperature was 35 degree Celsius (95 degree Fahrenheit), turned the plane around, and flew back to Katherine.

Limbunya’s body was later found in bushland about 800 metres from the airstrip, one week after police had abandoned their search for him. The 78-year-old was a former participant in the historic 1966 Wave Hill strike, when Aboriginal stockmen walked out to demand equal pay with white pastoral workers.

Limbunya’s tragic death is symbolic of the bureaucratic indifference and woefully inadequate health facilities for indigenous people in much of remote Australia.

As Josie Crawshaw-Guy, Limbunya’s niece, told the NT inquest: “We are the poorest and the sickest and yet cutting costs seems to be a major factor when decisions are made about our health care.”

Crawshaw-Guy later told the press that little had changed since her uncle’s death. She recounted a similar case in which an old, frail woman with failing eyesight from Boroloola in NT’s east was sent unaccompanied to Katherine for medical treatment. “It’s the culture that exists that Aboriginal people just get substandard care in everything and especially in health care,” she said.

The circumstances that led to Limbunya’s death are not uncommon in outback Aboriginal communities. The NT government, for example, is currently investigating the death in February of two Aborigines from remote communities. The men died while waiting to be flown to hospital for treatment. And in early May, a three-week-old baby girl from Blackwater, a small outstation near Papunya about 260 kilometres northwest of Alice Springs, died simply because her mother was unable to call a nearby local ambulance or on-duty nurses.

Blackwater has not had a working public pay phone since 2004, despite repeated appeals to Telstra from the community. The mother and grandmother were forced to walk to Papunya in the middle of the night carrying the baby girl, who had died by the time they reached the town.

These heart-wrenching stories were briefly mentioned in the inside pages of the national press and then dropped.

Just prior to our visit to Alice Springs, Prime Minister Rudd called a press conference to announce that his government would “close the gap” between indigenous and non-indigenous health within three decades. Rudd’s announcement was not matched, however, by any serious injection of government funds.

According to Professor Jon Altman, director of the Centre for Aboriginal Economic Policy Research, it would take 2,000 years to bridge the gap between indigenous and non-indigenous life expectancy, median income and unemployment, based on present trends and current government spending.

The following is a summary of some of the indices of the health inequality between Aboriginal people and non-indigenous Australians from *HealthInfoNet*.

* Indigenous women are three times more likely to die while pregnant, during labour or up to six weeks after giving birth than non-indigenous women, a figure that has not changed since statistics started being kept in the early 1990s.

* Babies born to indigenous women weigh on average 217 grams less than those born to non-indigenous women. In the NT almost 17 babies died out of 1,000 births, more than three times the rate for the rest of the Australian population in 2005.

* Respiratory illnesses in Aboriginal children aged 1 to 5 years are widespread and account for more than 15 percent of all NT Aboriginal

hospital admissions. The rate of bronchiectasis amongst Aboriginal children in central Australia is one of the highest in the world.

* Aboriginal children in the NT have high rates of growth faltering and anaemia, while skin infections, such as scabies and streptococcal pyoderma, are commonplace in remote communities. Up to half the children are infected.

* Diabetes is about three-and-a-half times more common among indigenous people than other Australians, with deaths from the disease 10 times higher.

* Eye-conditions affecting the indigenous population, including cataracts, trachoma and diabetic retinopathy, are endemic. Up to 30 percent of indigenous children in the Northern Territory suffer infectious trachoma.

* A recent Alice Springs Hospital survey found that Aboriginal people are 11 times more likely to die with an infectious disease than non-indigenous patients, a rate far higher than most third-world countries. Tuberculosis infection rates are 10 times higher; and haemophilus influenzae, which causes otitis media, conjunctivitis and sinusitis, 14 times higher in indigenous children under 5 years of age.

* End-stage renal disease is 25 times more common for indigenous people than for non-indigenous people, with the death rate from kidney disease at least 10 times higher. Some medical experts estimate that indigenous Australians in the Central Desert region are 30 to 50 times more likely to need dialysis than the national average.

* Indigenous people live 17 years less than the rest of total population and only 3 percent live to 65 years, the official retirement age. In central Australia, the average life expectancy difference is 24 years.

“We are so under-resourced”

We interviewed **Hilary Tyler**, an emergency doctor who has worked in central Australia for three years, about the ongoing government neglect of Aboriginal health. Her comments highlighted another side of the intervention—its debilitating impact on local medical staff.

“You don’t need to be emotive about what’s happening here,” she said. “All you have to do is explain the facts—they show the real extent of the disaster endured by Aboriginal people.

“In my first year here my favourite word to describe the situation facing Aboriginal people was ‘abhorrent’. There was such an obvious health crisis and yet so little money or resources. Maybe it was my problem that I hadn’t been aware of the severity of the crisis—the low life expectancy, the high rates of chronic disease and all that. But the government is fully aware and yet it fails to provide enough money to seriously address these issues. We are so under-resourced.

“Someone will say we should have an alcohol and drug rehabilitation service, which is great, and one is established but then not provided with any real resources or funding and therefore can’t function properly. This sort of thing goes on all the time, and across the board,” the emergency doctor explained.

Commenting on the intervention Tyler pointed out: “There’s been a hell of a lot of duplication. It’s almost as if they assume that nothing has been done in the past or that anything is already in place. They don’t consult with any of us who have been working in this area for years, or the acknowledged experts, but just make up their own slap-happy rules about what is good or not. Money has been spent, of course, but much of the intervention work has been a waste of time.

“For example, the intervention doctors identified about 80 to 100 kids who were supposed to have heart disease. But of all those referred in for echoes [testing] none had heart disease—not one. And as far as I am aware, not a single child has been referred in with a health problem that wasn’t already known by local health workers. Nor has the intervention identified any cases of child sex abuse.

“The intervention has estimated that 20 to 25 percent of Aboriginal children have ear problems but this figure is wrong, it’s much higher than that. This means it has duplicated what we already knew but then doesn’t get it right and yet spends all this money to do so.

“I was recently talking to a doctor friend in one of the remote communities and he was really upset because he is not being told what is happening with the intervention or able to participate. His expert knowledge in the field is simply being ignored. If this was properly planned you could put in some amazing health infrastructure, but instead it all feels like a political show.”

We asked Tyler what she thought about the Rudd government claims that it would close the health gap in 30 years. “That would be great,” she replied, “but the money being promised for this is completely inadequate.

“The only way to make a real change is if you consult with the people working on the ground. And most importantly, you cannot improve health if you don’t improve the quality of life overall—this means better living standards, jobs and everything else. Without that nothing will change. You can fix up peoples’ ears, but unless you change the overcrowding at home and other issues then the problem just reemerges.

“Labor is great on the symbolism—it comes out and says it’s sorry to the Stolen Generation, but continues to expand the intervention which is a racist piece of legislation. These two things just don’t go together and I find it incredible that Labor hasn’t reinstated the Racial Discrimination Act. Welfare quarantining doesn’t make sense either. How is controlling somebody’s income going to make them better citizens?

“I agree with you that this makes it very simple to roll out welfare quarantining onto non-Aboriginal sectors of society. I guess the government could reinstate the Racial Discrimination Act and then claim that what it’s doing with quarantining and prescribed communities is not racist and therefore okay. The end result for the government would be the same.

“The other point I want to make about the intervention is that there’s never been any framework to discuss it objectively. The government and media polarise the issue—you’re either for the intervention and therefore good, or against it and therefore supporting pedophilia.

“All this is part of the government’s non-consultative, almost colonialist, approach, where health workers and people on the ground are just not asked what they want or what should be done. There have been all sorts of delegations to [Minister for Indigenous Affairs] Macklin, but she only acknowledges those who are for the intervention. If you’re against, you’re just ignored.”

To be continued