The controversy over who controls funding for Aboriginal people avoids the real issue, says **PAUL PHOLEROS**. What is needed is a firm policy towards improving Aborigines' living standards, including such basics as clean water, waste removal and nutrition.

Treating the cause, not the symptoms

INTEREST in the current controversy about who should control Aboriginal health dollars will quickly diminish after the large bucket of money is finally claimed by either ATSIC or Commonwealth Health.

What happens to the money and how many of those dollars find their way not only to treating illness, but to preventing it, will probably command few headlines.

After the grand political funding decision, however, it will be the creative, slow, dirty and repetitive work done by many Aboriginal and non-Aboriginal people that will probably make the changes that people rightly expect.

In 1985 I was invited by senior members of the Pitjantjatjara tribe (in the north-west of South Australia) to join a team with the aim of improving the health of the local people. Having established their own Aboriginal controlled health service in 1984 (Nganampa Health Council), it was clear that while access to treatment had improved the number of patients attending the clinic had not been reduced.

The project brief was simple and profound. Pitjantjatjara people used the expression *Uwankara Palyanyku Kanyintjaku* – stop people getting sick – or UPK for simplicity.

The team comprised a medical doctor, an anthropologist (fluent in the Pitjantjatjara language and familiar with local people and customs) and a full survey team of Pitjantjatjara community members including researchers into nutrition, water, power, waste, income and management).

In remote areas, infectious disease among Aboriginal children remains the overwhelming health problem. Therefore, children aged 0-5 years became the focus of our work.

Aboriginal children's most common illnesses include acute respiratory infection (the rate of admission for x-ray proven pneumonia for Aboriginal children was 80 times that for non-Aboriginal children in central Australia), chronic nasal discharge and middle ear disease, and diarrhoeal disease (which is a major cause of presentation to clinics in rural communities). Other problems included skin and eye infections.

The work with Pitjantjatjara people was carried on over eight years. The team worked with Aboriginal people to set healthy living practices that everyone could understand and contribute to on a daily basis. In order of priority these were: washing people and particularly children, washing clothes/bedding, removing waste, improving nutrition, reducing crowding, separating dogs and children, controlling dust, temperature control, and reducing trauma. We had to find out why these simple living practices could not be carried out. From the perspective of most average suburban Australian homes, it is hard to imagine why washing a child, for example, should be so difficult.

But a detailed housing survey of the Pitjantjatjara community in 1985 showed on average at least 16 people had to share a combined shower, toilet and laundry area in a two-bedroom house. The chance of getting any water out of a tap was about 60 per cent, with hot water only about 45 per cent. Under these conditions washing a child was near impossible.

Our aim was to improve the living environment. The point is that we were able to do this to a great extent with simple, low-cost initiatives.

From water supply, tanks, pipes, taps, plugs, drains, etc ... attention was given to all the things normally taken for granted to ensure that children could be washed. We used the term "health hardware" to describe any equipment that could improve the health of people.

Aboriginal communities know the problems – they live with them – and with simple support such as screwdrivers and tap washers are able to make change. Yet almost 10 years after the Pitjantjatjara people initiated UPK, many of the simple lessons learnt there are yet to be implemented and developed by State or Federal Governments or any of the major bureaucratic players.

The main lessons were about the connections between housing, environment and health. These lessons can now be quantified and described.

- There is substantial evidence that improvements in essential health hardware in remote communities will lead to specific improvements in Aboriginal health status, particularly for children. Change is possible, affordable and sustainable.
- The design and construction process for house and yard areas, and power, water and waste facilities, developed in the original UPK report have led to major improvements in the functioning of health hardware.
- Our work refutes the view that Aboriginal people will not use health hardware facilities such as showers and laundries. It has been demonstrated that Aboriginal people enthusiastically use these facilities when they are functioning and maintained.
- The major cause of health hardware breakdown and the requirement for maintenance is not vandalism but rather poor initial construction.
- Major improvements in illness caused by infectious disease suffered by Aboriginal children will only occur with major improvements in their living environment. To improve environmental health for Aboriginal people, principles are no longer enough. It is attention to detail which is necessary to deliver the final health benefits.

Still, people unfamiliar with this area of work ask why the emphasis should be placed on the living environment to improve health and not on more medical staff.

Aboriginal people should have the same access to medical care as any other citizen, and in rural and remote areas this is still very limited. But more effort is needed to "stop people getting sick".

While the death rate, particularly for Aboriginal children 0-5 years, has fallen markedly during the past 25 years, morbidity (or sickness) remains extremely high. The availability and intervention of medical services has saved lives, but the cause of much of the infectious disease affecting young children is poor environment.

The role of medical services and primary health care obviously needs to be maintained and in most parts of Australia be made more accessible to Aboriginal people. But that is not enough. A doctor, sister, health worker and health clinic in every Aboriginal community will continue to treat the end results of a poor living environment.

Are improvements in Aboriginal health ever possible?

Change in both living environment and health can occur, the problem is not too hard, and it is possible to have some positive effect.

Simple, demonstrable changes should not be underestimated (ie: getting more taps working in a community and ensuring that they stay working so that children can be washed once a day) or forgotten in the rush to solve "the big issues" such as who controls budgets.

Paul Pholeros, an architect, is co-author of Housing for Health – Towards a Healthy Living Environment for Aboriginal Australia, *launched last year by Dr Carmen Lawrence.*