

Reconciliation and Australian Indigenous Health in the 1990s: A Failure of Public Policy

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Abstract In 1991, the Australian Commonwealth Parliament unanimously passed the Council for Aboriginal Reconciliation Act 1991. This Act implemented a 10-year process that aimed to reconcile Indigenous and non-Indigenous people by the end of 2000. One of the highest priorities of the reconciliation process was to address Indigenous socio-economic disadvantage, including health, education and housing. However, despite this prioritising, both the Keating Government (1991–1996) and the Howard Government (1996–2000) failed to substantially improve socio-economic outcomes for Indigenous people over the reconciliation decade. In this paper, I examine one of the most prominent socio-economic areas, that of Indigenous health. First, I discuss the appalling levels of Indigenous health throughout the reconciliation decade by analysing a number of health indicators, including life expectancy, infant mortality rate, standard mortality ratios, hospital rates and health Infrastructure. This analysis reveals significant and often worsening disadvantage in these health indicators. Second, I analyse a number of policies and programs concerning Indigenous socio-economic disadvantage that were developed by Commonwealth Governments in the 1990s. I argue

that these policies and programs largely failed to address Indigenous socio-economic disadvantage. I also discuss alternative policies and programs that could reduce the significant levels of socio-economic disadvantage suffered by Indigenous people.

Keywords Australian Indigenous people · Reconciliation · Health · Public policy

Introduction

Australian Indigenous people form part of the oldest continuing civilisation on the planet. Their length of occupation and ownership of Australia is at least 40,000 years. In 1788, the English invaded these Indigenous lands. The subsequent 200 years of colonisation has been marked by massacres and genocide of Indigenous people, forced removal of Indigenous people from their lands, government policies of assimilation that resulted in Indigenous children being stolen from their families and racist and oppressive laws that severely curtailed the human rights of Indigenous people and decimated Indigenous culture. Today, Indigenous people number approximately 2.5% of the Australian population and live throughout Australia in urban, rural and remote settings. Indigenous people generally have civil rights that are equal to the wider community, yet still largely do not enjoy many Indigenous rights such as self-determination or land rights.

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In the late 1980s, the Hawke Australian Government proposed the implementation of a national Indigenous policy following their failure to legislate on a treaty and national land rights. This policy was influenced by religious groups and proposed the establishment of a 10-year reconciliation process. The policy was widely endorsed by non-Indigenous political parties, organisations and people, but many Indigenous organisations and people were sceptical as they believed the Government should focus on their campaigns for Indigenous rights. Despite this scepticism, the Australian Parliament unanimously passed legislation in 1991 to establish a 10-year formal national reconciliation process. The aim of this process was to reconcile Indigenous and non-Indigenous peoples by the centenary of Australia's federation in 2001. This process had three main goals: educate the wider community about Indigenous issues; address Indigenous socio-economic disadvantage in areas such as health and education; and develop a document of reconciliation (Gunstone 2007).

In this paper, I will analyse one of the primary aims of the reconciliation process, the addressing of Indigenous health disadvantage. Firstly, I examine the appalling levels of Indigenous health throughout the reconciliation decade. I discuss a number of health indicators, including life expectancy, infant mortality rates, standard mortality rates, hospital rates and health infrastructure. This analysis reveals significant and often worsening disadvantage in these health indicators. Secondly, I analyse the broad approaches of Australian Governments in the 1990s to address Indigenous health disadvantage. I argue that, despite the prioritising of Indigenous health, these approaches largely failed to address Indigenous health disadvantage throughout the reconciliation decade. I also argue that these Government approaches generally ignored or marginalised alternative approaches that could have reduced the significant levels of health disadvantage suffered by Indigenous people.

Health Outcomes during the 1991–2000 Reconciliation Process

In this section, I explore several indicators of health, including life expectancy, median age of death, infant mortality and particular rates of illnesses and health conditions. This analysis clearly illustrates both that there

was virtually no improvement in Indigenous health indicators during the 10-year reconciliation process and that during this time there was an overall increase in the health disparities between Indigenous and non-Indigenous people (Ring and Brown 2002, pp. 629–630; Ring and Brown 2003, p. 3). Further, several other health indicators, not considered in this paper due to space constraints, also illustrate the significant, and often worsening, level of Indigenous health disadvantage that occurred throughout the reconciliation process (Altman and Hunter 2003; Hunter and Schwab 2003).

There are two particular data gathering issues that impact upon any discussion of Indigenous health. First, although the majority of Indigenous people live in urban areas, Indigenous people are also significantly more likely than non-Indigenous people to live in remote areas of Australia. In 2001, 26% of Indigenous people lived in remote or very remote areas, (an increase since 1991 of 16% for very remote areas), compared to only 3% for the wider community, (an increase since 1991 of –0.2% for remote areas and 4.5% for very remote areas; ABS 2003a, pp. 7–9, ABS 2002a, p. 77). Thus, the inherent disadvantages that come from living in rural areas, including greater unemployment and less access to health services, are reflected, to a certain extent, in the health indicators for Indigenous people (ABS 2000b, p. 22). Second, genuine national statistics on Indigenous deaths are not available due to the failure of some States and Territories to accurately record the Indigenous status of the deceased in their death statistics (ABS 2002a, p. 249). During the reconciliation decade only Western Australia, South Australia, Northern Territory and Queensland (from 1997–1999) collated accurate statistics and thus were the only jurisdictions to be incorporated into statistics on mortality rates (AIHW 2002, 198; ABS 2001a, p. 110). This lack of national data ensures that the actual number of Indigenous deaths is underestimated (ABS 2001a, p. 110; Hetzel 2000, p. 159). The failure of several States and Territories to provide accurate data on mortality rates restricts efforts to accurately quantify the health disparities between Indigenous and non-Indigenous peoples.

Life Expectancy, Median Age of Death

One of the primary indicators of health is life expectancy which is defined as “the average number

of years a person born in a particular year can expect to live if the age specific rates of mortality at that time continue to apply” (AMA 2002, p. 2). The 1981 Census and the 1986 Census were the first that accurately depicted Indigenous life expectancies and found that the life expectancy was 56 years for Indigenous men and 64 years for Indigenous women (Taylor 2000, p. 4). Although the 1991 Census indicated a marginal improvement in these rates, the 2001 Census found that life expectancy had decreased since 1991, with the life expectancy at 56 years for Indigenous males and 63 years for Indigenous females (ABS 2001b). In addition, the life expectancies of several sub-populations of Indigenous people, including Indigenous women in the Northern Territory and South Australia and Indigenous men in Western Australia, actually decreased throughout the reconciliation decade (Neill 2002, pp. 11–12, 274).

Over the same period that Indigenous life expectancies were either stagnating or declining, the life expectancies increased for both the wider Australian community and for Indigenous people in other Western countries. Since the 1981 Census, the life expectancy for the wider Australian community has significantly increased so that by the 2001 Census, the life expectancy was 77.0 years for Australian men and 82.4 years for Australian women (ABS 2001b). Thus, the life expectancies of Indigenous people and non-Indigenous people have grown further apart during the period of 1981 to 2001. Further, the life expectancies of indigenous people in a number of Western countries, including the USA, Canada and New Zealand, have steadily improved over recent years so that by the late 1990s, the discrepancies between indigenous and non-indigenous life expectancies was between 5 and 7 years (Hetzel 2000, p. 160; AMA 2002, p. 3).

One of the most reliable measures of health is the median age of death which is defined as “the age by which 50% of the population dies” (Ring and Brown 2002, p. 629). This indicator also illustrates the significant difference in mortality rates between Indigenous and non-Indigenous people. Throughout the 10-year reconciliation decade, the median age of death for Indigenous people remained at 53 years, whilst the median age of death for non-Indigenous people increased from 75 to 78 years (AMA 2002, p. 2). Thus, the gap in the median age of death between Indigenous and non-Indigenous people increased over the reconciliation decade from 22 to 25 years. Further,

the median age of death for indigenous people in the USA, Canada and New Zealand has increased over the last 25 years and was 63, 65 and 59 years respectively in 2002 (Ring and Brown 2002, p. 629).

Infant Mortality Rates and Standard Mortality Rates

Another measure of health is the infant mortality rate which is defined as “the number of deaths of children under 1 year of age per 1,000 live births” (AMA 2002, p. 2). Despite the significant reduction in Indigenous infant mortality rates in the 1960s and 1970s, the rate has remained approximately two and a half times that of the total Australian population since the early 1980s (AMA 2002, p. 2). In 2000, the infant mortality rates were 14 per 1000 births of Indigenous children compared to 5.2 per 1,000 births for the wider Australian population (AMA 2002, 2). Further, the infant mortality rate for Australian Indigenous people is 100% higher than the rate for indigenous people in New Zealand and 50% higher than the rate for indigenous people in the USA (Ring and Brown 2002, p. 629).

A significant factor in infant mortality rates is the rate of low birth weight babies which is defined as “the number of babies born weighing less than 2,500 grams” (Ring and Brown 2002, p. 629). Whilst there have been some marginal regional improvements, especially in the Northern Territory, across Australia there has been almost no reduction in the proportion of Indigenous mothers giving birth to low birth weight babies since 1991 (AMA 2002, p. 2). In 1996–1998, the proportion of low birth weight babies born to Indigenous mothers was stated to be about twice as high as the proportion of low birth weight babies born to non-Indigenous mothers (AMA 2002, p. 2).

The significant health disparities between Indigenous and non-Indigenous people are also illustrated by a comparison of standard mortality rates. This measurement enables “valid comparisons to be made that take account of differences e.g. in the age profile of the two populations” (AMA 2002, p. 2). This measurement shows that the overall death rates for Indigenous people remained approximately three times higher than the death rates for the wider population during the period 1990 to 2000, whilst in some regions, the differences in the death rates

actually increased (Ring and Brown 2002, p. 629; Neill 2002, p. 262).

Further, the standard mortality rates for specific causes of death are also higher for Indigenous people than for non-Indigenous people. In 1997–1999, the Indigenous death rate for diabetes, respiratory conditions, circulatory conditions and cancer, many of which are conditions that are often treatable and preventable, were respectively eight times, four times, almost three times and one and a half times higher than for non-Indigenous people (Ring and Brown 2002, p. 629). Pneumonia was one condition that did improve during the reconciliation decade. There was a significant reduction of approximately 40% in deaths caused by pneumonia between 1996 and 1999, most probably due to the availability and promotion of pneumococcal vaccination for Indigenous people (Ring and Brown 2002, p. 629).

Hospital Rates and Diseases

Another indicator of Indigenous and non-Indigenous health outcomes is that of hospital rates. This indicator covers both admissions and separations and illustrates the level of hospitalisation (AMA 2002, p. 4). In 2001, hospital admission rates for Indigenous people were about twice that for non-Indigenous people (AMA 2002, p. 4; ABS 2003b, p. 77). The separation rates for Indigenous people, due to illnesses, diseases and injuries, were also higher than for the wider community (AMA 2002, p. 4). In 1998–1999, the separation rates for endocrine diseases were about three times higher for Indigenous people than for the wider community; the separation rate for injury was about double; the separation rate for dialysis was 7–11 times higher; and, in remote Indigenous communities, the separation rate for end stage renal disease was 30 times higher (AMA 2002, p. 4). Further, there was no significant improvement in hospital rates for Indigenous people since the start of the reconciliation process in 1991. In 1992–1993, Indigenous men and women were respectively 2.5 times and 2.7 times more likely to be hospitalised than were men and women in the wider community (Jackson and Ward 1999, p. 437).

There are numerous and increasing diseases that lead to these high hospitalisation rates for Indigenous people. In 1999, the levels of kidney disease amongst some remote Indigenous communities in the Northern

Territory “hit epidemic proportions” with the rate of Indigenous people with end-stage renal failure at 60 times the rate for non-Indigenous people (Ryan 1999, 28). In 1998, the rate of type 2 diabetes amongst Indigenous people was estimated to be between 10% and 30%, one of the highest levels in the world, and at least two to four times the rate for non-Indigenous people (AMA 2002, p. 4). This level of diabetes has occurred recently as diabetes was unheard of in Indigenous communities 25 years ago (Gordon 2001, p. 26). Trachoma is a preventable disease that in Australia occurs virtually only within Indigenous communities and can cause conjunctival scarring and blindness (ABS 2003b, p. 154). Although trachoma has significantly decreased in some areas of Australia due to 1970s and 1980s programs, there has been virtually no improvement in other areas over the past 20 years (ABS 2003b, p. 154). Indigenous people also suffer from a high incidence of otitis media, an infection of the ear that can lead to severe hearing loss (Gordon 2001, p. 76). The impact of this disease is illustrated by the following comment:

The World Health Organization (2003) recognises that the prevalence of otitis media greater than 4 per cent in a population is indicative of a massive public health problem. Otitis media affects up to ten times this proportion of children in many Indigenous communities (ABS 2003b, p. 154).

Health Infrastructure and Community Infrastructure

Another determinant of Indigenous health is the extent of health infrastructure within Indigenous communities. Many Indigenous communities do not have easy access to hospitals or other health care services. In 2001, the Community Housing and Infrastructure Needs Survey found that 53% of Indigenous people lived 100 km or more from the nearest hospital (AMA 2002, p. 4). This lack of access to primary health care services has generally not improved in recent years and directly contributes to the high rates of hospitalisation for Indigenous people as many preventative and early intervention treatments are not available (AMA 2002, p. 3–5). Access to health professionals by Indigenous communities is also usually very poor and with the

increasing shortfall of health workers in Indigenous communities over recent years, Indigenous health requires a minimum increase of 3,200 health professionals, including doctors, nurses, Indigenous health workers and associated health staff (Ring and Brown 2002, p. 629; AMA 2002, pp. 4–5). Other concerns include a lack of Indigenous health professionals and inadequate cultural training for other health professionals (AMA 2002, p. 5).

Community infrastructure, including sewerage, electricity, water and rubbish removal, also impact upon health outcomes. Two surveys conducted by the Australian Bureau of Statistics (ABS) in 1999 and 2001 illustrated inadequate, and often worsening, community infrastructure in many Indigenous communities. With water, the 1999 survey found 16 Indigenous communities had no organised drinking water supply and the water supplies of 34% of communities that provided samples failed water quality tests, whilst the 2001 survey found 21 communities had no supply of drinking water and 33% of communities tested failed water quality tests (ABS 2000a, pp. 14–16; ABS 2002c, pp. 16–19). With electricity, whilst the number of Indigenous communities without any electricity supply fell from 10% in 1999 to 7% in 2001, the interruptions to power supply in communities with 50 or more people increased from 80% in 1999 to 82% in 2001 (ABS 2000a, pp. 16–17; ABS 2002c, pp. 19–20). With sewerage, whilst the percentage of communities with 50 or more people that reported sewerage overflows and leakages, often caused by insufficient sewerage systems, slightly decreased from 59% in 1999 to 48% in 2001, the number of communities with populations under 50 that had no sewerage system rose from 69 in 1999 to 91 in 2001 (ABS 2000a, pp. 18–20; ABS 2002c, pp. 21–22). With rubbish removal, in 1999, there was no organised collection system in 26 communities with 50 or more people compared with 18 similar-sized communities in 2001 and just 9.3% of communities in 1999 and 10.8% of communities in 2001 reported that they disposed of rubbish in fenced community tips (ABS 2000a, pp. 21, 47; ABS 2002c, pp. 23, 59).

Suicide

Another significant indicator of Indigenous health is suicide. From an almost unknown occurrence up to

the 1970s, the level of Indigenous youth suicide was the highest in the nation by the end of the century, being up to two to three times greater than for non-Indigenous youth (Tatz 1999, p. 55). In 2002, the Australian Institute of Health and Welfare (AIHW) reported that:

The highest age-specific death rate from suicide was 108 per 100,000 Indigenous males in the 15–24 age group compared with 27 per 100,000 for males in the same age group in the general population...for Indigenous females, the highest rate was 18 per 100,000 in the 15–24 age group compared with 6 per 100,000 for all females (AIHW 2002, p. 205).

Significant numbers of Indigenous children under 15 years also commit suicide. Tatz reported that Indigenous children in New South Wales had an annual suicide rate of 15.6 per 100,000, which was three times higher than for any other children in thirteen OECD countries (Tatz 1999, p. 59).

Further, the level of suicide amongst Indigenous people in police or prison custody increased during the reconciliation process. This is illustrated by comparing both the number of deaths in custody and the manner of the deaths in custody that occurred in the 1980s decade with those that occurred in the 1990s reconciliation decade. The 1991 Royal Commission into Aboriginal Deaths in Custody (RCIADIC), that discussed the high numbers of Indigenous people who died in police or prison custody during the 1980s, found that the main cause of death amongst the 99 deaths that they investigated was natural causes (Neill 2002, p. 212). In contrast, the leading cause of death amongst the 162 Indigenous people who died in custody during the 1990s was suicide (Collins and Mouzos 2001, p. 2; Neill 2002, p. 212).

The increasing levels of Indigenous suicides cannot be attributed solely, or even mainly, to issues of mental health. As Tatz (1999) argued, “there appears to be little or no correlation between [Indigenous] suicide and diagnosable mental illness” (Tatz 1999, p. 68). Rather, suicides can often result from several factors, including discrimination, alienation, unemployment, family violence, substance dependency, conflicts of different cultures, welfare dependence and “copycat” suicides (Tatz 1999, pp. 66–67; Neill 2002, pp. 221–225; Gordon 2001, pp. 77–78).

Mental Health

Although mental health is a significant indicator of overall Indigenous health, it is quite difficult to quantify. One reason for this difficulty is that despite mental health being viewed in a holistic manner by many Indigenous people to incorporate issues such as genocide, trauma, oppression, racism and grief, Western mental health definitions and collection devices are generally inadequate instruments to accurately measure this broad holistic notion of mental health (Brown 2001, p. 34). Other difficulties include inadequate mechanisms for analysing issues of mental health in many remote communities, lack of separate Indigenous statistics, lack of mental health specialists and culturally inappropriate research that could mistakenly identify reactions of shame as indicative of depression (Brown 2001, pp. 34, 40; Neill 2002, pp. 37, 223; Tatz 1999, p. 62).

With these difficulties, the mortality and hospitalisation rates of Indigenous people affected by mental health issues provide the primary way to measure Indigenous mental health (AIHW 2002, p. 204). These statistics illustrated the poor mental health that affects many Indigenous people. The ABS reported that:

There are...hospital data which indicate that Indigenous people suffer from higher levels of many mental and behavioural disorders. In 1998–99, there were about four times as many hospital separations as expected for mental disorders resulting from psychoactive drug use. Self-harm and assault may be indicators of social and emotional distress and psychological illness in a community. Hospitalisation data show that there were many more hospital separations than expected for intentional injury in the Indigenous population (ABS 2001a, p. 5; Hetzel 2000, p. 159).

The likelihood of hospitalisation from self-harm was twice that for Indigenous people than for the wider community (AIHW 2002, p. 205). Further, hospitalisation rates for mental disorders such as dementia and psychotic disorders were three times higher and two times higher respectively for Indigenous people than for the wider community (AIHW 2002, p. 205). Finally, in 1997–1999, Indigenous people were twice as likely as non-Indigenous people to die from deaths related to mental disorders, with psychoactive drugs causing 78% of the Indigenous deaths (AIHW 2002, p. 205).

Despite the difficulties in accurately ascertaining Indigenous mental health, it is still widely accepted that the history of invasion, dispossession, theft of land, attempted genocide, stolen generations and Government control and authoritarianism over the past two centuries have left its legacies on many Indigenous people's mental health (Jackson and Ward 1999, pp. 437–438; Ring and Elston 1999, pp. 228–229; Foley 2000, pp. 28–29). As Brown (2001) argued, “for Aboriginal and Torres Strait Islander people, in general, there are significantly higher levels of stress and anxiety in their lives resulting from the consequences of trauma and grief, and these are inextricably linked to mental health and disorder” (Brown 2001, p. 36).

Family Violence

Another significant indication of overall Indigenous health is family violence. In 1999, the Queensland Government's *Report on Aboriginal and Torres Strait Islander Women's Task Force on Violence* detailed the horrific epidemic of family violence occurring within Queensland Indigenous communities. It argued “increasing injuries and fatalities as a result of interpersonal violence have risen to levels which not only impair life but also threaten the continued existence of Australia's Indigenous peoples” (Robertson 1999, p. 31). The Women's Task Force found that the number of reported Indigenous offenders in Queensland for violent offences, sexual offences and domestic order breaches increased from 664 to 1,075 between 1994 and 1998 (Robertson 1999, p. 13). Further,

the Task Force believes the number of violent offences is much higher than the officially recorded data ... the Task Force researchers heard many stories about crimes that women did not report for fear of reprisals from the perpetrator, his kinfolk or the justice system (Robertson 1999, p. 13).

The Report also found over a 5-year period in Queensland, 1993–1998, that Indigenous people constituted 34.2% of murder victims and 47.3% of murderers (ABS 2001a, p. 93).

On a national level, the homicide rates were ten times higher for Indigenous people than for the wider community (Neill 2002, p. 78). A Commonwealth

report, *Violence in Indigenous Communities*, found that:

the incidence of violence in Indigenous communities and among Indigenous people is disproportionately high in comparison to the rates of the same types of violence in the Australian population as a whole [and] it is apparent that rates of violence are increasing, and the types of violence are worsening in some Indigenous communities and regions (Memmott et al. 2001, p. 6).

Another illustration of the significant levels of Indigenous family violence is the number of Indigenous children in the child protection system. The 2001 Census revealed that the rate of Indigenous children in the child protection system was 3.2 times higher than the rate of non-Indigenous children, being a level of 16.3 per 1,000 compared to 5.1 per 1,000 (ABS 2003b, p. 104).

Finally, an AIHW report, *Australia's Health 2002*, also discussed the high level of Indigenous violence. It found that the hospitalisation rates for Indigenous males and females due to assault was six times and almost 19 times higher respectively than the hospitalisation rates for the wider community (AIHW 2002, p. 205).

Substance Dependency

Substance dependency is another indicator of Indigenous health. In contrast to many non-Indigenous people's views, Indigenous people are actually less likely to consume alcohol than are non-Indigenous Australians (AIHW 2002, p. 207). However, of those people who do consume alcohol, a higher proportion of Indigenous people consume alcohol at risky levels. In 2001, of those who consumed alcohol, 29% of Indigenous people, compared to 17% of non-Indigenous people, consumed alcohol at "risky/high risk levels" (ABS 2003b, p. 174; AIHW 2002, p. 207). This level of drinking can lead to significant health problems. "The hazardous use of alcohol is related to conditions such as alcohol-dependence syndrome, alcoholic liver disease, high blood pressure, stroke and some cancers" (AIHW 2002, p. 207). Alcohol also is a direct cause of many social problems, including suicide and family violence, as well as negatively impacting upon other socio-economic factors, such as education and employment (Neill 2002, pp. 222, 225, 271). The number

of Indigenous people drinking at harmful levels is concerning. In 2001, 20% of Indigenous people drank at levels that put them at risk or high risk of long-term harm, compared with 10% of non-Indigenous people (AIHW 2002, p. 207).

Indigenous people are also more likely than non-Indigenous people to abuse other substances. Cigarette smoking is linked to a number of cancers such as lung, cervical and pancreatic, as well as to coronary heart diseases and strokes. Smoking amongst Indigenous people rose during the 1990s and by 2001, the rate of cigarette smoking amongst Indigenous people was about twice the rate for non-Indigenous people (Metherell 2002, p. 6; AIHW 2002, p. 208). Further, in 2001, Indigenous people used illegal drugs, such as marijuana, heroin and amphetamines, at just under twice the rate of non-Indigenous people (AIHW 2002, p. 208). Dependency on prescription drugs amongst Indigenous people is also a concern. Finally, inhalants such as petrol and glue, which cause aggressive behaviour, respiratory problems and chronic physical and mental disabilities, are used at significantly higher rates by Indigenous people as by non-Indigenous people (AIHW 2002, p. 208). As with alcohol, the level of abuse of these substances affects not only the individuals directly, but also their families and communities (AIHW 2002, p. 208). Also, as with the level of alcoholism, the level of substance dependency is escalating amongst Indigenous communities, particularly those in remote regions (Neill 2002, p. 18, xi).

Government Approaches to Indigenous Health

The Australian system of Government has two levels: a national or Commonwealth level and a State/Territory level. In this section, I focus predominantly on the Commonwealth Government level as this level provides both national leadership in addressing health outcomes and also significantly contributes towards health services. However, as State and Territory Governments have primary responsibility for delivering health services, I will also discuss these levels of Government. Further, many of the issues discussed concerning the Commonwealth level also concern the State and Territory levels.

There were two Commonwealth Governments during the 10-year reconciliation process: the Keating Labor Government (1991–1996) which bore some

similarity to Britain's New Labour and Continental European social democratic parties; and the Howard Liberal/National Coalition Government (1996–2000) which bore some resemblance to conservative Thatcher and Reagan politics. Neither of these Governments developed effective broad approaches to addressing the significant concerns with Indigenous health. In this section, I discuss some of the inadequate Government approaches over the reconciliation decade and argue for several alternative, more appropriate approaches.

In attempting to address Indigenous health, both the Labor and the Coalition Commonwealth Governments were predominantly guided by their respective progressive and conservative ideologies and generally failed to examine a broader range of ideas. The Labor Government's broad approach largely focussed on Indigenous rights, such as native title and a limited form of Indigenous self-determination, and symbolic issues, such as officially recognising the Aboriginal flag. However, despite their rhetorical emphasis on Indigenous rights, the Labor Government often implemented policies that actually did not support Indigenous rights. During the reconciliation decade, the Labor Party restricted Indigenous self-determination, through the imposition of a national Indigenous organisation, the Aboriginal and Torres Strait Islander Commission, that was generally not supported by Indigenous people, and attempted to avoid the responsibility of addressing land rights through shifting this responsibility onto the legal system following the 1992 High Court *Mabo* decision which recognised Indigenous native title (Milloo 1998, pp. 27–29). Following its defeat in the 1996 Commonwealth Election, the Labor Party continued to emphasise Indigenous rights and symbolic issues. In outlining its Indigenous Affairs policies for the 1998 election, Labor overwhelmingly concentrated on a rights agenda, discussing issues such as native title and constitutional recognition (ALP 1998, pp. 8–14).

Further, during the 1990s, the Labor Party generally did not focus in sufficient depth on Indigenous socio-economic issues. Whilst Labor policies advocated Indigenous rights and symbolic issues, they largely ignored or marginalised many socio-economic issues such as welfare dependency and substance abuse (Pearson 2002a, p. 11). In Government, Labor often failed to commit to addressing Indigenous socio-economic disadvantage when passing Indige-

nous legislation and developing Indigenous projects, and in Opposition, Labor generally failed to engage in policy debates on certain areas of Indigenous socio-economic disadvantage, such as welfare dependency (Pearson 2002b; Neill 2002, pp. 16–17, 53; Tickner 2001, p. 45). Also, in outlining its policy platform for the 1998 Commonwealth Election, the Labor Opposition mentioned just three Indigenous policy initiatives relating to socio-economic conditions – employment, health and deaths in custody – and failed to address issues of family violence, substance abuse or out-of-custody suicides (ALP 1998, pp. 8–14).

Following their victory in the 1996 Commonwealth Election, the Howard Coalition Government rejected the focus of the previous Labor Government on rights and symbolism. Prominent Indigenous leader Geoff Clark criticised this change, stating “from the outset, the Coalition Government has systematically attacked Indigenous rights” (Clark 1998, p. 5; Pearson 2002a, p. 11). Instead, the Coalition Government focussed on ‘practical reconciliation’ – an approach that prioritised the addressing of Indigenous socio-economic conditions (Howard 2000, 88–90). However, by adopting this practical reconciliation approach whilst simultaneously rejecting Indigenous rights and symbolic issues, the Coalition Government illustrated their failure to comprehend the fundamental links between Indigenous socio-economic disadvantage and Indigenous rights and also failed to understand the importance of symbolism in bringing some form of justice to Indigenous peoples (Naidoo 1998, p. 142).

Interestingly, the rhetoric of the Coalition Government's public commitment to practical reconciliation often failed to translate into appropriately funded and effective programs. This can be illustrated by the lack of funding the Coalition Government spent on Indigenous health. Despite Indigenous health being about three times worse than the wider community's health, the Coalition Government spent in 2002, on a per capita basis, just 74 cents on Indigenous people for every \$1 spent for the wider community in the health programs that the Commonwealth directly controlled (Ring and Elston 1999, p. 228; Ring and Brown 2002, p. 629). In terms of funding from all Government sources, in 1998–1999, despite the significant health disparities between Indigenous and non-Indigenous people, just \$1.22 was spent on Indigenous health for every \$1 spent on the wider

community's health (AIHW 2001, p. 2). Further, in the two primary Commonwealth-funded health programs – Medicare and the Pharmaceutical Benefits Scheme – the level of expenditure for each Indigenous person was only 37% of the level of expenditure for each non-Indigenous person and overall the two programs only contributed 7.3% of the total amount spent on Indigenous health, compared to 23.9% of the total amount spent on non-Indigenous health (AIHW 2001, p. xiv). Overall, Ring and Elston (1999) argued that “the current situation [Indigenous health funding], where the Commonwealth is spending perhaps a fifth of what it should be spending on a needs basis, is a major impediment to effective reconciliation” (Ring and Elston 1999, p. 231; Altman and Hunter 2003, p. v; Hunter and Schwab 2003, pp. 94–96).

Both the Labor and the Coalition Governments, through focussing predominantly on Indigenous rights and practical reconciliation respectively, largely failed to understand that their approach to addressing Indigenous health would be more effective if they recognised Indigenous rights, symbolic issues and practical issues. Policies on Indigenous health particularly, and Indigenous socio-economic conditions generally, need to acknowledge and reinforce Indigenous rights, recognise symbolic issues and address practical issues.

In addition to these limited approaches, both the Labor and Coalition Governments failed to appropriately deal with Indigenous self-determination. During the reconciliation decade, both Commonwealth Governments used the policy of Indigenous self-determination to avoid having to address Indigenous community problems. This avoidance of Government responsibility ensured that numerous Indigenous community problems that have a devastating impact upon Indigenous communities, including family violence, substance abuse and out-of-custody suicides, remained largely unacknowledged and undealt with by Labor and Coalition Governments (Tucak 2002, p. 16). It is ironic that not only was this practice undertaken by the Labor Government, but even the Coalition Government, with its aggressively hostile views on Indigenous rights, including self-determination, used the rhetoric of Indigenous self-determination to justify failing both to accept responsibility for Indigenous community problems and to develop policies concerning Indigenous social problems (Neill 2002, pp. 22–23, 85–86; Saunders 2002, p. 17). Another irony was that the abdication of responsibility by both the Labor and

Coalition Governments ignored that many Indigenous community problems were directly caused by government policies (Gordon 2001, p. 3).

As well as needing to accept their responsibilities to Indigenous communities, all levels of Government – Local, State, Territory and Commonwealth – also need to acknowledge the vital importance of Indigenous self-determination by ensuring they adequately support and fund Indigenous people, organisations and communities in their efforts to address Indigenous socio-economic disadvantage. Genuine Indigenous self-determination, not merely Government rhetoric, remains an essential component of improving Indigenous socio-economic conditions in general and Indigenous health in particular (Clark 2001, p. 12; Hetzel 2000, pp. 161–162; Gordon 2001, p. 125). However, despite Indigenous self-determination being Commonwealth Government policy from 1972 to 1996, the Labor and Coalition Governments during this period generally decided what limits would be placed upon self-determination. Accordingly, genuine Indigenous self-determination has never really been fully implemented in Australia; rather the rhetoric often obscured bureaucratic paternalism (Godwell 2003, p. 11). In discussing the importance of genuine Indigenous self-determination for his own communities, prominent Indigenous leader Noel Pearson (2000b) argued the need for:

Self-determination and our right to autonomy – Cape York Peninsula people must control our own representative organisations and must be free from arbitrary interference from the state and external quarters. Our regional, community and local structures – whilst having relations with government and outside agencies – must be independent and accountable to our own community (Pearson 2000b, p. 80).

Indigenous self-determination also means that Indigenous people should be able to decide for themselves their own goals, lifestyles and priorities that might not necessarily be the same as those preferred by the wider community. If this “choice in Aboriginal affairs policy is taken seriously and logically, it renders somewhat inappropriate and undesirable the simple and categorical pursuit of statistical equality between Aborigines and other Australians as a policy or program goal” (Sanders 1991, p. 17). Both the Labor and Coalition Commonwealth Governments largely

failed to recognise that, in addressing Indigenous socio-economic outcomes, they should not focus exclusively on statistical equality, a concept that can be argued to be “vaguely ‘assimilationist’”, as it is solely concerned with Indigenous people having the same socio-economic outcomes as non-Indigenous people and fails to consider Indigenous views and desired outcomes (Sanders 1991, p. 17).

Another factor behind the failure of Commonwealth Governments in the 1990s to substantially address Indigenous socio-economic outcomes was the rivalry and lack of cooperation between Commonwealth, State and Territory Governments in developing policies and funding programs to address the outcomes (Anderson 1997). While there have been some isolated exceptions, in general, many Indigenous communities and organisations have been overwhelmed during the reconciliation process by the bureaucratic weight of numerous, and often competing, socio-economic programs being administered by varying levels of Government (Pearson 2000a, pp. 170–171, Gordon 2001, p. 126). The lack of cooperation between the Commonwealth, State and Territory Governments also resulted in a significant wasting of resources. One such example occurred in the Northern Territory education sector where the Northern Territory Government levied Commonwealth funds for Indigenous education at a rate of 46.1% for ‘on-costs’, compared to on-costs in other states of between 4% and 18.6% (Collins 1999, 57). Another example occurred when the failure of the Northern Territory Government to access Commonwealth funding for Indigenous education due to “tensions” between the two Governments resulted in the Northern Territory Government accessing just \$196,000 out of a possible \$38 million Commonwealth funding (Collins 1999, 55). National, coordinated approaches to addressing Indigenous socio-economic disadvantages in general and Indigenous health disadvantages in particular need to be undertaken by all levels of Government, local Indigenous communities and a genuinely representative Indigenous national organisation.

A further significant factor that has contributed to Governments not adequately addressing Indigenous socio-economic disadvantage is the marginalising or ignoring by all levels of Government of numerous reports on Indigenous socio-economic disadvantage. Instead of implementing the recommendations contained in these reports, Governments have often

paid little attention to the reports and committed few resources to fund any of the recommendations (Ring and Brown 2002, pp. 629–630; Ring and Brown 2003, pp. 4–5). For instance, the Commonwealth, State and Territory Governments failed to implement several recommendations from the RCIADIC (Gunstone 2007). Also, Maree O’Halloran, the President of the NSW Teachers Federation, argued that the NSW State Government abandoned its review of its Indigenous education policy because it feared having the “damaging results” of its policies publicised prior to the State election (Doherty 2003, p. 4). Another example comes from the Northern Territory where successive governments and bureaucrats were accused of often failing to address concerns over Indigenous education and were instead trying to hide the failings of the education system:

For decades there has been no interest at departmental or governmental level in a dispassionate analysis of the educational outcomes of Indigenous students. Indeed, the review received credible evidence from current and former departmental officers that there had been a deliberate approach of burying or ‘toning down’ information about the poor results being achieved by Indigenous students (Collins 1999, p. 47).

One last example comes from analysing several major Commonwealth reports and strategies on Indigenous education developed throughout the reconciliation process. These included the *National Aboriginal and Torres Strait Islander Education Policy (1993)*, the *National Review of Education for Aboriginal and Torres Strait Islander People (1994)*, *A National Strategy for the Education of Aboriginal and Torres Strait Islander Peoples: 1996–2002 (1995)* and *The National Indigenous English Literacy and Numeracy Strategy 2000–2004 (2000)*. These reports and strategies all contained very similar recommendations (DEET 1993; Yunupingu 1994; MCEETYA 1995; CA 2000). Further, as the publication of these reports and strategies ranged from 1993 to 2000, it suggests that Commonwealth Governments largely failed to address a number of recommendations, despite being aware of many of them for several years.

There were several other reasons why all levels of Governments failed in their efforts to address Indigenous socio-economic disadvantage. Governments

often failed to address Indigenous issues in a holistic manner and preferred to compartmentalise issues into specific areas such as health or education that could be easily situated within the bureaucratic structure of a Department of Health or a Department of Education (Pearson 2002c, pp. 40–43). Another concern was the possibility of Governments imposing conditions on Indigenous communities before providing vital services to that community. This occurred when the Northern Territory Government required the Jowoyne people to abandon their native title claim in order to receive renal dialysis facilities (Ryan 1999, p. 28). Finally, Commonwealth Governments failed to ensure the collection of accurate statistics that could have pointed to long-term and short-term trends in socio-economic disparities between Indigenous and non-Indigenous people. During the reconciliation decade, the ABS did not measure any changes across many areas of Indigenous socio-economic disadvantage, and in some areas, such as suicides outside custody, there was a dearth of reliable statistics (ABS 2002b, p. 87; Altman and Hunter 2003, pp. 2–3).

Conclusion

In 1991, at the start of the formal 10-year reconciliation process, the health outcomes of Indigenous people in Australia were extremely poor. In 2000, at the conclusion of the process, these outcomes remained abysmally poor. As discussed in this paper, these health outcomes can be demonstrated in terms of the actual health of Indigenous people and in terms of comparisons with both the wider Australian community and indigenous peoples in countries such as New Zealand, Canada and the USA. In this paper, I detailed these health outcomes across several indicators, including life expectancy, mortality rates and health infrastructure. These Indigenous health outcomes, along with other socio-economic outcomes in areas such as education, employment, housing and law, are at such poor levels largely due to the history of the colonisation process in Australia. The impact of the invasion, massacres, diseases and government policies of assimilation and denial of basic human rights, through the Protection Acts, both decimated the Indigenous population and absolutely controlled the lives of those Indigenous people who had survived. These factors, some of which were still occurring as recently as

30 years ago, have substantially contributed to the poor socio-economic outcomes experienced by Indigenous people today (Gunstone 2007). An example of this link between past actions and contemporary Indigenous disadvantage is the significant influence on the present-day poverty of many Indigenous people by the past actions of Governments and ‘protectors’ stealing the wages and entitlements of generations of Indigenous people between approximately 1900 and 1970 (Kidd 2006).

Despite the addressing of health outcomes being one of the main priorities of the reconciliation process, successive Commonwealth Governments failed in their broad approaches to addressing Indigenous health outcomes during the reconciliation decade. In this paper, I argued that there were three particular reasons why the Government approaches failed to address Indigenous health disadvantage. The first reason was that both Labor and the Coalition predominantly focussed only on those policies that addressed their respective progressive and conservative ideologies. Thus Labor concentrated mainly on symbolism and some Indigenous rights whereas the Coalition largely focussed on practical reconciliation. The second reason was that both Labor and the Coalition marginalised or ignored the policy of Indigenous self-determination. The third reason was the general lack of cooperation and coordination between the Commonwealth, State, Territory and Local levels of Australian Governments.

I also argued in this paper for the need to introduce several alternative approaches to addressing Indigenous health disadvantage. These alternative policies included: first, looking at Indigenous health in a holistic manner through incorporating Indigenous rights, symbolism and practical issues; second, recognising and facilitating genuine Indigenous self-determination that enabled Indigenous people to determine their own policies and programs with sufficient Government funding and support; and third, developing mechanisms to ensure cooperation between all levels of Australian Governments, Local, State, Territory and Commonwealth, Indigenous organisations and communities and a genuinely representative national Indigenous organisation. A number of countries, including Canada, New Zealand and the USA, already have indigenous policies that address many of these alternative approaches. For instance, New Zealand conducted a treaty with

indigenous people in 1840 and have reserved seats in their Parliament for indigenous people; Canada negotiated the Nisga'a Agreement in 2000 that conferred ownership and control over substantial territory to indigenous people; and the USA have recognised since the early nineteenth century that indigenous people possess a limited form of sovereignty over their lands (Brennan et al. 2005, pp. 82–98). The significantly better health outcomes for indigenous peoples in these countries compared to Indigenous people in Australia, as discussed in this paper, suggest that these alternative approaches can deliver substantial outcomes. Thus, the implementation of these three alternative approaches in Australia could provide the most significant chance in over 200 years for Indigenous people to regain control over their lives and to improve their health outcomes. Unfortunately, both sides of Australian politics are extremely reluctant to develop any policies that genuinely address Indigenous rights, perhaps influenced by a widely held view in Australia, demonstrated constantly through opinion polls, that Indigenous people should have formal equality with other Australians and not have their specific Indigenous rights recognised (Gunstone 2007). Ultimately, both Governments and the wider Australian society bear responsibility for failing to comprehend the need for Indigenous rights to be recognised and protected.

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