

Aboriginal Assimilation and Nyungar Health 1948–72

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The policy of assimilation in mid-twentieth-century Australia holds a major place in the history of Aboriginal health. For the first time Australian governments endorsed equal citizenship for Aboriginal people with full access to mainstream medical and hospital services previously denied to them. After decades of neglect Aboriginal families could look forward to better health. Politicians were convinced that disparities in Aboriginal health would be readily assimilated into the profile of the general population. However, this case study of assimilation's mainstreaming of health services for Nyungar people in Western Australia demonstrates that the outcome was a mix of significant advances and enduring legacies of discrimination. Improvements were frustrated by endemic racism, contested understandings of assimilation, and the government's failure to meet its promises. A consequence was a legacy of suspicion and anxiety that continues to impact adversely on Nyungar health today.

Keywords

Assimilation, Aboriginal health, Aboriginal medical services, Nyungar people.

The adoption of a national policy of assimilation based on equal citizenship rights for Aboriginal people in mid-twentieth-century Australia marked a pivotal point in the history of Indigenous health in the settler nation. This was a significant step away from previous practices where governments had used discriminatory legislative and institutional controls to enforce settler standards of work and behaviour and rewarded conforming individuals with conditional forms of citizenship.

For the first time governments endorsed the vision of a modern Australian nation where all Aboriginal people would have equal rights and responsibilities with other citizens and access to mainstream state and federal government services. In terms of John Chesterman's definition of citizenship this meant that they would now acquire 'the political, legal and social rights that are integral to a person's membership of a political community'.¹ The official expectation was that as citizens they would abandon their cultures for the Australian way of life, settling as nuclear families in the suburbs of the nation's cities and towns. This was spelled out in the 1961 definition of assimilation, which stated that Aboriginal people were to 'eventually attain the same manner of living as other Australians and to live as members of a single Australian community enjoying the same rights and privileges, accepting the same responsibilities, observing the same customs and influenced by the same beliefs, hopes and loyalties as other Australians'.²

The mainstreaming of services meant that Aboriginal people could now expect to receive the benefits of better health through the nation's medical systems after decades of neglectful treatment and denial of services. Politicians and administrators were convinced that a vigilant medical system would readily resolve existing disparities in Aboriginal health and, as Warwick Anderson put it, they would 'gradually dwindle into ordinary problems of proletarian health'.³ This case study of the implications of assimilation policy for the health of Nyungar people in the south west of Western Australia demonstrates that the outcome was in fact a complicated mix of significant steps forward and enduring legacies of serious disadvantage. The hoped for equal playing field for Nyungar health was frustrated by contested understandings of what the policy meant in practice and the government's failure to break through barriers of institutionalised racism blocking access to mainstream medical services and to allocate sufficient funds to meet its promises to dramatically improve living conditions. As well as the impediments of racism, neglect, mismanagement, and resource scarcity there was also the universalising nature of assimilation policy that could not accommodate Nyungar economic, social, and cultural difference and that could be openly punitive of those who did not conform. Assimilation also brought new expectations and responsibilities for Nyungar

families and increased expenses including the payment of raised medical fees that few could afford, leading to an impasse with doctors in many country towns.

There was some relief as Nyungar people became eligible for federal government Social Security benefits from the late 1950s. This was followed by the successful 1967 Referendum to amend the Australian Constitution, which allowed the federal government to legislate for Aboriginal Australians and to count them in the national census. Federal intervention brought a dramatic increase in funding for Aboriginal health and housing and improved planning and more enlightened policies. This contributed, along with lobbying and protest by Aboriginal political organisations, to the gradual abandonment of assimilation in the early 1970s for the policy of self-determination and the emergence of Aboriginal medical services. Warwick Anderson points out that this commitment to self-determination proved ‘disappointingly evanescent’. Successive governments resisted the divisive assertion of ‘difference and independence’ and uncomfortable reminders of the ‘illegitimacy and violence’ of the settler state afforded by self-determination and many returned to implicit assimilatory principles to address disparities in Aboriginal health.⁴ The unfortunate outcome of the resulting shifting compromises and antagonisms in the provision of health services created an enduring impediment for governments and communities seeking to close the gap in Aboriginal and Torres Strait Islander health.

This study of assimilation policy and Aboriginal health is in part a response to the call in 2007 by Ian Anderson and Kim Humphery in a Special Issue of *Health and History* for further histories of medical policies, medical treatment and research, health institutions, and broader societal responses and influences.⁵ As such it documents for a particular time and place the complexities of the Aboriginal health field where, as Leonie Cox explains in her significant study of the parameters of health in the Aboriginal community of Cherbourg in South-East Queensland that:

it is not innate tendencies within individuals or cultures that make health difficult to achieve or maintain. Rather it is conflicting social and political values resulting in oppressive and inequitable structures and processes ... In short, health

and illness occur in a complex interrelationship of biological, environmental, cultural and social factors that have historical, political, economic and spiritual dimensions.⁶

The focus on Nyungar families in this paper points to differences and similarities in Aboriginal experiences of health services around the nation, in particular the lasting effects noted by Warwick Anderson of ‘racial discrimination, dispossession, family disruption, poverty, social marginalisation, and limited access to health care’.⁷ The conclusion is that, despite assimilation’s claims of better health through access to mainstream services, its broken promises built up personal and collective memories of punitive control, neglectful treatment, and violation of body and spirit. Cox argues that such memories created an enduring legacy in Aboriginal communities of ‘fear, mistrust, disappointment and resentment toward state institutions, including the health system’ to the point where some people avoid mainstream medical services to the detriment of their own health and well-being.⁸

New Directions

Mid-twentieth-century discourses of assimilation and Aboriginal health sit uncomfortably between the outmoded baggage of scientific racism and racial segregation and the unpredictability of societal responses to new theories of racial equality and citizenship. Colonial medicine, argues Shula Marks, had operated as an ‘instrument of empire’ and ‘imperializing cultural force’ that endorsed entrenched race difference and Indigenous peoples’ separate and inferior treatment.⁹ Megan Vaughan states that its power was the sum of its direct impact on human bodies and the ‘ability to provide a “naturalised” and pathologised account of these [Indigenous] subjects’.¹⁰ In early twentieth-century Australia, medical opinion followed popular assumptions and branded Aboriginal people as dying remnants, susceptible to disease and mortality, and contaminating for settler populations. As such they had no place in the vision of a healthy White Australia and the advances in public and medical health that forged Australia into one of the world’s healthiest nations. Aborigines were denied the benefits being extended to settler families of a secure family income, housing, public

health services, and access to primary health care. Instead they lived under discriminatory legislative regimes that segregated them from the wider community and forced many to live in government institutions or missions while others survived in rudimentary camps lacking sanitation and running water or in run-down accommodation in town. Individuals who passed draconian government tests regarding standards of ‘civilised’ lifestyle and health (applicants had to prove they were free from communicable disease) qualified for conditional forms of citizenship such as the Certificates of Citizenship introduced in Western Australia in 1944 but these could be cancelled for any misdemeanour.¹¹ Some families who managed to pass as white practised a covert form of citizenship circumscribed by fear of detection of their Aboriginal identity by the authorities. David Mercer describes Aborigines’ status prior to assimilation policy as ‘citizens minus’.¹²

How to shift Aborigines’ legal status was a major challenge facing administrators implementing assimilation in mid-twentieth-century Australia. And how could they achieve social and economic parity with settler and immigrant families who were already establishing their own suburban homes with sufficient income to contribute to vital costs of health and education? Achieving an assimilation package that promised the repeal of all discriminatory legislation, a secure family life, a home in the suburbs with the basic comforts of modern life, and full-time employment would prove an elusive dream. In Western Australia in 1964 government pamphlets depicted Aboriginal families living in immaculate suburban homes with dad a white collar worker who proudly proclaimed, ‘I bring home my wages to pay for food, clothes and house rent ... my wife and I care for the health, teeth and eyes of ourselves and our children’.¹³ However, the Minister for Native Welfare, E.M.H. Lewis, was forced to admit that after sixteen years of assimilation policy the pamphlets remained aspirational for most families. They showed ‘copybook families at a more advanced stage than they are now’ that he hoped would ‘play on [their] pride in their race, and urge them to prove they can behave as well as the white man’.¹⁴

In relation to the nation’s health system, the actions of the conservative Prime Minister Robert Menzies in placing the onus on responsible citizens to provide for their own health needs

sounded an alarm bell for Aboriginal families. Menzies rejected the British model of a tax-payer funded national health scheme in favour of private health insurance thereby highlighting what Milton Lewis describes as citizen's virtues of 'self-reliance ... personal responsibility' and 'the obligation of the individual'.¹⁵ The government's tough stance was demonstrated in 1955 when a new means test rendered 25 percent of pensioners ineligible for free medical and hospital care. Meanwhile doctors' incomes rose sharply and by the 1970s they were Australia's highest paid professionals. Such measures did not bode well for Aboriginal families now responsible for paying their own medical expenses in a mainstream system that was priced far beyond their means. Lewis describes a chronic situation of Aboriginal ill-health at the time due to the combination of 'low health status and inadequate nutrition, inadequate health services and underuse of such services as were available' and the urgent need for improvements in socio-economic environments and access to mainstream services.¹⁶ These were all problems that assimilation promised to remedy.

Contested Visions of Assimilation

There was no unified agreement about how best to achieve the goals of assimilation amongst policy makers and administrators, including its two leading exponents anthropologist A. P. Elkin and the federal Minister for Territories (Sir) Paul Hasluck (1951–63). While both endorsed new social explanations of Aboriginal disadvantage and the goals of equal citizenship they disagreed over the significance of Aboriginal culture and responses of Aboriginal people in northern and southern Australia. Elkin went against popular opinion by advocating that the strong cultures and communities he observed in the north would provide a sound foundation for building towards assimilation, although like his anthropologist colleagues he was also concerned to see the preservation of some aspects of Aboriginal life. He was also exceptional in his pessimism concerning the assimilation of populations in the south. Elkin argued that these groups of 'mixed-descent' lived in a cultural void with 'all its attendant evils' and that their advance to assimilation would be retarded by 'economic dependence on government and societal rejection' tainted with 'resentment and alienation' that would encourage

ghettoes and welfare dependency.¹⁷ By contrast Hasluck viewed Aboriginal culture as an impediment to change whose influence was waning rapidly. He believed that Aboriginal people were capable of becoming good citizens, in accord with their advancement towards civilisation and like his peers was convinced that the cultural void inhabited by Aboriginal populations in southern Australia made them ideal candidates for assimilating new ways of citizenship and lifestyle.¹⁸

In Western Australia the point of dissent between politicians and bureaucrats was over how to manage the practicalities of implementing assimilation. In 1948 a new conservative government adopted the policy, claiming that the time was right for change with ‘the current outlook of the natives as the result of the war, the growing number of half-castes [and] public sympathy’.¹⁹ The commitment to change was evident in the fourfold increase in funding between 1948 and 1959 when annual expenditure reached 848,792 pounds, although this was far less than the sum of 2.4 million pounds that a 1958 Select Committee ruled was essential to make real improvements.²⁰ The government advocated a gradualist approach to assimilation that mirrored the tactics of European colonial powers in the 1950s that were reluctant to grant independence to their colonies until after long periods of training and preparation. For assimilation in Western Australia this meant long delays in repealing the state’s discriminatory legislation and this created the paradoxical situation where the apparatus of segregation ordered the work of bureaucrats driving the assimilation project. That the government had no clear vision of the goals of assimilation or the policy’s implicit rejection of racist theories of the past was evident in its 1948 *Survey of Aboriginal Conditions in Western Australia*, led by F.E.A. Bateman. Rather than advocating equal citizenship the survey repeated racist adages of transforming Aboriginal people from ‘a nomadic, idle and discontented race to a settled, industrious, contented section of the community’ that fitted ‘into our economic and social structure’. Punitive practices of removing the ‘idle ... [and] useless’ to native settlements should continue and, as for the racism Aborigines experienced, ‘the prejudice would be largely broken down’ if they were to become ‘clean, tidy and reliable and lived under conditions similar to our own’.²¹ That politicians’ expectations changed only gradually is evident in a statement to the press

seventeen years later by the Minister for Native Welfare, E.M.H. Lewis, that ‘people should recognise that natives were being asked to lift themselves in a few generations to a standard which whites had taken centuries to achieve’.²²

By contrast, the state’s recently appointed Commissioner of Native Affairs, Stanley G. Middleton, had a radical vision of rapid Aboriginal assimilation into the general community on the basis of ‘equality in all facets of community life’.²³ He was appalled by the depth of racism in the discriminatory system he inherited that was ‘repugnant to basic humanitarian and welfare principles, devoid of any common ground with the people we are trying to help and creative of more misunderstanding, dissatisfaction and abuse than any other piece of similar legislation known to the free world today’.²⁴ His ambition was to extend citizenship rights to Aboriginal people through programs of immediate legislative and administrative reform to remedy the legacy of years of neglect and entrenched racism that had deprived them of proper services and created the endemic poverty of the majority of families who camped on scraps of unwanted land exposed to the weather and without sanitary services or running water. In this context the role of the Department of Native Affairs (DNA, Department of Native Welfare from 1954) and the field officers who replaced the police as its agents at the local level would be to attend to the social welfare of Aboriginal families and act as an ‘integrating authority’ assisting them to ‘make proper use of ordinary community facilities’.²⁵ Reflecting the opinion of his political masters, Middleton also believed that equal citizenship meant that Aborigines had to be trained to become responsible citizens who were ‘self-reliant, responsible and [able] to stand on [their] own two feet economically and socially’.²⁶

Middleton was under no illusion as to the enormity of the task. He wrote of the ‘feelings of despair and confusion, bordering sometimes on hopelessness’ within his department and later described how racism at all levels thwarted his efforts for legislative reform, which moved in gradual steps with the repeal of significant clauses in 1954 and 1965 but was not fully achieved until 1972, eleven years after he had retired exhausted and in poor health.²⁷ Still, Middleton believed, like historian Peter Biskup, that the tasks of transferring responsibilities for Aboriginal health to the relevant authorities and achieving the goal of ‘reasonable equality’ in health services would run

smoothly and were largely a matter of sufficient finance and careful planning.²⁸ This was not borne out by subsequent events.

The views of Western Australia's health bureaucrats mirrored the shift in medical discourse noted by David Piers Thomas from a primary concern about the threat of Aboriginal contagion for white populations towards a gradual acceptance of assimilation and recognition of how racism impacted on Aboriginal health.²⁹ Nevertheless, Melbourne activist Dr Barry Christophers remained a lone voice when he attacked medical opinion against Aboriginal drinking rights, arguing that alcohol abuse was a 'symptom' of the 'disease' of 'lack of citizenship, low wages and colour prejudice'. He also claimed that while medical treatment for other Australians ranked with the best, Aborigines 'receive perhaps the poorest medical attention in the world'.³⁰ In Western Australia Dr Alfred Jacobs was also exceptional in his staunch advocacy for immediate citizenship rights with full access to federal Social Security benefits and his regular attacks on the government for failing to provide proper housing and continuing to remove Aboriginal children from their families. Doctor Jacobs' views earned him the reputation of a Communist and the attention of the Australian Security Intelligence Organisation.³¹

The Commissioner of Public Health, Dr Linley Henzell, focussed his attention on socio-environmental factors contributing to Aboriginal ill-health and the urgent need for improved living conditions.³² In his 1951 annual report Henzell distinguished two problems in the state's estimated Aboriginal population of 21,092: the predominant 'full blood' population in the north 'torn from its traditional mode of life' and with 'nothing [yet] to substitute for it' and the much smaller but 'growing minority problem' of around 3,600 people of mixed descent in the south made up of landless families who were excluded from society. Their living conditions were a 'national reproach'. Although they worked and paid taxes they were denied access to state housing.³³ Henzell argued that since these families constituted 0.7 per cent of the local population then equal citizenship meant they should have 141 of the 20,190 government houses erected since 1945, most of them in the south. Henzell also stressed the importance of training the families who were presently 'incapable of using [houses] properly' and proposed a beginning where Aboriginal reserves would be

required to conform to the Camps and Caravan Regulations in the Health Act. Significantly he also acknowledged that little could be achieved as long as white racism and segregation persisted and that failure to take immediate decisive action would lead to a future ‘pregnant with dangerous social consequences’.³⁴

Nyungar Families

Like his peers Dr Henzell believed that Aboriginal people in the south would assimilate more readily than those in the north. Yet Nyungar people, traditional custodians of the southern region from Mullewa in the north to the coast east of Esperance in the south, had a distinctive shared culture and historical experience of dispossession and racism. Following the establishment of the Swan River Colony in 1829 their lands were progressively invaded and the combination of disease, malnutrition, and settler violence reduced their numbers drastically from an estimated population of between 6,000 and 13,000 to 1,400 by 1901. While public opinion held that their cultures had been destroyed, many Nyungar people maintained a unique way of life strongly grounded in Aboriginal traditions and connections to land as well as strategies of survival built up under imposed regimes of segregation and control and their adaptations to continuing social change. Nyungar shared commonalities were traversed by loyalties to locality and family and in Perth people sent down from the north by the department added a further layer of diversity.

In a region developed from the early 1900s into wheat and sheep farms clustered close to small rural towns, Nyungar families provided a cheap and reliable source of seasonal labour for local farmers and domestic servants in town. Extended family networks were the backbone of Nyungar life, providing economic, social, and emotional support. In the early 1950s most families were camped on unoccupied sites on the fringes of towns or in the bush and during work contracts on farmers’ land. Some lived in camps and rundown houses in Perth. Given that they numbered only around 3,600 at the time, it could be expected that Nyungar people would have vanished into the vast farming landscape they inhabited. Instead they loomed large as an imagined threat to moral and social order and a source of illness and contagion. Townspeople vigilantly policed and

enforced barriers of race across all areas of life so that families were denied proper medical attention and schooling for their children.³⁵

Nyungar people responded in various ways to the rhetoric of assimilation. Middleton described them as a 'Fifth Column' with an oppositional culture of distrust of outsiders and authority and a tough readiness to stand up for their rights. They had their own views on the promises of assimilation, claiming that 'this talk of a fair spin for the natives ... is eyewash when a coloured man is not even free to walk in the main street'. He wrote that they were 'very bitter' about the department and would rather pay their own way than seek assistance. During the war their experiences as soldiers and on the home front raised hopes of a better life and even the conservative Returned Services League backed Aboriginal ex-servicemen's demands for citizenship. In the 1920s Nyungar leader William Harris had called for the right 'to live up to the white man's standard' but 'in our own way'.³⁶ Thirty years later the goals of the New Coolbaroo League in Perth reflected the majority response of Nyungar people to assimilation who sought to harness its rhetoric to achieve their aspirations for improved health, education, and employment and to secure their democratic rights, while resisting assimilationist attempts to erode their culture and connections to family and homelands.³⁷

Reporting on Nyungar health in 1950, the DNA's Southern District Officer, G. Wright Webster, claimed that 'hard work and life outdoors' had bestowed a rough immunity to disease so they were less likely to be hospitalised than local townspeople.³⁸ Webster's view was simplistic. Certainly there were the advantages of an active life of seasonal work, regular movement between campsites, hunting and gathering bush foods, the support of extended family networks, and a strong sense of identity. However, these were tempered by rough living conditions, periods of unemployment relieved only by meagre rations, official intervention in family life, and the strain of endemic racism including discrimination by local hospitals and doctors. Typical maladies reported in departmental annual reports reflected Nyungar living conditions: respiratory conditions with epidemics of colds and influenza and complications of bronchitis and pneumonia; skin diseases such as scabies and infestations of lice; and gastroenteritis and sometimes malnutrition amongst

infants and children who were the worst affected. Nyungar elders Edward Brown and Darryl Kickett recall how their families relied on traditional skills sometimes combined with remedies picked up from town residents and farmers. Nyungar midwives delivered babies in the bush. Goanna and bobtail oils were used for aches and pains and eucalyptus inhalations for cold sickness. Rituals performed by *mabarn* men protected the general spiritual and physical wellbeing of family groups.³⁹

The increasing size of the Nyungar population during the 1950s, built on increases from the 1920s reported in the 1934 Moseley Royal Commission into Aboriginal conditions in the state, signalled an alarming trajectory of deteriorating living conditions and worsening health for families without official intervention to bring the promised benefits of assimilation.⁴⁰ With a birth rate of thirty-six per 1000 (50 percent above the national average) the population was set to expand rapidly bringing alarming new pressures for wage earners. Between 1951 and 1961 numbers increased from 3,600 to 5,500 and the percentage of children in the population escalated from forty-four to fifty-seven in a five-year period from 1950.⁴¹ The situation demanded immediate improvements across the board for Nyungar families in terms of housing, public health services, and primary health care. Given the population's proportionately small size there should have been sufficient resources and good will to achieve this outcome.

Stagnation and Change

Stagnation was a feature of the mainstreaming of Aboriginal health services in the south of Western Australia despite the rapid formal transfer of responsibilities to the Department of Public Health completed in 1948. This was due in part to the continuing involvement of the DNA, which maintained a significant operational role representing Aboriginal health interests and collaborating with health staff at all levels including through its new field system of patrol officers who reported on local health matters. As Gordon Briscoe notes there was also the DNA's history of conflict and 'frequent demarcation disputes' with health authorities over responsibilities for Aboriginal health.⁴² Medical departments demonstrated a greater interest in health conditions in the north and assumed that Nyungar families could

readily access mainstream services. A consequence was limited funding and ongoing neglect and, although the DNA continued to document Nyungar conditions, they were rarely mentioned in the annual reports of health authorities after the early 1950s.

These arrangements were unfortunate for Nyungar families expecting change. Henry Schapper argues that the DNA's continued involvement in functions of Aboriginal health as well as housing, child welfare, employment, education, and welfare services, rather than playing an integrating function as envisaged by Middleton, served to hinder Aboriginal people from gaining direct access to mainstream services.⁴³ This reflected in part the adherence to existing segregatory frameworks opposed to the goals of assimilation. Nyungar people were alienated by continuing invasive scrutiny and ordering of their lives and threats of punitive treatment for failure to meet new imposed standards of health and hygiene that could lead to removal of their children. And while they were told on the one hand to step up and meet their new responsibilities as citizens, they were still treated in infantilising ways that undermined their new status. This was evident in the provision of medical treatment following the state-wide trachoma survey conducted by Dr Ida Mann for the Public Health Department in 1956. Dr Mann advised that Aboriginal people would have to be supervised by responsible persons to ensure that they took their medication as 'otherwise they would not take them regularly, if at all'.⁴⁴ In response the department called on Apex club members in Fremantle and Northam to administer the treatments to Nyungar families in local camps over a two-week period. One consequence was that club members developed a strong interest in actively promoting the goals of assimilation.

As Cox argues, discriminatory legislative frameworks reinforced institutionalised racism and stereotypes of Aboriginal people and their medical problems, and activated their discriminatory and unequal treatment by mainstream health workers.⁴⁵ For services to be fully accessible to Nyungar families they required a strong mandate from senior politicians and bureaucrats. That this was sadly lacking was evident in Middleton's advice to his staff in his final annual report in 1961 to be prepared for 'indignities' at the hand of their colleagues 'whose views towards the natives are reflected in their attitudes towards officers of this Department'.⁴⁶

At the same time the DNA was working diligently to dismantle its own negligent medical services in the south. Under the 1905 Aborigines Act its responsibilities for Aboriginal health were minimal: to provide rations, medical attention, medicines, and shelter to the destitute—the sick, aged, and infirm—and children in institutions. Where practicable employers were to cover costs of workers' medical needs. Otherwise families were expected to provide for themselves.

Inferior medical assistance was available in under-resourced 'hospitals' in the department's centralised institutions, the Carrolup and Moore River native settlements. Paradoxically, these places were also sites of illness and poor health where children removed from their families and elderly, disabled, and destitute adults were detained in deplorable conditions that exposed them to mass infection and disease. Even Bateman in his 1948 report was moved to observe that at Moore River settlement 'sanitation and hygiene are merely words without meaning'.⁴⁷ Children were particularly vulnerable due to their poor diet and the lack of routine health checks available for state school children on the outside. In medical emergencies a doctor might be called in to the settlement hospitals that consisted of a single ward for men, women, and children, with no labour or isolation wards. Otherwise untrained carers attended to patients. In 1949 doctors at Princess Margaret Children's Hospital in Perth complained that urgent cases transferred there from Moore River settlement showed lack of proper care and that medical attention had not been called in early enough.⁴⁸

People living near the settlements and needing medical attention, and pregnant women nearing the end of their term were directed by the department to seek help there. Most refused to go, being aware of the woeful conditions and the likelihood they would be forcibly detained after their recovery. Families faced dire consequences as the DNA refused to assist them financially, and local doctors and hospitals denied them urgently needed treatments as well as any forms of routine health care and checks.

The department claimed that 'generally speaking' Nyungar people had access to local health facilities and that few complaints were made against them.⁴⁹ However, Gordon Briscoe documents decades of discriminatory practice and stand-offs between the DNA and health authorities, and local municipal

bodies refusing to intervene to provide services.⁵⁰ Evidence from government records supports these claims. During the 1940s it was practice to accommodate male Aboriginal outpatients sent to Perth for medical treatment in the police stables.⁵¹ In 1943 a report on country hospitals advised that due to their ‘dirty habits’ patients were sometimes accommodated on hospital verandas, which could be cold especially for midwifery patients. Beverley hospital was commended for providing tents for their use.⁵² In 1949 the Matron of King Edward Medical Hospital for Women complained about Aboriginal women’s lack of personal hygiene, adding that ‘it’s all very well to talk about the rights of natives, but I do not think that people who talk in this way would like to be in the next bed to some of these women’.⁵³ Nyungar oral history tells of numerous emergency cases refused entry to hospitals sometimes resulting in tragic deaths and an enduring sense of injustice that continues to rankle.⁵⁴

In 1951 the DNA closed Moore River and Carrolup settlements, which were to be rehabilitated as children’s missions. Adults were dispatched back to the districts they had been taken from years before. Presumably they settled in town camps, perhaps with their families, relying on government rations and medical support to survive. They received a major boon when they became eligible for federal Social Security benefits from the late 1950s and as the state government began to provide more assistance with fees for doctors, dentists, optometrists, and pharmacists.

The health of children in the new missions was boosted from 1954 when funding was put on a par with white institutions and with the addition of a lotteries subsidy in the following year.⁵⁵ They now had access to school health services including dental care, regular medical inspections, and immunisation schemes to combat epidemics of contagious disease.⁵⁶ The 1956 trachoma survey conducted by Dr Mann identified and treated children with trachoma and in the following year all school children received Salk vaccinations against polio.⁵⁷ Outside the missions Nyungar children who were previously excluded from state schools could now access these medical services as well.

There were other advances as authorities showed less tolerance of racist practices that had excluded Nyungar families from hospitals and doctors’ surgeries, although complaints and continued exclusions in some towns still necessitated

alternative arrangements. In the early 1950s a deputation of women from York supported by the National Council for Women failed in their call for a segregated Aboriginal maternity ward at the town hospital.⁵⁸ In 1953 Middleton commented on a complaint concerning a doctor who treated a woman in labour ‘like a cow’, saying that he was glad the man was going back to England.⁵⁹ In the following year officers at Gnowangerup hospital were asked to explain why they had refused to accept an Aboriginal maternity case. They gave staff shortages as the reason but the local United Aborigines Mission explained that Nyungar mothers were not welcome there and they had their babies at the mission outside the town instead. In that year, twelve babies were delivered there by Nyungar midwives.⁶⁰ Some doctors pressured to accept Aboriginal patients reportedly set up segregated waiting rooms, however, Nyungar families knew where to go to be treated and Drs Jacobs (Narrogin), Pope (Katanning), Constable (Guildford), and Jolley (Midland Junction) all had large Aboriginal patient lists.⁶¹

The Impasse Over Doctors’ Fees

Economically the decade of the 1950s proved a difficult time for the growing Nyungar population. Their usual employment was reduced by new methods of farming and competition from post-war immigrants; this at a time when they faced the new costs of assimilation in sending their children to school and meeting imposed higher living standards. Any sudden extra expense could tip families over the edge. In 1958 the department reported that employment was scarce and infant malnutrition had increased. Patrol officers were instructed to issue rations to *bona fide* cases and to commit children of ‘malingering’ parents to institutions to ensure their welfare.⁶² In the midst of this worsening situation the department became embroiled in a bitter wrangle over payment of doctors’ fees that impacted adversely on Nyungar families. Echoing through the insistence that they pay these fees as an imperative of their new responsibilities as citizens was the federal government’s earlier call for all Australians to practice ‘self-reliance ... personal responsibility’ in paying for their own medical costs.⁶³

The department’s principal mechanism for regulating medical payments from 1937 to 1955 was the Native Medical

Fund, a voluntary contribution scheme directed principally at employers in the north that contributed to workers' medical and hospital expenses and the DNA operated 'native hospitals' there. In the south few employers contributed to the Fund or honoured their moral obligations to their employees. Otherwise families living outside the settlements were expected to pay for their own medical costs on the rare occasions they could access the services. Hospital and medical fees had been pegged under an agreement made in 1938 between the DNA and doctors but even then they brought financial distress for most Nyungar families, while for doctors the combination of low fees and extra paper work rendered the treatment of Aboriginal patients an imposed irritation. The situation changed in 1950 when, following pressure from the State Health Council, doctors' fees for Aboriginal patients were raised and a new centralised fee payment system was introduced.⁶⁴ Doctors would now send accounts to the DNA for reimbursement and its officers would authorise payment for any destitute patients and seek to recoup fees from those not eligible for assistance.⁶⁵ This may have suited the doctors but after two years of operation the scheme brought severe financial embarrassment to the department. The cost of claims tripled and most claims were for patients not covered by the Native Medical Fund. Middleton complained that the system was a 'luxury that the dept. on its meagre vote could not afford'.⁶⁶ Nor should his officers be expected to act as debt collectors. Biskup argues that Aborigines 'made no attempt to meet their financial responsibilities'.⁶⁷ However, department records show that dissatisfaction was principally with doctors who failed to provide the required information and sent claims in after long delays, sometimes of up to twelve months. A few submitted accounts twice but the department was undecided whether this was 'deliberate or accidental'.⁶⁸ Middleton added that the system, by inadvertently providing a measure of protectionism, was not building Aboriginal citizenship. In a desperate attempt to cover costs he raised employer contributions to the Native Medical Fund.

A compromise solution reached in January 1953 meant that doctors would continue to send their accounts to the department, which would pay for persons covered by the Native Medical Fund and destitute cases but return all other patient bills to the doctors to recoup themselves. This system outraged doctors

who were quick to complain through the State Health Council and British Medical Association that they were being forced to write their accounts off as bad debts. Dr Vivian of Albany said he would refuse to treat Aborigines who could not pay up-front after the department returned his accounts unpaid. A consequence of the system was that the duty of care fell on the few 'idealistic' doctors as Nyungar families travelled far afield to consult those they reliably knew would fulfil their professional obligations.⁶⁹ To this day these men are remembered with respect and affection.

As tensions mounted Middleton advised his minister that Nyungar families were barely managing to make ends meet and without financial security could not afford the extra expenses of increased doctor's fees. The majority were not in private medical insurance schemes, having been refused membership or being unable to afford the subscription payments. The Native Medical Fund had failed; medical costs had spiralled, and were out of all proportion to employer payments that now met less than 50 percent of costs. As a radical alternative Middleton proposed that Nyungar families receive free medical attention to which he believed they were fully entitled as they made no other charge on the state and contributed to its economy through their work and taxes. They were pauperised and could not reach white standards without housing and regular employment, in short, they could not 'achieve the impossible'.⁷⁰

Meanwhile doctors' frustrations were such that even Dr Jacobs wrote in 1954 to the British Medical Association concerning delays in payment of his accounts. Pointing to a point of contention with the DNA field officers, Jacobs complained that they were shifting the onus back to doctors by repudiating their diagnoses and claiming that Aboriginal patients were in fact able to pay their costs. They had described one of his patients as a 'notorious rat-bag and alcoholic' when in fact the man had been 'incapacitated for months ... like the other Aborigines, he is untruthfully stated to be able to pay for medical expenses'. He concluded:

What a ramp this business is, the Government QUITE DISHONESTLY pushing onto a tiny minority of citizens—the medical men affected—the whole burden of medical treatment of natives. The Department annotations are frankly ludicrous as well as dishonest.⁷¹

Tensions became acute in 1955 when the Native Medical Fund was disbanded following the passage of the 1954 Native Welfare Act. Now Aboriginal people throughout the state, with the exception of those that the DNA deemed to be destitute, were required to pay all their medical expenses directly—expenses that were out of their means to pay and the vast majority of these people were without the benefit of private medical insurance.⁷²

Faced by a dramatic escalation in complaints and unpaid accounts, Middleton restated that the department covered only destitute patients and doctors would have to deal directly with the rest. He reiterated the assimilation directive that Aboriginal people must be taught to be responsible for their own health costs and care. That it would be wrong in the context of assimilation policy of ‘equality of opportunity’ to privilege their debts and ‘the general effect would be degrading on natives as a whole and [would] tend to retard, rather than advance their claim for equal civic rights’.⁷³

The decade closed without resolution of the fees issue. Middleton reported in 1958 that doctors remained disgruntled. Nyungar families were left to rely on their own resources. The circuit breakers would be access to federal Social Security benefits that brought urgently needed money into Nyungar households and, eventually, federal involvement in Aboriginal affairs leading to sufficient funds to build Aboriginal housing stocks and support the establishment of Aboriginal medical services pioneered by Aboriginal organisations with federal government financial support.

Conclusion

Assimilation did usher in significant advances in health by breaking down many negligent and discriminatory practices, and by opening the way for Nyungar people to begin to access mainstream health services. Judging from the silence of health authorities it could have been assumed that their health disparities had indeed ‘dwindled’ into ‘the ordinary problems of proletarian health’.⁷⁴ Yet this was far from the case. Entrenched racism, neglect, mismanagement, and assimilation’s intolerance of Nyungar social and cultural difference combined in many instances to encourage punitive behaviour towards those seeking medical treatment and denial of urgently needed

medical services, thereby alienating patients in urgent need of care and causing unnecessary complications and even deaths. There were also all of assimilation's broken promises, from proper housing to full legal equality. A consequence was continuing poor health in the Nyungar community. Speaking generally about conditions in the late 1960s, Lewis observed that Aboriginal ill-health resembled that of nineteenth-century working-class populations.⁷⁵ Discriminatory and punitive treatment left an enduring legacy of suspicion and anxiety that continues to impact adversely on Aboriginal health. As Cox observes, tragically for many Aboriginal people around the nation, the health system is regarded to this day as a force that has played 'a central role in their colonisation and ... in the deaths of many loved ones'.⁷⁶

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