Counting, Health and Identity

A history of Aboriginal health and demography in Western Australia and Queensland, 1900–1940

Gordon Briscoe

Aboriginal
Studies Press
2003

Readers are reminded that if members of some Aboriginal communities see names or images of the deceased, particularly their relatives, they may be distressed. Before using this work in such communities, readers should establish the wishes of senior members and take their advice on appropriate procedures and safeguards to be adopted.

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Dedication

Dedicated to the author's late mother, Eileen Briscoe, who bequeathed him his Aboriginality and Marduntjara heritage; and also to his wife Norma, his older son, daughter-in-law and grandson, Aaron, Meredith and Mitchell, his daughter Lisa, and younger son John.

Foreword

There is no need for the author of a brief foreword to go over again the biographical ground covered so capably and sensitively in Ian Howie-Willis' preface. My acquaintance with Gordon Briscoe and his work began with the BA honours dissertation mentioned there, `Aborigines in Australian History: The Development of Capitalism in the Northern Territory'. A strikingly ambitious title for a bold work, which I thought was a conglomerate of rich information, heady Marxism and fresh ideas. A fair while later I read his MA thesis, and noticed how comfortably he moved between subjects more commonly observed apart, such as the extension of a South Australian railway line and the fate of Aborigines. The next of his substantial writings I read was a powerful `appreciation' of Kevin Gilbert, and then an essay on `The historiography of relations between Indigenous people and other Australians, 1788–1988', sitting proudly in the international journal *History Workshop*, where it must have introduced many scholars outside Australia to that momentous subject.

His first words at our first meeting were `You wrote a book about my uncle!' That was *The Stuart Case*. This year, as I worked on an epilogue about Max Stuart's life from convicted murderer in 1959 to respected Arrernte elder in 2002, Gordon Briscoe gave me indispensable help towards understanding the personality and world of his kinsman. I still hope he himself will delve more deeply into that remarkable story than I could do as an outsider.

We got to know each other when he came to the history department in the Research School of Social Sciences as a doctoral student. I found in him a Socratic approach to truth, relishing disagreements and dissatisfied with agreements. In his own writing and in his comments on other people's work, as well as in seminar and tea-room, he always combined the strenuous quest for a theoretical framework with an equally energetic recognition of history's irreducible complexities. We've had many workouts, all of them stretching my mind and all conducted (on his side at least) with unflinching vigour and unfailing charm.

Like many people I had cause to be impressed by his fierce determination to travel the unusual track from dedicated activism to dedicated scholarship — a distinction he might well contest, on the ground that scholarship itself is, or ought to be, a kind of activism. The thesis which has become this book is so far the largest achievement of his journey.

Counting, Health and Identity is the fruit of wide, deep and astute reading in archival sources and public works. It is well-organised: the case for concentrating on and comparing Western Australia and Queensland is convincingly made, and the transitions from place to place and period to period are nicely ordered. In conversation along the way I'd never quite understood why Briscoe chose health as his theme. Now I see that this approach enables him to put Aborigines at the centre of a complex story, as other parties variously administer them, employ them, evangelise them, segregate them, and do their best and their worst to accommodate the old inhabitants in the newcomers' world — and as the indigenous parties to these encounters variously respond to their intruders.

The title signals the importance of *counting*. Governments and their servants couldn't avoid taking some responsibility for the health of Aborigines, if only from fear of infection. That required the authorities to have them counted; and for that to be done they had first to be defined. Briscoe shows how difficult it could be to answer the question `Who is an Aborigine'. He finds that some estimates of their numbers were wildly wrong, and wonders why, and he shows how mythical exaggeration of indigenous populations in both Western Australia and Queensland had practical consequences.

Above all, perhaps, the focus on health yields what I think may be new perspectives on the policy of *protection*. Briscoe explores the complexities covered and sometimes concealed by that word, revealing the hopes, dilemmas and failures of protection — and also its successes. As he sums up his findings about the two states over forty years: `Contrary to contemporary popular thinking, there was no protracted dwindling of the Aboriginal population but a resurgence to levels possibly higher than ever before. These circumstances, in contrast to present conventional wisdom, were both created and assisted by the policy and practice of protection.

Aboriginal females of both full and mixed descent benefited most, but so did the aged males of full descent.' Gordon Briscoe's journey to that conclusion is a model of judicious and patient scholarship.

Here as in earlier work, his curiosity is relentless and his recognition of complexity is unblinking; though when he questions `conventional wisdom' he does so with discrimination: Socratic, not iconoclastic. Among other quiet revelations he finds little racially motivated violence. Whatever may have been true at other times and places, massacres have hardly any place in this story. Occasionally he may see class where another observer might see race, as when he writes: `Relations were not always amicable between Aboriginal pastoral labour and pastoralists in the Gulf and Cape, but this represented an on-going structural conflict between land owners or managers and local labour rather than racial strife.' But such readings of events are rare: this is a work, it seems to me, more of mindful empiricism than of Marxism.

One publication Gordon Briscoe imagines coming out of the Australian National University's new Indigenous History Centre would be entitled `Questions, Questions, all the time Questions.' That could stand as a manifesto, and a message to all historians in the field.

For readers and writers about the interactions of indigenous and other Australians, and about comparable encounters in other colonized countries, the publication of *Counting, Health and Identity* is an event to be warmly welcomed.

Ken Inglis
Research School of Social Sciences
Australian National University

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About the Author

Gordon Briscoe, MA, Ph.D., was born in 1938 in a 'native institution' in Alice Springs in the Northern Territory of Australia. He was a refugee from the Japanese attack on Australia in 1942 and evacuated to Mulgoa, NSW. He was later educated in Adelaide, South Australia, at an institution for halfcaste Aborigines and then travelled to England to play sport. On his return to Australia he completed matriculation studies to enter the ANU, in 1968. In 1970, he became the first Field Officer for the Redfern Aboriginal Legal Service and the first President of the Redfern Aboriginal Medical Service. In 1972, he ran on a 'land rights' ticket for the Australia Party. He resumed studies in 1982, graduating with a BA (honours history) and an M.A. He began doctoral studies in 1992 and graduated with a Ph.D. in the history program, RSSS, ANU in 1997. He and his colleague, Len Smith, edited a book, *The Aboriginal Population Revisted* published by Aboriginal History Inc., in 2002. He is currently a Research Fellow in the new Centre for Australian Indigenous History, RSSS, ANU.

About the Artist

Lena Campbell, whose painting, *Honey Ants*, is on the cover, was born in Alice Springs and grew up in Titjikala. Her mother is a Luritja woman from Mt Eyre, near Finke, and her father was from Titjikala. Her grandfather was a Pitjantjatjarra man. Lena's Tjukurrpa is Eagle Dreaming and her language Luritja. Lena is an active member of the Titjikala Community Council and also the Titjikala Women's Advisory Council. She exhibited her work at the Araluen Cultural Centre in Alice Springs in 2001 and 2002.

Acknowledgments

While this book is my own work, it has benefited greatly from the input of a large circle of my advisers, critics and facilitators. The book has its origins in a doctoral thesis in the History program within the Research School of Social Science at the Australian National University (ANU). My work began under Professor Ken Inglis and continued under his successors, the late Professor Paul Bourke and Professor Barry Higman. Professor Higman provided essential support via my post-doctoral fellowship and subsequent visiting fellowships, which gave me the resources and convivial collegiate atmosphere to make possible my further research. My research also owed much to my colleagues, Dr Len Smith and Professor F.B. (Barry) Smith, for their encouragement and advice. I am grateful for the guidance and support that these eminent scholars so willingly gave me during my years at ANU.

My next debt is to the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) in Canberra, which accepted my manuscript for publication. Russell Taylor, the AIATSIS Principal, saw value in my work and placed it before the Publications Committee, chaired by Dr Luke Taylor, the AIATSIS Director of Research. Dr Taylor and another committee member, Dr Graham Henderson, an AIATSIS Senior Research Officer, strongly supported my work for publication. The AIATSIS staff who manage the library and photographic archives provided me with their accustomed excellent service as I revised the manuscript and selected photographs. Dr Richard Barwick of the ANU School of Botany and Zoology also did excellent work in producing my maps and developing the jacket design. The latter is based on a painting by Lena Campbell of Tjitjikala in the Northern Territory, whom I also wish to acknowledge. I thank Sandra Phillips, the Managing Editor of Aboriginal Studies Press, and her staff for their helpful, prompt and efficient action in taking the book through the successive stages of the publication process. In addition I thank Alana Harris and Otis Williams of the Access Unit of the AIATSIS Audio-Visual Archives for their help in accessing the huge AIATSIS photographic and film collections. Similarly, I thank Janice Aldridge for her efficient effort in producing the index. I also thank my editorial adviser, Dr Ian Howie-Willis, and his wife Margaret for their kindness and hospitality as we worked on the manuscript.

A debt of another kind is to my fellow historians, past and present. All historical writing builds on the work of earlier historians and earlier texts. In this context I acknowledge my debt to the late Charles Dunford Rowley, Peter Biskup, Anna Haebich, Mary Ann Jebb, Henry Reynolds and Tom Stannage, whose work on the indigenous source materials has pointed the way ahead for succeeding generations of historians of the Aborigines.

Finally, I thank my family—my wife, Norma, my older son, daughter-in-law and grandson, Aaron, Meredith and Mitchell, my daughter Lisa, and my younger son John—for their loving support, their loyalty and their patience. I have relied on this strongly for as long as they have been my family. They know that my research and writing often take me away from the family circle, but they may not know how profoundly aware I am of my debt to them.

Gordon Briscoe
Canberra
April 2003

Preface

This is a significant book. Its significance lies as much in its author and in the circumstances leading to its writing as in its subject matter, which is an extended argument about Aboriginal epidemiology and historical demography.

My conviction that the book is historically significant arises from my friendship with the author, Dr Gordon Briscoe, dating back some 12 years. I first met Gordon early in 1990, shortly after beginning work as the senior editor of *The Encyclopaedia of Aboriginal Australia*, a five-year project then just getting under way. Among my early tasks was the writing of his biographical entry for *The Encyclopaedia*. Our friendship began in the days I worked on that task, although he was initially suspicious of the motives of whites wanting to write the biographies of blacks. Soon realising that he had thought deeply about the portrayal of Aborigines in history texts, I persuaded him to contribute to *The Encyclopaedia* an entry on the historiography of Aboriginal history. His short (300-word) essay was typically thoughtful and provocative, arguing that because histories of Australia had generally 'written out' the Aborigines, the current historiographical task was to write them back in.

By the time Gordon had submitted his contribution we had debated the theory and practice of history at great length. My *Encyclopaedia* colleagues usually knew when Gordon was visiting because the sound of fierce argument would echo along the corridor. (To say that Gordon is passionate about historiography would be to understate the matter seriously.) Our collaboration continued as I provided him with editorial advice on the manuscript of his thesis, 'A Social History of the Northern Central Region of South Australia, 1950–79', for which the Australian National University (ANU) awarded him its M.A. degree in 1991. Our friendship also developed, helped possibly by the attraction of opposites. Although we were about the same age we were from opposite sides of the track — he was Aboriginal and had grown up in a boys' home in working class Adelaide; I was Anglo-Celtic and raised in the security of a close-knit family in middle class Melbourne.

It seemed a waste of talent for Gordon's blossoming academic career to end with his M.A., so I encouraged him to apply for a Ph.D. scholarship

at ANU. He was awarded the scholarship soon after and began working on his doctoral thesis in early 1993. He chose a difficult topic in historical demography, but it allowed him to explore one of his main interests — Aboriginal identity and the changing definitions of Aboriginality. As earlier with his M.A., I gave him editorial advice after he had written the first draft of his thesis. By this time he had become a friend of my family, and so we were all delighted when the university awarded him its Ph.D. degree in 1997. This book is based on his doctoral research.

Gordon Briscoe's journey into academia has been long and hard. Now approaching his 64th birthday, his life experiences reflect Aboriginal history since the late 1930s. Indeed his career can be seen as a microcosm of Aboriginal history over that time. Thus, he was born and spent his early childhood near Alice Springs at 'The Bungalow', the home for 'half-caste' Aboriginal women and children. He never knew his white father, who was killed in a truck accident before he was born, and he only learnt about his paternity decades later. During World War II he and his mother, Eileen Briscoe, were relocated to a hostel in rural New South Wales when the Northern Territory 'half-caste' population was deported interstate as a wartime precautionary measure. (Native Affairs officials feared that 'half-castes' might side with the Japanese if Australia were invaded.) At the war's end Gordon effectively became a member of the 'stolen generations' when he was placed in St Francis's Anglican home for 'half-caste' boys at Semaphore, Adelaide. Scrupulously honest intellectually, Gordon does not claim to have been 'stolen' because Eileen placed him in the home voluntarily. Despite that, his experience of being institutionalised was little different from that of other fair-complexioned Aborigines removed from their families for rearing in children's homes. He spent much of his boyhood and youth at St Francis's, along with other Aboriginal leaders of the future, notably John Moriarty and the late Charles Perkins.

Leaving school barely literate in 1953, Gordon Briscoe worked at shovelling coal and sweeping out trains for the South Australian railways. Life as an unskilled labourer turned him into an active trade unionist and awakened his life-long interest in social justice and social theory. In his late teens his natural sporting talent led him into a career as a professional sportsman, at first in boxing and Australian rules football with the Port Adelaide club, and later in soccer and cricket. Eventually his skills took him to the UK as a professional soccer player and cricketer in Lancashire in the early 1960s. While in England he met Norma Foster at a dance in

London. They married in 1962. The first of their three children — Aaron, Lisa and John — was born in England before the family decided to settle permanently in Australia.

After returning to Australia in the mid-1960s, Gordon became deeply involved in the emergent Aboriginal political movement. Based in Sydney at first, he was employed as a research officer by the Foundation for Aboriginal Affairs, an 'Aboriginal advancement' organisation of that era. It was a job his old friend from St Francis's, Charles Perkins, arranged for him. He soon came to prominence as one of the leading young activists of the advancement movement. Along with Charles ('Chicka') Dixon, Gordon was among the small group of younger activists who became the spokesmen for the first truly national indigenous political organisation in Australia, the Federal Council for the Advancement of Aborigines and Torres Strait Islanders (FCAATSI), of which Gordon eventually became National Secretary. This was the era of the 1967 referendum on Commonwealth powers in Aboriginal affairs and the 'Tent Embassy' in Canberra in 1971–72, in each of which Gordon played a key leadership role.

Always interested in the practical aspects of social theory, Gordon became *the* leading figure in the Aboriginal Health Service and Aboriginal Legal Service movements. He was the co-founder and principal activist of both the Redfern Aboriginal Health Service and the Redfern Aboriginal Legal Service during the late 1960s. It was Gordon who also sought and gained the involvement of the late Professor Fred Hollows in his national Aboriginal ophthalmic health program. Gordon then became the Assistant Director of the National Trachoma Program, which was Hollows' first major health project among Aborigines. Over the succeeding years Gordon and Fred remained close friends and collaborators; and after Fred's death, Gordon helped establish the Fred Hollows Foundation, of which he remains a member.

During the late 1960s Gordon also became a close friend and collaborator of the Communist novelist and social commentator Frank Hardy, who in 1967 spent time living among the Gurindji people after their famed 'walk-off' from Wave Hill station in the Northern Territory. During this period Gordon was one of Hardy's principal informants, and advised him as he was preparing his book *The Unlucky Australians*, an exposé of the 'Third World' living conditions of many Aboriginal communities.

Significantly, both Hardy and Hollows later named Gordon in a 1992 joint interview published in *The Australian* [newspaper's] *Weekend Magazine* as 'the most influential person' in their lives.

Gordon moved to Canberra with his young family in the early 1970s to join the Commonwealth Public Service at a time when its range of programs targeting the indigenous peoples was multiplying rapidly. He spent the next two decades working in various administrative positions in the Commonwealth Departments of health and Aboriginal affairs. His personal life experiences, political involvements and administrative career had convinced him that history was the best means for understanding the cultural and societal changes that had overtaken the Aborigines. He accordingly set out to learn more about it. This in turn led him to discover his historian's vocation.

Gordon Briscoe's career path as a professional historian has been long, tortuous and arduous. He became an historian the hard way. There is of course no 'easy' way, but Gordon's was particularly difficult. With his scant secondary education 20 years behind him, his first step was to gain an Intermediate [Year 9] Certificate at night school. The next step was a part-time adult matriculation course. He then enrolled at ANU and completed a B.A. (Hons. II[b]) degree in History and Sociology. Although his B.A. honours dissertation, 'Aborigines in Australian History: The Development of Capitalism in the Northern Territory', had won an Aboriginal writers' award, his 'Hons. II(b)' degree was deemed insufficient for postgraduate study, and so he undertook the university's M.A. qualifying program in history. This time his dissertation was on the documents of the British weapons and nuclear testing in South Australia in the 1950s. He passed muster in the 'MAQ' program and then went on to complete his M.A. He earned these qualifications part-time while working full-time in the Commonwealth Public Service, a period of employment that included an appointment as the Indigenous History adviser to the Australian Institute of Aboriginal and Torres Strait Island Studies during the late 1980s.

By completing his Ph.D. degree, Gordon Briscoe became the first Aboriginal person ever to have earned a doctorate in History. There had been other Aboriginal doctorates before his, most of them honorary, but his was the first in History. His interdisciplinary doctoral topic, at the point where historical demography intersects with epidemiology, was an

unusual choice for a student without an earlier degree in either demography, statistics or health studies. Gordon Briscoe has never shied away from a challenge, however, and through dogged persistence eventually stamped his own authority on his topic.

Since graduating, Gordon has worked full-time as a professional historian via a series of post-doctoral fellowships at ANU, where he is now a Visiting [i.e. non-salaried] Fellow in the Research School of Social Sciences. As such he has researched and written widely, served on a range of academic councils and boards, advised other historians, conducted seminars, arranged symposia, encouraged other scholars and especially younger indigenous scholars, and facilitated a series of historical research projects. Over the past decade he has published widely in academic journals and symposia. His published writings include research articles in refereed journals, review articles, correspondence, book reviews, obituaries and commentaries on historiographical issues. In November 1999 he organised and conducted a symposium on indigenous demography at the Jabal Centre at ANU, the papers from which he subsequently compiled and edited for the journal, *Aboriginal History,* in its occasional series of monographs.

Apart from his published works, Gordon's particular continuing interest is the historiography of Aboriginal history. He is a profound original thinker on this issue, and his views here are widely sought by scholars both in Australia and overseas. In part he has pursued this interest through his membership of the Editorial Board of the journal, *Aboriginal History*, of which he has been a leading member for the past decade. In his own contributions to the journal and in Editorial Board discussions he has stimulated debate on Aboriginal historiography and been largely responsible for prompting the Board to adopt a more pro-active focus upon historiographical discourse. His stimulating encouragement of other historians in their attempts to attain a more incisive, more rigorous and more comprehensive understanding of Aboriginal historiography has been highly productive.

One little known but critical aspect of Gordon Briscoe's academic career has been his encouragement of the next generations of Aboriginal scholars. Having personally blazed a trail through postgraduate studies in history, he is first and foremost a worthy, inspiring role model for younger Aborigines setting out into academic careers. His fostering of young

talent is, however, not only by example but through personal assistance. His advice to and nurturing of both undergraduate and postgraduate indigenous students at ANU in particular has been an important factor in the steady growth of indigenous enrolments at the university over the past decade. The abiding symbol of Gordon's commitment to Aboriginal education is the Jabal Centre, ANU's resource facility for indigenous students. He was a co-founder and is a continuing Management Board member of the Jabal Centre, an institution that is now central in the lives and academic careers of the university's indigenous students. More recently he has participated in a major review of indigenous education at ANU. This led to two major reforms—the creation of the university's Institute of Indigenous Studies and the Australian Indigenous History Centre within the Research School of Social Sciences.

The above reflections on Gordon Briscoe's life and career are but an outline. My conclusion is that he personally reflects the broad course of Aboriginal history over the past six and a half decades, as official policy on Australia's indigenous peoples has swung through successive phases, from 'protection', through 'assimilation', 'self-determination', 'integration' and, more recently, the seeking of 'separate sovereignty' (the last of these an indigenous rather than an official response to history). Gordon, however, is no passive, disinterested observer of historical trends. Instead, at all stages of his own personal journey he has been an agitator encouraging Aborigines to make their own conscious impact on Australian history. I am privileged to have known such a person. I feel honoured by his friendship. And I commend this book to readers.

Ian Howie-Willis, OAM
Canberra
April 2003

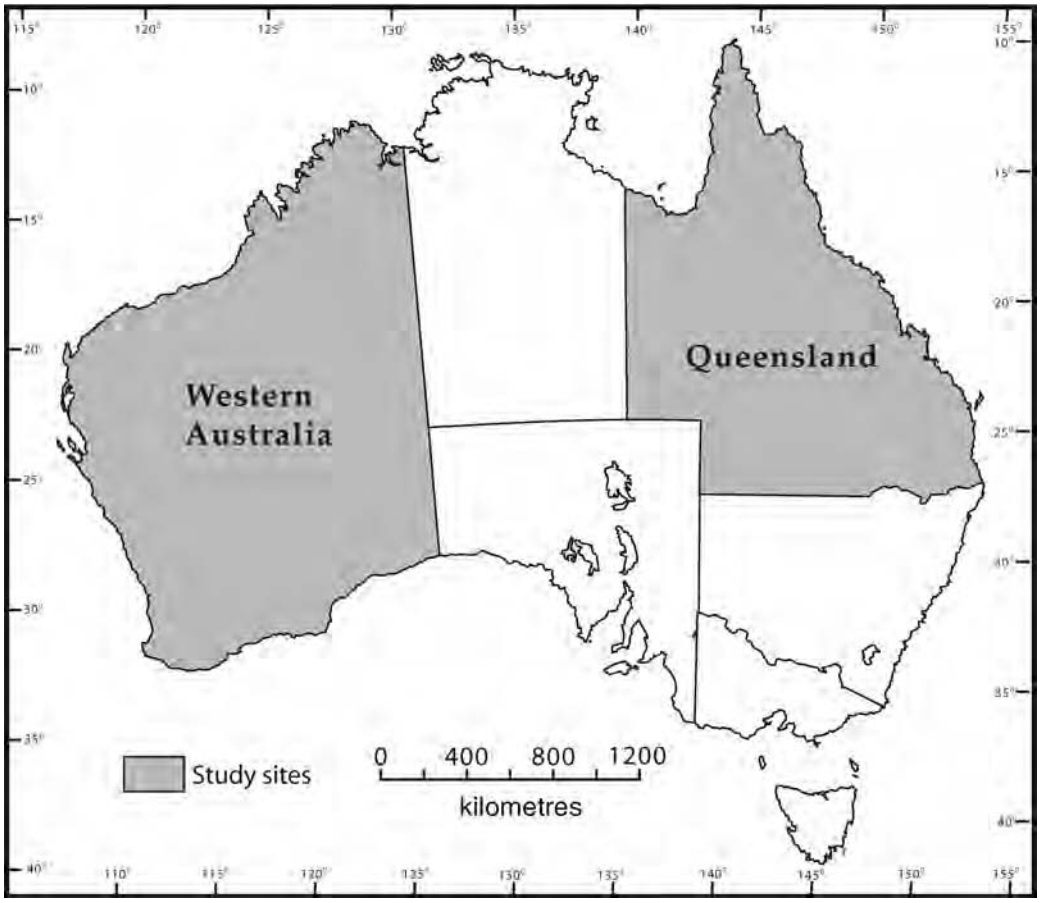
Introduction

As its title suggests, this book is about the counting of Australia's Aboriginal people in censuses. It is also about the vexed issues of Aboriginal health and Aboriginal identity, or, to use a term currently in vogue, Aboriginality.

The book investigates the biomedical and social consequences of disease, health and healing, and how these have shaped Aboriginal and settler history in Australia. In particular it deals with disease and the development of health and medical care services for indigenous people[1] in Queensland and Western Australia from 1900 to 1940.

Why limit the time span to 40 years in one century when Aboriginal health remains a scandal six decades later at the beginning of the next century? Most contemporary observers throughout this period believed that the Aborigines would disappear, eventually if not sooner. This sentiment was most famously expressed in Daisy Bates's book, *The Passing Of The Aborigines*.[2] The notion of a disappearing indigenous people persisted everywhere until World War II. The reality, however, was rather different. In part, the size and nature of a widely and sparsely scattered indigenous population hid the truth. In part, too, the differential rate of development in Queensland and Western Australia disguised what was happening. The pace was slower in the north than in the southern and coastal strips during the nineteenth century, and faster in the northern regions later on.

Why, too, does the book examine only two Australian States when there are four others, plus the vastness of the Northern Territory—all with Aboriginal populations, all with their own dynamics of Aboriginal demography? The answer lies in scope and scale. To have included all the States and Territories would have required more than one book, and more years of research than I can afford. Meanwhile, Queensland and Western Australia together comprise about 55 per cent of Australia's surface area and embrace 42 per cent of its present Aboriginal population.



Map of Australia indicating the regions discussed in the text.

Further, as well as occupying opposite sides of the continent they are the only States that extend into the tropics, where some diseases occurred—especially leprosy—that impacted much more heavily on Aborigines than on other racial groups. Further research in the other States and Territories would obviously lead to a clearer view of Aboriginal historical demography. In the meantime, however, it is safe to say that the experience of Queensland and Western Australia provides a generally accurate predictor of what was probably happening elsewhere in Australia in the four decades studied in this book.

Some observers believed that the disappearance of indigenous groups began with the violent confrontations between them and white settlers.[3] Others thought that Aborigines were dying out because of the effect of disease contracted from white settlers and Asian seamen. Still others believed the cause was the loss of customary living environments that contained sources of food and water.[4] As colonies, both Queensland and Western Australia had enacted legislation in an attempt to protect Aborigines from exploitation, violence, disease and starvation. Various studies have examined violence and Aboriginal labour exploitation[5] under colonial settlement;[6] few have looked at prewar disease, health and healing or the provision of health care services to indigenous people.

Diseases and social action do not always act independently of the social milieu in which they are found.[7] Stephen Kunitz has noted in *Disease and Social Diversity*[8] that developments in the biological sciences have transformed medical practices by promoting the idea that bacteria and viruses have a 'natural history' of their own. He argues that such knowledge from biology is relevant in cultural and institutional studies as well:[9] there is hope for productive 'cross-fertilisation between biomedical (universalistic) and anthropological (particularistic) models of causation'.[10]

Kunitz's approach is applicable to the study of disease, health and healing among indigenous people in Queensland and Western Australia because the natural history of disease helped shape the indigenous peoples' social relations during the nineteenth and twentieth centuries.[11] Other factors also exerted an influence. Disease cannot be divorced from history, either natural or social. The indigenous people can be seen as patients as well as colonised races. The system of Aboriginal administration, including government protectors, magistrates and police, along with doctors,

hospital health workers, pastoralists and missionaries, was crucial in shaping both indigenous and non-indigenous responses to disease and health.

Until D.J. Mulvaney's[12] and F.G.G. Rose's[13] ground-breaking work in the 1950s almost no historians had included accounts of Aborigines in their studies, let alone Aboriginal health. In the late 1960s and early 1970s C.D. Rowley drew heavily from the anthropological studies of W.E.H. Stanner, A.P. Elkin, and R.M. and C.H. Berndt,[14] and also from government records.[15]

Since Rowley blazed the trail with his trilogy of Aboriginal histories, completed in 1972, other writers have made efforts to include the indigenous peoples. They fall into two groups. The first includes historians and social anthropologists; the second consists of scholars who bring other disciplines to the study of the Aboriginal past. Of the first group, Mulvaney and Rose influenced other historians, notably Manning Clark and Russel Ward, who did attempt to accommodate Aboriginal history but only in a limited way. Clark mentioned Aborigines as being dispossessed and disease-ridden. Referring to Sturt's expedition to South Australia, he wrote that in January 1830 Sturt thought that he saw Aborigines bearing the effects of syphilis.[16] Ward wrote about Aborigines in a subservient role teaching bush skills to escaped convicts and pastoralists, who then thrived 'up country'.[17]

In contrast to the passivity which Clark and Ward ascribed to indigenous people, later historians and social anthropologists have been at the forefront of reconstructing a colonial history that does feature Aborigines. Such an approach was obvious in the first part of Rowley's trilogy, *The Destruction of Aboriginal Society: Aboriginal Policy And Practice*.[18] Rowley's main purpose was to identify Aboriginal Australians and to highlight for Australians the way they had oppressed the indigenous peoples, first by dispossessing them and then by denying them access to citizenship, democracy and a heritage. Rowley reconstructed his account of Aboriginal history from a combination of economic, political and anthropological sources, drawing together historical and ethnographic texts to include Aborigines into the narrative. He described and defined Aborigines (as people of Aboriginal descent and who are accepted by their own groups and, finally, who identify as such) for Australian society of the 1960s.

Rowley's contribution to a better understanding of Aborigines' place in Australian history is evident as indicated in a recent critique of Australian historiography. Keith Windschuttle has said that before Rowley,

> the great dramas of nineteenth century Australian history were all assumed to have taken place within the realm of the new arrivals: convicts versus jailers, gold diggers versus troopers, selectors versus squatters, labour versus capital. Without commenting at all on the existing picture, Rowley cut it down to size overnight.[19]

Rowley also described Aborigines from a national point of view. He defined them in national demographic, political and economic terms.[20] As Windschuttle has pointed out, Rowley's perspective was not an Aboriginal one[21] but arose largely from the paucity of Aboriginal documentary and biographical sources. As a result Aborigines remained shadowy figures in his trilogy, even in the events in which they participated, although he made every attempt to use diverse sources and methods,[22] to bring the Aboriginal point of view into the narrative. He borrowed the American historian Frederick Jackson Turner's[23] metaphor of a frontier moving over time to divide pre-contact indigenous people from settler society as the legal limits of the colonial state ebbed and flowed. He combined this metaphor with an analysis of the politico-economic effects of the settler society on Aborigines. Turner was reacting against abstract depersonalised political history,[24] but, writing much later, Rowley's intention was to highlight the dispossession, political and economical dependence of indigenous groups through colonial oppression. He saw that reparations could be won if Aborigines adopted political strategies based on their own self-interest within the Australian political structure. At the same time, other writers were beginning to write on both the epidemiological and demographic aspects of Aboriginal history.

One who had begun emphasising the importance of epidemiology and demography was Peter M. Moodie, a researcher at the School of Public Health and Tropical Medicine at Sydney University. In outlining the social nature of indigenous health, Moodie explained that to appreciate the epidemiology of indigenous health the nature and structure of the Aboriginal population had to be considered. Moodie wrote about Aboriginal health from data collected after World War II.[25] He published his work in 1973, a year after the last volume of Rowley's trilogy had appeared[26] and three years after the publication by J.P.M. Long,

Aboriginal Settlement, which was published in the same series of studies as Rowley's.[27] Two other works covered detailed analyses of the national Aboriginal population in this period. These were by writers Leonard Broom[28] and F. Lancaster Jones,[29] who wrote mainly about broad post-contact and post-Second World War national population trends, and questions of identity. These writers did not give any detailed localised analyses, nor did they explain what had happened to the Aboriginal populations at a regional level as their focus was on the broad demographic trends arising from population dynamics.

Among the works of other writers on Aboriginal depopulation from the 1920s to the 1980s two themes were most prominent. On the one hand, one group of writers, including Edmund Foxcroft (1920s),[30] Paul Hasluck (1930s)[31] and, more recently, Noel Butlin (1980s),[32] emphasised the impact of exotic disease on the level of mortality of Aborigines. On the other hand, another group of writers that included Grenfell-Price (1930s),[33] Charles Rowley (1960s),[34] Fay Gale (1960s),[35] Noel Loos (1980s)[36] and Diane Barwick (1970s),[37] emphasised the dominant role of violent massacres and colonial politics, as well as disease. All of these writers belonged to the group of earlier historians and social anthropologists who succeeded in writing Aborigines firmly into the mainstream of Australian historiography. There is, however, a second, later group, whose work I will now discuss.

This second group brought a new discipline to the study of Aboriginal history. The group consisted of three contemporary scholars who brought not only new epidemiological and demographic methodologies but also a level of fine detail to Aboriginal history.[38] The first of these scholars, Leonard R. Smith (1985),[39] wrote a monumental work on the national Aboriginal population. A demographer and epidemiologist, Smith followed Rowley by showing how the modern Aboriginal population was constructed and how a people without writing could speak through a larger process of demographic historical narrative. Smith demonstrated that the mixing of the races, resulting in substantial numbers of Aboriginal people of mixed descent, had a distorting effect on Aboriginal history. Employing national census material and other historical primary and secondary sources, he described how the Aboriginal population had recovered from the apparent decline in the colonial era, when each colony dealt with the issue in a different way. After federation a national

approach became possible, and the beginnings of a common approach emerged. Smith elected to focus on broad national demographic circumstances. Alan Gray (1980s) and Stephen Kunitz (1990s), by contrast, have emphasised the importance of local perspectives.

Gray's 1980s doctoral work focused on Aboriginal fertility and the determinants of Aboriginal population and health in a region of New South Wales.[40] This study was significant because it presented an alternative to all-embracing historic models and allowed us to see Aborigines as actors in their own right. Gray attacked popular ideas about disease as a factor in Aboriginal history, and also those ideas about massacres as a factor in the depopulation of Aboriginal groupings wherever white settlement occurred.[41]

An interest in disease patterns prompted Gray to focus on the occurrence in the Aboriginal population of disease syndromes 'interpreted as characteristics of a hunter-gatherer population … or in some cases of the disruptive effects of introduced diseases on a hunter-gatherer population'.[42] Gray attacked anthropologists of the period from the late-1930s to the 1950s, who dwelt on disease and massacres when assessing the Aborigines of mixed descent, claiming this prescription amounted to a form of 'social Darwinism'.[43] Recently the pendulum swung back, however, to place greater emphasis on the local cultural effects that European expansion had on indigenous peoples.

The other writer in the second group and writing in the 1980s and 90s, is Stephen Kunitz, an international scholar who writes widely on European settlement and its effects on indigenous health. He included a chapter on Queensland Aborigines and their epidemiological past in his most recent book, *Disease and Social Diversity*.[44] He called for a revisionist approach to the study of disease and the role it has played in European dominance over indigenous groups. The Queensland study briefly described aspects of Aboriginal health as Aborigines became affected by 'settler capitalism'[45] and the advance of the state in Australia during the nineteenth and twentieth centuries.[46] Kunitz exposed the way all-embracing generalisations obscure the real underlying mosaic of the struggles that indigenous populations maintained in the face of other peoples expanding into their environments and intruding on their ways of life.[47] He argued that if all these local encounters are indiscriminately lumped together, the histories of indigenous groups become obscured. This can happen if diseases are

assumed to have wiped them out, or seriously weakened their cultural resistance. Their action to escape such influences accordingly remains hidden. Their reactions are therefore omitted from the history that other non-Aboriginal writers produce. In addition, Kunitz believes that different kinds of federalism have produced different kinds of health outcomes for indigenous peoples.[48] The models developed by the second group of writers are particularly relevant to this study because they represent a historiographical shift towards the inclusion, in historical narrative, of peoples without historical writing of their own.[49]

With the foregoing historiography of the Aborigines in mind, I will now briefly discuss the content of this book. Chapters 1 and 2 are descriptive demographic studies. My purpose in Chapters 1 and 2, is to define what was meant by the use of the term 'Aborigines' as used in Western Australia and Queensland. I use the language as used by the official 'protection' agencies of these two States. There was a rhetoric of 'protection' which pervaded the administration of 'native' peoples and this rhetoric must be understood. For example, indigenous people were referred to either as 'natives' or 'full-bloods' and 'half-castes' by both administrators and settlers. In both colonies, administrative exigencies and population dynamics together changed the population components of these groups. That is the notion of what officials meant when they asked the questions: what and who was 'an Aborigine'? It is important to note that these terms changed over time, the focus shifting from biological to social determinants. I investigate these changes through time series studies. Both chapters investigate the Aboriginal population age structure, the contributions to total increase made by the various racial and cultural groups of the indigenous population and the sex ratios of males to females, and finally expose the differences and similarities of the Aboriginal population over time.

The purpose of Chapters 3 to 6 is to investigate the development of health and medical service provision to indigenous people in Western Australia from 1900 to 1940. Chapter 3 also investigates the transitions that saw the instigation of protective legislation—and subsequent employment of protectors—which remained in force from the 1890s to 1936. In the same chapter I describe the way the Chief Protectorate changed under Henry Prinsep and his successor Charles Gale between 1898 and 1910, a period that included an epidemic of venereal disease and the Royal Commission on the Condition of the Aborigines.

Following Prinsep's departure as Chief Protector Gale reduced the importance and scope of the position. The contraction occurred, for example, in the reporting mechanism for bringing together data on Aboriginal groups. Where information on the condition of the 'natives' consisted of statistical data, Gale disposed of some strategies for reporting to Parliament and personally carried out field trips to investigate Aborigines across the State.

Chapter 4 looks at the period 1910–20, Chapter 5 at 1920–30 and Chapter 6 at 1930–40. Chapter 4 explains the transition period when the responsibility for Aboriginal administration passed from Gale to A.O. Neville (who now seems destined to be remembered mostly for his unflattering portrayal in the 2002 film, *Rabbit-Proof Fence*). By 1919 the venereal disease epidemic had begun to subside, which in turn allowed the two lock-up hospitals to be closed. New hospitals on the mainland opened and soon began to fill up with leprosy patients.

Throughout the period 1920–30 leprosy increased slowly and moved north from the Gascoyne, the Pilbarra and into the Kimberley indigenous populations. Other health problems, including access to health services, continued into the 1930s and leprosy increased in alarming proportions, striking fear among the patients, the carers and the protection agents alike. Neville ushered in a process of movement by Aborigines into country towns, demanding hospital and general practitioner care. Separate 'native' hospitals were built, but this reduced rather than increased the prospects of Aborigines gaining hospital beds when they or their relatives became unwell.

Queensland history differs from that of Western Australia because of the higher degree of institutionalisation of Aborigines in that State from as early as the 1880s. Chapters 7 to 10 deal with Queensland and are structured in a similar way to the Western Australian chapters. My purpose is the same: to investigate the development of the provision of health services to indigenous people in Queensland

Although comparisons between the two States are made throughout, I look at each separately because even though they were similar they were separate, and any further comparisons would have made this study unmanageable. In addition, I examine each decade between 1900 and 1940 and pursue a study of the patterns of health and administrative health structures in Western Australia and Queensland as they affected

mission, reserve, institution, fringe-camp and bush populations. A short concluding chapter points to the differences and similarities between the experience of Western Australia and Queensland. It also suggests that parallel studies in the other States and Territories should be undertaken.

Throughout the book a continuing paradox lurks in the background. This is that Aboriginality is a condition defined not by the Aborigines themselves but by the settler societies. In the period of study questions of identity were not the primary concern of indigenous groups, for they knew who they were. By contrast, in the modern era the indigenous peoples no less than others are concerned with teasing out the complexities of 'Aboriginality'—a term that has only entered the Australian lexicon in recent decades. Coping with the onslaught of the settler State, as represented by legions of missionaries, protectors, police and townsfolk, was the major preoccupation of Aborigines in both Western Australia and Queensland for the whole period 1900–40. Compared with that, fretting over the nuances of their identity was a low priority, if it happened at all.

I hope that the book helps readers to see the Aborigines emerging from the past as authentic actors in their own right rather than as either resisters on the one hand or passive recipients of welfare on the other. I will be well pleased if my readers come away from the book understanding that the Aborigines have always been active participants in Australian history and not some aberrant element which the colonial state had to accommodate.

For full References see Bibliography.

Notes

1. In this book I use the term ‘indigenous’ as a synonym for ‘Aborigine’ and ‘Aboriginal’, and I use them interchangeably. I do not attempt in any way to reconstruct the Torres Strait Islanders’ past, which would involve a separate thesis.

2. Daisy Bates, 1938, pp.1-2.

3. C.D. Rowley, 1970-71, Vol. I, pp.213-214, and pp.290-292.

4. A. Grenfell Price, 1949; Diane Barwick, 1963, see also, Diane Barwick, 1971; see Daisy Bates, 1938, p.65.

5. Dawn May, 1994, pp.45-46, and see pp.155-156; Frank Stevens, 1971, p.47; see also, Rowley, 1970, pp.64-73, and pp.157-186.

6. Henry Reynolds and Noel A. Loos, 1976; Henry Reynolds, 1972; see also, for an alternative viewpoint, Beverley Nance, 1981, pp.532-552.

7. Stephen J. Kunitz, 1994, p.5.

8. *Ibid*., pp.5-6.

9. Donald Denoon, 1994, pp.231-232.

10. *Ibid*., p.231.

11. In the use of the term 'social relations', I follow F.B. Smith when he says, that 'medical history … [is] the history of social relations', in F.B. Smith, 1990, p.11.

12. D.J. Mulvaney, 1964, pp.1-56.

13. F.G.G. Rose, 1965; and also see, Rose, 1954, pp.150-172.

14. W.E.H. Stanner, 1960; see also, Stanner, 1963; see also, 'Religion, Totemism, and Symbolism', 1965; see also, Stanner, 1979.

15. K. Windschuttle, 1994, p.117.

16. Manning Clark, 1981, p.64.

17. Russel Ward, 1958; see also, J.R. Beckett, 1958. In the thesis Beckett matched the mores of Aboriginal pastoral workers with those of early rural workers.

18. Rowley, 1970, Vol I.

19. Windschuttle, 1994, p.117.

20. C.D. Rowley, 1970, Appendix A, pp.341-364; see also, Appendix B, pp.365-398. The first paper in Appendix A discusses defining 'Who is an Aborigine?', a subject I discuss in chapters two and three below; and Appendix B discusses aspects of the national characteristics of the Aboriginal population.

21. Windschuttle, 1994, pp.117-118.

22. J.R.W. Smail, 1961, pp.71-102; see also, E.J. Hobsbawm, 1971, pp.20-45.

23. Peter Bourke, 1980, p.24. Frederick Jackson Turner was the American historian who launched a criticism in the 1890s on the dominance of political history at the turn of the nineteenth and twentieth centuries.

24. *Ibid*., pf; see also, A.L. Rowse, 1963, p.153; see also, Jacques Le Goff, 1971, pp.1-19.

25. Peter M. Moodie, 1973, pp.1-25.

26. Rowley, 1970, Vols I-III, 1970-72.

27. J.P.M. Long, 1970.

28. Leonard Broom and F. Lancaster Jones, 1973.

29. F. Lancaster Jones, 1970.

30. E.J.B. Foxcroft, 1941.

31. P.M.C. Hasluck, 1942.

32. N.G. Butlin, 1983.

33. A. Grenfell Price, 1949.

34. Rowley, 1970, Vols I-III, see in particular, pp.36-38, 115-115, 145-159, 205-214.

35. Fay Gale, 1964.

36. N. Loos, 1982, see in particular, pp.22-71, 103-106, 131-132.

37. Diane Barwick, 1963.

38. Hobsbawm,1971, pp.32-34.

39. L.R. Smith, 1975. This Ph.D. was published as L.R. Smith, *The Aboriginal Population of Australia*, ANU Press, Canberra, 1985.

40. Alan Gray, 1991, pp, 355-379; see also, A. Gray, 1985, pp.136-149.

41. Gray, 1991, p.357; see also, Gray, 1985, pp.140-147.

42. Gray, 1991, p.355.

43. *Ibid*., p.355; see also, N.B. Tindale, pp.140-231.

44. Kunitz, 1994.

45. Ibid., p.49, the use of the term of which he acknowledges followed Donald Denoon, 1983, pp.221-224.

46. *Ibid*., pp.82-120.

47. *Ibid*., pp.121-148.

48. *Ibid*., pp.4-6.

49. R. MacLeod and D. Denoon, 1991; and see also, Donald Denoon, 1988, pp.121-139; also see, Denoon, 1983, pp.217-224.

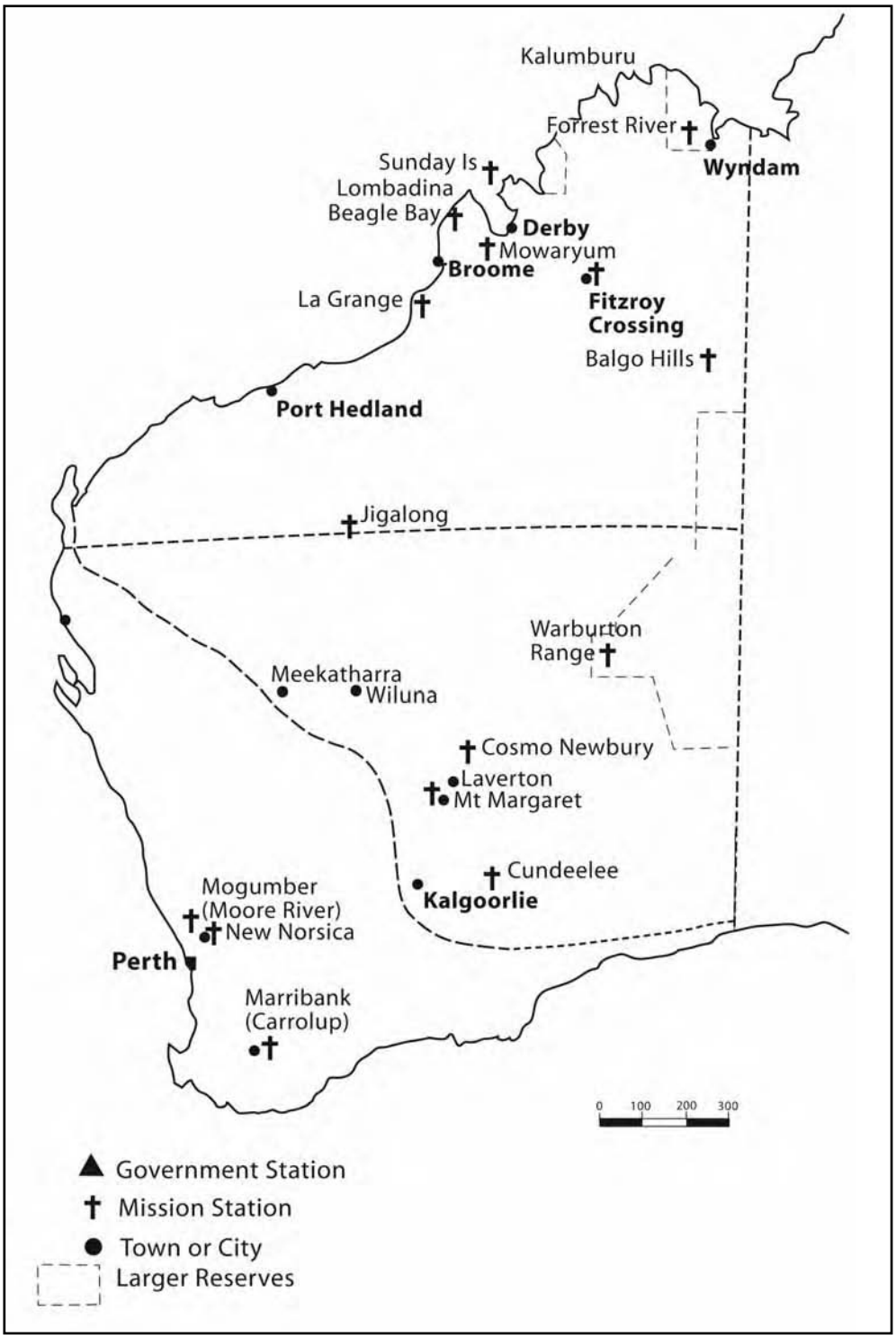
1

Disappearance or Resurgence: the Aboriginal population of Western Australia, 1900-40

Few events better suggest the dilemma of studying the Aboriginal population more than Daisy Bates' burial of an old man named Joobaitch in 1907. Bates, an eccentric daughter of the Northern Ireland gentry found her life's work among the Aborigines of Western Australia and South Australia. She later wrote that when Captain James Stirling sailed up the Swan River to found a colony in 1829, Joobaitch had been among the Aboriginal observers standing on the shore.[1] By the time he died he was in his early eighties and was, according to Bates, the last of his family group. In 1829 the family had numbered about 1,500 people living in the area now occupied by Perth.[2] People of full Aboriginal descent lived in most parts of Western Australia in 1900, yet Daisy Bates observed that, in areas where white settlers congregated, the numbers of Aborigines appeared to be falling drastically.

Assumptions about a 'disappearing population' often made by Bates and her contemporaries eventually proved to be a fiction. This was not easy to see at the time, however. Despite claims about a disappearing Aboriginal race, the number of Aboriginal people of Western Australia—people of full and mixed descent—actually continued growing. This resulted from the Aborigines' own internal population dynamics and government relief and protection policies.

Other studies of the Aboriginal population have focused on national questions and omitted analyses at the local level. This book approaches Aboriginal demography by separating the demographical from the epidemiological and social questions, and then reintegrating them later. Such a method simplifies the complex nature of the changes through which the indigenous population of Western Australia and Queensland were passing. A problem for such analysis is that each region placed different meanings



Map of Western Australia indicating the location of Aboriginal missions and settlements. The dotted line below Meekatharra and Kalgoorlie represent the limits of settled areas.

on who and what an Aborigine was. The differences and the similarities of the varying interpretations of that term are the key to understanding Aboriginal demography and epidemiology.

The use of demography is now widespread in Aboriginal historic reconstruction and is also used as the basis from which to structure research in other disciplines. However, before Charles Rowley's pioneering work of the late 1960s and early 70s it was almost unknown outside a few isolated anthropological studies. After Rowley led the way with his trilogy of seminal books,[3] various other demographic studies followed. The most comprehensive was by L.R. Smith,[4] whose study took account of the way the national Aboriginal population had recovered from early colonial decline. Meanwhile other writers had entered the field, notably F. Lancaster Jones and J.P.M. Long.[5] In addition, Noel Butlin produced a speculative account of pre-contact Aboriginal demography and of the effects of epidemics such as smallpox.[6] Apart from Smith, however, none of the other writers mentioned above produced substantial demographic data on Western Australian Aborigines.

Some explanation of the use of terms is necessary before continuing. It would be difficult to consult the historic records, for example, without understanding how terms such as 'natives', 'Aborigine', 'full-blood' and 'half-caste' were used.[7] Other frequently used terms included 'people of mixed and full descent', and 'camp-' and 'bush-dwelling' peoples. In some cases these groups contained members from a number of different racial groupings with different cultural backgrounds. Changing the terms to reflect modern usage not only makes primary source records difficult to interpret and understand, but also distorts the intentions of the people involved in past events. Throughout this book the noun 'Aborigine' and adjective 'Aboriginal' are both capitalised. In quoted sources, however, the 'aborigine' and 'aboriginal' sometimes appear in lower case because that is the usage in the sources. In other places the adjectival form appears in lower case and the proper noun in upper case.[8]

The source material includes rare government documents and archival materials reflecting on the Aborigines of Western Australia.[9] The census processes set up by the Commonwealth Bureau of Census and Statistics[10] in 1911 were modified in 1921, when a system of annual returns — produced by police who were Aboriginal protectors—was introduced in order to obtain better figures on the people in remote areas. The system

of counting the State's general population was less complex than that used to count Aborigines. The Western Australian collection system was based on three zones, each subdivided into statistical divisions made up of several Local Government Areas. For the special Aboriginal census from 1921, the basic collection area was the police district.[11]

Arrangements for the census changed when statistical divisions came into use in 1928. The Federal Health Council of Australia suggested this structure to the Western Australia Government. For our purposes, statistical divisions remained reasonably stable units for collection purposes.[12] The national census of 1901, conducted by the Western Australia Government in cooperation with the Commonwealth had also enumerated full-blood Aborigines and half-castes. The second, third and fourth censuses took place in 1911, 1921 and 1933, again with cooperation and consultation between the Federal and State govern ments. The Deputy Commonwealth Statistician worked simultaneously for the State and Federal Governments, acting as a State as well as a Commonwealth official.[13]

Aboriginal demography is concerned with the size and characteristics of the Aboriginal population, and how these have changed.[14] In accordance with this definition I have compiled a population profile of Aborigines from 1900 to 1933 and have analysed their age-sex distributions. There is scant data on Aboriginal births, deaths and migration, all of which present difficulties. These difficulties are explained at length in later chapters dealing with Aboriginal health patterns.[15] Demographic analyses of such data helps explain the impact of the urban, pastoral and industrial expansion into the indigenous peoples' living places.

The size of the Aboriginal and half-caste populations presented difficulties for two main reasons. First, government administrators dealt with those who needed relief and they primarily saw Aborigines as being people of full descent. Second, property owners used stock workers that were mainly people of mixed descent and they often brought full-blood dependants with them. These two circumstances tended to confuse the general public, who had no clear understanding of whom they were really referring to when they were talking about Aborigines.

In 1898 the Premier, John Forrest, wrote a circular for distribution by Henry C. Prinsep, the Chief Protector of Aborigines, to all government

staff. The circular indicated that, in addition to care of the aged, sick and infirm, the Aborigines Department the name by which it was known from 1897 wished to collect information about 'the names, sex, ages, and condition of the natives to whom relief has to be given'.[16] Prinsep advised the State Premier that he intended conducting an Aboriginal census, which he planned to complete by 1899; though as things turned out, the task remained unfinished until the seventh Western Australian census in 1901.[17]

When the 1901 census took place the Chief Protector's data became the basis for estimating the number of Aborigines living in contact with white settlers. All persons of mixed descent, at that stage mainly children, were counted.[18] The count totalled 5,261 people of full and mixed descent. The full-bloods comprised 2,933 males and 2,328 females (see Table 1.1 in Appendix 1), and the half-castes 492 males and 459 females (see Table 1.2 in Appendix 1). The combined population of people of full- and half-descent therefore totalled 6,212.[19] Despite these figures, Prinsep's report to Parliament on 30 June 1901 stated that the Aboriginal population 'in parts of the State settled in any way by whites' was about 12,000'.[20] Three decades later, in 1932, a later Chief Protector, A.O. Neville, acknowledged Prinsep's over-estimation but this information was never made public.[21] Most probably the larger figure helped to satisfy Colonial Office inquiries about relations between settlers and Aborigines.[22]

The great problem of interpreting the Western Australian federal, and state data is that the nineteenth century Aboriginal population remained undocumented, most probably because of the extent and rate of settlement as well as the costs of conducting regional censuses. The effect was the inclusion of an estimated 10,000 additional Aborigines living beyond areas not occupied by white settlers. The figures for censuses as far apart as 1881 and 1921 were consequently over-estimates.[23]

The officials who attended the Sydney conference of State and Commonwealth statisticians to plan the 1901 census would have decided on a strategy for conducting the census. They would also have decided what the Australian Constitution meant in its reference to Aborigines. Western Australia was represented by its statistician, M.A.L. Fraser. He and his peers decided to tabulate Chinese, Pacific Islanders, and Aborigines (including half-castes) by placing them in separate tables.[24]

This allowed for the compilation of data on each group, though in the end the figures for half-castes went into the general population totals.[25] The collectors had a 'native' stamp for marking cards created for Aborigines, whether full-blood or half-caste. It was generally intended to separate each group from the whole first and then reintegrate them later.[26] The cards had to be made out in duplicate, one copy was stamped 'aboriginal' and included in the general population numbers; the other was set aside in a separate 'full-blood' Aboriginal collection.[27]

Fraser and his fellow statisticians received advice that 'consequent upon a decision having been expressed by the Federal Attorney General ... full-blooded aboriginals alone were to be excluded from, and not deemed to form part of the legally recognised populations of the different States of the Commonwealth'.[28] Western Australian statisticians nevertheless continued using a separate card system to prevent collectors including half-caste records in returns for the total Aboriginal population. This enabled people of full Aboriginal descent to be distinguished from half-castes when tabulation took place. Although the 1901 census enumerated full-blood and half-caste people it was a State-based census and the Commonwealth figures as published in the *Commonwealth Year Book* excluded the full-blood population. Commonwealth figures have always included people defined as half-caste and of lesser proportions of Aboriginal descent. Whether or not Aborigines were counted was therefore a confused issue. The confusion arose not only from the advice from the Commonwealth but also from the way in which the Federal and State administrators interpreted the references to Aborigines in sections 51(xxvi) and 127 of the Constitution.[29]

Section 127 had a lasting impact on relations between white Australians and Aborigines. It specified that 'in reckoning the number of the people of the Commonwealth, or of a State or other part of the Commonwealth, aboriginal natives shall not be counted'. The derivation of this section, according to one constitutional historian, La Nauze, came from the belief of the constitutional drafters that:

> the reckoning of 'the numbers of the people' lay in the requirements of the finance clauses, including the cancelled clause concerning federal direct taxation. Not until a late stage of drafting was it decided to place this exclusion in the 'Miscellaneous' chapter, so that it would apply not only to the financial clauses but to 'numbers' on which each State's membership in the House of Representatives would be based.[30]

The exclusion of Aborigines was therefore a legal anomaly rather than maliciously discriminatory. The effects were nevertheless wide ranging. The full-blood Aborigines were omitted from census publications after 1901, and this affected their long term economic, political, cultural and social status. In turn, their omission allowed governments and institutions to omit them from sharing in any new accumulation of the State's resources. The lack of public knowledge about their numbers helped to create the myth of a disappearing race that became all the more difficult to reverse.[31]

This omission from census publications created further administrative problems because, as time passed, the issue of 'who is an Aborigine?' became more difficult to resolve. Race did emerge as an issue in some of the debates on the Constitution but was not a dominant issue.[32] The statisticians cooperated in 1901 because according to the published report, they felt more comfortable once they knew that the census count was to include everyone.[33] La Nauze asserts that 'the exclusion … was not based on the impossibility of counting nomads, nor on views about their inferiority'.[34] In addition, the omission appeared to be administrative rather than legal. Administrators such as Prinsep sought funding for their relief and protection programs based on the population in need. Winning economic support from governments remained a major problem for the Chief Protectors.[35]

M.A.C Fraser's 1904 annual report as Western Australia's Chief Statistician indicated that the settler population of Western Australia had more than sextupled, rising from 29,708 to 184,124 over the two decades, 1881–1901. At the same time, the Aboriginal population was small but increasing appreciably. The number of male and female Aborigines employed by white settlers, for example, was 2,346 in 1881; by 1901 the number had more than doubled to 5,261, this figure including the emerging group of half-castes,[36] whose total had reached 951. The 1901 total, 5,261, comprised 2,933 males and 2,328 females (see Table 1.1 in Appendix 1 and Figure 1.1 below). The male–female imbalance was marked. As we will see, females, both full-blood and half-caste, suffered the most under colonial rule—as the low number of females suggests.[37]

The 1901 conference of statisticians had understood that the original intention of State censuses was to include all Aboriginals, whether full-blood or half-caste, in the returns of the general population. They sought

advice from the Commonwealth, most probably because of cost factors associated with census collections. Fraser wrote that the Federal Attorney General had advised him that, 'in reckoning the population of the Commonwealth, half-castes are not aboriginal natives within the meaning of section 127 of the Commonwealth of Australia Constitution Act, and should therefore be included'.[38] In Western Australia, statisticians consequently adopted two strategies for enumerating Aborigines in 1901. The first involved counting half-caste Aborigines with the general population. The second related to full-blood Aborigines who were to be excluded from the national census. Fraser got around the problem by including presumed 'full-bloods' under the heading of 'Aboriginals and Chinese'.[39]

Early in his 1901 report Fraser indicated that at no census before 1891 had the term half-caste Aborigines been mentioned as a population category. Until then the term half-caste formed no part of the official Western Australia lexicon of censuses from 1848. The term came into statistical usage during the Western Australian census of 1891,[40] though it may have entered the language of Aboriginal protection.[41] Many of the camps, according to visiting protectors who collected the figures, included, 'in almost every case, half-caste aboriginals … [who were] brought up and subsequently continue to live with those of full-blood, it appears likely that in each State census before 1891 the term "aboriginal" included both "full-blooded" and "half-caste" natives'.[42] As a result, it was impossible to say how many half-castes lived cheek by jowl with full-bloods before 1901.

At the 1901 census, 110 half-castes were recorded as living in metropolitan Perth. About 1,419 persons of mixed descent lived in the south-western region of the State. In other regions settled by whites, the northern areas contained the largest populations of Aborigines—a total of 3,857. The full-bloods among this group numbered 3,618, or 69 per cent of the State total of 5,261. In this census the collectors found difficulty in distinguishing the various racial characteristics of each of the regional groups. The 787 enumerated in the south-west and the 767 in the central-eastern area presented the most difficulty for the collectors, but because of difficulties of identification and classification we cannot really be certain whether these totals included only people of full descent or whether those deemed 'half-castes' were in fact 'full-blood' or indeed

‘quarter-caste’ or ‘eighth-caste’ or less. The national census could only locate a total of 89 people of full-descent in the metropolitan area. Of the half-castes counted in the south-west, 632 out of a total of 951, or 66 per cent, considered themselves as permanent residents there. A further 239 urban residents identified themselves as Aborigines in the north and north-western region. At the same time a further 59 half-castes lived in the central-eastern region, with a further 21 residing in the Perth metropolitan area. Again, self-identification and classification difficulties render the numbers suspect.

The 1901 census may be analysed further by looking at the age distribution of the Western Australia Aboriginal population (see Figures 1.1 to 1.4). The first thing to notice is that the age-sex pyramid of the full-blood population reveals a rapidly declining population, highlighted by the undercutting of the pyramid in the 0-14 age groups among both males and females. There is also an imbalance of the sexes, with more males than females in all age groups. This may indicate that under colonial conditions females suffered more than males. Colonial contact impacted more heavily on the reproductive capacities of the females, who may have merged more readily with European society than males did. This may have caused higher infertility and maternal mortality because of changed lifestyles, diet, health practices, sexual activities and infertility, and new patterns of work. Many Aboriginal women moved from the bush to settled domestic life and would have experienced some or all of such changes.[43]

The pyramid also graphically illustrates the problem of ‘age heaping’, mainly around the 20, 40, 50 and 60 year age groups. Age heaping tended to occur when either the collector or persons being questioned were unsure how old they were, and a guess by either party was usually rounded to the nearest decadal point. Uncertainty about age by either party also results in a high ‘age not stated’ category, in this instance 879 full-bloods and 26 half-caste Aborigines of both sexes did not state their age. The 1901 half-caste age-sex pyramid (see Table 1.1, and see Figure 1.2 above) is typical of a young population, even though there is a slight undercutting of the base in the 0-4 age group for both males and females, probably a result of undercounting of young children. Bearing in mind the problems of collecting data on Aborigines, the graph reflects there were very few half-castes at that time.

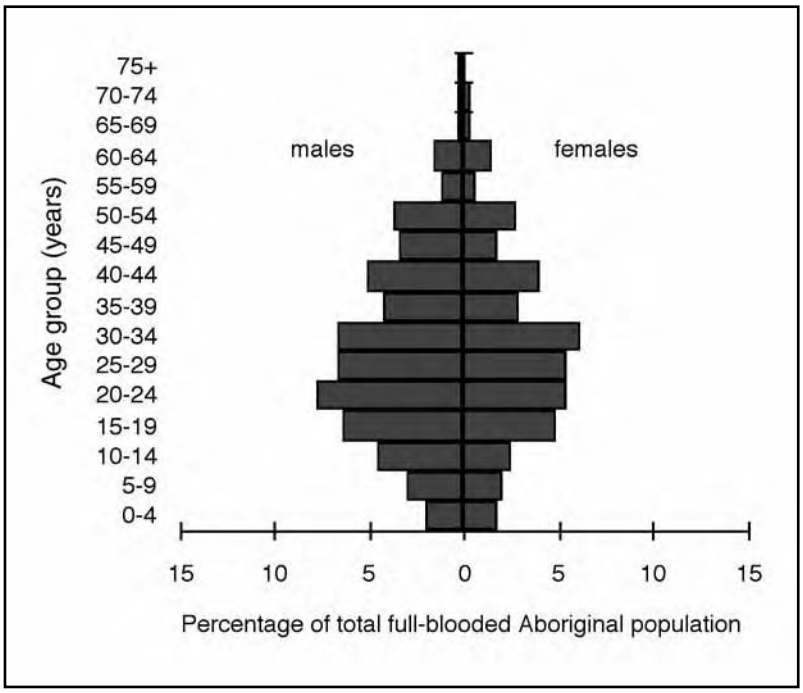


Figure 1.1: Full-blood Aborigines by age and sex in WA, 1901.
Source: Compiled from Table 1.1.

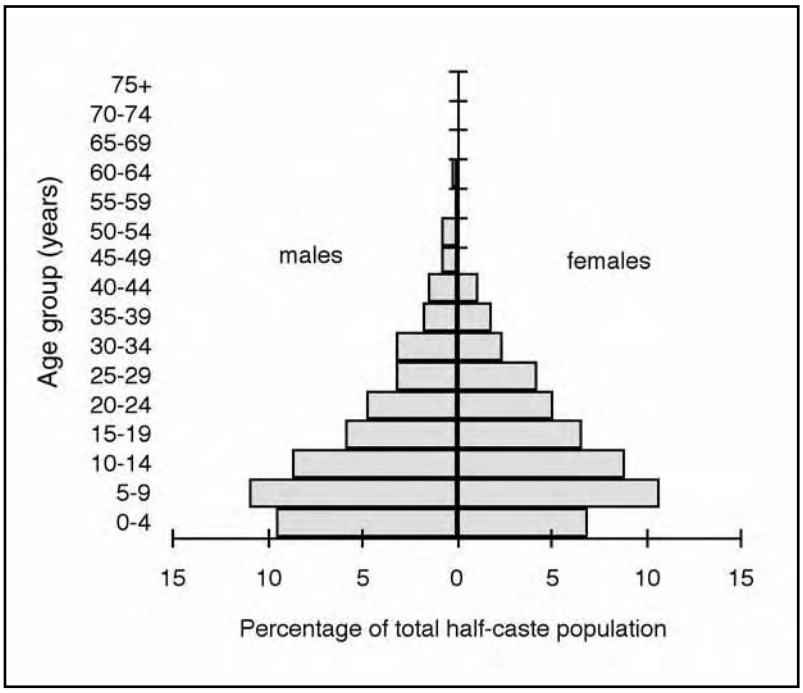


Figure 1.2: Half-caste Aborigines by age and sex in WA, 1901.
Source: Compiled from Table 1.1.

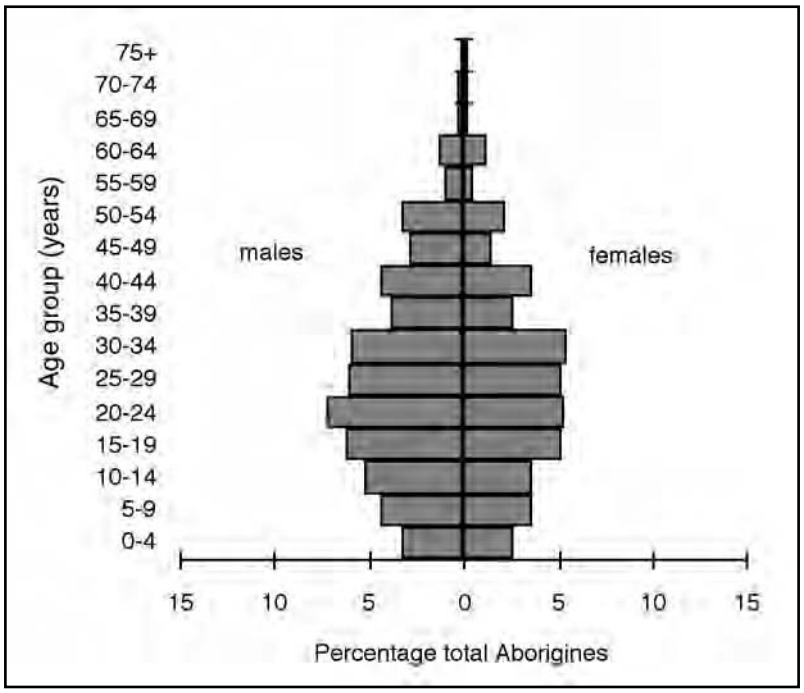


Figure 1.3: Total full-blood and half-caste Aborigines by age and sex in WA, 1901. Source: Compiled from Table 1.1.

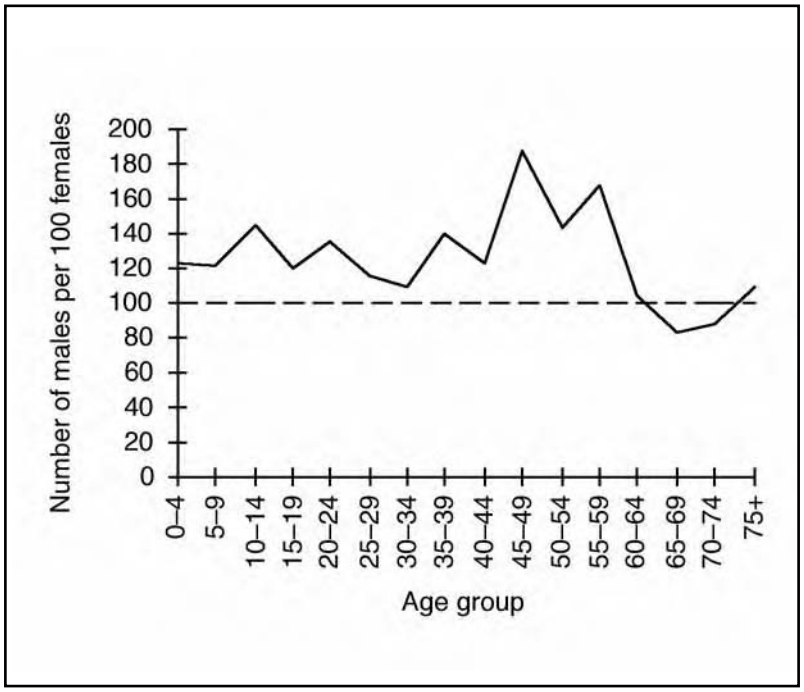


Figure 1.4: Age-specific sex ratio of full-blood and half-caste Aborigines in WA, 1901. Source: Compiled from Table 1.2.

The explanation for these phenomena lies in the timing and the pattern of colonisation in Western Australia. Colonisation took place slowly in the period from 1829 to the 1880s. The slow rate at which the settlement expanded in the early decades meant a containment of miscegenation. Following the spread of pearling, gold discoveries and expansion of pastoralism linked by the camel transport systems,[44] relationships between Aborigines and settlers, who included both Europeans and Asians (Afghans as well as Chinese, Japanese, Filipinos, Malays and others), increased rapidly.[45]

To digress briefly, until the 1940s there was virtually no population in the world in which women outnumbered men. It is not unusual that Aborigines should reflect human history by there being fewer Aboriginal females than males. The sex ratio graphs compiled from each census certainly indicate a paucity of females. In 1901, for example, males far out-numbered females (see Figure 1.4). Figure 1.4 combines females of both full- and mixed- descent and clearly shows a dominant male presence throughout the whole age structure except in the older age groups. I am not disputing this fact. My purpose in using sex ratios is to present a descriptive demographic proposition that, over the period 1900–40, the female component of the Aboriginal population gradually increased after Aboriginal women recovered from the onslaught of colonial settlement, from which they had suffered earlier.

The problem of identification intensified after 1901. Normally the issue only involved males of full-descent who cohabited with females of mixed race descent. That is, a female of mixed descent could be declared a full-blood if at any time she chose to marry a male of full-descent and the female was considered of half- or lesser caste of Aboriginal descent. The 1905 Aboriginal protection legislation delegated powers to the protectors for determining those who were full-bloods or half-castes, or definable at all as an Aborigine.[46] With the power to identify married couples thus residing with the protectors, the individual's racial status became subject to official whim. For instance, if a half-caste married another person of less than half-caste descent individual protectors could subjectively change his or her status as Aboriginal by an 'educated guess' at best, or on the caprice of personal prejudice.[47] This factor may have contributed not only to the fluctuating numbers of Aboriginal women (see Tables 1.1 and 1.2 in Appendix 1) but also to the huge peaks and troughs in the ratios of

males to females (see Figure 1.4). The excess of males in the 40-60 age groups highlights the point made about the impact of colonialism on Aboriginal women.

From the collected data (see Table 1.1), it appears that the chaotic demographic aspects of the Aboriginal population illustrate a range of complex changes in the geographic, economic, political, cultural and historic circumstances of both Aborigines and settlers. The data needs cautious interpretation. First, the colonial governments, as well as their Aboriginal protectors and individual settlers, had difficulty knowing how to assess people of mixed-descent.[48] Second, in the Murchison, Pilbara and Kimberley regions in particular, the burgeoning mixed race populations[49] could not readily understand their fluctuating official status.[50]

Soon after the 1901 census the Commonwealth Government began preparing itself for its first national federal census in 1911. Section 127 of the *Commonwealth Constitution Act 1900* influenced administration of the *Census and Statistics Act 1905*.[51] The Commonwealth Attorney-General advised the States on how to interpret sections 51(xxvi) and 127 regarding Aborigines. As indicated above, bureaucratic interpretation rather than legal intention meant that full-blood Aborigines were omitted. The 1911 census provided the Commonwealth with the opportunity of clarifying its own view on who could be defined as Aboriginal.[52] In Western Australia the Aborigines Department continued to conduct its own count of full-bloods and half-castes, at least among people living within what it called the civilised areas. In this sense the Western Australia Government positioned itself well to participate in the 1911 census.[53] How individual collectors would act in gathering, and how the statisticians would interpret the Aboriginal data, nevertheless remained problems despite attempts to make corrections to refine the process.

The 1911 census was the first conducted under the auspices of federal census legislation. It revealed that the Aboriginal population in settled areas of Western Australia had apparently increased to 7,844. The total included 6,369 full-bloods and 1,475 half-castes. The former included 3,433 males and 2,936 females and showed a smaller rate of increase over the 1901 figures. The half-castes, on the other hand, had nearly doubled. This trend appears to continue throughout the whole period 1901–33, as the half-caste growth rate appeared to out-strip the reported marginal

increases experienced by the full-blood population. The population of full-bloods in 1911 showed an increase of males by nearly 500, from 2,936 to 3,433 1901–11. At the same time female numbers grew from between 2,328 in 1901 to 2,936 in 1911, an increase of 608. The rate of growth for males and females was thus 17 per cent and 26 per cent respectively. Of note also was the growth of the half-caste population, which appeared to increase markedly: half-caste males increased by 54 per cent and females by 56 per cent between 1901–11. The faster growth of the half-castes should not have been unexpected for several reasons. First, a younger population has lower mortality than an older one. Second, the parents of mixed-descent children were from both the full-blood and half-caste groups, or were people of full- or mixed- descent cohabiting with whites. Third, full-bloods (normally females) gave birth to children of mixed descent when cohabiting with settlers (normally European males but also often Asian).

The Royal Commissioner reporting on 'The Condition Of The Natives' in 1905 discussed the burgeoning half-caste problem extensively.[54] In doing so he made an underlying assumption that people of full-descent, and of Aboriginal mixtures with other races, were suffering similar difficulties because they lived and worked together either on properties as pastoral labourers or in bush camps as 'nomads'. The sharing of half-caste women had become customary among both white and half-caste adult males by this time. This custom resulted in the birth of many children of mixed-descent. As later chapters indicate, travelling protectors reported 'abandoned' children in camps and removed them to missions for care by missionaries. Abandoned children were a matter of concern for the Royal Commissioners of 1904–05 and 1934–35. Witnesses supplying evidence about abandoned children spoke at length about this problem.[55] The poor living conditions forced the Royal Commissioner of 1905 to recommend common treatment and a common policy of government services. It was this redirection of approach which resulted in full-bloods and half-castes being treated by the new legislation as socially the same. All people of Aboriginal descent were now wards of the Protector; but, as seen later in the book, the economic benefits available to people of full-descent were denied to half-castes. Half-castes had been denied subsidised access to hospitals, treatment by medical practitioners at government expense and rations at some (mostly northern) depots.[56]

Although Federal and most State bureaucrats interpreted the Commonwealth constitution as requiring the omission of people of full descent from census publications, the Western Australia Government still collected its own data as a means of estimating the numbers of people living within its borders. The Commonwealth, meanwhile, continued to include people of half-caste or less descent in the census reports, but people considered to be full-bloods were omitted.[57]

In conducting the census of 1911 authorities employed the same strategies in counting Aborigines, and incorporated the same anomalies, as in 1901. The census tabulations show the total Western Australian full-blood population as 6,369 persons (3,433 males and 2,936 females). As in 1901, the age distribution shows the numbers of full-blood females fluctuating. For example, in the 30-65 year age groups, numbers rose and fell rapidly. This could have meant either age heaping as described above or a continuing high mortality among full-blood females. Similarly, it could have meant that half-caste females moved between the groups for a number of decades, or from the mid-nineteenth century (see Figure 1.5 below, and Table 1.3 in Appendix 1).

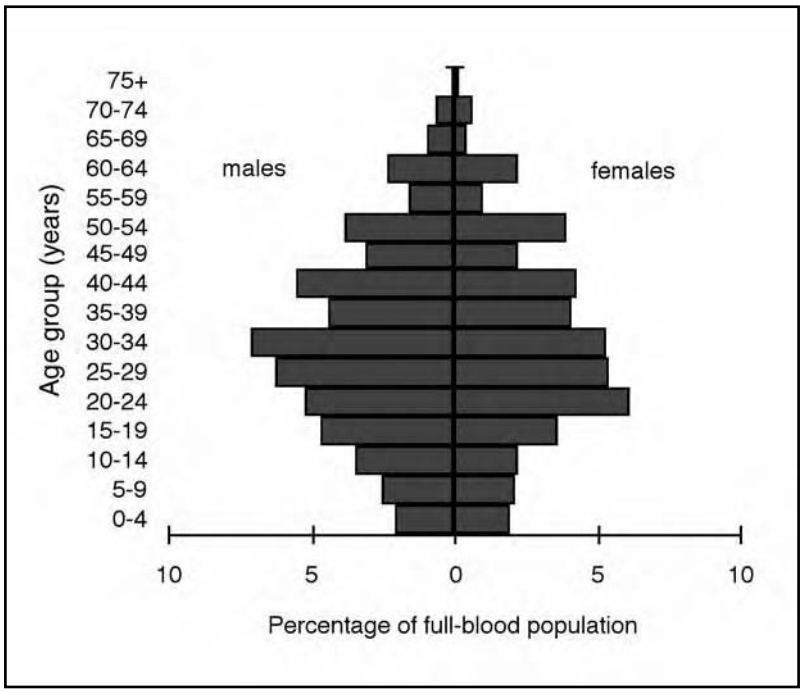


Figure 1.5: Full-blood Aborigines by age and sex in WA, 1911.
Source compiled from Table 1.3.

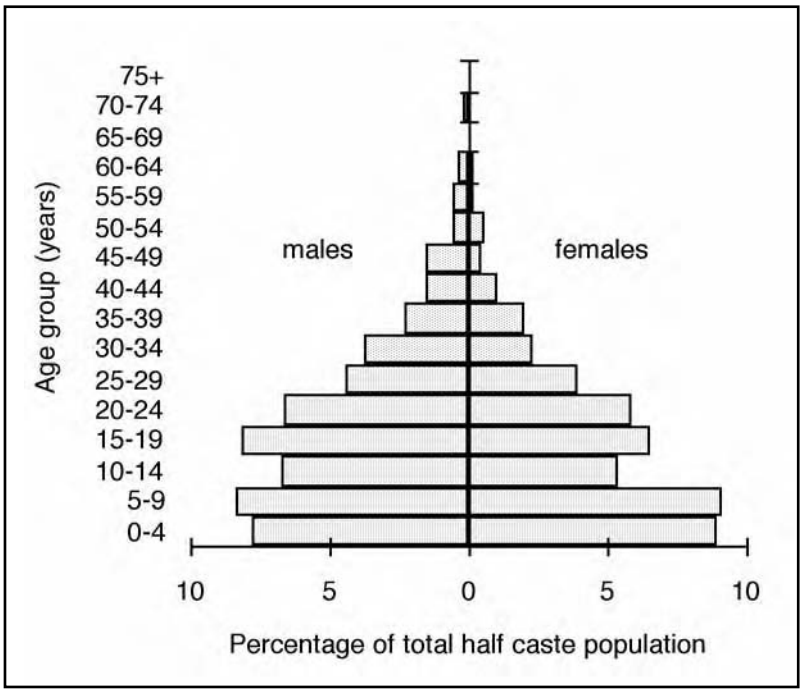


Figure 1.6: Half-caste Aborigines by age and sex in WA, 1911.
Source: Compiled from Table 1.3.

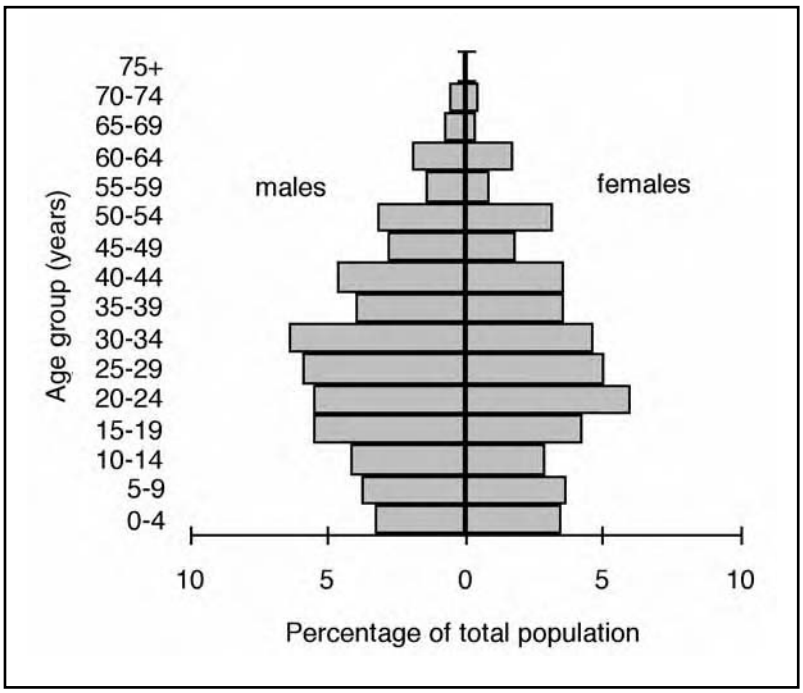


Figure 1.7: Total full-blood and half-caste Aborigines by age and sex in WA, 1911. Source compiled from Table 1.3.

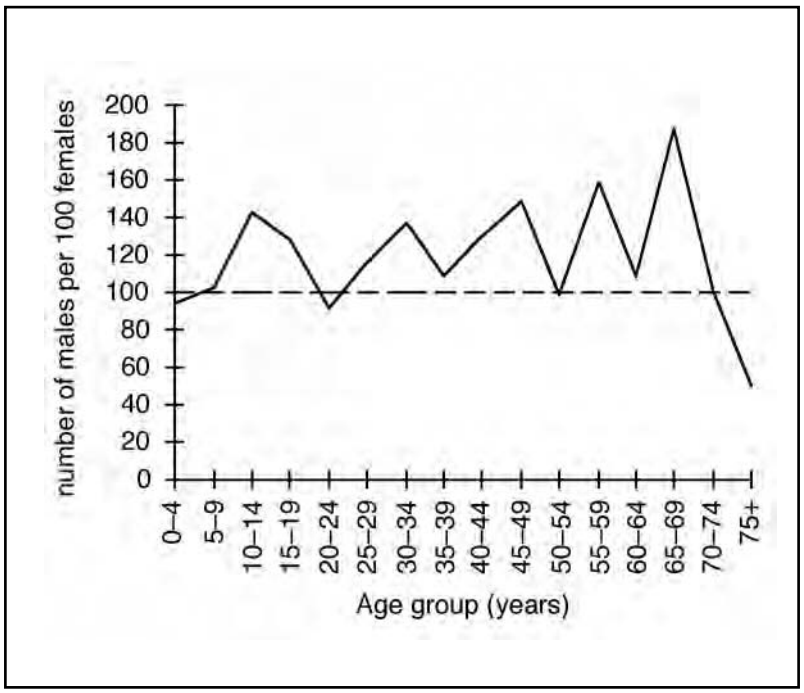


Figure 1.8: Age-specific sex ratio of full-blood and half-caste Aborigines in WA, 1911. Source compiled from Table 1.3.

At the same time, there were 1,475 half-castes (760 males, 715 females; see Figure 1.6 and Tables 1.3 and 1.4 at the end of this chapter). In contrast to the full-blood population, the half-caste population presented a young age structure, with a continuing increase in the 0-4 age groups (see Figure 1.6). As in 1901, full-bloods continued to show a declining population in the 0-14 age groups, with the deficit in female children (see also, Figure 1.1). At ages 50 to 75 and above there were still more full-bloods than half-castes for the same reason as in 1901 (see Table 1.3). Both census results highlighted the problem of age heaping around the ten year age groupings (see Figures 1.5 and 1.6).

The combined population of full-bloods and half-castes shows a trend towards a more normal population structure (see Figure 1.7), although the sex ratio of the total population shows a continuing preponderance of males. While still heavily weighted towards males in the older 50 to 69 age groups, signs existed then that the imbalance of Aboriginal males to females had disappeared in the younger age groups (see Figure 1.8).

It is noteworthy that the new Chief Protector, C.F. Gale, made no mention of these trends in reporting the census results.[58] In his 1912 report, however, Gale included a summary of the police district collection reports. These gave a brief statement of the physical health and condition of Aborigines of both full-blood and half-caste descent. Similarly they provided information on total numbers, including data on numbers employed on pastoral properties.[59] A.O. Neville mentioned a comprehensive census conducted in 1919 of all Aborigines in Western Australia in his 1920 report as Chief Protector of Aborigines, but records of the special Aboriginal censuses from 1919 to 1923 were either disposed of or lost.[60]

When the 1921 census took place the full-bloods were still omitted from the final Statistician's report. The blame rested with both the Western Australia Government and the Commonwealth, which had failed to cooperate in the period proceeding the census.[61] As usual, all those persons classified as half-caste made the count as part of the general population. The difference between the two earlier censuses and 1921 was that data on the full-blood population was neither processed nor published. Half-caste males had increased from 760 to 1,101 during 1911–21 (see Table 1.3 and Table 1.5 in Appendix 1). Half-caste females increased from 459 to 859 during 1901-21 (see Table 1.1 and 1.5). Thus, the half-caste male population had grown by 45 per cent in 10 years and the female population by 87 per cent in 20 years. That is, they had expanded at roughly the same rate, albeit over different time spans. One point of difference between the half-caste women and men was probably their mobility between different racial and social groups. The half-caste females moved freely from one racial and cultural group to another in search of, or leaving, marriage partners. Some females took male partners who were either white or nearly white and then experienced difficulties of identification because of their choice of marriage partner. Where some people took their partner's racial and social identity they experienced a change in their racial status.

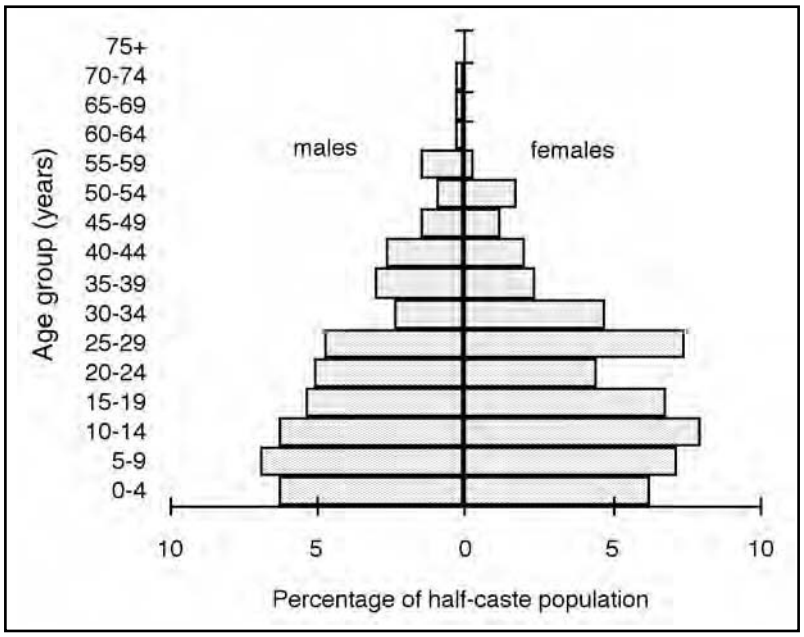


Figure 1.9: Half-caste Aborigines by age and sex in WA, 1921
Source: Compiled from Table 1.5.

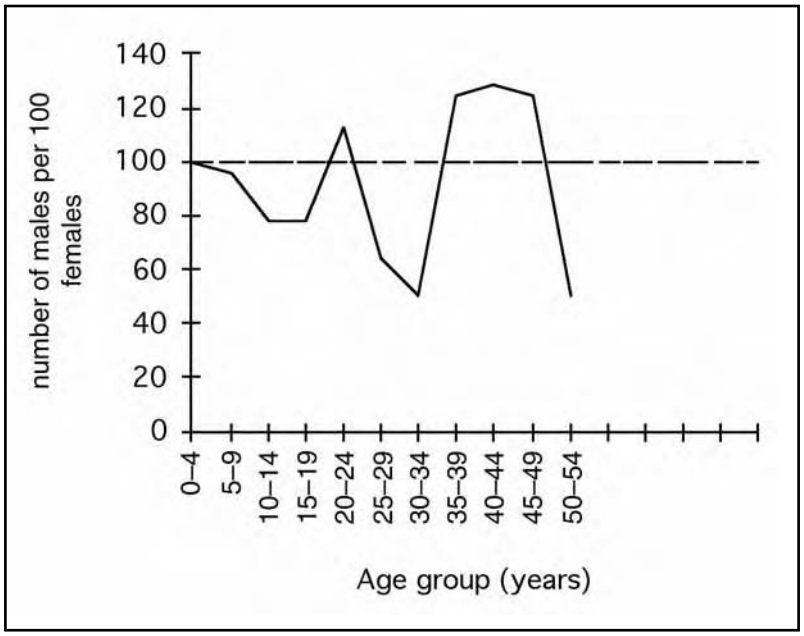


Figure 1.10: Age specific sex ratio of half-caste Aborigines in WA, 1921
Source: Compiled from Table 1.6.
* No figures for full-blood Aborigines available.

Of the two component groups—full-blood and half-caste[62]—the half-caste males and females increased in all stages at a faster rate than the full-bloods. The reason could have been the blurring of the racial divisions between full-bloods, those deemed to be half-caste and those half-castes deemed not to be Aborigines. The population pyramid for 1921 (see Figure 1.9) for the half-caste population was typically young. Moreover, the pyramid reflects the historic demographic relations between half-castes and white settlers. For instance, as suggested by the half-caste population pyramid of 1933, during the period 1921–33, the pyramid began to accumulate older people in the 50 to 75+ year age ranges for the first time since about the 1840s (see Figure 1.13, see Table 1.13).

The full-blood population posed the greatest problem for observers because, by 1933, their population pyramid showed characteristics of a stationary population. This prompts the inference that this group was under great social stress. On the one hand, the total full-blood population appeared to decrease long-term. On the other hand, after 1933, the full-blood female population appeared to be trending downwards, but in fact, over the period 1901–33, full-blood females increased by nearly 100 per cent (see Figure 1.15, and Table 1.17). In spite of this real increase, the full-blood female age–sex pyramid showed characteristics of a population that had been declining over a number of years (see Figure 1.11). The general conclusion was that full-bloods were disappearing while half-castes were on the increase. However, by the 1933 census, the full-blood population pyramid was beginning to take a normal shape. Put another way, what emerged was a mature age-sex distribution. In addition, the whole of the State, except for the extreme eastern sections, had been fully settled by the 1930s. Rumours and reports of death by disease and violence persisted.[63] Equally, large groups began living in supervised camps, missions and work-camps on pastoral properties that restricted their mobility and kept them away from rural and pastoral towns and service centres, thereby hiding them from the settlers' view. Even so, increased mobility in the 1930s applied mostly to males rather than females. Males moved around from one employer to the next and in proximity to settler pastoralists, mining company operations and emerging or established missions. Because of the changes in the mode of subsistence and dwelling places, traditional practice, and thus ethno-racial differences, became either increasingly more difficult to maintain, or, for the younger females, to understand.[64]

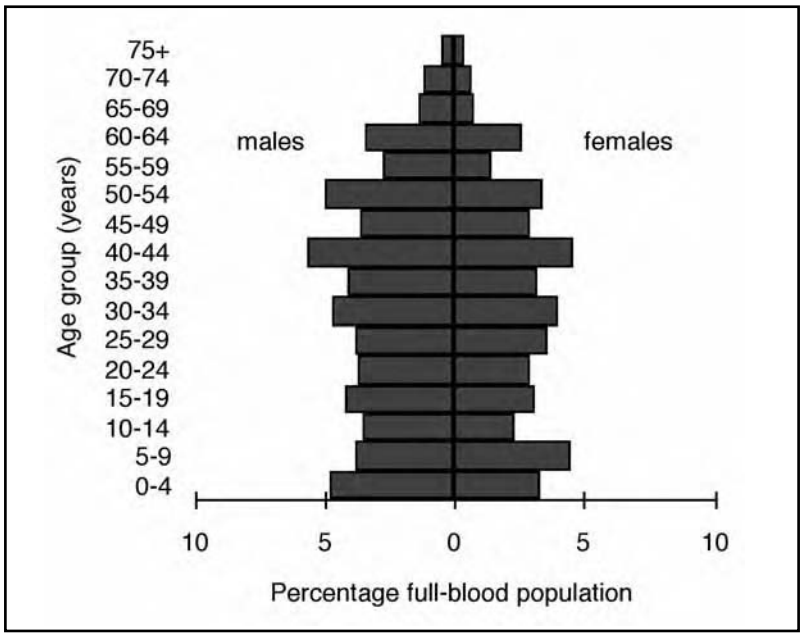


Figure 1.11: Full-blood Aborigines by age and sex in WA, 1933
Source: Compiled from Table 1.8.

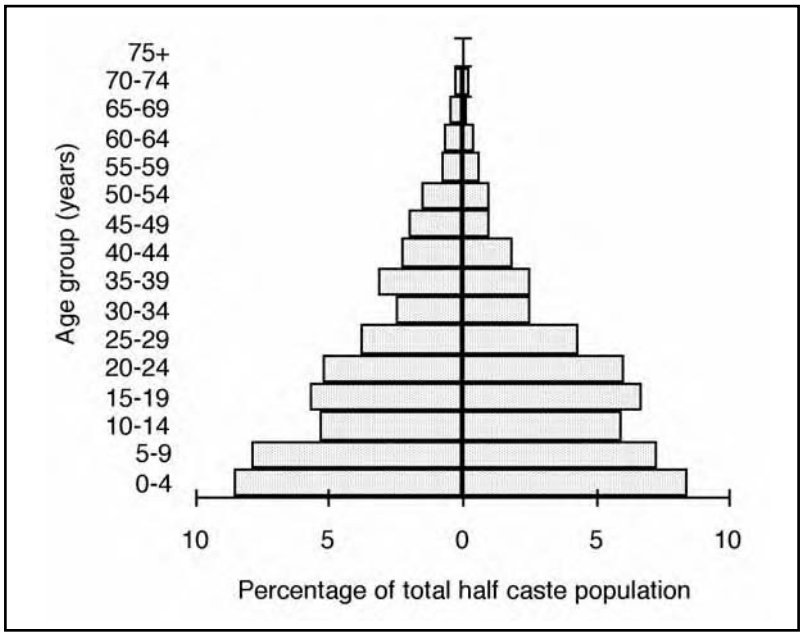


Figure 1.12: Half-caste Aborigines by age and sex in WA, 1933
Source: Compiled from Table 1.8.

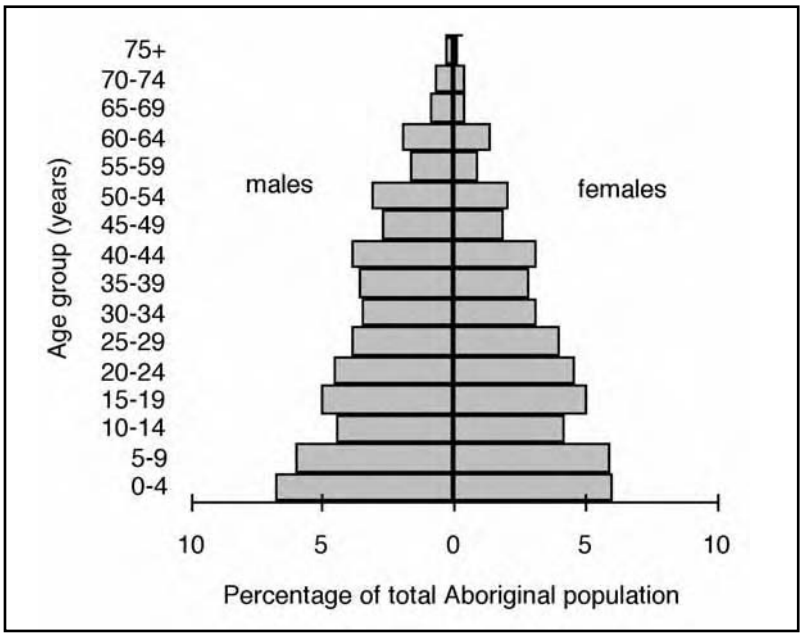


Figure 1.13: Total full-blood and half-caste Aborigines by age and sex in WA, 1933. Source: Compiled from Table 1.8.

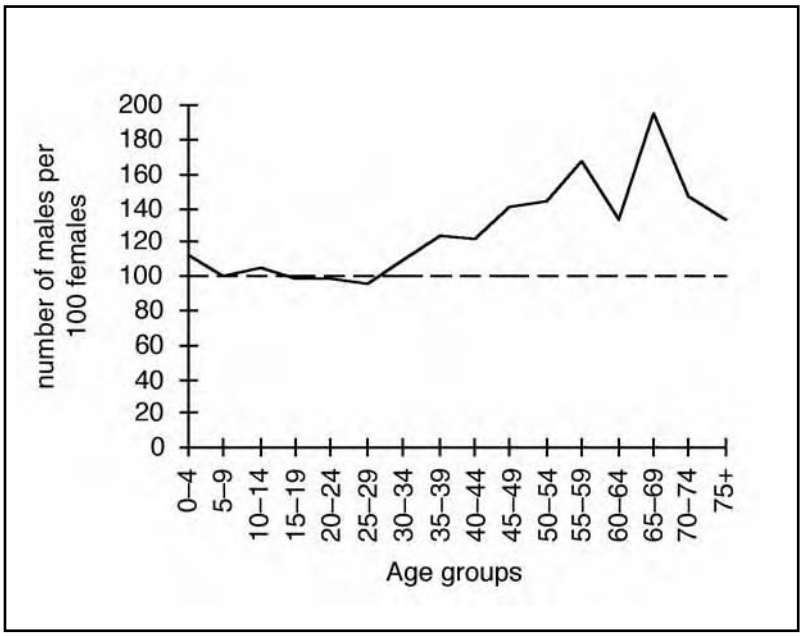


Figure 1.14: Age-specific sex ratio of Aboriginal and half-caste population in WA, 1933. Source: Compiled from Table 1.9.

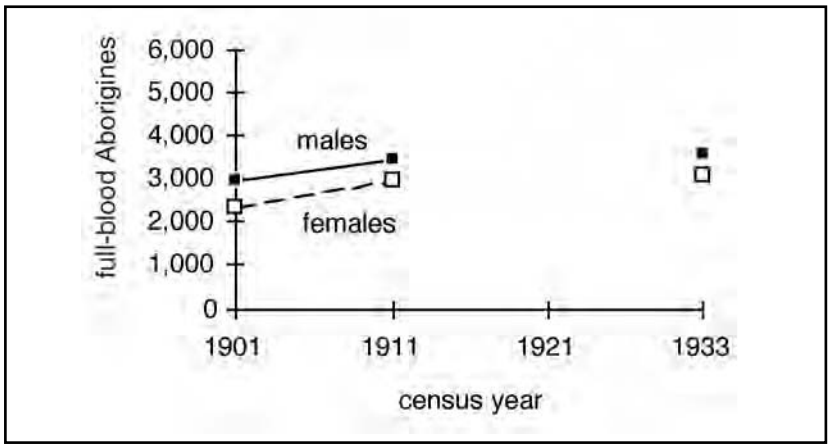


Figure 1.15: Full-blood Aborigines in WA, 1901-1933.

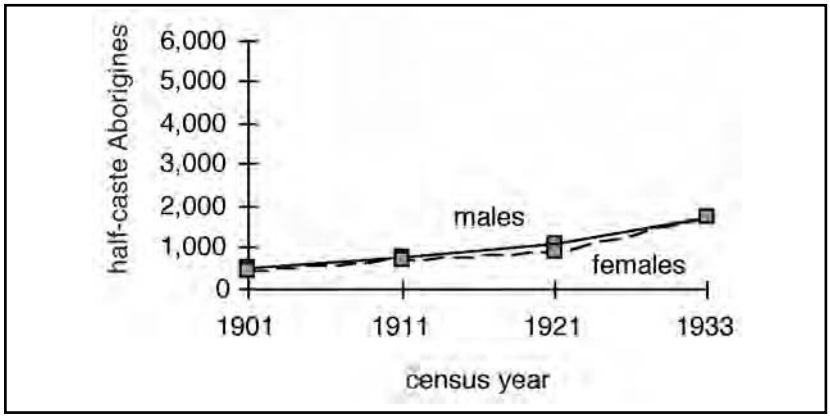


Figure 1.16: Half-caste Aborigines in WA, 1901-1933.

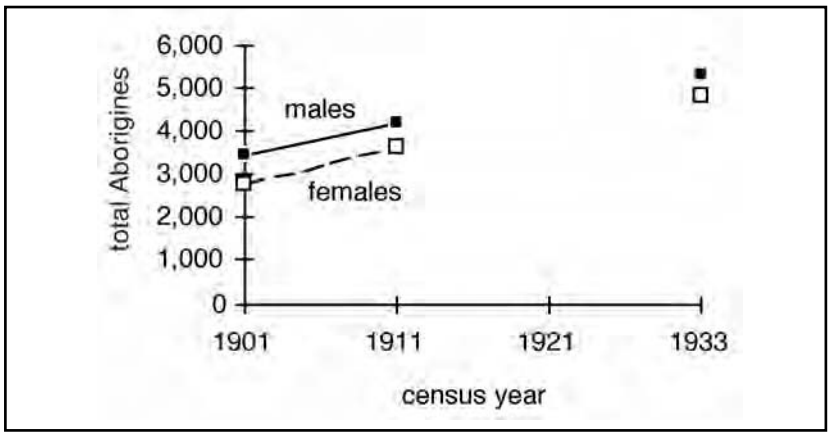


Figure 1.17: Total Aboriginal and half-caste population in WA, 1901-1933
Source: Compiled from Table 7.1, 'Time Series of population' for 1901-1933.

In the years 1933–40 camp groups supervised either by travelling protectors or by missionaries and pastoralists became more numerous. Populations of male and female half-castes, despite their small numbers, emerged as the more politically dominant grouping among the Aboriginal population. The females of this new group had a wider choice of partners than in 1901. For example, half-caste males could gain sexual partners from full-blood groupings, either by taking a female of full- or half-caste descent thus it became possible for half-caste females to move from one group to another, sometimes without changing their racial definition. A feature of the 1901–33 census reports was references to the dominance of half-caste women as both bread-winners and marriage partners. This was a result of increased cohabitation with a number of other male racial groups (Europeans, Afghans and other Asians as well as full-blood Aborigines).

Similarly, as a further explanation for the increasing maturity of the 1933 age-sex pyramid, fewer numbers were registered in both the male and female 0-14 year age groups. The older males and females in the 50 to 54 year age groups began to show that government protection policies were apparently helping them prolong their own and their childrens' lives (see Figure 1.11, and Table 1.15 in Appendix 1). From 1901 to 1933 full-blood males increased by 27 per cent (from 2,933 to 3,570). The number of full-blood females increased by 33 per cent (from 2,328 to 3,093). Added to this is the evidence in the age-sex pyramid of 1933 that equal numbers of male and female babies made up the 0-4 year age group. In the 5-9 and the 25-29 year age groups there are similar male and female numbers. However, there are many more males than females in the 35-40 age group. The underlying cause of the latter imbalance is difficult to ascertain. It seems that the identification problem and group swapping strategies adopted by Aboriginal females generally led to a better quality of life for them under the government's protection policies. As a rule of thumb it is generally true that, throughout human history, all societies have had a lower proportion of females than males. In Western Australia, however, the reverse was the case. While all Aborigines experienced great suffering and losses, the women suffered more than the men.[65]

Other developments relevant to the demography of Aborigines in Western Australia included action by the Commonwealth Bureau of Census and Statistics in the census of 1933, which improved systems for estimating Aboriginal populations. The Bureau improved the census by not only employing trained Collectors but also increased these numbers. In

addition, Aboriginal censuses were conducted each year from 1921 to 1944, and the 1934-35 Royal Commission into the Condition and Treatment of Aborigines heightened awareness of their situation in the north of the State.

At the same time, the census authorities made no attempt to develop a special collection methodology. For instance, the methods of counting people in bush camps did not improve although authorities knew about many of the difficulties there.[66] The accuracy of the count was often impaired because collectors waited for bush groups to come to them rather than for collectors to go out searching for the bush people.[67] Some attempt to count Aborigines did occur but the dangers of bush travel limited their effectiveness. Collectors, often police magistrates, missionaries, travelling protectors and pastoralists, knew the dangers of the bush and some were not as thorough when travelling in particular areas even when they knew where isolated campsites were located. In any case, Aborigines in outlying areas were often highly mobile and therefore difficult to find for the census.

The Western Australia Government conducted a comprehensive Aboriginal census each year beginning in 1919 through until 1944. Unfortunately the data collected in 1919 and 1921 are missing,[68] though it is known that the State and Commonwealth governments co-operated closely after 1921 when conducting censuses. For all that, the Western Australian figures must be used cautiously because although the number of Aborigines increased, in Western Australia the census figures fluctuated noticeably.[69] Such fluctuations were minor in the total population from one Aboriginal census to the next from 1921–40 (see Figures 1.15 to 1.17, and Tables 1.10 and 1.11). The reason for some fluctuations was the mobility of rural populations, which presented huge enumeration problems for the collectors. In part also, collectors had problems defining the individuals they were sent to count. The Aborigines themselves caused some difficulties by choosing with whom they wanted to live. If collectors lacked bush experience they met difficulties with every Aboriginal group they faced, especially eastwards into the outback.

Despite the demographic problems mentioned above, at least an effort was made by the State and Commonwealth authorities to collect Aboriginal data. The age–sex distribution compiled from the 1921 census reflects the kinds of collection problems already mentioned. Even though the numbers and increases were still small, half-caste age structures showed a greater trend towards normality, as revealed in the 1911 age structure pyramid (see Figure 1.7).

In addition, although there was a rise in the total numbers of males and females, the proportion of infants fell. Similarly, changes in the Western Australian ratios of Aboriginal males to females appeared to strengthen in favour of females in both years 1911 and 1933, in the 15 to 24 and 50 to 54 year age groups in particular (see Figures 1.3 to 1.17 above, and Tables 1.1 to 1.19). Finally, the Aboriginal census counted only those people defined as either half-caste or as full-blood, and this development proved significant.[70]

The *Australian Year Book* alluded to one particular difficulty in enumerating Aborigines in 1921. This was, 'the most serious defect, an estimate of 10,000 Aboriginals which the Chief Protector of Western Australia regards as out of touch with his Department and consequently not included in figures supplied by him'.[71] Even when the 10,000 Aborigines out of contact are deducted, the figures appear much higher than earlier census counts of 1901, 1911 and 1921. The figures tabulated by Smith[72] and reproduced in Table 1.10, show the way in which census estimates of 'full-bloods' were adjusted upwards to correspond with the total population estimated by the State at all censuses to 1961. The 'half-caste' figures (see Tables 1.10 and Table 1.11 under 'Other') are reasonably consistent.[73]

The Aboriginal censuses from 1921 to 1940 are presented in two differing tabular forms in the Appendix. Table 1.10 gives the total counts for persons of full-descent and others, and includes a figure of an additional '10,000' people of full-descent (the figure causing the over-estimation just discussed). Table 1.11 does not include the 'additional 10,000' mentioned above (see Figures 1.18 and 1.19 and 1.21 to 1.23 below). These censuses indicated that the total number of Aborigines declined from 27,671 in 1921 to 24,028 in 1924. (If the 'additional 10,000' persons are removed, the decline is from 17,671 to 14,028.) There are inconsistencies in the figures, however. The totals rose sharply from 26,507 in 1931 to 29,298 in 1933, followed by another sharp decline to 26,515 in 1934. The only group with any consistency were the half-castes (see the category 'Other', in Figures 1.18 and 1.19), whose numbers continued rising. When the figures for full-bloods and half-castes are combined, the 1933–34 decline is still evident (see Figure 1.20).

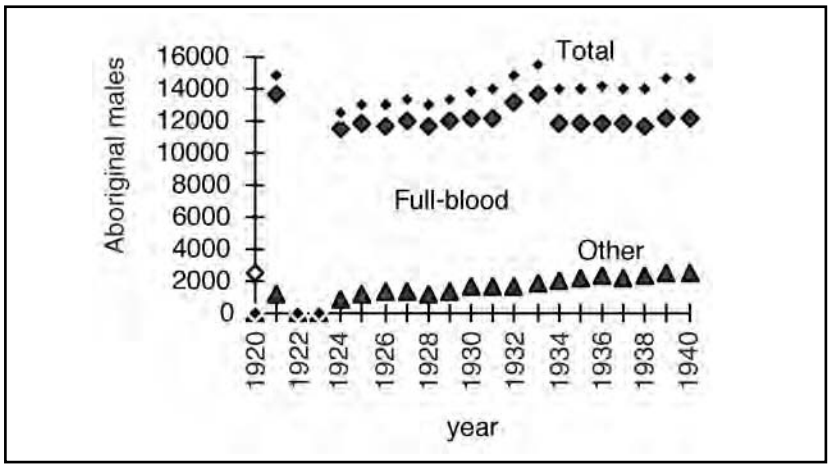


Figure 1.18: 'Estimated' Aboriginal males, full-blood, other and total in WA, 1921-1940. Source: Compiled from Table 1.10.

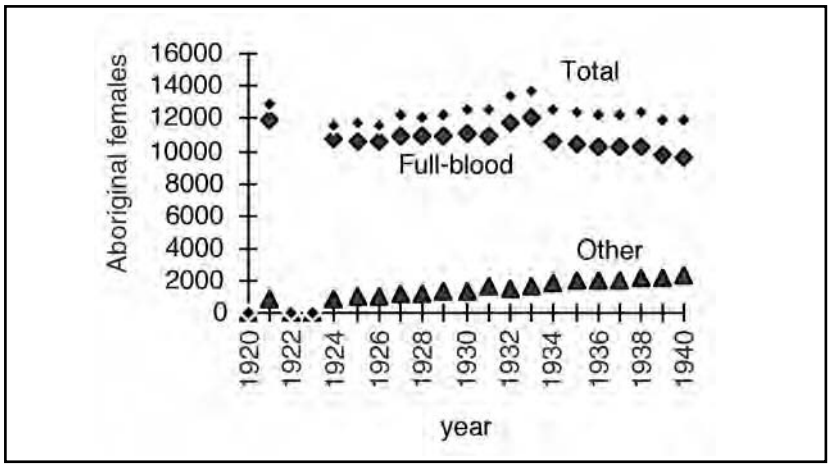


Figure 1.19: 'Estimated' Aboriginal females, full-blood, other and total in WA, 1921-1940. Source: Compiled from Table 1.10.

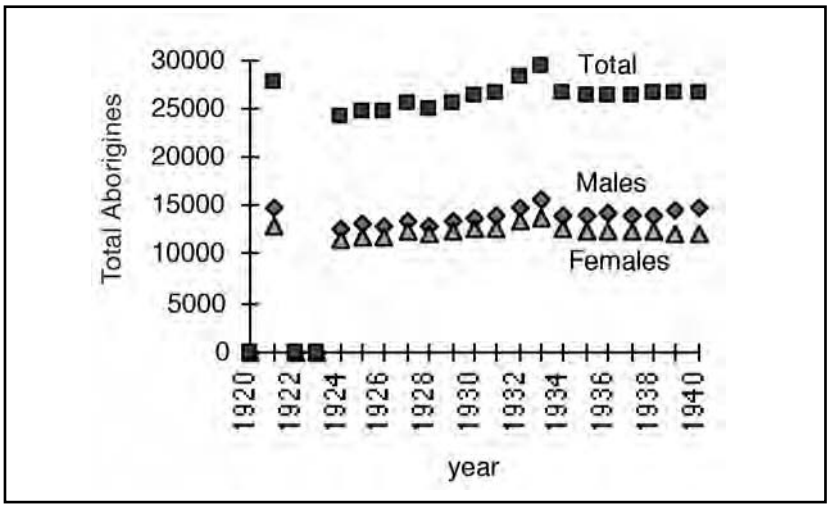


Figure 1.20: 'Estimated' Aboriginal persons, males, females and total in WA, 1921-1940. Source: Compiled from Table 1.10.

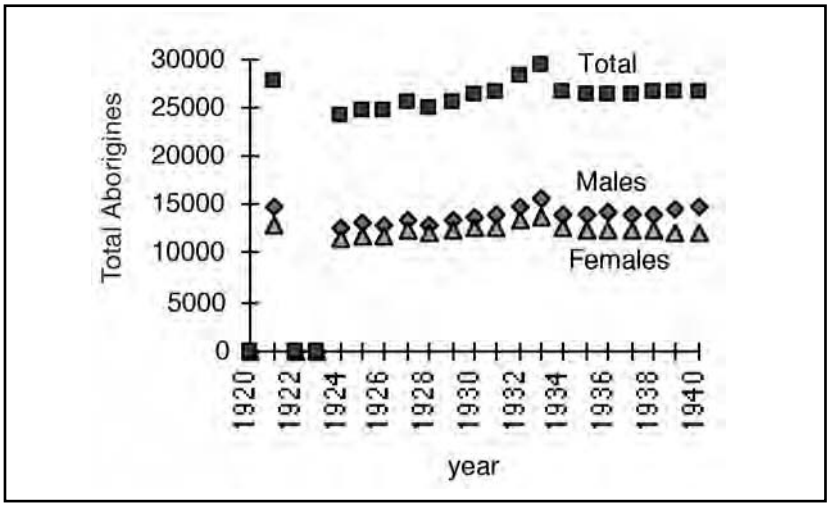


Figure 1.21: 'Returned' Aboriginal males, full-blood, other and total in WA, 1921-1940. Source: Compiled from Table 1.11.

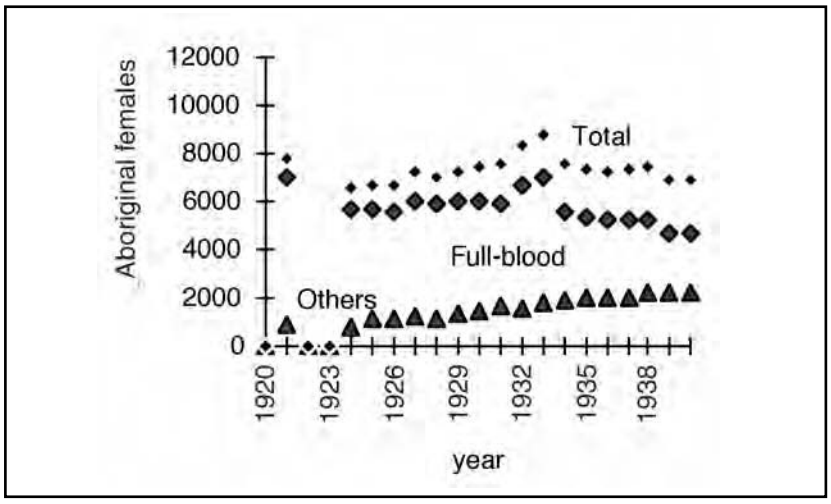


Figure 1.22: 'Returned' Aboriginal females, full-blood, other and total in WA, 1921-1940. Source: Compiled from Table 1.11.

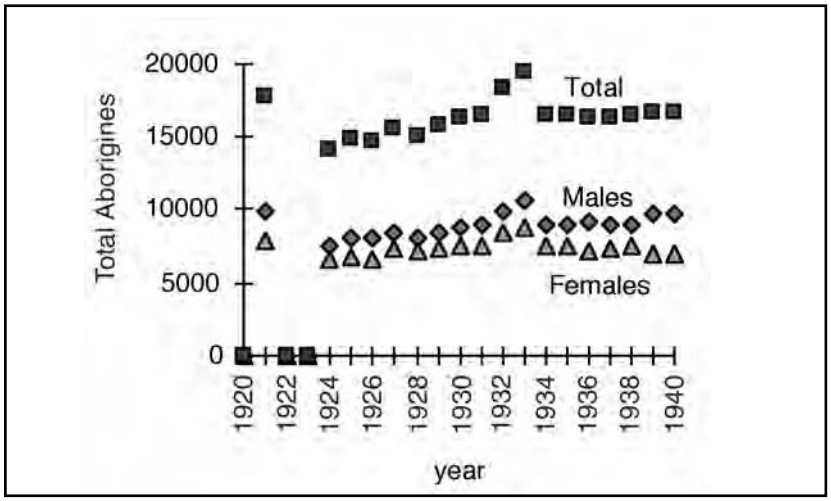


Figure 1.23: 'Returned' Aboriginal persons, males, females and total in WA, 1921-1940. Source: Compiled from Table 1.11.

In 1932, the Chief Protector felt it was time to question or explain the missing 10,000 that had been such a problem since the mid-nineteenth century.[74] Under the heading 'Population',[75] A.O. Neville indicated that Aboriginal numbers had grown from 26,727 to 28,481 in the past year. The latter figures comprised 14,766 full-bloods, 3,715 half-castes and the additional figure of 10,000. There had thus been an effective increase of 1,754. He observed that he 'assumed that many natives hitherto regarded as being outside the confines of civilisation have … now been included amongst the known population, pointing to the necessity for revision of the figures given as 10,000 supposed to be still living beyond the fringes of settlement throughout the State'.[76] The increase of 1,754 was real enough but, as Neville pointed out, the 10,000 Aborigines supposed to be living beyond civilisation distorted the picture. The bulk of the Aboriginal population was not, as it has been historically suggested, in the Kimberley region, but elsewhere.[77] There were 9,893 people in the Kimberley, a figure which took account of the 'bush natives'. Elsewhere in the state there were 3,447 natives between Perth and the Pilbara and a further 5,141 in the region south of Perth and eastwards towards the eastern goldfields and the South Australian border.[78]

The Chief Protector's reversal of attitude towards the elusive 10,000 had its own underlying rationale. Neville conceded that the efforts of the State government in providing long term relief and protection had failed. He wrote that it 'cannot be contended that the condition of the natives improved during the year.'[79] The obligation of providing relief had increased considerably. This, he argued, showed that the southern natives had 'never before … sunk to such a condition of penury'.[80] At the same time, both Neville and H.D. Moseley, the Royal Commissioner who conducted the 1934-35 inquiry into the condition of West Australian Aborigines, believed that people of full-descent were disappearing. As Moseley observed,

> while it appears beyond doubt … that the full-blooded aborigines are decreasing in number, it is … certain that the half-castes are multiplying rapidly … As to the numbers of natives in the State, it has been impossible for me to estimate this in any way, but, taking the Departmental figures as being as accurate … there appear to be 29,021 natives throughout the State. Of these, 10,000 are included as 'bush natives'.[81]

Moseley went on to indicate how many Aborigines lived in various regions of the State. The Kimberley had 10,015; in the north-west near

Carnarvon area there were 2,497; the Murchison district south of Carnarvon had 1,497; and, finally, around Geraldton there were 5,012. The total was 19,021, and he added the missing 10,000 to this figure. The figures came from the Aborigines Department, and helped it argue for greater resources. Neville had already admitted in 1932 that the 10,000 extra was a myth but in 1935 he provided the Royal Commission with the old figures, perhaps thinking that if the Commissioner accepted them they would add weight to his case for increased funding.[82]

Moseley accepted Neville's spurious estimates of bush people. As a result, Moseley was wrong on various points when discussing the Aboriginal population in his final report to Parliament.[83] The total number of people of full-descent was increasing. The first figures available in 1924 from the Aboriginal census had revealed that the total full-blood population numbered 12,260 (6,557 males and 5,703 females). In 1940 the total Aboriginal population was given as only 11,827 (7,152 males and 4,669 females). This reduction is explained by looking at Aboriginal women as represented in the age pyramids for the 1933 census. For example, as Figures 1.12, 1.13 and 1.14 suggest, an increase in the total population was occurring even though the full-blood female population was not showing a revival in the 1930s. The figures in the female population pyramid of 1911 totalled 2,936 (see Table 1.5 in Appendix 1) but in 1933 totalled 3,093 (see Table 1.12 in Appendix 1). While this table shows an increase of only 157, the increase in females was greater than the Aboriginal census revealed (see Table 1.11 at the end of this chapter).

Later in his report Moseley described the conditions of life of the people he deemed Aboriginal or of Aboriginal origin.[84] In the northern Kimberley they were either in the bush 'in their natural state', or in camps or pastoral stations.[85] In speaking of cattle workers, Moseley commented that they located themselves 'in the country to which they belonged—an important consideration from the point of view of the native'.[86] These groups made their shelters out of recycled four-gallon petrol cans, bags and bush material, but Moseley said they wanted for nothing and displayed no sign of unhappiness. He even imagined it was a virtue that 'the children … [were] trained at an early age to make [such improvised materials] useful'.[87] But in response to Neville's proposal for the purchase for more land to provide work, Moseley could not bring himself to believe that 'a native of the Kimberley … [could settle] and remain on the property where they were born: of what other use would money be to him?'.[88]

Having mentioned bush and station people in the north, Moseley went on to consider 'miscegenation', an eventuality which, given the prevailing notions about racial mixing, he assumed to be wholly undesirable. He observed that

> in the north few half-castes are to be found on the stations. That is a gratifying fact but one difficult to explain: for it is regrettable that my investigations have satisfied me that in certain parts of the north intercourse between the white man and aboriginal women exists to a degree which is as amazing as it is undesirable.[89]

Moseley's prudery notwithstanding, he had identified the cause of the rapidly increasing half-caste population. His comments about the sexual relations between white men and Aboriginal women may also explain the low numbers of births by bush people because many bush females were having children by white men and remaining in town fringe-camps. The other part of the dynamic came from the liaisons between males of mixed descent and full-blood females.

Only one other change to Aboriginal identity influenced the enumeration of the Aboriginal population, and that was the inclusion of people who had any portion at all of Aboriginal descent. In the remaining period between the Moseley Reports in 1935 and 1940, the Aboriginal population increased but it did so in a different way than previously. Moseley suggested a new approach: 'The definition of an Aborigine [should] be broadened to include 'persons of [Aboriginal] origin in a remote degree'; the Minister (not the Chief Protector!) [should] become the legal guardian of all part-Aboriginal children up to the age of sixteen'.[90] He might not have realised that, ironically, the liberal definition he was recommending—the most inclusive devised up till then—would soon become an instrument of oppression. In the hands of over-zealous officials, it legitimated the removal of light-skinned children from their families, setting in train events, the results of which are still apparent 60 years later. The State Government acted with great haste in implementing many of Moseley's recommendations, largely because of the growth of an Aboriginal political welfare lobby that included both Aborigines and Christian mission bodies, and the increasing interest in matters related to Aboriginal poverty by the daily press. The significant thing to note here is that the definition of Aboriginal identity had been changed, and at the stroke of Moseley's pen. Western Australian protection policy had a 'knock-on' effect in other places, leading to complex and unforeseen outcomes. How this occurred becomes clear in the next chapter, which considers Queensland's Aboriginal population.

Appendix 1

Table 1.1
Aborigines by age and sex in WA, 1901

	Full-bloods			Half-castes			Total		
Age	Male	Female	Persons	Male	Female	Persons	Male	Female	Persons
0-4	88	80	168	89	64	153	177	144	321
5-9	132	93	225	102	99	201	234	192	426
10-14	199	112	311	80	82	162	279	194	473
15-19	278	216	494	54	62	116	332	278	610
20-24	342	238	580	44	47	91	386	285	671
25-29	291	240	531	30	39	69	321	279	600
30-34	289	269	558	29	22	51	318	291	609
35-39	184	126	310	17	18	35	201	144	345
40-44	220	180	400	14	11	25	234	191	425
45-49	146	80	226	7	2	9	153	82	235
50-54	164	120	284	8	1	9	172	121	293
55-59	49	30	79	1	0	1	50	30	80
60-64	67	65	132	2	1	3	69	66	135
65-69	14	17	31	0	0	0	14	17	31
70-74	14	20	34	0	0	0	14	20	34
75+	12	7	19	0	0	0	12	7	19
Sub Total	2,489	1,893	4,382	477	448	925	2,966	2,341	5,307
N/S*	444	435	879	15	11	26	459	446	905
Total	2,933	2,328	5,261	492	459	951	3,425	2,787	6,212

Source: M.A.C. Fraser, 'Chapter XIX, Aboriginals', *op.cit.*, pp.203-207.
* NS: Not stated.

Table 1.2
Age-specific sex ratio(a) of full-blood and half-caste Aborigines in WA, 1901

Age group	Males	Females
0-4	123	100
5-9	122	100
10-14	144	100
15-19	119	100
20-24	135	100
25-29	115	100
30-34	109	100
35-39	140	100
40-44	123	100
45-49	187	100
50-54	142	100
55-59	167	100
60-64	105	100
65-69	82	100
70-74	70	100
75+	171	100

Source: Compiled from Table 1.1 (above).
(a) the number of males per 100 females.

Table 1.3
Aborigines by age and sex in WA, 1911

	Full-bloods			Half-castes			Total		
Age	Male	Female	Persons	Male	Female	Persons	Male	Female	Persons
0-4	95	92	187	100	116	216	195	208	403
5-9	116	99	215	108	119	227	224	218	442
10-14	160	104	264	87	70	157	247	174	421
15-19	219	167	386	105	85	190	324	252	576
20-24	241	284	525	86	76	162	327	360	687
25-29	290	251	541	57	51	108	347	302	649
30-34	329	247	576	48	30	78	377	277	654
35-39	204	189	393	30	27	57	234	216	450
40-44	255	199	454	20	14	34	275	213	488
45-49	143	102	245	19	7	26	162	109	271
50-54	180	182	362	7	8	15	187	190	377
55-59	75	49	124	7	3	10	82	52	134

Table 3 cont.

	Full-bloods			Half-castes			Total		
Age	Male	Female	Persons	Male	Female	Persons	Male	Female	Persons
60-64	109	102	211	5	3	8	114	105	219
65-69	43	21	64	0	2	2	43	23	66
70-74	29	30	59	2	1	3	31	31	62
75+	5	9	14	0	1	1	5	10	15
Sub Total	2493	2127	4620	681	613	1294	3174	2740	5914
N/S	940	809	1749	79	102	181	1019	911	1930
Total	3433	2936	6369	760	715	1475	4193	3651	7844

Source: Statistician's Report, Bureau of Census and Statistics, Census of the Commonwealth of Australia, 1911, Bulletin No., 1, 'Population of States and Territories Report'.

Table 1.4
Age specific sex ratio(a) of full-blood and half-caste Aborigines in WA, 1911

Age group	Males	Females
0-4	94	100
5-9	103	100
10-14	142	100
15-19	129	100
20-24	91	100
25-29	115	100
30-34	136	100
35-39	108	100
40-44	129	100
45-49	149	100
50-54	98	100
55-59	158	100
60-64	109	100
65-69	187	100
70-74	100	100
75+	50	100

Source: Compiled from Table 1.3 above. (a) the number of males per 100 females.

Table 1.5
Aborigines by age and sex in WA, 1921

	Full-bloods*			Half-castes			Total		
Age	Male	Female	Persons	Male	Female	Persons	Male	Female	Persons
0-4				21	21	42			
5-9				23	24	47			
10-14				21	27	48			
15-19				18	23	41			
20-24				17	15	32			
25-29				16	25	41			
30-34				8	16	24			
35-39				10	8	18			
40-44				9	7	16			
45-49				5	4	9			
50-54				3	6	9			
55-59				5	1	6			
60-64				1	0	1			
65-69				1	0	1			
70-74				1	0	1			
75+				0	0	0			
Sub Total				159	177	336			
N/S				942	682	1624			
Total				1101	859	1960			

Source: Bureau of Census and Statistics, *Census of the Commonwealth 1921*, 'Statisticians Report', AGPS, Melbourne; Commonwealth of Australia, *Australian Year Book*, AGPS, Melbourne, No 14, 1921, p.1128.

*Full-blood Aborigines, and therefore total figures by age were not included.

Table 1.6
Age-specific sex ratio(a)of half-caste Aborigines, 1921

Age group	Males	Females
0-4	100	100
5-9	96	100
10-14	78	100
15-19	78	100
20-24	113	100
25-29	64	100
30-34	50	100
35-39	125	100
40-44	129	100
45-49	125	100
50-54	50	100
55-59	(b)	100
60-64	(b)	100
65-69	(b)	100
70-74	(b)	100
75+	(b)	100

(a) the number of males per 100 females. (b) the numbers in these cells are too small to calculate a ratio.
Sources: Compiled from figures for 1921 in Table 1.5 above.

Table 1.7
Aborigines in WA, 1901-1933

	Full-bloods			Half-castes			Total		
Year	Male	Female	Persons	Male	Female	Persons	Male	Female	Persons
1901	2933	2328	5261	492	459	951	3425	2787	6212
1911	3433	2936	6369	760	715	1475	4193	3651	7844
1921(a)				1101	859	1960	1101	859	1960
1933	3570	3093	6663	1735	1709	3444	5305	4802	10107

(a) full-blood Aborigines were not counted in 1921 but estimated in 1921 (not included here). Sources: Fraser, '7th Census of WA, 1901', *op.cit.*, pp.203-207. Also, See Statistician's Report, Bureau of Census and Statistics, Census of the Commonwealth of Australia, 1911 Bulletin No. 1, Reports of States and Territories', AGPS, Melbourne, 1913; Statistician's Report, Bureau of Census and Statistics, Census of the Commonwealth of Australia, 1921.

Table 1.8
Aborigines by age and sex in WA,1933

	Full-bloods			Half-castes			Total		
Age	Male	Female	Persons	Male	Female	Persons	Male	Female	Persons
0-4	137	95	232	280	276	556	417	371	788
5-9	109	126	235	256	238	494	365	364	729
10-14	100	65	165	175	196	371	275	261	536
15-19	120	89	209	187	221	408	307	310	617
20-24	107	82	189	172	199	371	279	281	560
25-29	110	103	213	125	143	268	235	246	481
30-34	134	112	246	81	84	165	215	196	411
35-39	116	91	207	102	85	187	218	176	394
40-44	161	131	292	75	63	138	236	194	430
45-49	102	83	185	64	35	99	166	118	284
50-54	141	97	238	49	35	84	190	132	322
55-59	77	41	118	25	20	45	102	61	163
60-64	99	75	174	21	15	36	120	90	210
65-69	38	22	60	15	5	20	53	27	80
70-74	35	20	55	9	10	19	44	30	74
75+	15	10	25	1	2	3	16	12	28
Sub Total	1601	1242	2843	1637	1627	3264	3238	2869	6107
N/S	1969	1851	3820	98	82	26	2067	1933	4000
Total	3570	3093	6663	1735	1709	3290	5305	4802	10107

Source: Statistician's Report, 1933, Census of the Commonwealth of Australia. Bulletin No. 24. 'Summaries relating to 'Full-blood' Aboriginals'; mixed descent people included in general & Abor. 1933 census.

Table 1.9
Age-specific sex ratio (a) of full-blood and half-caste Aborigines in WA, 1933

Age group	Males	Females
0-4	112	100
5-9	100	100
10-14	105	100
15-19	99	100
20-24	99	100
25-29	96	100
30-34	110	100
35-39	124	100
40-44	122	100
45-49	141	100
50-54	144	100
55-59	167	100
60-64	133	100
65-69	196	100
70-74	147	100
75+	133	100

(a) the number of males per 100 females.
Source: Compiled from figures for 1933 in Table 1.8 above.

Table 1.10
Annual Aboriginal census in WA, 1921-1940
(includes the estimated 10,000 persons)

	Full-descent		Others		Total(a)		
	Male	Female	Male	Female	Male	Female	Persons
1921	13611	11976	1199	885	14810	12861	27671
1922	N/A	N/A	N/A	N/A	N/A	N/A	N/A
1923	N/A	N/A	N/A	N/A	N/A	N/A	N/A
1924	11557	10703	934	834	12491	11537	24028
1925	11830	10641	1238	1085	13068	11726	24794
1926	11662	10560	1341	1079	13003	11639	24642
1927	12027	10968	1332	1255	13359	12223	25582
1928	11689	10908	1288	1149	12977	12057	25034
1929	11941	10975	1416	1295	13357	12270	25627
1930	12112	11062	1679	1447	13791	12509	26300
1931	12207	10903	1738	1659	13945	12562	26507

Table 1.10 cont.

	Full-descent		Others		Total(a)		
	Male	Female	Male	Female	Male	Female	Persons
1932	13147	11736	1745	1606	14892	13342	28234
1933	13608	12015	1927	1748	15535	13763	29298
1934	11916	10587	2071	1941	13987	12528	26515
1935	11780	10408	2258	1996	14038	12404	26442
1936	11820	10227	2297	1969	14117	12196	26313
1937	11850	10268	2172	2037	14022	12305	26327
1938	11657	10225	2382	2220	14039	12445	26484
1939	12166	9712	2473	2215	14639	11927	26566
1940	12152	9669	2507	2274	14659	11943	26606

(a) includes the estimated 10,000 persons.
Source: L.R.Smith, 'Aboriginal Population'.*op.cit.*,p.166.

For full references see Bibliography

Notes

1. Daisy Bates, 1938, pp.61-62.

2. *Ibid*., pp, xvii-xviii, and pp.67-72.

3. Rowley, Vol. I, 1970; Rowley, Vol. II, 1971; Rowley, Vol. III, 1971.

4. L.R. Smith, 1975; Smith, 1980.

5. F. Lancaster Jones, 1970, see also, L. Broom and F. Lancaster Jones, 1973; see also J.P.M. Long, 1970; see also P. Biskup, 1973; see also M.C. Howard, 1981; see also A. Gray, 1983.

6. Butlin, 1983, pp.64-67.

7. For an excellent example of the uses of these terms in a sensitive manner, see Rowley, 1970, Vol. I, Appendix A/B, 'Who is an Aborigine', and Smith, 1980, pp.341-398.

8. Wherever possible I follow the Australian Government *Style Manual: For Authors Editors And Printers*, Fifth edition, AGPS, Canberra, 1994, pp.137-144.

9. From recent studies, and from the administrative records of Western Australia, these sources come mainly from working documents from scholars compiled for other purposes, Commonwealth Government statistical records, Commonwealth Year Books, State and Commonwealth census record. Also, I make use of forms used for the Aboriginal census after 1921 (although I use only total figures in this chapter) by Aborigines Department protectors. In addition use is made of Chief Protector's Annual Reports from the late 1890s to 1940. The following study is made as comprehensive as possible, by including the use of selected social indicators from 1901 and 1930s. All figures are clearly marked near the texts and attachments are included as an Appendix.

10. Hereafter referred to as the Commonwealth Bureau.

11. Commonwealth Bureau of Census and Statistics, WA, 1968, ABS Library Series No. C.S. 312.09941, AUS. WA. These administrative units received funds directly from State contributions. Subsequent chapters describe how bodies such as the Road Boards controlled matters like hospital fees for Aborigines. Some local government districts became municipalities and some Road Board districts changed to shires. Changes in these intricate structures made it difficult for those involved closely with Aborigines to understand the complexities of the relationships that state and local authorities possessed when either dealing with indigenous people or choosing not to do so.

12. *Ibid*., pp.2-3.

13. Census, 1911, *Statistician's Report*, 1911, CBCS, Melbourne, 1912.

14. A.H. Pollard, Farhat Yusuf and G.N. Pollard, 1991, p.1; see also, G. Hugo, 1986, pp.1-41; see also, David Coleman and Roger Schofield (eds), 1986, pp.1-14; see also, D. Lucas, P. McDonald, E. Young, C. Young, 1980; see also, D. Lucas and Penny Kane, 1985.

15. P.M. Moodie, 1973 Canberra, pp.27-42.

16. John Forrest, 'Copies of Circulars issued by Aborigines Department', 1.5.98, *Colonial Records*, in Battye Library, Perth.

17. Annual Report, *Aborigines Department*, WAGP, Perth, 1900, p.1.

18. These children were not regarded as Aborigines and were, in general, referred to as 'wards', as they were in the Northern Territory or New South Wales. See J. McCorquodale, 1987, p.23, and see pp.23-37; for a more descriptive analysis see, F. Stevens, *The Politics Of Prejudice*, APCOL, Sydney, 1980, pp.66-75.

19. B. Doyle, 'Ethnicity', in Lucas and Kane, 1998, pp.209-220.

20. Chief Protector of Aborigines, *Annual Report*, 1899, p.1, and *Ibid*., *Annual Report*, 1901, p.1.

21. Battye Library Native Affairs Indexes, AN 1-6, Acc. 1393, file entitled '*Chief Protector of Aborigines Draft Annual Report*', p.1.

22. Biskup, 1973 pp.1-44.

23. L.R. Smith, 1985, p.156.

24. Conference of Statisticians of Australia, *Report*, Part 1, 'Historical', Hobart, 1902, p.5.

25. *Ibid*., Chapter VI, p.43.

26. *Ibid*., Part IV, 'Records of Resolutions', see resolution No. 12, from Sydney conference, pp.45-47.

27. *Ibid*., Part VIII, 'Collection and Compilation', p.80.

28. *Ibid*., pf.

29. *Commonwealth of Australia Constitution Act 1900*, (63 and 64 Victoria, c12), in John McCorquodale, 1987, p.3, and see p.9, and see also, reference p.201, to Geoffrey Sawer, 1966, pp.17-36.

30. J.A. La Nauze, 1972, pp.67-68; La Nauze agrees with both Smith, *Aboriginal Population*, pp.20-21, and Sawer, 'The Australian Constitution', 1966, pp.17-36, [and I presume McCorquodale even though he does not consult La Nauze] when he says that, 'Although the origin of the section was a good deal more complicated than is implied by Geoffrey Sawer in his article … [quoted above] he is completely justified in holding that it had no relevance at all to the taking of the census'. La Nauze is right in his argument about the cause of why the section came to be located where it was in the Constitution. I am addressing the effects. In doing so I am arguing that the interpretive error had a devastating impact on Aboriginal–white relations. I do not take issue with any of the above writers on the cause.

31. Smith, 1980, p.21; for a political argument on the growth of the full-blood population, see Charles Duguid, 1963.

32. La Nauze, 1972, p.68.

33. Conference of Statisticians of Australia, *Report*, Part 1, 'Historical', Hobart, 1902, p.5.

34. Australian Federation Conventions Conference, *Official Records and Proceedings*, Melbourne, 1890; see also, Convention Conference, *Debates*, Sydney, 1891; Convention Conference, *Debates*, Adelaide, 1897; see also, Federal Convention, *Official Records*, Sydney, 1897; see also, Federal Conference, *Official Records*, Melbourne, 1899.

35. Aborigines Department, *Annual Report*, WAGP, Perth, 1901, pp.1-8.

36. This group was later to be described as half-castes deemed to be Aborigines, and half-castes deemed not to be Aborigines.

37. Fraser, 'WA Statistician's Report, 1901', Chapter XIX, 'Aboriginals', pp.203-207.

38. *Ibid*., 'Aboriginals', p.203.

39. *Ibid*., pf.

40. *Ibid*., pf.

41. Aborigines Department, *Annual Report*, 1899, pp.1-6; 1900, pp.3-4; 1901, pp.1-8.

42. Fraser, 'Report 1901', pp.203-204.

43. A. Grenfell Price, 1946, pp.557-558.

44. Archives Perth WA, see CRS 394/21/7/1858; SSR, 6233/84. These notes are on early development of transportation system and relations with Aborigines and sourced by T.L. McKnight, 1969, p.27, and see, pp.90-91.

45. Aborigines Department, *Annual Report*, 30th June 1901, WAGP, Perth, 1901, p.3; but see also, J.S. Battye, 1925; see also, J.S. Battye, 1913; J.S. Battye, 1915; see also, G.C. Bolton and D. Hutchinson, pp.50-59; see also, J.C. Caldwell, 1987, pp.23-26.

46. For an important discussion on this phenomenon, see, Rowley, 1970, Vol. I, pp.365-368, and see also, F. Lancaster Jones, 1970, pp.6-13, for Western Australia see *Aborigines Act*, 1905 (no. 14, of 1905). This legislation, among other things, defined persons deemed to be Aborigines which included an Aboriginal inhabitant of Australia and half-castes or their children.

47. Fraser, 'Report 1901', see Chapters XIX under headings on 'Population and Habitation', p.100, and p.131, and 'Aboriginals', pp.203-207.

48. Lancaster Jones, 1970, pp.6-13.

49. Appendix 1, see Table 1.2; this table reveals a growing half-caste population. Figure 1.2, shows clearly the age structure increases relative to contact with white settlers.

50. The 'Travelling Inspector's' reports and Police Protectors' collected from sheep properties make clear distinctions between the numbers of 'natives' and 'half-castes' either on ration relief or resident on the properties visited.

51. British Parliament, *The Commonwealth Constitution Act 1900*, (63 and 64 Vic. c.12), in McCorquodale, 1987, p.3, and when seen in the context of s51 it is possible to appreciate that s127 clarifies the financial clause which became a matter of misplaced interpretation.

52. Statistician's Report, *Census of the Commonwealth of Australia, 1911*, Bulletin No. 1, 'Population of States and Territories Report'.

53. For an example of annual accounts, see *Protector's Reports*, 1905-1910.

54. Western Australia Parliament, Report By *The Royal Commission on The Condition of The Natives*, WAGP, Perth 1905.

55. *Ibid*., pp.25-32; see transcripts of evidence, 'Appendix B', pp.34-121; see also, Biskup, 1973, pp.45-95, for cause and effects and other detail of Royal Commissions.

56. *Ibid*., pp.1-32; see also, Biskup, 1973, pp. 67-75.

57. ABS, '*Population and Dwellings: Census, 1911 to 1966*', p.3.

58. Chief Protector, *Annual Report* 1911, WAGP, 1912.

59. *Ibid*., 'Annual Report', 1912, pp.2-3.

60. Chief Protector, *Annual Report*, 1920, p.11-12.

61. According to the Bureau of Census and Statistics Library these records no longer exist.

62. Lancaster Jones, 1970, p.8. Jones suggests about eight ethnic arrangements were possible.

63. See Chief Protector, Battye Library Native Affairs Indexes, AN 1-6, Acc. 1393, file entitled, '*Chief Protector of Aborigines Draft Annual Report*', pp.1-50; see also, Western Australian Government, *Royal Commission of Inquiry into Alleged Killing and Burning of Bodies in Eastern Kimberley and into Police Methods when effecting Arrests*, WAVP, WAGP, Perth, 1927, Vol. I, p.xv; see also, R.D. Moseley (Royal Commissioner), *Report of the Royal Commission appointed to Investigate, Report and Advise upon Matters in Relation to the Condition and Treatment of Aborigines*, WALAV&P, WAGP, Perth, 1935, pp, 5-6; see also, Rowley, 1970, pp.300-304.

64. Mosley, 'Royal Commission Report 1934-35', pp.5-6, and pp.16-17.

65. A. Grenfell Price, 1949; see also, Fay Gale, 1964; see also, Rowley, 1970, Vol. 1; see also, Dianne Barwick, 1971, pp.288-315.

66. Smith, 1980, pf.

67. Smith, *Ibid.*, pf.

68. Smith, *Ibid.*, p.35.

69. See *Western Australian Year Book*, where results are published.

70. *Australian Year Book*, No. 14, 1921: p.1128. Referred to in Smith, 1980, pp.58-60.

71. *Ibid.*, pf. For other sources see *Australian Board of Missions Review*, 'Aboriginal Census', March 1933; see also, *American Journal of Physical Anthropology*, 'Aboriginal Census of Australia', 1927, No. 10, pp.486-489.

72. *Ibid.*, p.166. See also, a reproduction of these figures in Table 1.6. Figures in Table 1.7 are compiled by me from ABS publications.

73. *Ibid.*, p.156.

74. Battye Library Native Affairs Indexes, AN 1-6, Acc. 1393, 'Neville's Draft Annual Report', pp.1-50.

75. Neville, 'Draft Annual Report', p.1.

76. *Ibid.*, p.1.

77. *Ibid.*, p.2.

78. *Ibid.*, p.f.

79. *Ibid.*, pf.

80. *Ibid.*, pp.2-3.

81. Moseley, 'Royal Commission Report 1934-35', p.3.

82. Transcripts, *Royal Commission appointed to Investigate, Report and Advise upon matters in relation to the Condition and Treatment of Aborigines*', WAGP, 1935, in Battye Library Perth Western Australia, Series No. 2922/V.1-2. Paragraphs are marked chronologically and references refer to those paragraphs. See A.O. Neville's evidence in paras 1-109.

83. Moseley, 'Royal Commission Report 1934-35', p.4.

84. *Ibid.*, p.5.

85. *Ibid*., p.4.
86. *Ibid*., pf.
87. *Ibid*., pf.
88. *Ibid*., pf.
89. *Ibid*., p.5.
90. Biskup, 1973, *pp*.167-169.

2

‘To leave them alone’:[1] an analysis of the Aboriginal population of Queensland, 1900–40

Our attention now shifts from Western Australia to Queensland in the period 1900–40.[2] Like the last, this chapter is a precursor to the study of the historic epidemiology of an Aboriginal population. The book makes no attempt to pose or answer either pre-contact or colonial demographic questions except for descriptive purposes, but focuses on the same four decades examined in the previous chapter. The emphasis is on the Gulf region because this was the area where most commentators had once expected that substantial populations might be located. That was not the case, however, because by 1900 the Aboriginal populations in the Gulf and Cape York region were largely known. The numbers of Aborigines counted in the censuses were nevertheless grossly over-estimated both in the nineteenth century and up until World War II. The total Aboriginal population continued growing after 1900, mostly due to the fertility of Aboriginal women of mixed descent. As in Western Australia, Aboriginal women of full-descent had suffered under colonialism, and so it was they and also the men of full-descent who became the beneficiaries of Queensland protection and welfare relief policies during the twentieth century.

The last phase of white settlement in Queensland began around 1900 and lasted until just after World War I. The only lands then left to settle were sections of the Gulf of Carpentaria and Cape York hinterland, and various pastoral areas along the New South Wales border west from Roma to Cloncurry and the Northern Territory. White settlement in these regions left a small Aboriginal population, whose numbers could only be estimated by the protectors and missionaries working there.

Map of Queensland indicating the Aboriginal ration depots, compounds, missions and government settlements, 1890s–1940s.

How did land settlement west of the Great Dividing Range impact on the Aboriginal population? Writers from Rowley,[3] Long[4] and most recently Dawn May,[5] have all assumed that large numbers of Aborigines lived there in the bush beyond white settlement. Those best qualified to determine accurately the size of the Aboriginal population were the early government protectors and missionaries[6] working in the Gulf and Cape regions. However, no comprehensive research, covering the whole of Queensland, was ever carried out until Broom, Jones,[7] Long and Rowley published their studies in the early 1970s. They largely ignored the observations of the protectors and missionaries, however, and so scholars have continued to assume that Aborigines lived in large numbers in the Gulf and Cape regions. The demographic evidence indicates that this assumption was wrong.

By the first decade of the twentieth century the Queensland Government's dispersal[8] and protection policies had brought only about 1,500 people into the Aboriginal relief depots. Most such depots were located near coastal service towns within a few days' journey of Brisbane.[9] Not until World War I did Aborigines prove useful in the pastoral industry in Queensland. It was in the 1920s that small Aboriginal populations living on cattle and sheep stations began to reproduce a labour force of size. This pastoral labour force was isolated and had little contact with either mission or government depot populations, except when the pastoral properties were located near missions, from which they drew surplus labour until the great economic depression of 1929–32.

White settlement did not begin in the Gulf region until about 1864. This region was huge, extending from the Mitchell River to the source of the Flinders River and north-west to the present Northern Territory.[10] In 1867 the Moorehead and Young stock company drove livestock for agistment as far west as the Albert River. Between then and the 1880s settlements such as Burketown, Normanton, the port at Sweers Island and the mining railhead at Croydon became the service centres for the settler communities of the region.[11] Settler life was subject to the vagaries of events at the limits of settlement. In the early 1860s, for instance, residents of Burketown were struck by a mysterious fever that routed both the whites and what remained of the indigenous populations.[12] Only a few people were left alive there. The epidemic closed Burketown and allowed Normanton to become the main service centre for the Gulf region. The

native police were never active in this area and few, if any, major confrontations between Aborigines and settlers took place. The white population never rose above 1,000 in the period before 1903. The main contact with the outside world was the fortnightly postal service which continued, weather permitting, from 1870 to 1900 and beyond.[13] Two other factors impinge on the link between white settlement and the size of the Aboriginal population in the period up to 1930. One was the failure of closer settlement and the other was subsidised Aboriginal pastoral labour.

The Queensland *Land Act 1910*, became 'the most important land legislation since 1884' for encouraging closer settlement.[14] Apart from dividing up the land into smaller lots, it provided a base for the later post-World War I land selection program. Selection policies designed for soldiers returning home after World War I generally failed, however. This meant that, particularly in the Gulf and far western regions, selectors came and went quickly.[15] The two regions suffered economically, not only because of the heat, tropical weather and human and animal diseases present in that environment but also through the failure of the pastoral system to attract greater settlement. The consequent slow development of the western districts beyond the Great Dividing Range lessened the impact of pastoral settlement on the sparse indigenous population.

In relation to subsidised labour, good water and grass for stock were necessary for small pastoral holdings, a factor which constrained the numbers of pastoralists who could settle in the region. Only those selectors who could get access to water stayed. The failure of the region to attract new pastoralists was a major reason why this area stagnated economically between 1900 and 1914. When WWI erupted in 1914 it boosted the prospects of the beef and wool industries. The war had an enormous effect on the coastal areas of Queensland because it exacerbated labour shortages, drove up wages and the cost of machinery, fencing and transport, and depleted the pastoralists' supplies of materials. The western districts, however, were partly protected from labour shortages because of the presence of Aboriginal labour. A benefit of Aboriginal labour was its cheapness because of the subsidies made available under the Queensland *Aborigines Protection and Restriction of Opium Act of 1897*.[16] Some Aboriginal people, legally exempted from this legislation, entered active war service but Aborigines were generally

excluded from military service under the Commonwealth's *Defence Act 1910*.[17] Two droughts reduced labour needs but the white population remained fairly stable between the 1890s and 1920s.

What made it easier for pastoralists to remain was that the pastoral properties in the western Queensland Gulf and in districts further south, were free of the disasters[18] that elsewhere affected black – white relations most severely. Such disasters included massacres of the settlers in the mining and pastoral industries on the one hand and of Aborigines on the other. A persistent assumption is that all areas experienced massacres during the earlier colonial periods. Such assumptions cannot be made in the Gulf and Cape hinterland, however, for no massacres of Aborigines, or of settlers, occurred in the region. In Queensland, massacres were a nineteenth century phenomenon. Even then, the depredations of the Native Police were confined to central and southern coastal regions and did not reach the Gulf or Cape areas.[19] Relations were not always amicable between Aboriginal pastoral labour and pastoralists in the Gulf and Cape, but this represented an on-going structural conflict between the land owners and managers and local labour rather than racial strife.[20] A likely reason for the absence of racial conflicts was the small size of the Aboriginal population, which remained at low levels from the 1880s to the 1940s and beyond. Throughout this whole period differences between the enumerated and estimated Aboriginal population figures (see Figures 2.1, 2.2 and 2.3 below) remained a conundrum.

According to the 1901 census data on Aborigines in Queensland there were 6,670 Aborigines, comprising 5,137 full-bloods and 1,533 half-castes.[21] It was also estimated that the great bulk of the Aboriginal population, a further 20,000 full-bloods, were living 'out bush'. The practice of estimating Aborigines went back to the 1881 colonial census when 20,585 Aborigines were counted in collectors' districts. A further 50,000 Aborigines were 'estimated' to be in the north and north-west.[22] By 1901 these estimates had been revised downwards to 20,000 persons, and further still were revised in 1933. At that time, only an estimated 2,291 persons were thought to be living in remote areas. These estimates were significant in that they gave the overall impression of a large number of Aborigines disappearing during the study period. No large scale disappearance had occurred, however, for the estimates of Aborigines 'in the bush' had been grossly over-stated. At the same time, the number of

Aborigines that were actually counted, that is—those that were enumerated were actually increasing (see Figures 2.1 to 2.3).

Further, in relation to problems of collection, it was obviously difficult for collectors to assess accurately the age of older Aborigines, those over 50. Collectors almost always made their own subjective judgements about age.

The first Commonwealth census in 1911 categorised Aborigines in Queensland as either half-castes or full-bloods. A total of 11,195 Aborigines (6,506 males, 4,689 females) were enumerated at this census. Of these, 1,361 males and 1,147 females were classified as half-castes and 5,145 males and 3,542 females as full-bloods. These figures represented an increase of nearly 70 per cent over the 1901 Queensland census. The following analysis reveals the very different evolving patterns of growth of the two groups. The 1911 census showed an emerging young population as revealed in the age population pyramid for half-castes (see Figure 2.7 below).[23] The sex ratio appears to be fairly balanced in most age groups, although there were generally more males than females in all groups (see Figure 2.9 below, and Table 2.5 at the end of the chapter). As would be expected at this time, the peoples classified as half-castes did not by 1901 include many older men or women (those in the over 60 age groups). This in turn reflected the fewer numbers of liaisons between Aboriginal women and male settlers of other races in the earlier colonial period. In Queensland, the relationships between Aboriginal women and men of other races resembled those already noted in Chapter 1 in the southern and northern coastal areas of Western Australia.[24]

The most significant difference between Aborigines in the 1901 and 1911 censuses in Queensland (see Table 2.1) is the downward revision of the 'estimated' Aborigines of full-descent from 20,000 in 1901 to an 'enumerated' total of 11,313 in 1911. The result was that the number of persons of Aboriginal descent appeared to have declined. The 'decline', however, occurred only on paper, due to the revised number in the 'estimated' population group. As Figures 2.1 to 2.3 show, those enumerated actually rose from 6,670 to 11,195 over the period 1901–11.

In the 1921 national census the Aboriginal population totals were a composite of the Australian and annual State 'native' censuses. This made it possible for the Aborigines to be both enumerated and estimated. In

Queensland the 1921 total figure of 17,104 is considered the most reliable since the counting of Aborigines began.[25] This figure was made up of 3,090 half-castes and 14,014 full-bloods, of whom 7,527 were enumerated and 6,487 were estimated on the basis of annual Aboriginal censuses.[26] Between 1901 and 1921 the half-caste population had increased rapidly, both numerically and also relative to the total Aboriginal population. In 1901, 1,533 half-castes had been enumerated, comprising 23 per cent of the total Aboriginal population. By 1921 they had almost doubled to 3,090, or 30 per cent of the enumerated total (see Figure 2.3, and Table 2.1).

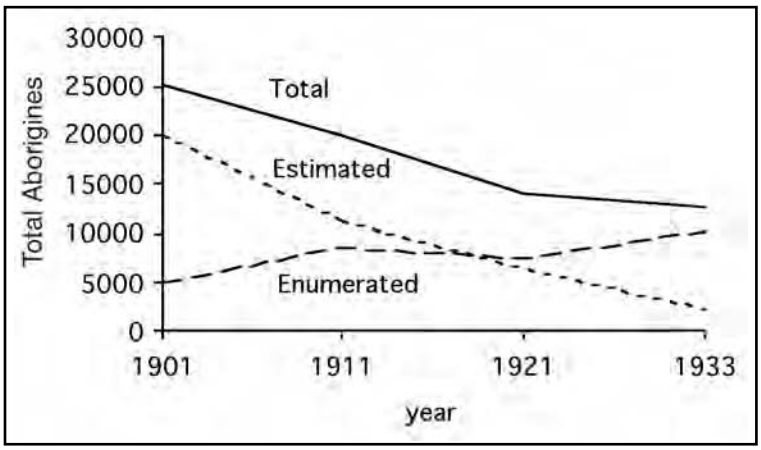


*Figure 2.1: Full-blood Aborigines in Queensland, 1901-1933**

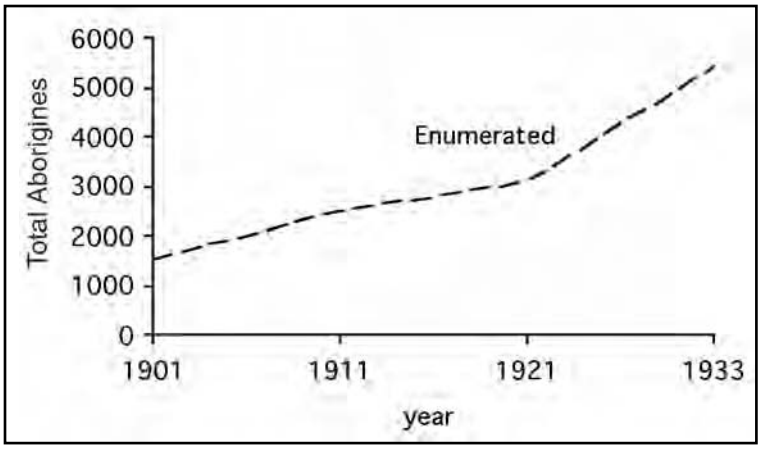


*Figure 2.2: Half-caste Aborigines in Queensland, 1901-1933**

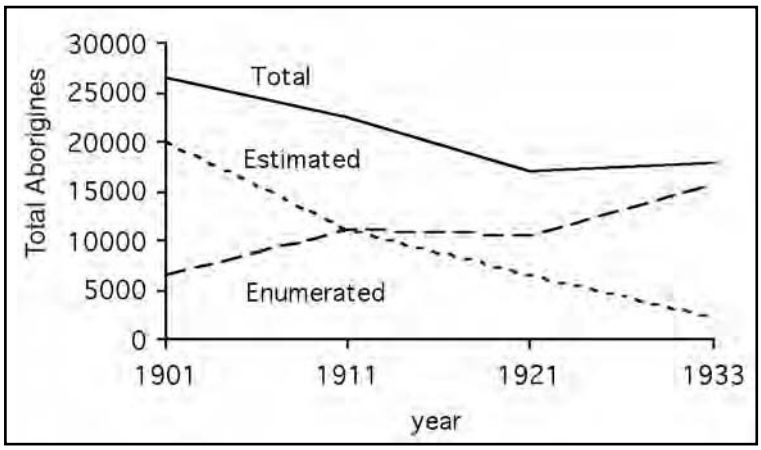


*Figure 2.3: Total Aborigines in Queensland, 1901-1933**
Source: Compiled from Table 2.1.
* These Graphs compare the way in which the different modes of counting and estimating Aborigines of both full- and mixed-descent during the period from 1901 to 1933. The three figures (2.1–3,) clearly show that the actual (i.e. enumerated) population of Aboriginal people (both half-caste and fullblood) increased during the period 1901 to 1933. Wheras, the estimated (i.e. guess at) fugures gave the impression that the total Aboriginal population was declining during this period.

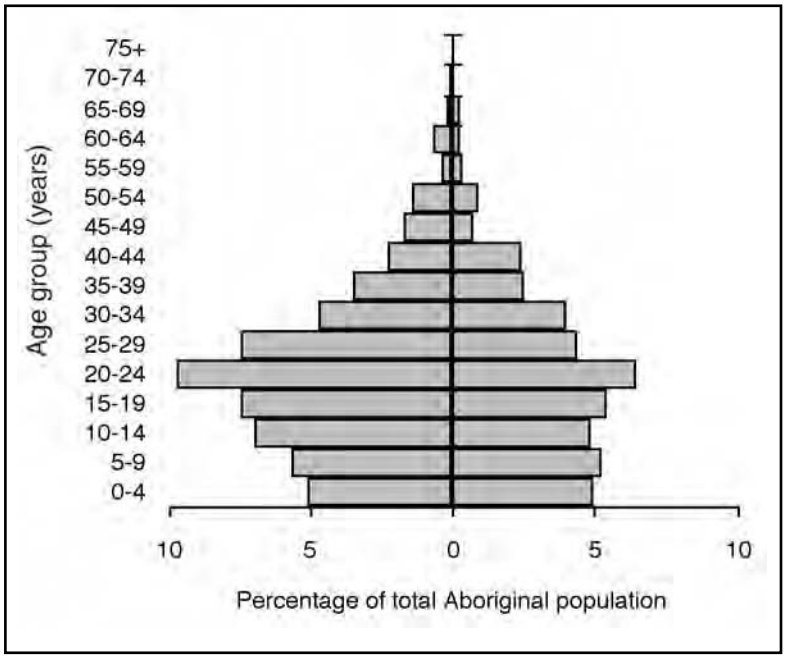


Figure 2.4: Half-caste Aborigines by age and sex in Queensland, 1901. Source: Compiled from Table 2.2 (only half-caste data available).

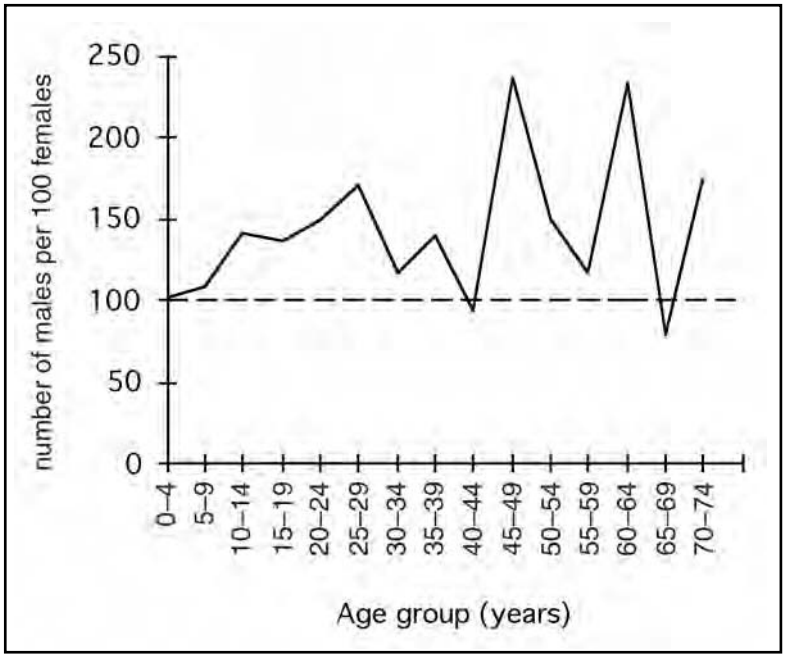


Figure 2.5: Age-specific sex ratio of full-blood and half-caste Aborigines in Queensland, 1901. Sources: Compiled from Table 2.3.

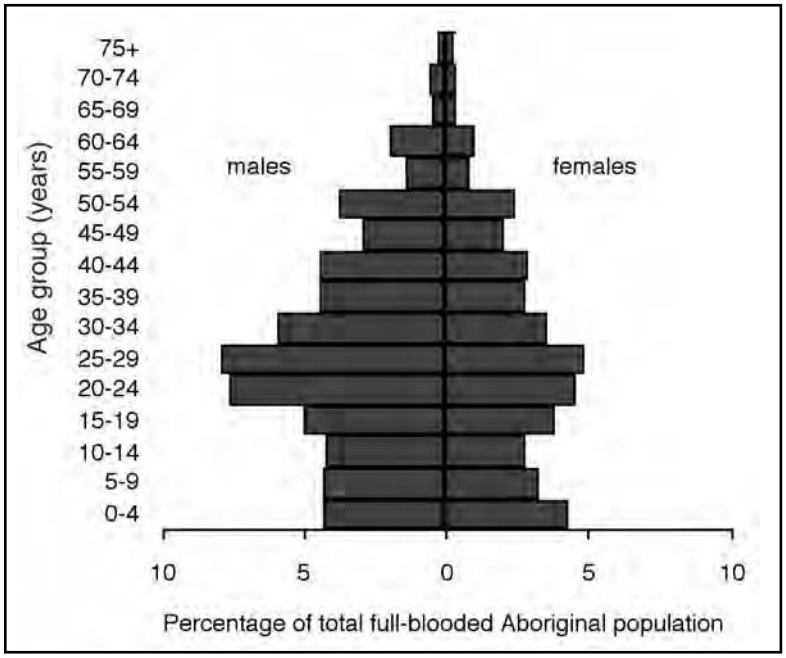


Figure 2.6: Full-blood Aborigines by age and sex in Queensland, 1911. Source: Compiled from Table 2.4.

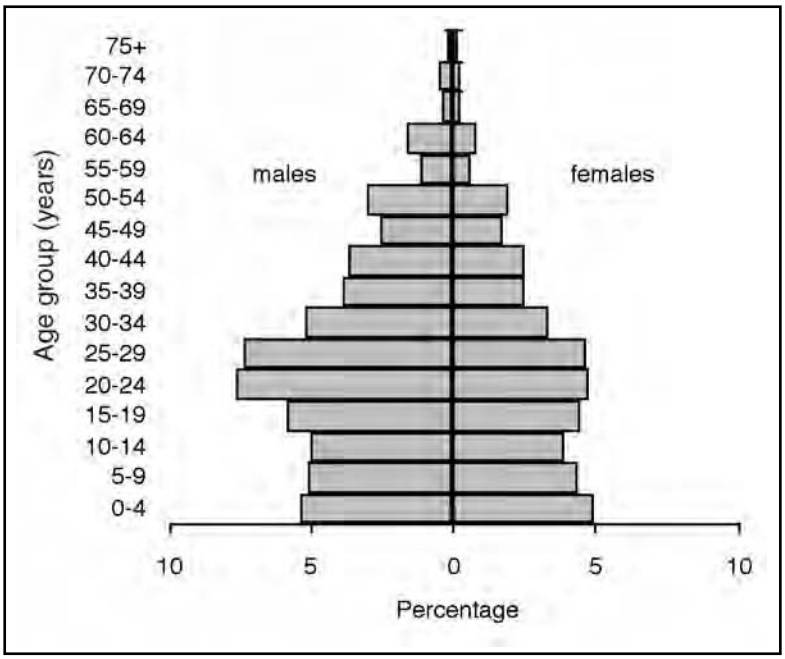


Figure 2.7: Half-caste Aborigines by age and sex in Queensland, 1911. Source: Compiled from Table 2.4.

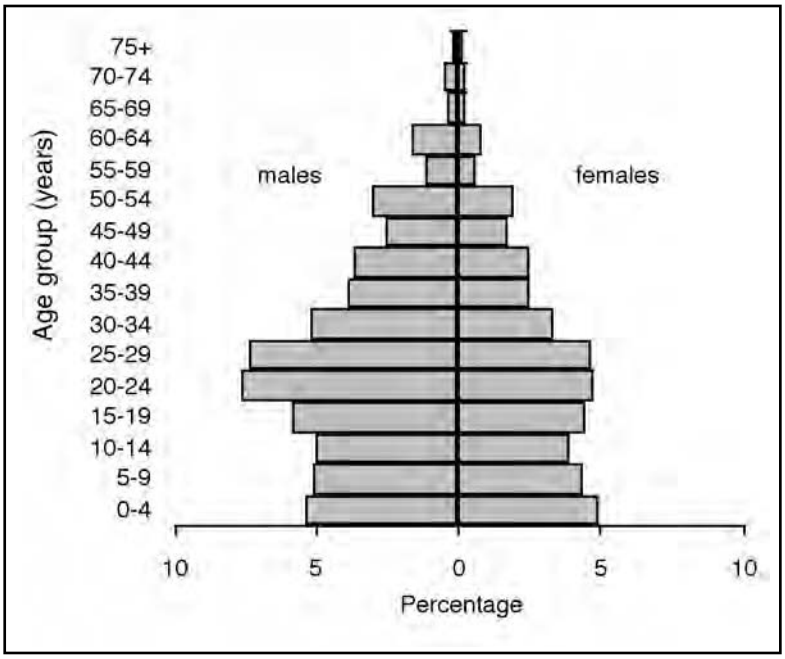


Figure 2.8: Total full-blood and half-caste Aborigines by age in Queensland, 1911. Source: Compiled from Table 2.4.

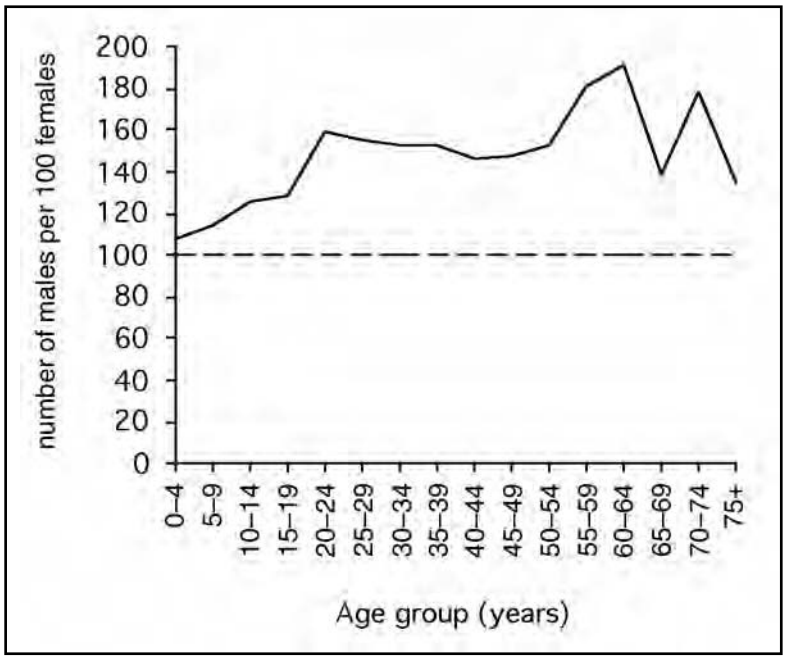


Figure 2.9: Age-specific sex ratio of full-blood and half-caste Aborigines in Queensland, 1911. Source: Compiled from Table 2.4.

Figure 2.3 indicates the paradox of the full-blood population's estimated numbers appearing to decline at the 1921 census when their enumerated figure was increasing. By 1921 the total number of full-bloods had declined to 14,014, mainly because of the drastic downward revision to 6,487 of the 20,000 estimated in 1901. Far from declining, the enumerated full-blood Aboriginal population increased by 2,390, from 5,137 to 7,527 (see Table 2.1), giving the lie to suggestions that the full-bloods were vanishing.

Doubts about the size of the Aboriginal population affected the work of the Queensland officials most intimately involved with the Aborigines–administrators, protectors, police, missionaries and health workers. In the period from 1824 to 1892 the colonial authorities persisted in the belief that about 100,000 Aboriginal people were living in Queensland. Then from 1892 to about 1930 the estimated figures gradually became realistic, falling by 20,000 between the State census of 1901 and the Common-wealth census of 1911.[27] The figure fell further to 10,000 during the period from 1911 to 1930, when an assessment was

carried out for the *Commonwealth Year Book 1932*.[28] The adoption of more realistic estimates was appropriate because, as a number of commentators have since observed, the pre-1901 estimates for Queensland had been far too high.[29]

Radcliffe-Brown's 1930 estimate of the size of the Queensland Aboriginal population remained the accepted view until the 1960s.[30] Radcliffe-Brown,[31] Professor of Anthropology at the Sydney University, produced an estimate of possible Aboriginal numbers occupying the continent at the time of the European settlement in 1788.[32] This work did nothing to dispel the myth that large numbers of Aborigines still existed in outback areas in the early years of this century. Because no studies were undertaken, these assumed 'large populations' of Aborigines reinforced the myth of a disappearing population when the said Aborigines failed to materialise. Further confusion arose because Aborigines in northern and eastern regions of the State remained free of missions and governments until the period from 1910 to the 1920s. In northern Queensland Aborigines had a background of greater concentration on church missions. By the late 1890s, missions had been planted across northern Queensland from the Mitchell River in the far north of the Cape York region down to Cairns. In the south, greater institutional concentration on government depots and reservations had occurred. Relief depots existed between the Gold Coast and Brisbane, west to Cloncurry and from Ipswich north to Mona Mona near Mackay. Archibald Meston opened the first ration and relief depot at Deebing Creek, near Ipswich west of Brisbane, in 1898.[33] Others opened soon after at Barambah and Taroom near Murgon.[34] More *ad hoc* relief depots existed in western areas like Charleville, Roma, Winton and Cloncurry. Until 1897 no special government agency existed to administer native policy. The Protector's Office, with Meston and later, Walter Roth as Protectors, came under the responsibility of the Police Commissioner.[35]

Although Queensland was not fully settled until the 1920s, most Aboriginal mainland groups were in contact with Europeans in the west and along the coast. The proposition that there were large numbers of people out of reach of settlers has never been supported by proper research. In addition, given the climate and the landforms in the west, it is doubtful that the region ever held anything but small indigenous populations. According to the historian Rusden, in the Hull and Forest

River areas indigenous groupings began coming together under Christian influences which centralised them on mission and depot reserves from about 1870. In general, it may be argued that 'concentration' of the indigenous population rather than 'dispersal', appears to be a better metaphorical description of what happened.[36] Methodist and Lutheran missionaries began gathering Aborigines together as early as the 1870s and continued doing so through to the first decade of the twentieth century.[37] Archibald Meston, the first Queensland Government Chief Protector, recommended in an 1896 report that the policy should be that white settlers, Asian fishermen and Chinese traders cease interfering with Aboriginal women.[38] Earlier in the 1890s Meston and Roth[39] had reported to the Queensland Government on the location of the bush people. They indicated that the only places where such people lived out of contact with white settlement were in the far south-western and north-western areas and in the areas north of Croydon station on Cape York. The populations in desert regions probably always remained sparse because of the low yield of desert food sources, which, because of their consequential low body weight, in turn reduced women's ovulation rates.[40] On top of that, loss of living place and disease subsequently played a part in keeping the population at low levels.[41]

Regular contact between Aborigines and settlers occurred along the trade routes west to Cloncurry and north along the telegraph route from Charters Towers to Normanton. Populations here and along the New South Wales border regions had already been systematically moved east, or had congregated on pastoral leases as stock labour.[42] For our purposes, however, the western region from along the southern and western borders to the Gulf of Carpentaria was fully (though sparsely) settled by 1904. The known Aboriginal populations were mainly distributed along a thin inland corridor stretching from Brisbane to Cloncurry and north around the Gulf to Normanton. The first reliable figures from Protectors' reports indicated that approximately 20,585 Aborigines were living in areas serviced by collectors during the 1891 Colonial census. A further 50,000, some writers claimed, lived in the bush, but from 1900 the validity of such estimates was increasingly doubted.[43]

No census data on Aborigines exists before 1881, and the earliest colonial estimate available is for 1898.[44] No figures before 1901 can be accepted as reliable, and 'the period of the [assumed] Aboriginal population decline, is

almost entirely undocumented'.[45] There was the usual confusion with turn-of-the-century points of view about who an Aborigine was.[46] Smith has explained that before the first Commonwealth census in 1911, information on race was simply noted by collectors under 'place of birth' and whether those being enumerated were Chinese, Pacific Islander or Aboriginal. In the report of the 1901 census these groups were separated from the main figures, but no record exists about whether or not they were included before 1881[47]. The Colonial Office data does not consequently specify what racial groups the people counted belonged to, or if some people were excluded altogether. The 1901 Chief Protector's Annual Report indicated that 'whilst 5,137 full-blooded Aborigines, as well as 1,533 half-castes … who became integral parts of the industrial population [were included in the census] … all those whether full-blooded or half-caste, living in camps and leading the lives usual to Aborigines, were excluded'.[48] What the Statistician called 'civilised half-castes' became incorporated in the general Queensland colonial population from 1891 and then in the general Australian population until well after 1940.

A common assumption in historical accounts based mainly on secondary source materials,[49] is that from the initial operation of the *Protection Act 1897* a systematic removal of Aborigines from western hinterland properties occurred. Myths of large numbers of Aborigines who were never counted, and of large groups being removed from their dwelling places, persist. Many people certainly left 'native' living sites for various reasons, including caring for sick adults and children at government depots and missions. The protection legislation in place from 1897 made life difficult for Aborigines because adults offending against the legislation were often removed by the courts. The Chief Protectors recorded most of the removals in their annual reports, but no comprehensive studies of this movement of people have been undertaken. When considered in relation to the limited number of depots in the south and the annual tally of about 1,500 people accounted for at the depots, the exodus was comparatively small. This is confirmed by the fact that, to cater for the population movement, the creation of only three new reserves was necessary in the south. One was located at Barambah near Murgon, another at Taroom further north and the other was at Duaringa near Hull River.[50] Palm Island was first opened in 1918 as a leprosarium and converted into a small Aboriginal settlement at the end of the 1920s. It is often held up as the example of official oppression of Aborigines.

From the 1911 census onwards the Commonwealth began to show an increasing interest in the Aboriginal data. When the Commonwealth began discussing the possibility of special Aboriginal censuses with the States in 1918, those involved hoped that by using special collection methods a clearer demographic picture of the total Aboriginal population would emerge.[51] A number of problems in deciding on appropriate criteria for defining Aborigines had emerged, however. Sometimes it was purity of race and at other times it was social habit and custom. Sometimes people of half-caste or less than half Aboriginal descent were counted, and at other times they were not.

In yet another category were those people of mixed descent dwelling in the bush and living in the traditional Aboriginal way, who were sometimes omitted but were now meant to be included. In Queensland, as in other States, the major problem appeared to be the inability of collectors to distinguish people of mixed Aboriginal descent from 'natives'. Collectors relied on local protectors (that is, mostly the local police), pastoralists, property owners and managers to identify who could be regarded as an Aborigine as distinct from a person of mixed race.[52] As for full-bloods, State and Federal statisticians have always gathered relevant data and, although this was excluded from published final reports of the general population, the actual numbers of Aborigines were well known to officials responsible for the administration of Aboriginal people.[53]

Such problems of identification notwithstanding, it is possible to draw certain conclusions from the data gathered during successive censuses. Thus, the age structure pyramid of the combined total full-blood and half-caste population for 1901 reveals a population with deep-seated demographic problems. It strongly suggests a population in decline (see Figure 2.4 above). In each age group under 20 years of age the numbers of males decline; females too seem to be missing in large numbers; there are abnormally more males and females in the 20-24 year age group than in any other. The percentages of persons aged 60 or more decline sharply. (The social factors contributing to this are discussed in later chapters). As with the colonial data, there is an excess of males to females within all age categories.

The imbalance in the sex ratio of 1901 (see Figure 2.5 above) continues in most age groups until well after Federation, and is particularly noticeable in the young adult and older age groups. The fluctuations in

the sex ratio in the older age groups may, in part, be explained by age heaping — that is, rounding a person's age to the nearest ten-year group. This may not be the only explanation, but no data exists to elaborate on other underlying reasons. The sudden upsurge in the white population in the 1890s and early twentieth century, plus an increased presence of Asian pearlers, could have been a factor. The imbalance may be explained in terms of the custom of white and Asian settlers and South Pacific seamen to cohabit at will with Aboriginal women of full - and mixed-descent.

A number of racial groups existed in remote areas. There were Afghans, Asian, South Sea and Torres Strait Islanders and Japanese seamen. All of these males cohabited with a small group of Aboriginal females. White women did not go into the outlying regions of settlement until after the 1920s, and generally they went to isolated properties. In these instances, Aboriginal males were kept on outstations some distance from the homestead.[54] The health and social consequences of this phenomenon are discussed in other chapters, but these factors compounded collection problems.

In the 1911 census, there were 8,687 Aborigines of full descent (5,145 males, 3,542 females).[55] Their age distribution tells a dramatic story. Both the full-blood and half-caste populations appear to be on the way to demographic recovery. It is almost certain that the cohabitation of full-blood males and females with half-caste and other white, Asian and Pacific Island male populations resulted in substantial increases in the numbers of 'half-caste' children, as reflected in Figure 2.7 above. This clearly demonstrates that males exceeded females in each age group in the full-blood population distribution (see Figures 2.6 and 2.9 above). What the figures do not indicate is the great variety of racial mixing accommodated under the all-embracing term 'half-caste'.

It is difficult to establish the exact dynamics of what was happening to the full-blood Aboriginal population because of the paucity of recorded information. There is sketchy information about individual missions that could provide some signposts. Jeremy Long estimated that at Aurukun Mission, deaths increased from 12 in the period 1904-05 to 30 in 1911-15, resulting in a negative growth rate of nearly two per cent for the latter period. As Long acknowledges, these records are of limited value because it is unlikely that all births and deaths were recorded.[56] In addition, the resident population of the Aboriginal camps increased and decreased

unpredictably, making any accurate record keeping difficult if not impossible. Most of the adult population lived at some distance from the mission and when children became sick they were brought in by missionaries from the larger bush camps. According to Roth, the population sometimes reached 200 to 400 bush people.[57]

The southern populations were made up mostly of government and mission depot people who came to these institutions with either a health complaint or because they were destitute. The concentration of populations had a marked effect on the deterioration of people's physical condition. Once remote station and mission people became ill or were injured they were moved to new and, ironically, infectious surroundings. Even if people came to the depots free of any health complaint they soon became vulnerable to infection. In addition, such problems increased as the population of the ration and relief depots and hospital fringe-camps increased.

Figure 2.8 shows the combined Aboriginal population in 1911; the pyramid clearly contrasts with the earlier one for full-bloods, which displayed a population under great stress. The combined pyramid of the 1911 population looks like a population only just sustaining itself.

The sex ratio shown in Figure 2.9 clearly displays the heavy imbalance of males to females, with a ratio of 1.4 males to every female overall. The ratio comes close to normal in the younger age groups, which is a further indicator of a population in recovery. The half-caste age structure (see Figure 2.7) reflects the past sexual relations between indigenous groups and white settlers. In addition, the half-caste groups were beginning to show substantial numbers at older ages. By 1911, Queensland Government policies were beginning to restrict the previously chaotic relations between white settlers and the bush, station and depot populations. At the same time, the older full-blood population began stabilising under the combined influence of both protection policies and relief programs.

The imbalance of the sex ratios defies simple explanation. The change which occurred between 1901 and 1911 involved an increasingly pronounced skewing of the overall sex ratio in favour of males. Figure 2.9 suggests an increase in 1911 in the capacity for survival of females at younger ages. In the younger age groups there were only marginally more males than females. The ratio was 108 males to every 100 females in the 0-4 age group, a figure only a little higher than that in the non-

Aboriginal population.[58] But the sex ratio increased substantially in the middle age groups, averaging 153 males to every 100 females, which reflected the earlier constricted body of females moving through the age structure. In the older age groups the ratio fluctuates considerably, reflecting probable age heaping as described above for the 1901 analysis.

The age pyramid structure of the 1921 census revealed further changes, though the national census did not record the age structure of the full-bloods. It is only the half-caste population which provides data with which to construct an age pyramid (see Figure 2.10). The 1921 census counted 3,090 half-castes (1,604 males, 1,486 females). The pyramid reflects a young and rapidly growing population (see Table 2.6). In the 0-4 age group the number of males exceeded females while the opposite occurred in the 5 to 9 age group. In the middle age groups there is a trend towards equal numbers of males and females. Overall, the sex ratios below age 50 look demographically normal.

As we move to the 1933 full-blood Aboriginal population the male figures are much higher than those for females. This group, according to some writers, was still recovering from

> the nineteenth century depopulation [that] resulted in … a gross excess of males in the population in settled areas … In this century, remote Aboriginal groups brought under control were not subject to the same drastic assault and destruction so their progressive inclusion in the censuses since 1901 may have even reduced the overall masculinity of the enumerated population throughout the age ranges.[59]

The total number of Aborigines enumerated at the 1933 census was 15,676 (8,465 males, 7,211 females) (see Table 2.8, and see Figure 2.14 below). The group contained 5,709 males and 4,532 females of full-blood descent and 2,756 males and 2,679 females of half-caste descent. It was estimated that an additional 2,291 persons existed in remote areas, making a total Aboriginal population of 17,967 (see Table 2.1).[60]

The following discussion is based on the enumerated figure 15,676. The age distribution is the key component of this analysis.[61] The enumerated population of full-bloods totalled 10,241, and the age distribution provides some insight into what was happening during this period. The 1933 age structure reflects a mature profile characteristic of a population that is just replacing itself. The structure of the full-blood population

suggests that there were probably just sufficient numbers in the younger age groups to sustain population growth greater than the numbers of people who died. Although mortality data from disease was collected, the Queensland Government did not collect general mortality information on Aborigines of either full- or half-descent. It was impossible, therefore, to match only the mortality data by causes and by sex. Although the males outnumbered the females at all ages, the differential is greatest in the older age groups (see Figure 2.12 below). By contrast, the age structure of the half-castes displayed the characteristics of a young population with the potential for rapid growth (see Figure 2.13).

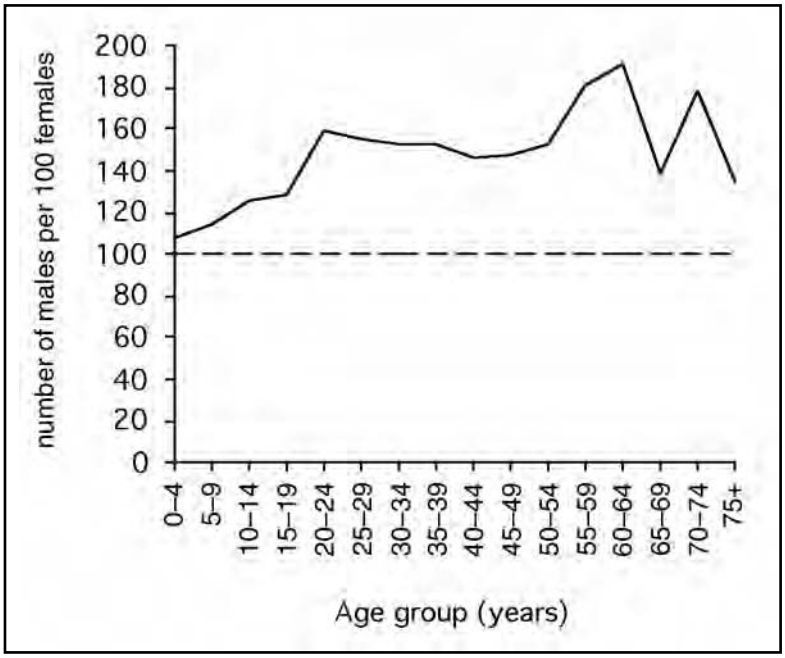


Figure 2.10: Half-caste Aborigines by age and sex in Queensland, 1921. Source: Compiled from Table 2.6.

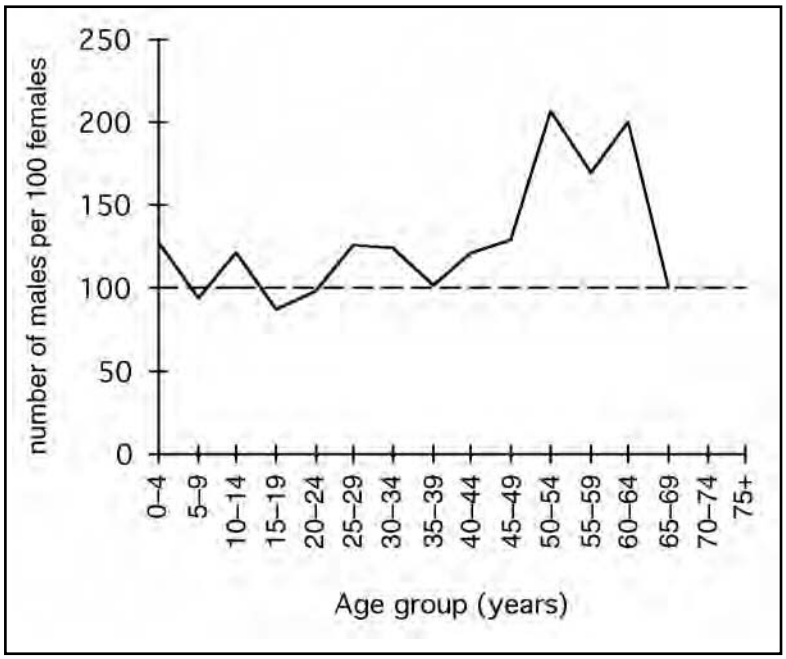


Figure 2.11: Age-specific sex ratio of half-caste Aborigines in Queensland, 1921. Source: Constructed from Table 2.7.

By 1933, then, the total Aboriginal age structure was assuming the characteristics of a population already entering a period of growth. The younger age groups displayed greater resilience, and a larger proportion of Aborigines was surviving in the older age groups. In 1901, by contrast, only 97 full-blood and half-caste persons combined had survived to age 60, whereas in 1933 the numbers in the latter age group had increased to 985. The 1933 figures consisted of 619 males and 366 females compared with only 42 males and 18 females in 1901. Presumably the government's Aboriginal welfare and protection policies of earlier decades had begun making an impression on the older as well as the younger age groups.

The overall trend of a converging sex ratio appears to have continued in the 1933 census. In 1901 no full-blood figures were separated out from the total Aboriginal population so no comparison is possible. For 1911, a comparison of the data reveals that, although the total Aboriginal population is on the increase, it is the half-castes that give the population the strength displayed in the pyramid shown in Figure 2.8. This is a reflection of the Aborigines' historic potential for growth. Although there was government dissatisfaction with the management philosophies of depots and health facilities operated by the Christian missions during the two decades from 1919 to the late 1930s, two issues were becoming evident. First, the Queensland Government was driven by a broader political concern for Aboriginal welfare. Second, the population reversals were beginning to show that protection and relief programs were succeeding. The advances became more evident after 1921 due to the State's increasing awareness of its role in public health, particularly regarding the health of Aborigines. From the 1920s, the Queensland Government was attempting to keep track of infectious diseases, for instance the respiratory ailments which killed the aged and infirm in considerable numbers. Other lethal diseases were also cause for public concern and from the turn of the century child mortality became a wider Australian public health issue. These trends affected Aborigines and the Queensland depots. As the 'baby health' movement began influencing Aborigines in the 1920s, better pre-natal care for younger pregnant women was one outcome which helped to strengthen the Aboriginal population growth potential.[62] Finally, easier access to professional medical care for Aborigines became an option for both government protectors and the Christian missions. From 1921 Aboriginal women began thriving under the protection policies, a phenomenon that became more marked during the following two decades. In this period the Queensland Government began taking greater responsibility for the prevention of disease and improving health and healing in Aboriginal depots, on missions, in work-camps on pastoral properties, and in town and hospital fringe-camps.

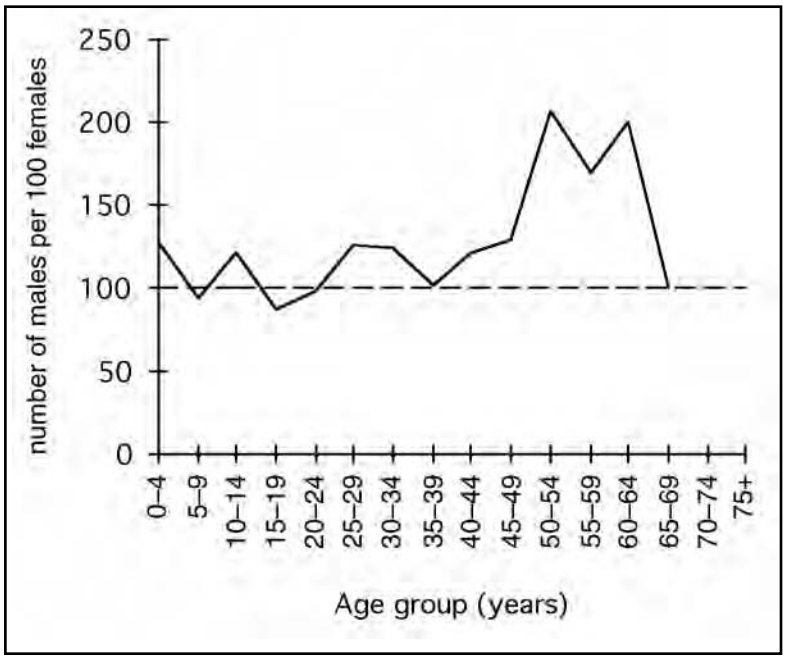


Figure 2.12: Full-blood Aborigines by age and sex in Queensland, 1933.
Source: Compiled from Table 2.8.

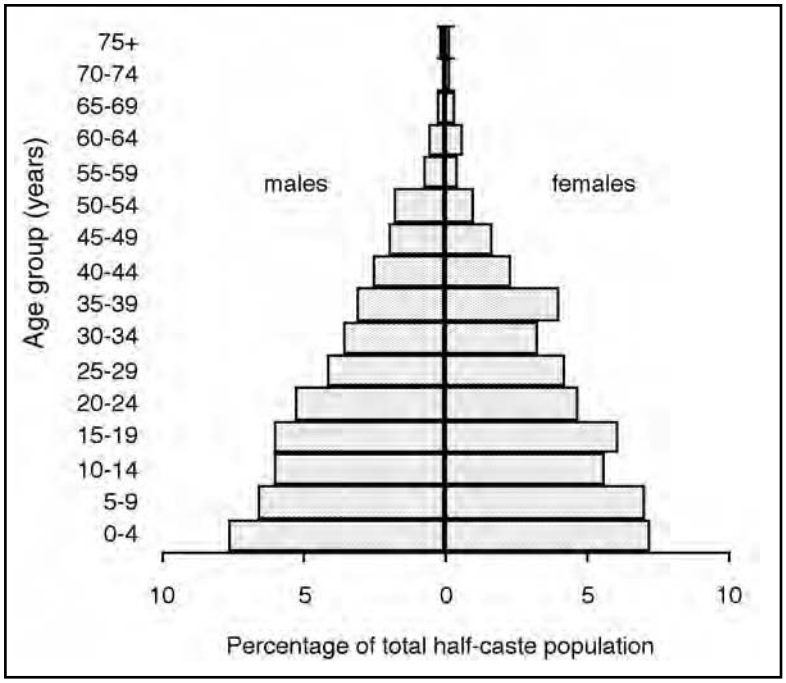


Figure 2.13: Half-caste Aborigines by age and sex in Queensland, 1933.
Source: Compiled from Table 2.8.

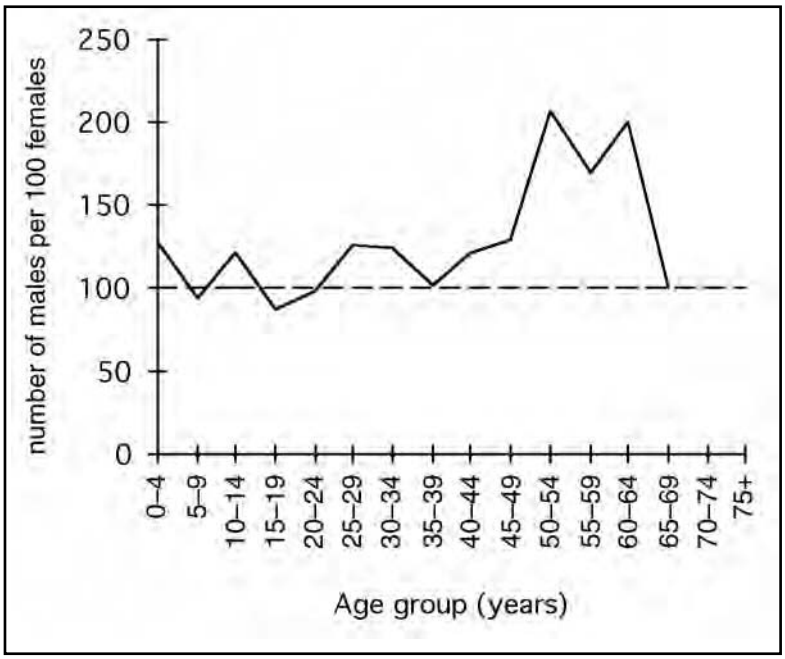


Figure 2.14: Total Aborigines by age and sex in Queensland 1933. Source: Compiled from Table 2.8.

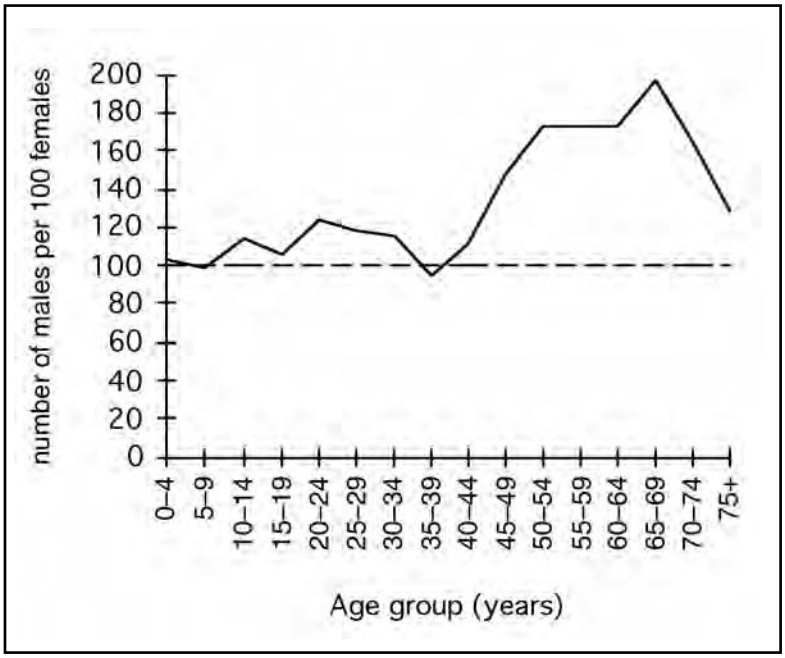


Figure 2.15: Age-specific sex ratio of full-blood and half-caste Aborigines in Queensland, 1933. Source: Compiled from Table 2.9.

White settlement continued from 1901 to 1940. Such settlement was less traumatic to Aborigines in the western and northern hinterland because of the strengthening of legal protection after 1897. Once the protection process began operating more effectively there was greater possibility for the Aboriginal population to increase. The full-blood population grew slowly because of the demographic problems resulting from its nineteenth century experiences. The mixed-descent groups increased their numbers more quickly, and as governments incorporated people of mixed descent into the State's health and relief programs they thrived, at least in a demographic sense, under the protection policies. The difficulty in knowing whether the Aboriginal population was either increasing or disappearing arose from the constantly shifting interaction between the enumerated and estimated Aboriginal populations in Queensland. One further complication was a changing understanding of what Aboriginal identity meant among people of full-half and - other mixed-descent peoples. Yet another complication was the imperative of estimating the number of Aborigines of full-descent who lived beyond census collection districts. These estimates became subject to constant revision throughout the period from Federation until well after 1940. The figures fluctuated from a high of 20,000 in 1901 to a low of 2,291 in 1933 (see Figures 2.1 to 2.3 and Tables 2.1 and 2.3). The earlier gross over-estimation led to false assumptions that the population was declining dramatically (Figures 2.1 to 2.3), and that large numbers of bush people lived in locations away from white pastoral settlers.

As a result of the distorted perspective adopted by the State, federal and mission administrations the total population appeared to decline from 26,670 to 17,967 during the study period. On further analysis, however, the total enumerated Aboriginal population increased substantially, from 6,670 in 1901 to 15,676 in 1933 (Table 2.1). People of full-descent increased by 100 per cent, and the half-castes by over 250 per cent. Figure 2.1 above, and Tables 2.1 to 2.3 below, summarise what the true demographic trends were.

Appendix 2

Table 2.1
Aborigines in Qld, 1901-1933

	Full-descent			Others			Total		
	Male	Female	Persons	Male	Female	Persons	Male	Female	Persons
1901									
Enumerated	3,089	2,048	5,137	773	760	1,533	3,862	2,808	6670
Estimated	9,911	10,089	20,000				9,911	10,089	20,000
Total	13,000	12,137	25,137	773	760	1,533	13,773	12,897	26,670
1911									
Enumerated	5,145	3,542	8,687	1,361	1,147	2,508	6,506	4,689	11,195
Estimated	11,313						11,313		
Total	20,000	1,361	1,147	2,508			22,508		
1921									
Enumerated	4,501	3,026	7,527	1,604	1,486	3,090	6,105	4,512	10,617
Estimated	3,536	2,951	6,487				3,536	2,951	6,487
Total	8,037	5,977	14,014	1,604	1,486	3,090	9,641	7,463	17,104
1933									
Enumerated	5,709	4,532	10,241	2,756	2,679	5,435	8,465	7,211	15,676
Estimated	1,364	927	2,291				1,364	1,927	2,291
Total	7,073	5,459	12,532	2,756	2,679	5,435	9,829	8,138	17,967

Source: Smith L R, *The Aboriginal Population of Australia, 1980* page131.

Table 2.2
Aborigines by age and sex in Queensland,1901

	Full-bloods*			Half-castes			Total		
Age	Male	Female	Persons	Male	Female	Persons	Male	Female	Persons
0-4							319	313	632
5-9							356	326	682
10-14							434	306	740
15-19							464	339	803
20-24							607	404	1011
25-29							468	275	743
30-34							296	255	551
35-39							220	158	378
40-44							143	151	294
45-49							109	46	155

Table 2.2 cont.

	Full-bloods*			Half-castes			Total		
Age	Male	Female	Persons	Male	Female	Persons	Male	Female	Persons
50-54							87	58	145
55-59							27	23	50
60-64							42	18	60
65-69							11	14	25
70-74							7	4	11
75+							1	0	1
Sub Total							3591	2690	6281
N/S							271	118	389
Total							3862	2808	6670

Source: *CA, 74, 1901*, Ninth Census of Queensland, QGP, Brisbane, 1902, Table L1, p.115.
N/S: Not stated
* Separate figures for full-bloods and half-castes are not available.

Table 2.3
Age-specific sex ratio of Aborigines and half-caste population in Queensland, 1901.

Age group	Males	Females
0-4	102	100
5-9	109	100
10-14	142	100
15-19	137	100
20-24	150	100
25-29	170	100
30-34	116	100
35-39	139	100
40-44	95	100
45-49	237	100
50-54	150	100
55-59	117	100
60-64	233	100
65-69	79	100
70-74	175	100
75+		100

Compiled from Table 2.2. (a) the number of males per 100 females.

Table 2.4: Aborigines by age and sex in Queensland,1911.

	Full-bloods*			Half-castes			Total		
Age	Male	Female	Persons	Male	Female	Persons	Male	Female	Persons
0-4	304	304	608	195	158	353	499	462	961
5-9	300	226	526	171	187	358	471	413	884
10-14	296	199	495	168	171	339	464	370	834
15-19	347	265	612	194	155	349	541	420	961
20-24	530	323	853	177	119	296	707	442	1149
25-29	555	339	894	125	97	222	680	436	1116
30-34	415	247	662	65	66	131	480	313	793
35-39	311	193	504	46	40	86	357	233	590
40-44	309	201	510	37	36	73	346	237	583
45-49	207	141	348	30	20	50	237	161	398
50-54	263	170	433	17	13	30	280	183	463
55-59	102	57	159	7	3	10	109	60	169
60-64	140	74	214	9	4	13	149	78	227
65-69	35	25	60	4	3	7	39	28	67
70-74	41	24	65	2	0	2	43	24	67
75+	23	17	40	0	0	0	23	17	40
Sub Total	4178	2805	6983	1247	1072	2319	5425	3877	9302
N/S	967	737	1704	114	75	26	1081	812	1893
Total	5145	3542	8687	1361	1147	2345	6506	4689	11195

Source: L.R.Smith, 1980 '1911 Worksheet on full-bloods as enumerated', *op.cit.*, p.4.

Table 2.5
Age-specific sex ratio of Aborigines and half-caste population in Queensland, 1911.

Age group	Males	Females
0-4	108	100
5-9	114	100
10-14	125	100
15-19	129	100
20-24	160	100
25-29	156	100
30-34	153	100
35-39	153	100
40-44	146	100

Table 2.5 cont.

Age group	Males	Females
45-49	147	100
50-54	153	100
55-59	182	100
60-64	191	100
65-69	139	100
70-74	175	100
75+	135	100

Source: Compiled from Table 2.4. (a) the number of males per 100 females.

Table 2.6
Aborigines by age and sex in Queensland,1921.

	Full-bloods*			Half-castes			Total*		
Age	Male	Female	Persons	Male	Female	Persons	Male	Female	Persons
0-4				275	214	489			
5-9				225	240	465			
10-14				214	176	390			
15-19				159	183	342			
20-24				165	167	332			
25-29				151	120	271			
30-34				97	78	175			
35-39				79	77	156			
40-44				45	37	82			
45-49				36	28	64			
50-54				31	15	46			
55-59				17	10	27			
60-64				12	6	18			
65-69				5	5	10			
70-74				5	1	6			
75+				1	2	3			
Sub Total				1517	1359	2876			
N/S				87	127	214			
Total				1604	1486	3090			

Source: L.R.Smith, 1980 '1921 Worksheet on Census for 1921, 'half-castes'', *op.cit.*, p.2.

Table 2.7
Age-specific sex ratio(a) of Aborigines in Queensland, 1921*

Age group	Males	Females
0-4	129	100
5-9	94	100
10-14	122	100
15-19	87	100
20-24	99	100
25-29	126	100
30-34	124	100
35-39	103	100
40-44	122	100
45-49	129	100
50-54	207	100
55-59	170	100
60-64	200	100
65-69	100	100
70-74	500	100
75+	50	100

Source: Compiled from Table 2.6. (a) the number of males per 100 females.
* Full-blood figures not available for 1921.

Table 2.8
Aborigines by age and sex in Queensland,1933.

	Full-bloods			Half-castes			Total		
Age	Male	Female	Persons	Male	Female	Persons	Male	Female	Persons
0-4	522	510	1032	411	391	802	933	901	1834
5-9	578	569	1147	356	381	737	934	950	1884
10-14	470	395	865	327	306	633	797	701	1498
15-19	481	426	907	324	331	655	805	757	1562
20-24	457	344	801	283	255	538	740	599	1339
25-29	443	337	780	223	228	451	666	565	1231
30-34	376	311	687	192	179	371	568	490	1058
35-39	316	299	615	169	215	384	485	514	999
40-44	317	286	603	138	124	262	455	410	865

Table 2.8 cont.

	Full-bloods			Half-castes			Total		
Age	Male	Female	Persons	Male	Female	Persons	Male	Female	Persons
45-49	347	216	563	105	89	194	452	305	757
50-54	372	216	588	96	54	150	468	270	738
55-59	229	134	363	43	23	66	272	157	429
60-64	257	133	390	29	33	62	286	166	452
65-69	132	58	190	18	18	36	150	76	226
70-74	99	55	154	8	10	18	107	65	172
75+	66	50	116	10	9	19	76	59	135
Sub Total	5462	4339	9801	2732	2646	5378	8194	6985	15179
N/S	247	193	440	24	33	26	271	226	497
Total	5709	4532	10241	2756	2679	5404	8465	7211	15676

Source: L.R.Smith, '1933 Worksheet on Age Distribution File Enumerated for full-bloods', *op.cit.*, p.1.

Table 2.9
Age-specific sex ratio(a) of Aborigines and half-caste population in Queensland, 1933.

Age group	Males	Females
0-4	104	100
5-9	98	100
10-14	114	100
15-19	106	100
20-24	124	100
25-29	118	100
30-34	116	100
35-39	94	100
40-44	111	100
45-49	148	100
50-54	173	100
55-59	173	100
60-64	172	100
65-69	197	100
70-74	165	100
75+	129	100

Source: Compiled from Table 2.8. (a) the number of males per 100 females.

Notes

1. Archibald Meston, *Report on the Aboriginals of Queensland*, Queensland Legislative Assembly, Votes and Proceedings (QLAV&P), 1896, Vol. iv, pp.723-740.

2. As indicated earlier, Torres Strait Islanders are omitted from any analysis because of the paucity of source material.

3. Rowley, 1970, pp.368-398.

4. Long, 1970, pp.4-5, and see also, pp.91-98.

5. Dawn May, 1994 in pre-contact p.13, and in post-contract p.94, where May believed that 'depopulation' among Aborigines in the 1930s was still proceeding. No definition is posited and no analysis is offered even though the use of recent studies could have helped her to be less dependent on abstractions.

6. S.E. Stephens, 1974, pp.243-244 (this entry contains a corrigendum published in ADB Index, Vols 1-2, p.313, referred to 'Archibald Meston' file, ADB, RSSS, ANU, 1994); see also, Archibald Meston, 'Report on the Government Scientific Expedition to Bellenden Ker Range, 1889', in *Annual Report of the Department of Agriculture, Queensland, 1889-1890*; see also, Queensland Parliament, *Report on the Aboriginals of Queensland (by Special Commissioner, Archibald Meston)*, QL1896 QLAV&P, 1896, Vol. IV, pp.723-170; see also, F.A. Hagenauer, 'Notes of a Missionary Journey to North Queensland 1885', published with *Report of the Aboriginal Mission at Ramahyuck, Victoria, 1885*, this report was located in the Victorian Public Records Series (PRS) 1856-1873, among items classified as Registered Inward Correspondence to Surveyor-General, Board of Land and Works, located in Public Records Office of Victoria, see index *Australian Archives and the Public Records Office Victoria, 'My heart is breaking'*, A Joint Guide to Records about Aboriginal People in the Public Records Office of Victoria and the Australian Archives, Victorian Regional Office, AGPS, Canberra, 1993, see p.15 and p.19.

7. Leonard Broom and F. Lancaster Jones, 1973, and see F. Lancaster Jones, 1970.

8. Noel Loos, 1982, pp.160-182.

9. Long, *Aboriginal Settlement*, 1970, pp.91-101.

10. *Port Denison Times*, 30 December, 1865.

11. *Australasian*, 13 July, 1867, p.134.

12. William Lansborough, 'Extracts from report of W. Landsborough, in command of the Queensland Burke Relief Expedition, to Captain Norman with reference to the Albert River', in *Journal of The Royal Society of London*, Volume 33, 1863, pp.79-132.

13. F.H. Bauer, Part 1, 1959, pp.35-37.

14. *Ibid*, Historical Geographic Survey, p.53.

15. *Ibid*., pp.66-67.

16. *QLAV&P*, (61 Vic., No. 17), and assented on 15th December, 1897.

17. The Defence Act, 1910, No. 37 of 1910, quoted in McCorquodale, 1987, p.5.

18. Bauer, *Historical 1959 Geographic Survey*, pp.51-69.

19. L.E. Skinner, 1975; see later episodes, also, in Rowley, 1970 pp.179-181, where Meston mentions continuing brutality and lawlessness of the 'Native Police' on northern coastal Aborigines.

20. Jan Walker, 1988.

21. L.R. Smith, 1975 'Queensland Census 1901, Aborigines and Half-Castes, 5yr Age Distribution Worksheet, 1970-71, for Ph.D. thesis'; also, Smith, 1975 'Queensland Census 1901, Aborigines and

Half-Castes, Single year Age Distribution Worksheet, 1970-71, for Ph.D. thesis', unused and unpublished documents kindly provided by Dr L.R. Smith for my use.

22. L.R. 1980, p.122.

23. L.R. Smith, 1975 'Census, 1911, Aboriginal age distribution, worksheets 1971-72, for Ph.D. thesis', pp.1-3, and are unused and unpublished documents kindly provided by Dr L.R. Smith for my use (hereafter referred to as author's '1911 worksheets').

24. George Grey, 1841, p.240, where Grey explains how almost no racial mixing took place because there were no convicts to begin with; see also, J.S. Battye, (Oxford 1924); see also, A. Forrest, 'North-West Exploration: Journal of Expedition from De Grey to Port Darwin, 1880', p.40, in F.K. Crowley, A Documentary History, Vol. 3, 'Kimberley District Explored', October 1879, pp.67-68; see also, Pall Mall Gazette, quoted in New York Times, 13 February, 1882, in Crowley, 1879 A Documentary History, pp.80-81, where mention is made of half-castes beginning to be seen in the workforce more frequently; see also, H. Colebatch (ed.), 1929; see also, C.T. Stannage, 1981; but, for a better exposition of the growth of the half-caste population, Rowley, 1970, pp.145-156, and see, pp.384-385; see also, N.B. Tindale, pp.140-231; see also, Tindale, 1940-41 1980, pp.67-161; finally, see L.R. Smith, Aboriginal Population, pp.6-9.

25. Smith, 1980 p.128.

26. Smith, 1980, see Table 7.3.1, p.131.

27. Lancaster Jones, 1970 pp.3-4; this reference is also quoted in Bauer, 1959, p.29.

28. *Australia, Official Year Book No. 23*, (1930), pp.687-696.

29. Lancaster Jones,1970 pp.3-4; see also, Rowley, 1970 pp. 2-3.

30. L.R. Smith, 1975, (this work was published as, L.R. Smith, *The Aboriginal Population of Australia*, ANU Press, Canberra, 1980).

31. Tigger Wise, 1985.

32. A.R. Radcliffe-Brown, 'Former Numbers and Distribution of the Australian Aborigines', in *Australia, Official Year Book No. 23, (1930)*, pp.687-696.

33. J.W. Bleakley, 1961, p.115.

34. Long, 1970 pp.91-175.

35. *Ibid*., p.95.

36. G.W. Rusden, (first printed 1887), Reissue of 2nd ed., Melbourne, 1908. Rusden's account seems more authentic than R. Evans, Kay Saunders and Kathryn Cronin, 1975, pp.64-66; see also, from similar secondary sources, R. Fitzgerald, 1982, pp.138-143.

37. AA/VPRS, 2896, see, F.A. Hagenauer, 'Notes of a Missionary Journey to North Queensland 1885'.

38. A. Meston, Special Commissioner for Queensland Government, *Report on the Aboriginal of Queensland, 1896*, in *QLAV&P*, Vol. IV, pp.723-740.

39. Barry Reynolds, 'Roth, Walter Edmund (1861-1933)', in Nairn and Searle (eds), ADB, Vol. 10, pp.463-464.

40. J.A. Eden (MD), 1996, pp.1-11.

41. Smith, 1980 pp.93-95; see also, Alfred W. Crosby, 1989, pp.10-11, and see A.W. Crosby, 1994, pp.82-108; see 1994 pp.3-43, see for Australian Aborigines, Chapters 71-120; see also, Denoon, 1983 p.231-232.

42. QLAV&P, 1860, pp.529-783 and to 1873, pp.1173-85; see also, Dawn May, 1994 pp.85-98.

43. Smith, 1980 pp.10-12, and p.122.

44. *Ibid*., see Table 7.3.1, p.131, and 122-131.

45. *Ibid*., p.122.

46. Queensland Statisticians Ninth Census Report, 1902, in QLAV&P, 1902, QGP, Brisbane, 1902, p.vii.

47. Smith, 1980 p.10.

48. Chief Protector, *Annual Report*, 1902, QLAV&P, QGP, Brisbane, 1903, p.1.

49. Bleakley 1961 pp.11-100; Long, 1970 pp.94-95; see also, 1994, pp.40-101; Rowley, 1961

50. Bleakley, *Aborigines of Australia*, p.115.

51. Smith, 1980 pp.34-66.

52. *Ibid*., pp.34-66.

53. *Ibid*., pp.29-34.

54. Dawn May, 1994 pp.44-74; Rowley, 1970 pp.157-186, see also, Rowley, 1971, pp.227-240.

55. L.R. Smith, 1975 '1911 worksheet', pp.1-2.

56. Long, 1970 p.144; for an appreciation of infant mortality from 1933-47 see Kunitz, 1994 pp.89-93.

57. Long 1994 p.144; see also, Chief Protector, *Reports*, 1905, p.19 (in QGP, 1906, Vol. II, p.931).

58. Smith, 1975 'Census, 1911, Aboriginal age distribution, worksheets', p.1.

59. Smith, 1980 pp.128-129.

60. *Ibid*., see Table 7.3.1, p.131.

61. Smith, 1975 '1933 worksheet', p.1.

62. Phillippa Mein Smith, January 1990, pp.106-188.

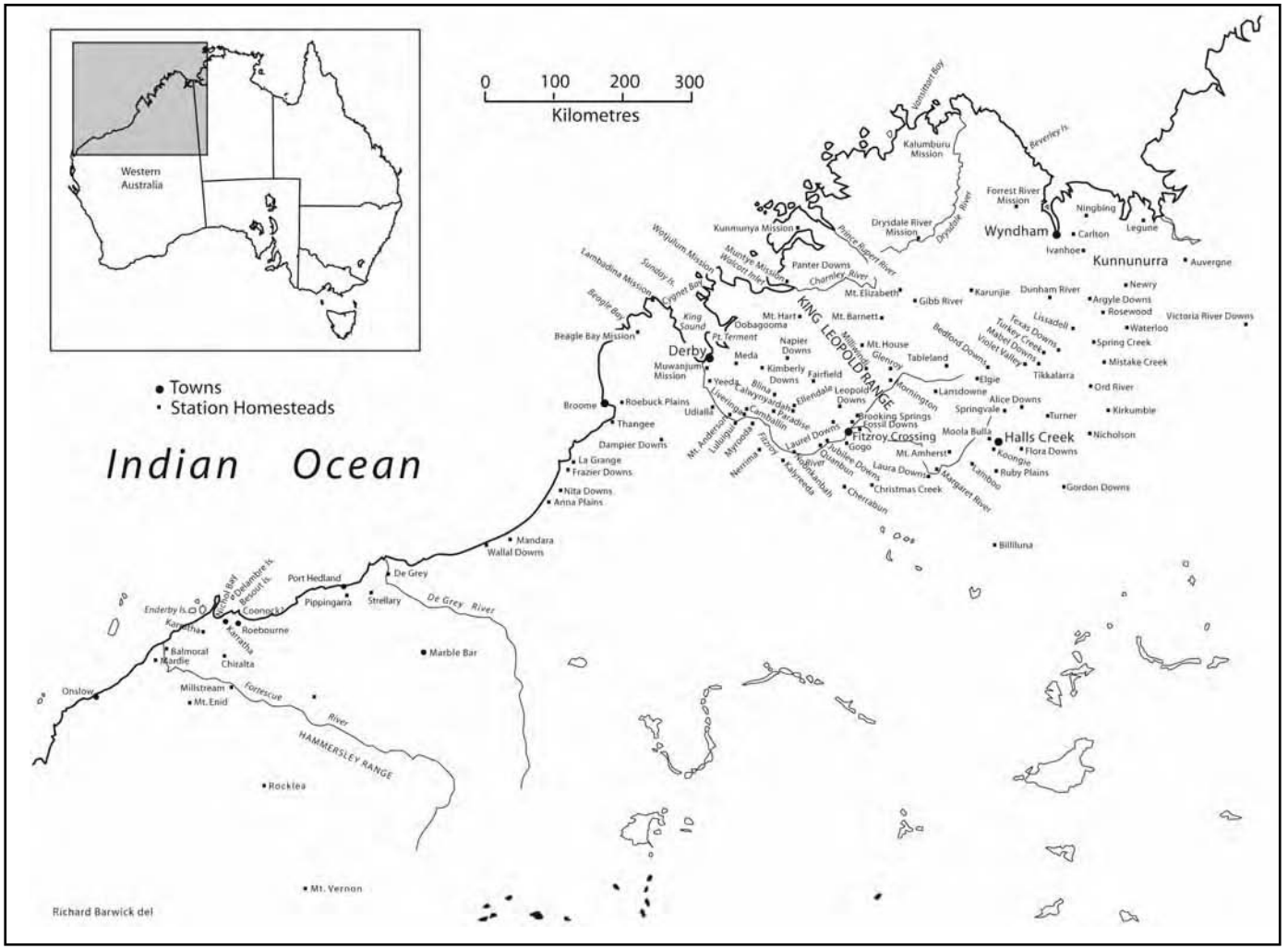
3

Protection as a health service: Aboriginal health in Western Australia, 1900–10

By 1900 the settler community of Western Australia was aware that its government's long-established policy towards Aborigines needed change. British colonial policy had given the Aborigines full legal and civil liberties as British subjects. In addition, British civilisation was meant to embrace them through the agency of Christianity. They were also to receive protection, which included safeguarding their well-being.[1] These ideals underlay the views on Aboriginal administration formulated by the Colonial Office. The policy was eventually enshrined in the colony of Western Australia, *Aborigines Act 1886*, which conferred wide powers on the Perth-based Aborigines Protection Board which oversaw both Aboriginal labour and the land owning employers.[2]

By the 1890s relations between the settlers and Aborigines had deteriorated, however, and change was demanded. Settlers wanted self-government and less control by the Colonial Office in Britain. By the turn of the century the policy flowing from the 1886 legislation had become unworkable. Those interested in protecting the Aborigines wanted a new and stronger legislative structure for protection. Aborigines still coming into first contact with settlers lacked the protection they needed. The pastoral settlements continued to expand across Aboriginal land and, although there was hardship for the settlers, the Aborigines suffered in all the ensuing exchanges.

On top of the changes to earlier black–white social relationships came the catastrophic impact on Aboriginal customs and behaviour of new diseases. Aboriginal women and the older men were affected most.[3] One reason was that although many people of full-descent lived in the bush, many also lived in the areas newly settled by colonists. Another reason was that people living in the south-western corner of the colony were mostly



Map of Western Australia; the Gascoyne, Pilbara and Kimberley regions—referred to as the north-west—the area serviced by lock-up hospitals.

people of mixed-descent. The people lived closer to, or even in, white settlements, although it was not guaranteed they could receive medical treatment. In the north, however, most Aborigines had only recently begun to move from the traditional bush life on to newly established missions.[4] As the end of the century approached, the care of Aborigines became the responsibility of the newly created Aborigines Department established by the colonial government under the *Aborigines Protection Act 1897*.[5]

The churches, scholars, journalists, government protectors and some sympathetic land owners shared an interest in protecting Aborigines and in learning as much about Aboriginal customs, habits and practices as the Aborigines themselves could impart. Early in the twentieth century the ethnographer and writer Daisy Bates[6] travelled widely around the south of Western Australia and north into the Kimberley region, both as the wife of a property manager and as a researcher with the anthropologist Radcliffe-Brown.[7] Much of what we know about Aboriginal health in Western Australia in the nineteenth century relies on her observations. She worked among the Aborigines and became intimately associated with them. Her scholarly writing contributed to the development of ethnographic methodology because, while living among the Aborigines, she witnessed and then carefully recorded their customs, manners, languages and ceremonial practices. Importantly, too, at least from the perspective of this book, she wrote about the Aborigines' attitudes to and their treatment of the illnesses afflicting them.[8]

What Aborigines understood as disease and sickness was intrinsically bound up in other complex ideas about their birth places, their relationships with each other and their beliefs about the animal world. Magic played an important role in Aboriginal thinking about disease because magic was understood to be at the root of disease, causing people to become sick, die or be cured.[9] Bates wrote variously on the magic of the Murchison peoples as well as on some groups in the Kimberley. She accepted that what she observed were forms of superstition which she regarded as part of general Aboriginal religiosity.[10] Isobel White's biography of Bates indicates that she concluded that Aborigines had no concept of death from disease. Disease for them was always a manifestation of sorcery. Thus, if an Aborigine died after eating rancid whale or fish meat, other Aborigines believed that magic rather than food

poisoning had been responsible. Further, if someone choked on a bone from an animal or fish, it was because they had been bewitched. If they died from gluttony, either sorcerers had tampered with their food or food preparation taboos had been broken.[11] If an animal was caught, cooked and eaten and stomach pains followed, the victim would become suspicious of magic, and look for the likeliest sorcerer.

Ideas of the causes of disease and their cures appeared to Bates to be part of the sorcerer's retinue. Normally, sorcerers had names that reflected natural phenomena such as thunder or sparks from a fire.[12] Sorcerers and their practices appeared to be ubiquitous, and Bates noticed that the 'magic stick' was in common use among all groups, often in concert with plants and other items that sorcerers carried to make magic with. She wrote that 'their greatest power … came from their metaphysical strength, and magic … [which] was secreted … from within themselves, and their apparent control … over the elements'.[13] Other signs of impending doom or illness, for instance the unusual actions or sounds of animals and birds, such as the crowing of a crow or the screech of a cockatoo at night, explained injuries and illnesses.[14]

Bates noticed how fearful of sorcerers many Aborigines were and how fear gripped those with whom she spoke when sorcery was mentioned. They believed that sorcerers could harm them from afar. If storms occurred the sorcerer would be blamed, and sick or dying people believed this meant that sorcerers were trying to communicate with them.[15] Other natural phenomena—eclipses of the sun or moon—frightened Aborigines into believing that a sorcerer was trying to contact them. Unknown events also played on people's fears, giving the sorcerer physical power. The 'mulgarguttuk', as she wrote, might tell of a distant illness or death, or suggest that a person had suddenly developed powers of sorcery, or that a sorcerer was about to die. Sorcerers were also thought to afflict the healthy and strong, which made them even more powerful.[16] Sorcerers' powers could be graded according to potency, and one sorcerer could die from the spells of another more powerful sorcerer. Men more generally practised sorcery but women were also practitioners.[17]

Of particular importance to Bates were the traditional cures for sickness, pain and injury. She recorded events that her informants considered to be natural events rather than illnesses, especially if the illness was unfamiliar to the sorcerer. Sorcerers could heal as well as harm. They used herbal

potions for some complaints; they used 'topical bleeding' in a common place such as the arms; they rubbed or left body hair from their own armpits or pubic areas on the sick person; and many used urine, either their own or from older women. Some of the diseases brought by Europeans were unknown to the sorcerers to whom Bates spoke. She found that there were many illnesses with which Aborigines were acquainted and for which they had customary treatments.[18] Most of those they contracted arose directly from 'over-indulgence in food, over-excitement in dancing, or … ceremonies'.[19] As she travelled among her informants she noticed the presence of 'ophthalmia' as trachoma was then popularly known. Ophthalmia was regularly present, 'particularly amongst the north west natives, and was due mainly to great plagues of flies which infest the district during two-thirds of the year'.[20] She noticed that flies, the wind, sun, dry dust and sand over much of Western Australia had a detrimental effect on the eyes of settlers and Aborigines alike. Once the eyes became irritated and sore, infection followed and often led to ophthalmia, also commonly called 'sandy blight'.[21]

Other illnesses known by Aborigines before European settlement included dysentery, diarrhoea, pneumonia, colds, headaches, liver troubles, biliousness, sores, rheumatism, inflammation, and various skin complaints, including erysipelas.[22] Mental illness, or what Bates describes as idiocy and temporary madness, were known to Aborigines up and down the coastline of Western Australia, as were deformities, but most of the deformed babies either died at birth or were killed.

Bates wrote that, except for gonorrhoea[23] and other introduced diseases, the Aborigines had apparently experienced none of the infectious diseases familiar to Europeans. Because she had a limited knowledge of bacteriology, she could not elaborate on some of the body-wasting and deforming diseases she came across. She most certainly believed that some sexually transmitted diseases and diseases caused by poor hygiene, for example yaws (discussed below), leprosy (a chronic bacterial disease of the skin, peripheral nerves and the upper airways, also known as Hansen's Disease)[24] and tuberculosis (a mycobacterial disease, which also includes phthythis, or pulmonary tuberculosis, also discussed below), had been introduced either by visitors or settlers. Later researchers, however, have thrown a different light on this matter. In trying to dispel the earlier pejorative opinion of a decrepit, blinded race, as suggested by the English

navigator Dampier two centuries earlier, Bates promoted her own view that Aborigines were not as diseased as the evidence might have indicated.[25]

Acceptance of Bates's idealistic view failed to eliminate doubt, especially the suspicion that infectious diseases existed among the Aborigines before European settlement.[26] Did bacterial and viral infections, then, afflict Aborigines before European settlement? Is it possible that sexually transmitted diseases[27] had existed among the mainland populations? If such infectious diseases did exist before 1788, who or what brought them, and, in particular, was their passage made possible by the Asian and Pacific navigators known to have contacted mainlanders over preceding centuries?[28] Bates's comments on such matters were contradictory. Her unpublished material suggests that an informant's evidence showed that sexually transmitted diseases had existed, formed part of a system of knowledge used by Aborigines, and was 'called koo-ar-oo ... common to coastal ... [groups]'.[29] They knew also that the disease affected 'newborns as well, [and] could have been related ... to the occurrence of yaws[30] or endemic syphilis[31] in the pre-European era'.[32]

By contrast, the medical anthropologist Herbert Basedow said he believed that both syphilis and gonorrhoea came with Europeans.[33] Recent physical and biological anthropological research, however, indicates that treponemal diseases such as syphilis and yaws may have been present well before European settlement.[34] Similarly, missionaries on the Kimberley coast revealed that forms of venereal diseases and skin complaints were already present when they arrived to live among the Aborigines just after 1910.[35] They support the published evidence that Daisy Bates gathered directly from Aborigines. This suggests that conditions showing symptoms similar to endemic and congenital syphilis and yaws had existed prior to white settlement, possibly after contact with seasonal Macassan visitors.

At this point it is useful to review what is known now about the likely presence of bacterial and viral infections in hunter-gatherer groups similar to Australian Aborigines before and following outside contact. Yaws (which is not sexually transmitted) and syphilis (which is) are closely related. Moreover, the bacterium *Treponema pertenue* that causes yaws provides immunity to syphilis by conferring cross-immunity against *Treponema pallidum*, which causes syphilis.[36] Yaws is found in areas of

tropical rain forest and was first named by Castellani in 1905.[37] Mostly a disease of childhood, yaws spreads by direct contact with other human hosts. Hosts may also pass the infection on through direct skin contact by exposing broken skin directly to infectious lesions, usually on the mouth or limbs, where the bacteria can spread. The disease can then spread to the hands and feet, infecting the bones as well. This form of yaws is morphologically identical to sexually-transmitted syphilis.[38] These diseases have been particularly difficult to detect, even for trained health workers. Syphilis has been described as 'a democratic disease for it does not discriminate between people of different social classes, races, sexes, religions, ages, or countries'.[39]

As hunters and gatherers moved out of Africa to other parts of the globe they took parasites with them.[40] Although there is no absolute means of knowing, one writer, W.H. McNeill, has persuasively speculated that parasites were probably passed from one host to another by direct contact and passing body fluids either by sexual intercourse or between mothers and babies before, during and after birth. It is equally probable that yaws could survive in temperate climates within small populations of migratory hunters.[41] The process of infection could well have lasted for some time 'as long as the infection acted slowly and did not incapacitate the human host too severely'.[42] Parasites most probably travelled with the hunter-gatherers 'from humanity's tropical cradle lands throughout the earth'.[43] Among Aborigines the research conducted by Cleland[44] (a research biologist) and Basedow[45] (a medical practitioner) demonstrated the presence of forms of venereal diseases. In 1908 Cleland wrote about his study of *Granuloma pudenda*, a disease which he found among Aborigines in north Queensland[46] and even more commonly among Aborigines of Western Australia.[47]

The presence of yaws has been a contentious issue, as recent research indicates. Noel Butlin, for example, believed that yaws existed in Victoria, but Gray doubted this proposition. Gray claimed that these two forms—*Treponema pertenue* and *Treponema pallidum*—occurred on the mainland as a disease mostly affecting childhood.[48] The important point to be made here, as Goldsmid (a noted biologist, researcher and epidemicologist) emphasised, is that yaws most probably existed in many Aboriginal communities when Europeans first arrived. Researchers have found that yaws has been endemic for a long time among the Aranda people of

central Australia, and discovered yaws lesions in Aboriginal skeletal remains from southern and eastern Australia.[49] Others argue that such treponemal infections became endemic in Aboriginal populations long before Asian and white contact.[50]

Gray also wrote about *Lymphogranuloma venereum*, which is caused by strains of trachoma or chlamydial disease. Trachoma affected Aborigines in Western Australia and Queensland.[51] Although trachoma surveys began in Queensland as early as 1907, there were no research projects in Western Australia until the ophthalmologist Ida Mann's in the 1950s. Mann commented on how white settlers had coped as trachoma had appeared in epidemic proportions in Victoria in the nineteenth century.[52] It disappeared from settler communities after the adoption of hygiene controls which ultimately curbed the infection.[53]

In Western Australia Ida Mann, who disagreed with Daisy Bates, doubted that trachoma had affected Aborigines before white settlement. She argued that it occurred only after close bodily contact with the white population. This raised the question of the origin of trachoma in Australia. According to Mann the disease had become endemic in New Guinea and adjacent islands by the seventeenth century. The islanders had had contact with Aborigines even earlier, making possible its early passage on to the mainland.[54] Some forms of blindness from trachoma are transmitted during birth in both bacterial and viral forms from mother to child, and may also be contracted through sexual intercourse.

The diseases suffered by Aborigines partly explain why the Western Australian Government passed the *Aborigines Protection Act 1897*.[55] As already seen, this legislation established the Aborigines Department, and following its passage the Premier, John Forrest, appointed Henry C. Prinsep as Chief Protector of Aborigines in 1898. The rush of prosperity caused by the mining boom of the 1890s profoundly impacted on the well-being of Aborigines in parts of the colony occupied by settlers.[56] It was possibly the impact of disease on sedentary groups that forced the appointment of a travelling inspector with medical training. The first task Prinsep gave the travelling inspector, Dr G.S. Olivey from the London Hospital,[57] involved counting the Aborigines. Another immediate task was to assess their health and living conditions.

Olivey's reports told of the widespread effects of venereal disease among Aborigines.[58] Prinsep wrote immediately to Forrest to tell him that venereal disease among Aborigines was serious and appeared to be spreading. He said that in some places government efforts should be backed by 'legislation with the object of preventing the Aborigines, in their own interest … from affecting … both the black and white population'.[59] From his own experiences, gained during his exploratory journeys across Western Australia, Forrest had some knowledge of Aborigines and would consequently have been receptive to Prinsep's proposal.[60] The public, too, was similarly concerned, for not only were there general fears about a disease which whites might contract from Aborigines but the added fear of 'miscegenation' between the races, producing an increasing half-caste population.[61]

During the period 1900–10, the most common sexually transmitted diseases in Western Australia were gonorrhoea, syphilis and non-specific urethritis. Gonorrhoea was a new infection for Aborigines. A highly contagious infection caused by the *Neisseria gonorrhoeae* bacterium, it attacks the mucous membranes of male and female genitalia, the anus, mouth and eyes. Its symptoms are a discharge from the urethra and pain when urinating. Its most important long term effect is sterility in women, but it may also affect other internal organs and can cause kidney failure. Aborigines occasionally suffered from symptoms closely resembling gonorrhoea, but sometimes the diagnosis failed to trace the cause to the gonococci. This form of disorder became known as non-gonococcal, or non-specific urethritis. By the 1930s, most health service workers knew something about bacteriological processes and could apply some forms of preventive treatments and cures. At the turn of the century, however, Aboriginal groups had little understanding of bacterial or viral infection, nor could they take preventive measures to ensure their immunity. Moreover, the size of the pre- and post-contact Aboriginal groupings affected physiological and biological defences against viral and bacterial diseases.[62]

Aborigines were most certainly disadvantaged by the many millennia of their separation from overseas populations: their ability to develop the immunity to infections that other races had acquired had been restricted. In addition, their mobility and the small size of their family groups (the immune responses need larger populations) proved to be further

disadvantaged.[63] Where syphilis occurred, it is possible that after some time resistance could have built up in some Aboriginal populations. However, it seems likely that the seasonal nature of the contact between seamen from Asia, the Pacific Islands and small groups of Aborigines would have made it difficult for them to build up resistance.

Ronald Berndt and Peter Worsley, two anthropologists conducting research among Aboriginal populations in the 1950s, studied groups in the far north of Western Australia and the Northern Territory. They learned what Aborigines remembered about their people's contacts with Asian sailors. Such accounts suggested a less violent contact than occurred post-settlement. The historian Campbell Macknight, however, has questioned their views on the grounds that their work was flawed by the absence of any satisfactory independent account from the Macassan perspective.[64] Resolving this dispute might now be difficult, yet it is true that the records left by government officials, missionaries and the earlier ethnographic writers reveal a society under great stress by 1900.[65]

Fringe-camp life, which tended to pollute the living area, was most probably a post-settlement phenomenon, but it could have developed earlier. Fringe-camps became common in southern and eastern areas of Western Australia. Infections arising from the fringe-camp lifestyle became endemic. Aborigines who moved from the semi-nomadic bush life to a sedentary life in the camps began developing a range of disabilities and health problems. For example, blindness and crippling bone diseases often preceded dementia, especially among the old, frail and infirm. The blind must perforce become sedentary and this added to living site pollution and the consequent build-up of infective agents that camp people could not combat. Sedentary lifestyles could have developed in advance of European settlement in northern Australia through the seasonal visits of the Macassan traders, who were visiting the north regularly for at least 200 years before the 1800s. Their visits continued after white settlement.[66] As suggested by Table 3.1, compiled from information in the annual reports of the Chief Protector, by the early 1900s increasingly large numbers of Aborigines were suffering from disabling diseases resulting from changes in lifestyle.

Table 3.1
Disability in Aborigines of WA, 1900-10.

Disability	1900-1	1902-3	1904-5	1907	1908-10	totals
Blindness						
male	78	na	70	30	125	303
females	144	na	181	60	145	530
Aged/Crippled						
males	353	na	561	270	654	1838
females	681	na	702	366	977	2726
Destitute						
males	64	na	175	112	310	661
females	110	na	242	158	533	1043

Sources.[67] na = data not available.Parlimentry Papers for the Legislative Assembly, WA, Protection of Aborigines Annual Reports 1900 – 1910, WAGP, Perth 1900 – 1910.

Such afflictions seem to have appeared soon after the emergence of the fringe-camp life-style. Once this occurred, infectious illnesses became endemic. Generations passed and some infections became congenital, associated with permanent pools of infection. The creation of such pools helped Aborigines share the same disease patterns across Western Australia. In every group of people shown as destitute the women fared worse than the men, except for those older full-blood men suffering the long term effects of venereal diseases. Aboriginal women were generally more disadvantaged because they were forced by circumstances to become sole carers for children and young adults. Certainly from the 1890s through to 1904, the level of disability proved worrisome to property owners, police protectors, hospital medical staff and administrators. It was these members of the settler community in particular who bore the brunt of providing ever greater amounts of relief and care for sick, disabled, indigent and dying Aborigines.

The extent of the burden is evident in a host of incidents. For example, on 25 September 1898 the Resident Medical Officer at Derby reported to the Chief Protector that he had provided medical treatment to six Aborigines for a month at 9 pence a day. These people had worked or lived on cattle properties owned by Adcock Brothers and Company near Derby. Most were old and infirm and one was totally blind.[68] In the same

year, William Padbury of Guildford near Perth applied to the Chief Protector for a refund for supplying a tent 'for the use of a sick native' which had cost him £1.17.0.[69] Similarly, at a camp site at Norseman in the same year, Sergeant Lappin authorised a Dr Harvey to supply medical treatment to a native woman named Kitty.[70] Lappin said he had asked the doctor to treat Kitty in her camp because she was dangerously ill with a chest complaint.[71]

It was not always easy for treatment to be sought or demanded, as indicated in an incident reported in the *Mount Magnet Miner* on 27 October 1898. A number of Aborigines camping at the Yowera water hole near Cue were suffering from measles. The local doctor had refused to attend them despite a request by the police, who reported the situation to the Aborigines Department. The doctor had refused to attend because neither the police nor the department could guarantee payment. The department arranged for medicines to be sent from Cue to a Mr W. Watson, who had first reported the incident, but he refused to administer these himself because he had no idea what the Aborigines were suffering from. Further representations were made to the Chief Protector in Perth for the doctor to be offered a moderate fee to treat the group. Watson agreed to provide the vehicle to take the doctor out to their water hole. Prinsep, however, failed to respond to these requests. With heavy sarcasm, the newspaper later commented that the government and pastoralists would have acted more promptly and effectively in treating scabby sheep than in attending sick Aborigines. It observed that in this case at least nothing was done despite the existence of a Protection Board charged with the responsibility for Aboriginal welfare.[72]

Another incident involving such criticism of the department occurrred the same year at Northam, where the Town Clerk wrote to the Colonial Secretary about the condition of natives in the colony. 'I think I am right in saying that beyond an annual distribution of clothes and food by the Government nothing is done for these poor creatures', he wrote.[73] In a subsequent letter he asked whether, in the Chief Protector's view, some action could be taken to establish shelters which could also serve as school buildings for Aboriginal children.[74]

At about the same time Prinsep noted that during his travels he had found that syphilis in the Wyndham area was prevalent and had caused several Aboriginal deaths over the past year.[75] Most of the camps in or

near the towns had been visited by either the itinerant inspectors or the district medical officers.[76] One inspector commented that, generally, Aborigines in the Kimberley appeared to be in good health, apart from venereal disease, which abounded throughout the district. Malcolm Fraser, a Kimberley land owner, blamed the victims for this. The source of the infection, he advised the Protection Board, was the 'unspeakable dirt of the native women'.[77]

In 1899, the year after the Protection Board was abolished in favour of a Department and individual protectors, the manager of a property owned by Nairn and Sons wrote to the Chief Protector on 10 April about his concern for an Aborigine seen crossing his leasehold. The man was crippled, and could no longer walk. That was on the 14 March, after which the station manager fed him. He was old, could go no further and it appeared he would perish if given no food. The property owners were reluctant to feed the man indefinitely and asked the Chief Protector for the daily food ration that the manager was willing to issue. Adding urgency to the request, they pointed out that as winter was coming the man would be needing further food and blankets soon.[78] Compassion was a value often displayed by Aborigines but in some cases hunting parties would leave strugglers behind. The station owners however whose own value of compassion would be limited unless the protection covered the cost. Destitution was general, as was venereal disease among the Aborigines in fringe-camps near the towns and on private properties. It might have worried some settlers, but many others could remain aloof.

Just before 1900 the Kimberley land owner, Malcolm Fraser, wrote once more to the Chief Protector about his concerns for the health of Aborigines working for the R.H. Habgood Company on the Kimberley coast. He advised that the most common forms of illnesses in the fringe-camps were chest, skin and eye infections.[79] Many other white settlers showed similar concern for diseased, indigent and sick Aborigines. Some pastoralists at least worried about the condition of those who had made permanent camps on their properties. The concern, it might be said, probably arose from mixed motives — a humanitarian desire to see distress alleviated but also fear that the Aborigines would pass on their diseases to the white community. The Aborigines were unable to adapt as

successfully to the changing circumstances as the whites would have wished. They had to cope with dwindling food resources, competition for water from pastoral expansion, and problems associated with their newly adopted sedentary camp life. Some pastoralists were disdainful of the Aborigines in their predicament, but the response of magistrates, land owners, contractors, missionaries and protectors was generally humane and compassionate. Despite that, Aborigines in many places continued suffering severely from various complaints—bone and joint disorders (reported as 'rheumatics'), dysentery, asthma, colds and venereal diseases.

In the Kimberley district some sick elderly Aborigines sought relief at the telegraph station at La Grange, where a number of camps had formed. Others congregated at the remote interior telegraph station at Hall's Creek, where camps of sick, starving, blind and crippled Aborigines worried officials. Indeed the telegraph operator at Hall's Creek became so distressed at their plight that he sent for medicines, which had to be brought in by boat from Broome via Wyndham. This particular crisis developed after the hospitals at both Hall's Creek and Wyndham had closed. Some relief had become available after a mission opened near Hall's Creek. Thereafter the missionaries treated Aboriginal patients in emergencies.[80]

The Government might have been lethargic but many of its officials were deeply concerned about the poverty and destitution into which the Aborigines were subsiding. Some recorded their private worries. On 5 October 1900 a resident magistrate wrote as follows to the Chief Protector about his concern for the Aborigines on G.I. Brockman's Nimilya station:

1. I have written to Mr. Brockman explaining his accounts for feeding twelve (12) natives for nine months.
2. I do not see how owners of stations could be compelled to feed the old and infirm natives … unless Parliament legislates on the subject.
3. I am afraid that if old and infirm natives had to …[look after themselves and] their relatives on the various stations for the means of subsistence they would [all] soon die of starvation.
4. I know of several settlers who would feed the old and infirm natives on their stations were they in a position to do so but drought and bad seasons stand in their way.[81]

As his numbered points suggest, while some settlers went out of their way

to give humanitarian assistance, others wanted payment.

On top of other diseases, malaria and whooping cough had begun spreading through the camps around the ration depot at the Fitzroy telegraph station. Many old and crippled people had moved there while their younger kinfolk remained in the bush. White townspeople blamed local illnesses on the contact between Aboriginal women and 'Mongolian and Asian pearlers'. C.J. Annear, the telegraph operator at Fitzroy, informed the Chief Protector that such contacts were frequent during 'the fever months' when the pearlers were present.[82]

In the La Grange and Beagle Bay areas during 1901-02 the protectors' reports included accounts of how Aboriginal health and living conditions were being degraded as a result of the old men living off the earnings of the prostitution of their wives and younger women. Venereal disease had taken a firm footing there by 1903, and was causing much distress. The telephonist at La Grange advised the Chief Protector that gonorrhoea was rife throughout the district and was causing severe problems for Aboriginal women in particular. Syphilis, too, and various skin diseases seemed to be something Aborigines caught from Asian sailors, he said, and half-caste women appeared to be the most affected because they came into the towns more often. Among those affected were girls of only 12 and 13 years.[83]

By 1903 the eastern Kimberley pastoral station owners were also growing concerned about the health of their Aboriginal labour. Mr Kearney of Argyle station, for example, wrote of a number of natives who were feeble and crippled, some children who were orphaned and one blind boy. They had colds, rheumatics and venereal diseases. He said his station was a route to the hinterland and many Aborigines passed through, travelling both east and west. He called for medicines and a doctor from Wyndham to treat them. Similarly, at the Halls Creek and Fitzroy ration stations, the police officers reported that an influenza epidemic had struck the camp people. And in May 1903, at nearby Flora Valley, at least 16 deaths occurred after about 200 Aborigines had camped nearby and influenza broke out among them. A supply of medicines was sent to them in an attempt to halt its spread. Included in the supply was medicine for a child suffering from syphilis.[84]

A year later, in 1904, Constable Cadlow reported a fresh influenza

epidemic, and the presence of other diseases. One of the conditions was 'ague' (a form of malaria), that manifested itself with variations of chronic shivering.[85] Four people died from one or other of these diseases. A disease which the police report was unable to specify seemed similar to 'swamp fever', or beri-beri. It had possibly been introduced by Asian mariners, who were soon cohabiting with Aboriginal women. Asian fishermen were thought to arrive with venereal diseases and sometimes small-pox. Passenger ships also brought small-pox, but only one case ever came to light among the Aborigines.[86] Strict quarantine was generally applied and managed by the local medical practitioner, with positive effect.[87] Aborigines around La Grange, Broome and Beagle Bay were quarantined for six weeks and the Asian sailors prevented from mixing at all with the Aborigines, male or female. Drs Blick and Thompson and the local police constable at La Grange, Kuhlmann, co-operated in vaccinating as many Aborigines as possible.[88]

In country towns the provision of medical care to Aborigines remained in the hands of either district hospital staff or private medical practitioners. Not all districts had hospitals, however, and if they did the payment of the hospitals' and doctors' fees proved the only sure way for Aborigines to gain access to medical services. Even emergency cases were sometimes rejected. The fees of Aborigines under contract to pastoralists sometimes, but not always, were paid by the pastoralists.[89] The bills of destitute were sent to the Chief Protector while those of poor white people went to the Medical Department in Perth.

Poverty was no guarantee of access to hospitals or medical care for either blacks or whites. The hospitals themselves decided who should be admitted, the decision depending on the general condition of the individual patient. The attitudes of the hospital staff and general practitioners was also critical element.[90] Some health workers simply passed the accounts directly on to the Chief Protector's office, and if funded from Government revenue they sometimes waived the costs. Half-castes were in a separate category because they were not what the bureaucracy understood or accepted as Aborigines. From the Chief Protector's records, it seems that the average length of stay in hospital per patient was about 24 days—a lengthy period by comparison with the present-day situation. The average cost per patient in the annual accounts sent to the Chief Protector's Office from the Health Department was

£48.16.0, a large amount at the time (equivalent to about $4635 a century later). Some patients stayed longer, but most stayed for short periods. The records reveal that in 1901–02 about 236 Aboriginal patients were received into country hospitals all over the State. This figure was probably only a relatively small proportion of those who were seriously ill, but it signifies that appreciable numbers of Aborigines were entering hospitals for treatment. Although in many cases access was denied to both white paupers and the Aborigines of the fringe-camps, it is also true that many hospitals did care for indigent Aboriginal and white patients.[91]

In 1902 the Principal Medical Officer wrote to the Under Secretary concerning the type of payment structure in place and the problems in delivering health care to out-lying 'lock-up hospitals' (that is, secure hospitals from which patients needed a medical permit to leave)[92] such as the one at Peak Hill. The doctor managing the Peak Hill hospital had been placed in an invidious position because he was appointed by a committee that, he claimed, was irresponsible for refusing to admit Aborigines when they became ill. He said he tried his best to treat them but he felt he had been betrayed by higher authorities because they made no effort to force hospitals to admit sick Aborigines.

One instance demonstrates how hospitals might respond. The Principal Medical Officer complained in 1902 that an Aboriginal patient who had died, Edward Whitworth, might have been saved if admitted earlier to the Peak Hill hospital.[93] This incident became public when the local police constable of the Murchison district, John McGinley, reported the circumstances by telegram to the Principal Medical Officer. McGinley said that Whitworth had arrived in the town about three weeks earlier. He had been suffering from syphilis and was admitted to hospital on the order of a Mr Bagot, the warden of the Peak Hill lock-up hospital. When the hospital authorities discovered that he had been diagnosed with syphilis 'they turned him out. He has since been wandering Peak Hill quite literally dying on his feet'.[94] That had been in December 1902. Three weeks later Bagot ordered that Whitworth should be locked up as a vagrant, and that the spread of his syphilis had made him 'critically ill'. Whitworth had become so ill that he was 'unable to face the court for the vagrancy charges', yet the hospital authorities had 'refused to have anything to do with him as his case [was] very infectious'.[95]

In the southern region of the State, south of Perth, the total Aboriginal

population was 1,216, and of these, eight out of every hundred were living on the fringes of towns.[96] Of all the Aborigines in the region, only about 15 were permanently on relief. Work for Aborigines, both men and women, was fairly easy to find; moreover, their population was small. This helped insulate them from the pauperising effects of long periods of unemployment. When they were out of work they received some relief from local settlers and missionaries. As one protector observed in 1904, 'they are civilised, and their wants are well attended'.[97] That year, however, a severe winter caused more deaths among the older people than usual. They had little protection 'from the inevitable cold which their mode of living brings on and this time among those who died was Billy Kickett, who had been the guide to the former Premier, Sir John Forrest during his earlier years as an explorer'.[98] Kickett, also known as Noongali, had been receiving a government pension for his services to Forrest. Another old man at Pinjarra caused some concern because of his blindness. 'He was very much diseased and had given much trouble and expense',[99] the Chief Protector noted, adding that the man's disease had made it impossible to move him. A large shelter had been built for the man and a cottager's wife employed 'to look after his wants and his warmth—a most unpleasant duty'.[100] For this, the Chief Protector had had to pay at a higher rate than elsewhere. In the same report he recorded his pleasure that at Katanning and Guildford it had been possible to provide special camping places for the fringe-camp dwellers, and that these had proved successful.[101]

Along the south coast, towards Esperance, kangaroo shooters used Aboriginal hunters, and few travelling inspectors visited the region because it was isolated, lonely country. Even so, the Southern Protector felt that commercial roo hunting had enabled the Aborigines to maintain their independence. He was nevertheless concerned about two things—the dwindling numbers of Aborigines and the over-killing of kangaroos. He also wrote that a man called Castilla had been in the area for many months in charge of a water boring party. While Castilla was there he saw Aboriginal men and women suffering 'awful mutilations of the generative organs of both men and women … [which] militates against the continuance of their race … Should the kangaroo-hunters' camps cease to exist, the natives would lose many benefits'.[102] The disease that Castilla had observed had already been studied and named *Granuloma pudenda*.[103] This condition came as no surprise to either the Chief Protector or medical practitioners in the north, who had already expressed their alarm at the occurrence of venereal disease among the Aborigines. Accurate diagnosis presented great difficulty for protectors with no medical

training, but the prevalence of such disease nevertheless aroused their concern.[104]

The Chief Protector's correspondence conveys vividly the kinds of difficulties and occupational stress confronting the doctors in particular. The problem was not theirs alone, however, for the police, magistrates, hospital workers and departmental officers also had to contend with rising rates of infectious disease among Aborigines.[105] The correspondence of such officials opens a window on their difficulties in coping with escalating infections among the Aborigines during this period. The doctors especially were called upon to travel long distances by horse and buggy to outlying camps to provide medication to sick and dying camp Aborigines. In addition, police officers and magistrates sometimes had to fill in for medical personnel, as did the local protectors of Aborigines. At the same time, Aborigines' difficulties in gaining access to hospitals, usually complicated by staff attitudes, was a further situation confronting the officials. Providing medical care to Aborigines and meeting their welfare needs were increasingly vexed issues.

The difficulties of adequately catering to Aboriginal health and welfare became apparent during the course of the Royal Commission on the Condition of the Natives, which the Western Australia Government appointed in 1905. The Commission's terms of reference required it to investigate venereal disease, health care costs and general matters relating to treatment of Aborigines by the medical system.[106] Further terms of reference related to the general conditions of life and treatment of Aborigines and half-castes by the settler population.[107] The Commissioner in charge of the inquiry was Walter E. Roth, the Chief Protector of Aborigines of Queensland and a greatly respected ethnographer and administrator. His appointment was a measure of the Western Australia Government's concern about the problem that Aboriginal health and welfare presented. He began his inquiry early that year.[108]

Roth's general task was to investigate the employment and treatment of Aborigines and half-castes by white and Asian people in Western Australia. His inquiries soon revealed a shocking state of affairs. His anger at what he found was plain. He bluntly reported that there were no legal protections to stop the 'greatest scoundrel unhung, European or Asiatic, putting under contract any black he pleases'.[109] At Broome, the northern pearling port, for instance, 'quite half the children from ten years and

upwards [were] indentured to the pearling industry and taken out in the boats ... and the Chief Protector [could] not prevent this'.[110]

Roth's report went on to address the issue of medical care for sick Aborigines and its provision by medical officers at local hospitals. Section C of the report considered the medical fees paid by the Aborigines Department which, for the previous three years, had varied between £92 and £96. The practice was for the Medical Department annually to forward directly to the Aborigines Department the Government Medical Officer's accounts for treating Aboriginal maternity cases, epidemics, injuries and long standing ailments. The amounts involved were paltry: those for 1902-4 were the equivalent of no more than $11,500 when converted into the values of the early twenty-first century. The report also revealed that the government medical officers were obliged to treat indigent Aborigines, 'though the only authority appears to be a circular, dated May 1898, and issued by the Premier'.[111] At that time Forrest had said that attending Aborigines in their camps was part of the duties of the resident magistrate, the resident medical officer and local police constable. In addition, Forrest had thought that property owners had a duty to care for the health of the Aborigines they employed, and that this duty extended to assisting the 'aged, infirm and sick'.[112] However, because 'employers [were] neglecting … natives working in their service, a certain expense had to … be incurred by the Aborigines Department in attending to the medical relief of such cases'. Employers of sick Aboriginal labour were also supposed to 'cover the costs of service and care', but they rarely did so.[113]

In his evidence to Roth, the Chief Protector contradicted himself when he suggested that the general health of the Aborigines was good. In his annual report to Parliament in 1905-6 Prinsep wrote more frankly than previously, perhaps chastened by Roth's findings. Many of the severe Aboriginal illnesses, he asserted, could be attributed to venereal disease. Medical expenses for treating such complaints had almost doubled in a year. Indeed, Aboriginal venereal infection had become an epidemic. Prinsep was personally greatly distressed about Aboriginal suffering from the disease.[114] The proceedings of the Royal Commission had shown that Roth and Prinsep shared common views on what legislative changes should be made to make Aboriginal health policy more effective. They agreed that health responsibilities should be spread between the

Aborigines and the Medical Departments, the two agencies most directly interested in the matter. Similarly, they both thought that half-castes ought to be covered by the legislative changes.

According to Roth, the condition of Aborigines in the north of the State was more desperate in 1905 than at the time of the introduction of the 1897 Aboriginal protection legislation. Pastoral expansion and pearling had caused greater health problems as well as social and economic hardship to the Aborigines of the north. The recommendations of his report therefore allowed for the option of people of mixed-descent being identified as Aborigines rather than of European, Chinese, Japanese and Afghan descent. Half-castes had no legal status and their liberties had become highly ambiguous. The historian Peter Biskup, writing in the late 1960s, noted that 'most part-Aborigines of the nineteenth century were true half-castes, the off-spring of white men', and as such 'they demanded the rights of the white men'.[115] The first legislation designed to reduce the status of part-Aborigines had been enacted in 1874. A little more than a decade later, the *Aborigines Protection Act 1886* focused on only half-castes and their offspring 'who were habitually associating and living with' other Aborigines.[116] This was one point of difficulty for protectors, but others also existed. The confusion over the new identity of half-castes also caused problems for people of full-descent. Who would pay for their health costs? Health costs were now linked to the ability of Aborigines or their relatives to pay for services provided by doctors and nurses at country hospitals.

Some understanding of the difficulties faced by those closely associated with providing Aboriginal social welfare is necessary, and so we now turn to that issue. The health services in Western Australia at the turn of the century were by no means easy to understand, either for Aborigines or health officials. It was even more difficult for Aborigines when their understanding of the health maintenance system, and that of the State's flimsy rural health service, upon which they came to rely, had begun to crumble. Indeed, the policy adopted under the 1897 legislation collapsed almost overnight, mainly because of the confusion over who had to pay for medical treatment and who was exempt from payment.[117] The 1904-5 inquiries initiated by the Western Australian parliament were intended to rectify the disease, health and healing problems that Aborigines faced by fixing a system already in place since 1897. In the wake of the 1905 Royal Commission, the 1906 legislation hoped to end the confusion

over such matters. The WA *Aborigines Act 1906* resulted directly from Roth's recommendations.

Peter Biskup's 1973 book blamed Roth for an identity crisis inflicted on Aborigines. This, he argued, was causing much confusion over health questions by 1910. Biskup wrote that Roth had failed to face the health and identity questions squarely: 'the impression … from contemporary records is one of optimism, of hope that the half-caste, like the man who wasn't there, would somehow go away'.[118] People of mixed racial descent would presumably be absorbed without trace into the white community. Although Roth saw part-Aborigines as 'a social problem', he did recognise their existence and brought with him a humanitarian perspective from his work in Queensland.[119] Unfortunately his inquiry created uncertainty over who should pay for Aborigines' health fees, and the consequent legislation never made sufficiently clear, either to the health and medical system or to the Aborigines, who would be responsible when they became ill.

The 1906 legislation corrected some anomalies, such as the provision of material support for half-castes who became entitled to be recognition as 'Aborigines'. The question of who had responsibility for the payment of their medical fees unfortunately remained unanswered. The responsibility still formally resided with the Aborigines Department. Public health responsibilities, however, were passed to the Medical Department, which took on the task of developing facilities for controlling venereal disease, which continued to be the most intractable of health problems. A remedy was soon to come in the building of a segregated lock-up hospital for sufferers of venereal disease. This remedy masked the more serious problem of leprosy, which entered the Western Australian indigenous population late in the nineteenth century (see Table 6.1 in Chapter 6).

The manner in which leprosy entered the Gascoyne, Pilbara and Kimberley districts and its impact on the Aboriginal population requires explanation. Because of the leprosy found among Chinese miners brought to the northern Territory in the late nineteenth century, popular wisdom was that they introduced leprosy into the Daly River, a location not previously known to contain it.[120] The Chinese had been imported from Singapore, shipped in as mining labourers by the South Australia Government to fill labour shortages during the late-nineteenth century. They soon began cohabiting with Aborigines, who subsequently

contracted the disease. Infected Aborigines and Chinese carriers subsequently moved across to northern Western Australia. It is equally possible that the animals used as food sources, including rodents and mud crabs,[121] carried the disease, or perhaps it had been introduced by the Macassans. The Macassans came for *bêche-de-mer* (sea cucumbers) and to harvest pearls. Leprosy may also have arrived with the pearlers working out of Roebourne, Broome, Derby and Wyndham.[122] The disease then spread among the Aboriginal groups and across the Kimberley region, where it had taken hold by about 1900.[123]

The first reported case of leprosy in Western Australia was in 1880. The victim was a Chinese man who had worked at Roebourne and Onslow as a cook on pastoral stations.[124] In 1902, however, a white male was admitted to Guildford hospital and later moved to Woodman's Point along the Swan River.[125] There was a dispute over whether this man, a pauper from Sydney, was contagious enough to be detained and, if so, where he should be kept until he was returned to his home State.[126] In a letter to the District Medical Officer, the Principal Medical Officer in Perth stated that the patient was only mildly infectious and so there was little reason to return him to Sydney. The real problem was that no adequate facility existed for him to be treated or hospitalised.[127] Although no data existed at the time, reports claimed that the numbers of lepers among Aborigines was growing. The system of recognisance introduced by Prinsep proved weaker than expected.

The Chief Protector's *Annual Report 1907* announced that lock-up hospitals were to be established on Dorré or Bernier Islands. The islands were said to be ideally 'separated from one another so that Aborigines could be treated under lock and key' until completely cured. In fact, no cure existed and sick Aborigines were effectively detained under false pretences because administrators believed that a temporary halt to the disease was 'of little use'.[128] The advent of lock-up hospitals began a long process of isolating the people diagnosed as infected with either venereal disease or leprosy. A study of the lock-up hospitals by Mary Anne Jebb[129] has shown that Charles Fartier, a travelling inspector of Aborigines, first suggested the idea of such institutions on islands as a way of handling the venereal disease epidemic. His view was then taken up by the Ashburton district shire. An article appeared in the *West Australian*[130] in December 1907 saying that a systematic treatment program for Aborigines suffering

from forms of venereal disease had begun. The Medical Department emphasised the need to segregate patients under medical supervision. Aboriginal patients diagnosed as lepers had no prospect of receiving medical care before 1907 and were refused treatment by hospitals. Fartier said his concern was that Aborigines were 'being wiped out' by infectious disease.[131] In his first medical report from the island, the medical superintendent, Dr Frederick Lovegrove, wrote that 'the condition of some of my patients bears eloquent testimony to the urgent necessity for maintaining these institutions for the segregation and treatment of these unfortunate people[132] in the most efficient way possible, not only for their own sakes but for the good of the community'.[133] On the completion of hospital buildings and staff quarters, infected Aboriginal men were despatched by ship across to the hospital on Dorré Island. Venereal disease concerned settlers greatly but it was leprosy that struck the most fear in their hearts.

Leprosy was emerging as a serious threat to the Aborigines in Western Australia, particularly in the north. In the period 1900–10, 129 patients with active or neutral leprosy notifications were brought in by police from the northern regions of the State.[134] Why this apparent upsurge? Leprosy has had an enigmatic past in Australia, as elsewhere. The organism causing it is *Mycobacterium leprae*.[135] The disease has long had emotionally loaded nuances because of its biblical connotations and its visual symptoms and long-term effects. Its *stigmata* acquired close and xenophobic associations with racial prejudice against the Chinese, Kanakas and Aborigines. Leprosy may affect the skin, the mucous membranes and the nerves. The incubation period ranges from 1 to 30 years and the symptoms develop slowly, characterised by widely distributed lumps on the skin. The lumps result from a pronounced thickening of the skin and nerves and sometimes come with a loss of feeling in the limbs muscular weakening followed by paralysis and disfigurement. Tuberculosis—which was also confused by some observers with phthisis—sometimes developed alongside sufferers of leprosy, but whereas leprosy is contagious, *Tuberculoid leprosy* is often benign.[136] In either form, diagnosis was always difficult. In the northern areas of Western Australia, the primitive level of technology and health expertise in both the missions and government medical services meant that health workers found it almost impossible to diagnose these diseases.[137] Moreover, they experienced difficulty in communicating their own helplessness and the lepers' plight.

Dr W.J. Durack, the District medical officer at Marble Bar, wrote to the Principal Medical Officer in Perth on 10 August 1904 saying that leprosy had been diagnosed in the Pilbara region. No record of infection appeared in the Kimberley region until 1908, however. As the advanced leprosy cases were diagnosed it began spreading north along the coastal areas to King Sound near Derby, two cases were diagnosed at Cygnet Bay and another at Point Torment. These three people died a short time after diagnosis and another patient died inland at Mount Anderson station; it was clear that bush people would soon be presenting with the disease.[138] As the disease spread to the bush people, segregation of lepers as the favoured form of treatment began to raise the prospects of white settlers being locked away in the same institutions as full-blood Aborigines.[139] While this form of quarantine was initially successful, it terrified white settlers and soon raised the prospect that leprosariums would be located close to white towns.[140]

The government took control of recording both the incidences and mortality figures of lepers. This event meant records came directly to the Chief Protector. However, only material thought relevant to Parliament by the Proctector was published. The Medical Department did likewise, but combined leprosy figures without reference to race. This complicated the method of reporting the statistics, and as a result, the data on Aboriginal health generally was unclear. Moodie makes reference to this problem of distortion in the Western Australian Aboriginal data, which continued until after 1960, but it was much worse in the first decade of the twentieth century, compared to the 1930s.[141]

Biskup's history of Aboriginal administration makes the point that the report of Roth's Royal Commission in 1905 had called for reform. Improved reporting of data on Aboriginal health to the Chief Protector after 1905 represented an important administrative achievement. When Prinsep resigned and C.F. Gale replaced him as Chief Protector in 1908,[142] the mounting incidence of venereal disease became an increasingly alarming official preoccupation. Concern about 'Aboriginal' diseases spreading into the white community added impetus to the opening of the lock-up hospitals, for which the new *Aborigines Protection Act 1906* made provision.[143] When they finally opened in 1908, Aborigines from the various ration depots, bush and fringe-camps, pastoral properties and missions were rounded up and taken there to

receive treatment for syphilis and other venereal diseases. In the same year, there was a large increase in all categories of Aboriginal destitution and illness. Gale apparently had less interest in alleviating such conditions than Prinsep, however, for while he reported on his many trips to rural ration depots he made rather less mention of Aboriginal social and health conditions.[144]

Gale's manner of reporting the condition of Aborigines meant that the tabulation of data on blindness and infirmity ceased until 1912. Interest shifted temporarily to the prevalence of leprosy and venereal disease, and the associated cost of constructing lock-up hospitals.[145] Under Gale, Aboriginal health generally ranked second in importance after the elimination of cattle killing. Roth's Royal commission had much to say about cattle killing by Aborigines.[146] Health for Roth had been a major issue but only in so far as it was a factor in race relations, as when Aboriginal women contracted diseases from pearlers and Asian seamen in the north of the State. Roth largely left the southern region of the State out of this consideration. The southern region took in Perth and stretched south along the western and southern seaboard to Cape Leeuwin and then east to Albany and Esperance. The regional boundary also took in all the inland towns between Norseman and Perth and included various Aboriginal institutions and missions, such as Mogumba, Moore River and New Norcia. The illnesses from which the Aborigines of the region suffered were blindness, injuries resulting from domestic violence, sexually transmitted diseases, premature senility and periodic epidemics as well as general indigence.[147]

In his numerous and extensive travels around Western Australia Gale found little illness or disease among the northern coastal natives. The absence of venereal disease surprised him, considering the reports by local protectors and police of the increased level of intercourse between Aboriginal women and lugger crews. He could only account for this apparently odd phenomenon by his own observation that it was the 'cleanly habits of the coloured crews', who were constantly in the salt water. The Aborigines, Gale remarked, also swam a lot during the hot weather. He reported that 'blindness was the most prevalent disease amongst almost every mob of blacks'.[148] He concluded that there were 'sure to be one or two blind women or men, and nearly every station has blind people amongst their old natives'.[149] He mistakenly thought that because young Aborigines showed no outward effects from the infection,

the affliction had something to do with aging. Many of the older Aborigines were suffering from syphilis sores, which in most instances healed up but were sure to break out again. Young children were subject to the same complaint, but they would grow out of it. What Gale observed was a cause unrelated to aging but to hygiene and the social habits of camp life.[150]

In 1908, a total of 1,200 Aborigines were reported as being in the 'blind aged', 'decrepit' and 'destitute' categories. In the first category, 119 people (43 males, 76 females) were blind and consequently also suffered reduced mobility and independence. The aged and decrepit numbered 735 (314 males, 421 females). The destitute totalled 346 (144 males, 202 females). The heavy imbalance of females to males was evident in every category.[151] Gale first visited the eastern goldfields (centred on Coolgardie) and the north-western central gold fields of the Pilbara as well as pastoral stations of the Kimberley, but his initial health report covered conditions across the whole of the State. It focused on the indigent and infirm and the increased number of fringe-camp, station and mission people who had contracted leprosy. He made special mention of the 112 ration stations which were scattered across the State.[152] The figures in the three categories rose to 1,504 in 1909, with the largest increases coming in the female 'aged', 'decrepit' and 'destitute' categories. While there had been an overall fall in the three categories by 1910, the decrease was among the males while the female numbers increased.[153] Finally, Gale noted that venereal disease and leprosy were being monitored and that those suspected of having these diseases were being taken to a government property called Mount Wangee, about 140 kilometres from Roebourne. From there, they were taken to various lock-up hospitals if they tested positive.[154] The patients were taken from one destination to another by police disease patrols.[155]

Under Gale's administration the nakedness of the Aboriginal population became an issue of concern for administrators and protectors. Administrators had to justify the expenditure on clothing as bush and fringe people wore their issue of clothing until it fell from the body. The bush and fringe-camp people were constantly entering mining and service towns during their travels and to obtain food at the town stores. Most came into the stores and depots either naked or scantily dressed. Not only did nakedness offend the sensibilities of the settlers in the towns

and mining establishments, it exposed the debilitating deformities the Aborigines suffered in fights and from leprosy, tuberculosis and venereal disease. Clothing, therefore, played a particularly important part in the minds of some protectors because it simultaneously provided Aborigines with some protection against from the elements and from abuse by settlers who were highly critical of their nakedness.

Some district inspectors rejected the idea that clothing could provide warmth even when wet. Some claimed that tunics would engender the idea that clothing should be on permanent issue, like rations. Such notions, some protectors argued, should not be encouraged because they believed that camp people would become dependent. Nevertheless, the Chief Protector recommended that the supply of cheaply made clothing solved the problem of Aboriginal nudity. A large number of warm tunics with belts was ordered by Protector Gale who felt that this system was more convenient for natives and far more suitable than expensive trousers, shirts and jackets. The detractors argued that to give natives such good clothing was foolhardy because it would either turn to rags soon or become too dirty to wear. In addition, when the clothing got wet it would cling to the wearers' bodies and would thus be more likely to induce colds and chills.[156]

The paradoxical position of protectors was evident. They wanted to protect Aborigines from the white townsfolk's criticisms. The whites in the towns had many complaints about them. These included the way bush people congregated around mining camps for food and money. According to the rural protectors, the bush Aborigines were forced by circumstance to change their eating habits, their haphazard shelters and their bush customs. The protectors laboured to shield the Aborigines from settler prudery while helping the camp people keep body and soul together. All this proved a difficult task for isolated protectors.

Aboriginal remedies were ineffective against the diseases prevalent in 1910. Western medicine, by contrast, was, and thus could consequently help build good relations between settlers and Aboriginal groups. In 1900 only the Aborigines Department had been involved in protecting Aborigines, but by 1910 other agencies had begun sharing the task. By then Western Australia Government had begun employing protectors with medical knowledge. The lock-up hospitals created in 1907–08 were specifically designed to cope with the venereal disease epidemic identified by Roth's Royal Commission. To pastoralists, the protection policy signified the retardation of the State's economic growth but to others it

meant that the State could maintain an appropriate distance between settlers and the Aborigines wherever possible. This matter is the subject of the next chapter.

For full references see Bibliography.

Notes

1. P.M.C. 1942; see also, Rowley, 1970, pp.64-73;
Keith Cole, 1985 p.19.

2. John McCorquodale, 1987 p.92.

3. A. Grenfell Price, *1949* see in particular Chapter VI, on the decline of Aborigines due to disease; see also, L.R. Smith, 1980, pp.260-261.

4. Hasluck, *1942*, pp.122-161; see also, Rowley, *The Destruction*, pp.86-107 and pp.187-191; Daisy Bates, *1938*, pp. 1-29.

5. McCorquodale, *1987*, p.92.

6. Isobel White (ed.), Daisy Bates, The Native Tribes Of Western Australia, National Library of Australia, Canberra, 1985, pp.1-35; see also, Daisy Bates, 1938.

7. Isobel White, 1985, pp.1-35.

8. *Ibid*., pp.18-20.

9. *Ibid*., pp.226-238.

10. *Ibid*., p.216, in the notes to Chapter 6 Isobel White explains how Daisy Bates arrived at this view in her unpublished manuscripts; see notes 1-2, p.238, see ANL Series, 365/33/5-6, quoted in *Ibid*., p.290.

11. *Ibid*., p.230.

12. *Ibid*., pf.

13. *Ibid*., p.231.

14. *Ibid*., pf.

15. *Ibid*., p.232.

16. *Ibid*., pp.232-233.

17. *Ibid*., pp.234-235.

18. *Ibid*., p.288.

19. *Ibid*., pf.

20. *Ibid*., pf.

21. *Ibid*., pf.

22. *Ibid*., p.289. p.84 Erysipelas is an inflamation of the skin, caused by Streptococcus. In white skinned people it presents as red patches on the skin but in dark skinned people as swelling and hot to touch.

23. Abrams S. Benenson (ed.), 1990, p.185. See also *Concise Oxford Medcial Dictionary*, 1990, p.294.

24. Benenson, 1990 p.243.

25. William Dampier: A New Voyage Around The World, 3rd ed. (London 1698) Vol. (i) pp.350-351, in C.M.H. Clark, 1962, pp.39-41.

26. Butlin, 1983 p.8; see also, A. Gray, 1985, pp.136-149.

27. *Concise Medical Dictionary*, 1990 p.631. Of the diseases which are discussed in this text, the definition includes syphilis and gonorrhoea.

28. R.L. Kirk, 1979, pp.18-38; see also, C.C. Macknight, 1972, pp.283-321.

29. Goldsmid, 1988, p.15. See also Daisy Bates, 1938, pp.4-6; see also Kirk, 1938, p.170.

30. Benenson, 1990, p.483.

31. *Ibid*., p.420. This disease comes in two forms (sexually transmitted disease [STD] and non-STD) and is discussed further on in the text.

32. *Ibid*., pf.

33. H. Basedow, 1932, pp.193-277.

34. M. Prokopec, 1979, pp.11-26.

35. Maisie McKenzie, 1969.

36. A. Castellani, 1905, 2, 1280; see also, A. Gray, 1985, pp.136-149.

37. G.D. Wasley and H.H.Y. Wong, 1988, p.5 and also, pp. 53-67; see also, Benenson, 1990 pp.438-439.

38. Wasley and Wong, 1988 p.9; see also, John P. Fox, Carrie E. Hall, Lila R. Elverback, 1970, pp.61-67; see also, M. Prokopec, 1979, pp.11-26.

39. D.J. Mulvaney, 1975, pp.128-171; see also, A.G. Thorne, 1976, pp.95-112; see also, J.M. Bowler, 1976, pp.55-77; see also, Kirk, 1979 pp.18-38, p.170; see also, Goldsmid, 1988, p.15; see also, Isobel White,1985, pp.288-297; see also Daisy Bates, 1938, pp.4-6.

40. W.H. McNeill, 1976, 1976, pp.38-39.

41. *Ibid*., p.39.

42. *Ibid*., pf.

43. *Ibid*., pf.

44. J.B. Cleland, 'Contributions to the History of Diseases of Man in Australia', 3rd Report Government Bureau of Microbiology, 1914, pp.226-232; see also, J.B. Cleland, 1928, pp.157-160, pp.173-177, pp.216-220, and pp.232-235.

45. Herbert Basedow, 1932, pp.177-185, pp.193-198, pp.209-213, pp.229-233, pp.247-250, pp.273-277.

46. M.J. Lewis (ed), 1989, p.271; see also, J.B. Cleland, 1908 (2), pp.266-269; Cleland, 1909 (2), pp.143-151.

47. Basedow, 1932, pp.193-277; see also, D. Kaus, 'Basedow, H.', in D. Horton (gen. ed.), 1994, pp.106-107.

48. McNeill, 1976 pp.38-39; see also, Wasley and Wong, 1988, pp.5-12; see also, Butlin, 1983 pp.8-9, see where, Butlin argues that anthropological descriptions of indigenous groups could not be described as in a stable relationship with their environment. But, see Gray in a paper above, Gray, 1985, pp.136-138, and in this paper, Gray disputes Butlin's point by saying that the way he argues constructs new myths out of old ones and in

doing so restricts sound analyses; see also, Macknight, 1972, pp.283-321. The quotation used from Macknight is taken from p.317.

49. C.J. Hackett, 1936, p.735.

50. Kirk, 1986 pp.170-184, on syphilis, see also, p.170 and p.183, on yaws; see A.T. Sandison, pp.45-48.

51. Gray, 1985, p.136-137.

52. Ida Mann, 1961.

53. *Ibid*., pp.454 -458.

54. *Ibid*., p.459.

55. McCorquodale, 1987, p.94.

56. Hasluck, 1942, pp18-41.

57. *Annual Report*, Aborigines Department, 1899, WAGP, Perth, p.1, in Western Australian Parliamentary Votes and Proceedings, (WALAV&P) 1898-1900, WAGP, Perth, 1900.

58. *Ibid*., pp.1-8.

59. 'H.C. Prinsep to John Forrest, 17.10.1898-99, private letter', quoted in Mary Anne Jebb, 1984, pp.68-88.

60. Elizabeth Goddard and Tom Stannage, 1984, pp.52-58.

61. Aborigines Department, *Annual Report* of Chief Protector, 1899, p.1; see also, P. Biskup, 1973 pp.27-44.

62. A.W. Crosby, 1994, pp. 82-108; see also, A.W. Crosby, 1989, pp.227-263. This chapter discusses the impact of the pandemic of 1918-1919 on indigenous people of Alaska and Samoa.

63. Butlin, 1983 pp.8-9. See Gray, 1985, pp.136-138.

64. Macknight, 1972, pp.283-321.

65. Rowley, 1975, pp.1-127; see also, Leslie R. Marchant, 1981.

66. Macknight, 1972, pp.283-321; for a compact interpretation of the saga see also, Mulvaney, 1975, pp.14-41.

67. Chief Protector, *Annual Report*, WAPP, 1900-1, pp.7-14; see also, *Annual Report*, WAPP, 1904-5, pp.13-14; see also, Chief Protectors, *Annual Report*, WAPP, 1907, p.17; see also, Chief Protectors, *Annual Report*, WAPP, 1908-10, pp.8-14.

68. Public Records Office (PRO), Battye Library, Perth, AN, 1/3, Acc. No. 255, file 1898/262, file name, and subject, 'Resident Magistrate Derby: Relief of Natives'.

69. *Ibid*., no folio numbers.

70. *Ibid*., see, 'Relief of Natives: Sergeant of Police Norseman April 30th 1889, Sergeant Lappin'.

71. *Ibid*., no folio numbers.

72. *Mount Magnet Miner,* 27.10.1898, in PRO, AN, 1/3, Acc. 255, file 496/1898, 'Resident Magistrate Murchison, Mount Magnet Miner'.

73. PRO, AN, 1/3, Acc. 255, file 577/1898, J. D'Alton, 'Town Clerk Northam: Condition of Natives in the Colony'.

74. *Ibid*., no folio numbers.

75. Aborigines Department, Chief Protector's Report, June, 1898, see, 'East Kimberley', *WALAV&P*, 1889, WAGP, p.5.

76. Report Protector Aborigines, *Annual Report, 1898*, *WALAV&P*, WAGP, p.5.

77. Report of the Aborigines Protection Board, 1897, *WALAV&P*, WAGP, 1897, see, 'Appendix I – East Kimberley', pp.5-6.

78. AN, 1/3, Acc. 255, file 324/1899, Relief to Cripple "Yallajarra", 'I. Nair and Sons to Chief Protector'.

79. Malcolm Fraser, 'R.H. Habgood to Chief Protector of Aborigines, 1887-1888', in Report of the Aborigines Protection Board of Western Australia, 1887-1888, *WAPP*, p.4.

80. Report Protector Aborigines, *Annual Report*, 1899 WALAV&P, pp.5-6.

81. AN, 1/3, Acc. 255, file 8/1900, Aboriginal Natives At Nimilya – Mr G.J. Brockman, re support of old and infirm, 'Resident Magistrate to Chief Protector' October 5 1899.

82. *Ibid*., p.6.

83. Chief Protector Aborigines, Annual Report, 1903, *WAPP*, WAGP, 1904, Perth, p.1.

84. *Ibid*., pp.6-18.

85. 1990, pp.405-406.

86. Chief Protector Aborigines, *Annual Report*, 1905, *WAPP*, WAGP, Perth, 1905, pp.11-14.

87. Chief Protector Aborigines, *Annual Report*, 1904, WAPP, WAGP, 190, p.8.

88. See, 'letter from Tuckett to Prinsep, 6th September 1904', in Chief Protector Aborigines, *Annual Report*, 1905, WAPP, WAGP, Perth, 1905, p.14; see also, 'letter from Constable Kuhlmann to Prinsep', *Ibid*., p.15, this letter, among another things, describes in detail the quarantine arrangements put in place by those medical quarantine teams named in the text.

89. Biskup, 1973 pp.111-113.

90. AN, 120/4, Acc. 1003, file 292/1901-1902, 'Hospital treatment of "Aboriginals"', folio 5.

91. *Ibid*., see 'Statement showing amounts due for treatment of natives: for 1901-1902', on same file but with no folio numbers.

92. The lock-hospital was a British invention used for containing people with contagious diseases. These lockup hospitals were legislated for under the British (1866) and then Tasmanian Contagious Diseases Act, 1879, see F.B. Smith, 1971.

93. AN, 120/4, Acc. 1003, file 282/1902, 'Death of Edward Whitworth in Peak Hill'.

94. Telegram 1, in *Ibid*., f.2.

95. Telegram 2, in *Ibid*., f.3.

96. Anna Haebich, 1985, pp.39-40.

97. Chief Protector, *Annual Report*, WAPP, 1904, pp.10-11.

98. *Ibid*., p.10.

99. *Ibid*., pf.

100. *Ibid*., pf.

101. *Ibid*., pf.

102. *Ibid*., p.24

103. J.R. Hickenbothem, 1908, Vol. II, pp.264-9, also cited in Mary Anne Jebb, 1984 pp.68-87.

104. J. Sergeant, 1989.

105. AN, 120/4, Acc 1003, file 175/1901, New Norcia, 'Complaint of Conduct of Doctor for the District'.

106. Western Australian Government Gazette, on 31st August 1904, gave the order from Governor Sir Fredrick G.D. Bedford to Walter Edmund Roth, Esq., to conduct a Royal Commission into the administration of the Aborigines Department, and the employment and treatment of the aborigines and half-caste inhabitants of the State; this letter is contained also in, Report, Western Australia Royal Commission On The Condition Of The Natives, WAGP, Perth, 1905, p.1.

107. WAPV&P, No. 5, 1905, Report, Western Australia Royal Commission On The Condition Of The Natives, WAGP, Perth, 1905, p.(i).

108. *Ibid*., pp.1-121.

109. *Ibid*., pp.1-26.

110. *Ibid*., p.26.

111. *Ibid*., p.100.

112. *Ibid*., p.24.

113. *Ibid*., p.25

114. Chief Protectors, *Annual Report*, WAPP, 1906, p.5.

115. Biskup, 1973 p.44.

116. *Ibid*., pf.

117. *Ibid*., pp.111-113.

118. *Ibid*., p.66.

119. *Ibid*., pf.

120. Editorial, *The Journal of Tropical Medicine and Hygiene*, Vol. XX, Jan. 1 to Dec. 15, 1917, p.41; see also, (Sir) Leonard Rogers, 1930, pp.524-527; see also, C.E. Cook, 1926; see also, E.H. Molesworth, 1927; see also, Suzanne Saunders, 1986; see also, Cecil Cook, 1927; see also, Lewis, *1989*, pp.207-218.

121. J.M. Dalziel, 1912, pp.70-72; see also, E.C. Long, 1912, p.72.

122. Macknight, 1972, pp.283-321; see also, Mulvaney, 1975 pp.24-39.

123. Cook, 1925, pp.9-71.

124. Davidson, 1978 pp.4-6.

125. AN, 120/4, Acc. 1003, file 235/1902, 'Guildford Hospital—Case of Leprosy'.

126. *Ibid*., see 'Principal Medical Officer's letter dated, 27th August, 1902'.

127. *Ibid*., see 'letter from PMO to DMO, 27th Aug, 1902'.

128. Aborigines Department *Annual Report*, 1907, p.1.

129. Mary Anne Jebb, 1984, p.74; see also, Public Records Office, Battye Library, 2425/2, from cutting of article in the *West Australian*.

130. *Ibid*., p.74.
131. PRO, file 2425 B/L, and cited in *Ibid*., p.74.
132. *Ibid*., pf.
133. *Ibid*., p.6.
134. *Ibid*., 'Table 1', pp.124-127.
135. S.G. Browne, 1975, pp.485-493.
136. 1990, p.385.
137. W.S. Davidson,1978, pp.3-11.
138. *Ibid*., pp.8-9.
139. See 1990, p.568; but see also, Suzanne Saunders, 1990, pp.170-184.
140. Suzanne Saunders, 1990 pp.168-169; see also, Suzanne Saunders,1986, pp.14-33.
141. Moodie, 1973 pp.146.
142. Biskup, 1973 pp.111-113.
143. *Ibid*., p.112.
144. *Ibid* pp.111-113.
145. Chief Protector, *Annual Report*, WAPP, 1911, p.3.
146. Chief Protector, *Annual Report*, WAPP, 1912, pp.3-7.
147. Chief Protector, *Annual Report*, WAPP, 1908, pp.1-5 and 1909, pp.3-4 and, pp.12-13, and 1910, pp.12-15.
148. Chief Protector, *Annual Report*, WAPP, 1908, pp.3-5.
149. *Ibid*., p.4.
150. *Ibid*., pp.4-5.
151. *Ibid*., pp.5-7.
152. *Ibid*., p.4.
153. *Ibid*., pp.1-4.
154. Chief Protector, *Annual Report*, 1910, p.5.
155. *Ibid*., 1910, pf; for a description of what occurred see Daisy Bates, 1938, pp.93-96.
156. Chief Protector, *Annual Reports*, 1908, p.4.

4

An imperative to isolate: Incarceration as an official response to Aboriginal disease in Western Australia, 1910–20[1]

Two administrative changes greatly influenced the system of Aboriginal health management in Western Australia in the decade 1910–20. First, the Aborigines Department amalgamated with the Department of Fisheries; and second, Immigration was added in 1915, when the Department became the Department of Aborigines, Fisheries and Immigration.[2] Charles F. Gale remained in charge of the Aboriginal branch of the Department until April 1915, when A.O. Neville who was an existing government bureaucrat replaced him as Chief Protector. In this period the departments responsible for Aboriginal protection and primary health care became preoccupied with venereal disease, leprosy, hookworm and access by Aborigines to country hospitals.

One of C.F. Gale's first tasks after becoming Chief Protector was to appoint Daisy Bates as a travelling protector in 1910 and to pay her as a special commissioner. At the same time, Bates joined an international party to study Aborigines in the central and northern areas of Western Australia. Part of her duties was to 'conduct inquiries into all native conditions and problems'.[3] Another was to investigate the employment of Aborigines, including half-castes, on stations. Yet another was to act as guardian of indigent Aborigines, a duty which included monitoring the distribution of rations. The half-caste question loomed large in her mind, along with the 'morality of native and half-caste women in towns and mining camps'.[4] In these multiple roles she witnessed police rounding up Aborigines suspected of having chronic infections.[5]

From Laverton, in the central eastern part of the State, Bates travelled to Dorré and Bernier Islands. Little more than desolate sandbars in the

Indian Ocean some 50 kilometres west of Carnarvon, the islands were the location of separate male and female lock-up hospitals. Decades later the shock of her experiences there remained vivid in her memory. She wrote that the two lock-up hospitals were no places of refuge for the sick. She described them as places of 'misery and horror unalleviated … tombs of the dead'.[6] Her concern was that the Government had abandoned its previous generally humane protection policy when faced by the potential scourge of venereal disease. In doing so, 'regardless of tribe and custom and country and relationship, they were herded together—the women on Dorré and the men on Bernier. Many had not seen the sea before, and died in terror of it'.[7]

Bates remarked that very little companionship existed in the hospitals, and most of the inmates feared contact with each other because they regarded Aborigines from beyond their homelands as foreigners. Most of the women on Dorré roamed aimlessly in all weather and at most times of the day. Some cried from loneliness, others stood for hours in one position peering across the water because they missed their relations and grieved for their country. Many simply died of grief, their graves sad testament to their anguish.[8] They were buried there, far from their homelands, because the hospitals had no responsibility or wish to send their bodies back to the families. Similarly, when the police disease patrols brought the patients in they had no legal responsibility to record where they had come from. Bates described one policeman who arrived

> with new consignments of unfortunates collected throughout the vast State, and [she] went over to Carnarvon to meet them. [The police] … camped four miles away on the outskirts, with about 133 natives, all stricken with disease … Shall I ever forget the surge of emotion that overcame me as they saw me, and they lifted their manacled hands in a faint shout of welcome, for some of them recognised me? There was a half-caste assistant … and the natives were chained to prevent them from escaping … In one donkey-wagon were forty-five men, women, and children, unable to walk.[9]

To Bates the inhumanity of the Government's attempt to arrest the spread of venereal diseases was as evil as the disease itself, and perhaps even more so since dealing with the epidemic required that the government measures must continue for a very long time before they began producing results. Unfortunately, Bates could only decry the Government's efforts but was unable to suggest an alternative approach.

From the opening of the lock-up hospitals in 1908 to their closure in 1918, police collected diseased Aboriginal men and women on behalf of the Medical and Public Health Department. Those thus rounded up were then isolated on Dorré and Bernier, the women on the former and the men on the latter. The cause of most of Aboriginal female venereal infections was the scarcity of white women in the mining, fishing and pastoral service towns. White men had sexual relations with Aboriginal women instead. The women became infected, and many ended up on Dorré. Women always made up the largest proportion of patients in the lock-up hospitals. In 1910, for example, 72 women and 57 men were transported to Dorré and Bernier suffering from sexually transmitted diseases.[10] Only 10 men and 27 women were discharged to their homes as cured that year. As we will see below, of the 635 Aborigines sent to the islands, fully a quarter never left. The fortunate 37 sent home in 1910 were drawn from widely dispersed homelands between Wyndham in the north and Carnarvon in the south, and their departure left a total of 119 patients on the two islands. Many of the patients, according to the Chief Protector, were in the older age groups and had been suffering from some form of venereal disease from well before the advent of the lock-up hospital.[11]

Once on the islands the patients were 'allowed to live their own lives in their natural way'.[12] What this meant was that when bush and camp people came they were allowed to live in the sand hills and erect their own shelters. By 1910, however, the hospital staff were finding it 'impossible to give the very bad cases the necessary attention'.[13] The erection of an 'incurable ward' of 20 beds for women and 10 for men was authorised.[14] In addition, an expert pathologist, Dr Steel, took up duties to try and 'discover the aetiology, treatment, and cure of the venereal diseases from which the natives suffered'.[15] That year the male patients gathered the timber to build the new ward, and they collected 500 loads of coral, sand and limestone. With the coral they helped to mix the concrete to build constructions. When that was finished they built the fences and looked after the domestic animals that provided the meat for the medical staff.[16] Building and farm-worker jobs were allocated to the able-bodied men. For women bread-making, collection of firewood and transport of drinking water by bucket made up their contribution to daily operations. To collect the fresh water the women dug holes in the sand to access the underground water system and then carried the fresh water

back to the hospital kitchen to supplement rain water from the hospital roof which drained into concrete storage tanks. Apart from carrying water, bush people were neither familiar with such tasks nor used to hard labour. As a result, conflict between the nursing staff and inmates often arose over the way Aborigines were expected to perform these duties. The inmates' work saved the Department money but caused problems in other directions. 'The standard of medical care … was undermined by the persistent punishment applied to Aborigines'. 'Persistent punishment' included the hospital staff whipping the patients if they failed to do their allocated tasks.[17]

In the following year, a number of fights occurred among the Aborigines. A white female employee later reported that the medical staff 'locked up the ringleaders'[18] involved in the troubles. Part of the problem arose from an attempt to keep some Aboriginal men on Dorré island rather than to transfer them back to Bernier Island where they were normally hospitalised. Travel between the mainland and the two islands was always fraught with danger because of the westerly winds and swift-flowing tides.[19] When the men were allowed to stay, some of the women objected and fights broke out. Mary Anne Jebb argued that the austere management practices adopted by the medical staff caused conflict,[20] but in Daisy Bates's opinion pre-existing 'tribal' hostilities among the patients was probably a cause.[21] Conditions did improve in 1912 when the extension to the Bernier Island hospital permitted some patients to receive surgical treatment that would otherwise have been unavailable.[22] Such operations involved repairing genital damage or wasting from long-term neglect of the infected parts of their bodies.[23]

During the period 1911–16, although the numbers of patients with diseases began to decline, the method of collecting patients became more organised. For example, patients were collected by boat from a number of mid-west coast ports and taken to the islands.[24] In 1911, 1912 and 1916 special disease patrols were sent into the Gascoyne, Ashburton and De Grey districts to bring Aborigines into coastal towns for venereal disease screening prior to their dispatch to the island lock-up hospitals. In 1911 the disease patrol brought 96 men, women and children to Carnarvon. According to the Chief Protector's *Annual Reports 1912–16*, the disease patrols were headed by travelling inspectors. These inspectors collected smaller numbers of Aborigines in this period because minor cases of

infection were treated on the spot while other cases were transported to Marble Bar for dispatch to the island hospitals.[25]

Though controversial, a research project on venereal disease which commenced in 1911 began to reveal a new perspective on the variety of disease from which indigenous people were suffering.[26] According to Biskup, early research proved inconclusive, but 'the break-through came on the eve of the war when the ailment was finally diagnosed as *Granuloma pudenda*, an infection which at the time was thought to be venereal disease. In addition, this disease was assumed to be peculiar to the Aboriginal race'.[27] Mary Anne Jebb disagrees with the idea of an infectious disease peculiar to Aborigines. She points out that a contemporary medical researcher, J.R. Hickenbotham,[28] had noticed 'interesting discrepancies in the manifestations of syphilitic lesions present in white stockmen'.[29] The disease, Hickenbotham observed, was also present among the Aboriginal women with whom they cohabited. Furthermore he had treated the patients for syphilis and only the white stockmen had responded'.[30] Hickenbotham speculated that the white men might have had a milder form of the disease than the Aboriginal women, but their malady had little to do with race.[31] In any event, Aborigines had less chance of getting the treatment they needed in the general hospitals of the day.

Throughout the period a total of 635 Aborigines (426 women, 209 men) were admitted to the lock-up hospitals on Dorré and Bernier. Only blacks were ever sent there: white people infected with sexually transmitted diseases were sent to Perth. There is no obvious reason why twice as many women as men were sent to the islands. One possible explanation is that infected males, mostly white, could always go south to Perth or other cities for treatment, while Aboriginal females stayed in the camps. Another is that in the Gascoyne, Pilbara and Kimberley regions females were attracted to white settlement in greater numbers. As with the Asian mariners in the north, older Aboriginal males could trade their women's sexual favours for cash from Asian sailors. Camps were established throughout the large river systems frequented by white and Asian settlers. Both pastoralists and Aboriginal settlers were attracted to the more productive lands around the mouths of the Fortescue River just south of Roebourne, the De Grey River north of Port Hedland and the Fitzroy and Drysdale Rivers. Here, Aborigines could establish their camps

in situations offering advantages such as permanent fresh water, bush food sources in the rivers and the sea, permanent dwelling places and easy access to the nearby towns, where store-food could be obtained for cash earned from white settlers.

In 1917 only 18 women and four men were admitted to the lock-up hospitals but 25 women and seven men were allowed to return home. The numbers of people who died at the hospitals totalled 116 women and 46 men, which (as seen) was a quarter of those admitted. According to Mary Anne Jebb's calculations, only 13 people stayed longer than three years, most of them women. Many stayed for only six months to a year and were then sent home as cured.[32] Meanwhile, some local government bodies in the north began constituting themselves as local authorities under the new State health legislation.[33] They began exercising their legal capacity to frustrate projects that would benefit Aborigines suffering from sexually transmitted diseases. They did so by constructing Aboriginal hospitals near the towns within their jurisdiction. The new hospital at Port Hedland, for instance, might have been built further north at either Wyndham, Derby or Broome but for the protests of local Broome townsfolk who successfully lobbied to prevent the Government from doing so.[34] Similarly, there were attempts to involve the Commonwealth in the debate over the venereal disease epidemic and hospitals for infected Aborigines.[35] The closure of the lock-up hospitals on both Bernier and Dorré Islands took place in 1918 and a new 'native hospital' was opened at Port Hedland to deal with a range of illnesses and diseases suffered by Aborigines.[36] As the incidence of venereal disease subsided, leprosy acquired greater prominence for the health and Aboriginal protection agencies and, of course, the white settlers in country towns in particular. Although only 22 cases of leprosy were reported in Western Australia between 1898 and 1920, reports showed that it had been steadily spreading from the Gascoyne area into the Fitzroy River region of the Kimberley from about 1908.[37]

Leprosy was first recorded among Aborigines from the mouth of the Fortescue River near Roebourne and around the Fitzroy estuary at King Sound. These two areas provided the largest number of lepers and the first group to be segregated in make-shift lazarets on Barrett and Berzout Islands.[38] It was from there that leprosy had spread throughout the Kimberley by 1920.[39] The rising numbers of diseased Aborigines, Asians

and whites became an alarming issue. Who should accept the responsibility for the crisis was not altogether clear, and the overlapping legislation on infectious diseases, quarantine, local government, public health and Aboriginal protection led to disputes between agencies involved in the administration of these matters.[40]

One missionary's interpretation enables us to appreciate the difficulties which arose from trying to care for Aboriginal and Chinese lepers on isolated tidal sand islands like Barret and Berzout.[41] On 18 February 1908 a Dr Cortis wrote to the Principal Medical Officer in Perth to say that an outbreak of leprosy had occurred on Sunday and Cygnet Islands located in King Sound.[42] Cortis reported that he had visited the islands, where he found that the Catholic missionary, Father Nicholas Maria, had assembled most of the sick, blind and infirm Aborigines.[43] There were about 45 men and about 50 women, and also a baby 'with an infected arm hanging from the body as if to drop off'.[44] The adult Aborigines that Cortis examined appeared to have cancer-like lesions covering their faces. Cortis asked for larger subsidies and more medical assistance.[45] Some time would elapse, however, before order would be brought to the chaotic health situation. Walter Roth's Royal Commission of 1904–05 had suggested means for handling the confused situation, but legislative changes still had to be made in public health administration and disease control, and regional health authorities created, before the confusion would end.

Partial reform had come in June 1911 with the passage of the *Health Act 1911-12*.[46] This legislation changed the infectious disease clauses to take account of rural Aborigines needing attention. The most significant changes related to the organisation of public health at the local government level. The legislation made it possible for the State government to designate 20 new Road Board districts as health regions. At the same time it enabled existing Road Boards to receive government funding as health districts. A further 47 health districts became subject to direct control from the Board of Health, and a further 29 municipal districts came under the direction of the Health Department, which, with enhanced powers, was able to begin reorganising the public health system. Sufficient legislation existed to tackle the related problems of public health, Aboriginal protection and the treatment of Aborigines with infectious diseases.

The new *Health Act 1911-12* also embodied significant restructuring of

the public health agencies.[47] The most important was the creation of the Medical and Public Health Department through the amalgamation of the two existing and separate Medical and Health Departments. Among other responsibilities, the new Department assumed control of the venereal disease hospitals on Bernier and Dorré Islands, which had been established under the *Aborigines Protection Act 1906*.[48] Although attention to Aboriginal lepers remained the responsibility of the Chief Protector (and, through him, of his staff in rural and isolated regions), the newly amalgamated Department received additional powers under the *Infectious Diseases Act 1896* to administer treatment to anyone suffering an infectious disease. Unfortunately, the Department did not exercise its new powers,[49] largely because it lacked both the health infrastructure and the resources to influence what it could do in either the southern or the far northern areas of the State in particular.

In one sense, the new public health administration structure was a natural development arising from increases in the State's population and advances in its economic development. In another sense, it reflected the heightened awareness of local settler society in the remote regions about public health issues. That in turn prompted moves among the settlers to reject local measures to aid sufferers of leprosy and venereal disease: no one, it seemed, wished to have leprosaria or venereal disease clinics in their neighbourhoods. 'Not in my backyard' was an attitude that complicated and hampered the efforts of government agencies responsible for treating patients with serious infectious diseases.[50]

In the period from 1910–15, medical identification of leprosy improved, but diagnosis by health workers and government agents remained problematic.[51] The main complication was that highly infectious diseases such as tuberculosis, syphilis and gonorrhoea were often difficult for doctors and hospital staff to diagnose accurately. For untrained police and Aboriginal protectors diagnosis was well nigh impossible. Although there was some debate about what ought to be done about lepers, the spread of leprosy in the north continued because almost no health authority existed there. Lepers were simply deposited on the islands in Cygnet Bay, 300 kilometres north-west of Derby. This served to isolate the leprosy victims from the general public, but it also meant that they were rarely visited by medical personnel. About once in every eight months the police delivered water, firewood, flour and tea.[52] Otherwise, those confined on the islands were largely left to their own devices.

Medical services for special diseases such as leprosy developed slowly. As in mediaeval Europe, those infected were generally isolated from villages, towns and cities. In Western Australia the early practice was for police to round up the victims, both Chinese and Aborigines. If some one in either group was suspected of being a carrier or diagnosed with leprosy they faced the terrors of isolation and harsh, painful treatment regimes. Early medication for leprosy in Australia consisted of oral or intravenous infusions of chaulmoogra and hydnocarpus oils, derived from the East Indian chaulmoogra tree. These oils were more effective if injected intramuscularly, but were then more nauseating and traumatic than if ingested by mouth.[53] This form of treatment was adopted by Dr Durack of Marble Bar in the Pilbara district, who treated infected 'Manilamen' (Philippinos) with oral doses of chaulmoogra oil. Some local treatments were rather more severe: in Roebourne Dr Maunsell added arsenic to the medication, while in Derby Dr Hodge added antimony.[54]

Administering chaulmoogra oil orally with a small amount of strychnine was a practice adopted overseas. This caused nausea in some patients. In 1911 an alternative treatment was adopted by Dr Victor Heiser in the Philippines. He tried a new course of treatment involving 'hypodermic injection with a formula composed of chaulmoogra oil, resorcin, and camphorated olive oil in 1 cubic centimetre doses'.[55] The Heiser regime consisted of six weeks of daily 1 c.c. injections increasing to 12 c.c. in the daily dosage over two months, then a reduction back to 1 c.c. and finally back to the maximum dose over six months. Before the treatment began the patient had to test positive to a bacteriological test. On the completion of his trials Heiser found that 'the patient [tested] microscopically negative for leprosy'.[56] Although the leprous macules (a spot of discolouration of the skin or thickening and swelling to the skin that forms a distinct area from the normal tissue) developed as ulcers, they took some years to heal. A cure was declared when microscopic tests could reveal no presence of leprosy bacilli.[57] This was a short-term result because no cure had been recognised at the time. Research on leprosy treatment continued throughout the world; by 1914 researchers had only just begun to observe similarities between the leprosy and tuberculosis bacilli.[58] In Australia, however, only 'standard' treatments were available.

In 1911 Chief Protector Gale visited the lazarets on the Cygnet Bay islands.[59] He kept in close contact with Dr Maloney of Roebourne[60] and

Dr Maunsell of Broome,[61] both of whom cooperated in keeping him informed about the progress of the disease. Dr Maunsell went to Bezout Island on 15 September 1911 and examined five Aboriginal women. He reported that two Aborigines, a man named Jimmy and his wife Nangetty, were caring for about five adult women there. After bacteriological examination, four of the women tested positive for leprosy. Maunsell added that there was 'no doubt that Wagar and Cooranung ... suffered from leprosy and the disease had become more marked in the last six months'.[62] In addition, he saw an Aboriginal woman called Parley, alias Jemima, whom he diagnosed as 'syphilitic and not suffering from leprosy…The … eruption she had before she went to Bezout [Island in King Sound] has practically cleared away'.[63] Many sufferers were understandably shy about being closely examined by male doctors. The doctors performed their duties under constraints of their own. They could only guess at the stage of progress of the disease in such isolated groups because they had no legal power to remove them to the mainland for thorough testing.[64]

During his tour of the region, and particularly on Berzout Island, Gale experienced at first hand the difficulties his staff faced. On Berzout he saw that 'the natives were at the time of ... his visit living principally on turtle meat and eggs, which they much prefer to the food supplied to them'[65] by the Government. The island was only about two kilometres long and between 100 and 200 metres wide but 'well above the sea level, [and] so in every way … suitable for the purposes of segregation'.[66] While there, he saw the sheds in which stores were kept and those where patients sheltered from the elements. Large water tanks provided water for drinking and cooking. Before leaving the island Gale 'made arrangements for all the tanks to be filled in case anything unforeseen happened preventing a regular supply [of firewood and stores] being delivered'.[67] The supply was sufficient to last for about eight months.[68]

Gale wrote that when he arrived on the island he 'found 7 bags of flour, 2 bags of sugar, 4 bags of tea, 4 dozen 2-pound tins of meat, and 3 dozen tins of jam in the stores, which the patients have access to any time'.[69] Dr Maloney, the District Medical Officer at Roebourne, who had protested about the conditions, had been criticised by the Health Department as the holder of 'alarmist' views, but his complaints had been enough to bring Gale to the area. Once there, Gale satisfied himself that

the depot staff under his control were carrying out their tasks as satisfactorily as possible.[70] He nevertheless felt that, from the medical perspective, 'there was much left wanting in the proper treatment of these leper patients'.[71]

There were about eight adults (two men, six women) on Berzout whom Gale thought were suffering from leprosy. Some of the lepers had other relatives with them and Gale advised the head of the Premier's Department that he thought this was unsatisfactory.[72] He pointed out that the Health Department had authorised the police to place the lepers on the island but that the morality of incarcerating diseased Aborigines on barren, remote islands was dubious. The vexed nature of the issue was evident in his advice:

> I admit the difficulty of holding any native suspect until his or her disease is determined, but the opinion of Dr Maloney has been frequently voiced by himself when at Roebourne that an illegal action is taking place with natives which the authorities would dare not do if the subjects were Europeans, and I feel sure this phase of the question will be ventilated by the public sooner or later.[73]

One of the difficulties was that the island was 20 kilometres from the mainland, which made travel dangerous for the medical staff. In heavy weather the time taken to travel to and from the island, was about 13 hours. Further, the police cutter that ferried the stores, firewood and water, and took the medical officers to and from the island was inadequate.[74] In view of such difficulties Gale thought that a place on the mainland had to be found, despite public objections.[75]

Between 1912–14 debate continued over whether leper patients ought to be taken south to one of the islands offshore from Carnarvon.[76] No decision was possible, however, due to the conflicting interests involved. That was until a white woman presented at a Perth hospital with symptoms of leprosy. The head of the Health Department, Everrett Atkinson, then pressed the Minister for Health to take action. A tidal island close to Roebourne was located, and the quarantine station at Cossack was designated as an alternative location. A District Medical Officer, Dr Davidson, put the indecision over the sites for a lazaret down to a lack of communication between the interested parties.[77] Meanwhile, the number of leprosy victims was growing and western medicine seemed

little more able to halt its spread than the Aborigines' own customary bush remedies.[78]

Traditional medication and even cures for some illnesses were indeed known among the bush people. In some cases, especially with fevers, treatment had mixed benefits. Sorcerers treated the sick person by ordering that they eat particular plants or by rubbing the juice and oils of the plants on the body with animal fat. This activity was accompanied by the patient being treated by a traditional healer, or 'clever' person, who could be male or female. These practitioners sat near their patients, or placed them wholly in water to lower their temperature. Thus, the symptoms rather than the disease were treated. As far as Aboriginal lepers were concerned, such traditional practices were as useful as medical science in explaining what leprosy was, how people contracted it and how it should be treated.[79]

The Western Australian Government began collecting aggregate data on leprosy as early as 1905. The first researcher to use that data was Dr Cecil Cook, who in 1922–23 produced a paper on the topic 'The epidemiology of leprosy'.[80] Surprisingly, given the widespread public fear that the very thought of leprosy aroused, the management and treatment of the disease have not been well known before this paper was published. This possibly reflects the official restrictions placed on the use of government records on the disease.[81]

At the end of Gale's term as Chief Protector communicable diseases among Aborigines, particularly venereal disease and leprosy, had become endemic. These were not necessarily Gale's main priorities, but he did have two major reasons for extending health care to Aborigines. First was the international hookworm campaign, which in Western Australia largely focused on Aboriginal missions and government settlements. Second was medical care for Aborigines in rural hospitals.

Infestation by hookworm or Ancylostomiasis[82] was well described in the reports of the Australian Hookworm Campaign.[83] Ancylostomiasis has been defined as 'an insidious infectious malady, caused by two species of parasitic intestinal worms (*Necator americanus* and *Ancylstoma duodenale*) which attach themselves to the delicate mucous membrane of the small intestine, and there give rise to multiple small haemorrhages'.[84] Both species of hookworm are nematodes, worm-like parasites of animals

and plants.[85] The worm passes through the larval stage in the ground.[86] The final report of the Australian Hookworm Campaign noted 'a preponderance of the *Necator*', and commented that 'where the *Ancylostoma* is predominant it is believed to [come] from Chinese and Southern European sources, while the origin of the *Necator* [is] the Melanesian archipelagos'.[87]

Hookworm larvae prefer warm, moist, oxygenated habitats.[88] Such conditions stimulate the hatching of the egg, after which the larvae cut through the human (or other animal) host's skin to enter the blood stream.[89] Once in the blood stream the larvae travel through the lymphatic and blood vessels to the heart and lungs. They break the thin walls of the alveoli of the lungs, travelling up the trachea, down the oesophagus, and finally attach themselves to the wall of the small intestine.[90] Communities practising poor hygiene are most likely to be affected. This was especially the case in Aboriginal fringe-camps, where poor hygiene resulted in the creation of reservoirs of hookworm infection.[91]

Although hookworm also infected white Australians, became more widely reported among Aborigines in the decade 1910–20.[92] The first survey in 1918 among Western Australian Aborigines[93] reported rates of infestation ranged between 50 and 90 per cent.[94] The Chairman of the Road Board at Broome wrote to the District Medical Officer, Dr Atkinson, to notify him that a case of hookworm had been found in Broome.[95] This prompted the State government to contribute a third of the total cost of a hookworm survey in the north,[96] the rest of the cost being met by contributions from the Commonwealth Government and the International Health Board of the J.D. Rockefeller Foundation.[97] A sample survey in 1918 in Western Australia showed the presence of hookworm.[98] Regular inspections for hookworm and communicable diseases among Aborigines on missions by the district medical officers would probably have continued but for World War I.

The Medical and Public Health Department had already been monitoring hookworm infection in the north of the State. Dr Hayes of that Department had stated his belief that the missions provided favourable conditions for the spread of hookworm because bare-footed children played there amidst pools of stagnant water. At some locations crude

sanitation aided its spread rather than helped in its prevention. The incidence of the disease was not surprising considering 'the number of Malays [and] Manilamen in the north west, spreading the disease to Aborigines'.[99] A later letter from John Dale, the Deputy Commissioner of Public Health, advised the Minister about the anti-hookworm campaigns of the eastern States. Dale told the Minister that the impetus for such campaigns came from the International Health Board, an establishment of the J.D. Rockefeller Foundation in the USA.[100] The interest of the Rockefeller Foundation in developing a worldwide hookworm campaign had been aroused among other things by the research of Joseph Bancroft (1836–94), a Brisbane-based physician who had conducted pioneering research in parasitology.[101]

After World War I ended in 1918 the Australian Institute of Tropical Medicine re-commenced its efforts in the hookworm campaign in cooperation with the Rockefeller Foundation. The campaign was based on criteria established by Anton Breinl in 1911.[102] Breinl had written that notification of the presence of hookworm was insufficient and that its geographical distribution had to be known, as well as its demographic distribution. Compulsory treatment then had to be imposed on sufferers.[103] The thrust of the first survey focused on Queensland, where a high prevalence had already been identified. In Western Australia interest was focused on the north, and data collected there. The initial sample survey commenced in 1918–19 among school children selected as a representative sample of the Aboriginal institutionalised population. This method changed when some mission populations needed a different sampling approach. In those cases adults were taken as the representative group. At missions where hookworm was thought to be endemic, mass screening occurred.[104] The results of the Western Australian sample survey were reported to parliament, but not until 1921. Following the sample survey, the hookworm campaign centred on the Aboriginal community at Beagle Bay, 120 kilometres north of Broome.[105] An agreement for the campaign to proceed was jointly approved by Dr Sawyer of the State Health Department and Dr Cumpston, the Director General of the Commonwealth Health Department, in May 1921.[106]

While concern about hookworm infestations in Aboriginal groups preoccupied Western Australian health officials, the struggle to extend primary health care to Aborigines continued. Another dispute centred on gaining access for them to country hospitals and private medical practitioners' clinics.[107] From 1900 to the 1920s the Medical Department

in Perth administered country hospitals.[108] This meant that stockworkers and Aboriginal mission populations were denied direct access to health care from doctors. Stockworkers in most regions of the State had to rely heavily on pastoralists' medicine chests for their primary health care needs because little professional help was available.[109] Aborigines on missions largely had to fend for themselves or rely on missionaries to meet their primary health care needs. This often meant that the missionaries became involved in political and legal battles over the care and cost of treating the Aboriginal residents at their missions.[110]

Father Lyon Weiss wrote to the President of the Medical Board of Western Australia in Perth as early as 1905, asking for pressure to be brought to bear on the Government to use its influence with hospital administrators to have Aborigines admitted to their hospitals. Weiss told the Board that local hospital establishments at Broome, Derby and Wyndham[111] would not cooperate in admitting Aborigines.[112] Weiss asked whether hospitals in Western Australia had 'a rule which debarred people from hospitals on the basis of their race'.[113] The Board's reply indicated that Aboriginals were admitted and did receive the same treatment and care as other patients. Hospitals had special wards for Aborigines in many parts of the State, and where such provision was not provided the Aborigines were placed in the general wards among the other patients.[114] Weiss knew that the Board was protecting the medical profession and the status quo, and he was unable to argue about health practices elsewhere. Weiss's correspondence with the Board exemplified the continuing disagreement between missionaries, protectors and property owners over whose responsibility it was to pay for the treatment of sick Aborigines.

As country hospitals increased in number, their centralised management became unworkable. After 1 July 1911, when the *Heath Act 1911-12* came into force, municipalities everywhere became health districts and Road Boards became local health authorities.[115] The legislation created a dilemma for medical practitioners and hospitals in rural districts. On the one hand, they accepted responsibility for Aboriginal health. On the other hand, they demanded payment from the Aborigines before treating them. Chief Protector Gale knew this and he indicated that every care and consideration should be given to sick Aborigines because as patients hospital staff were duty bound to 'make them as comfortable as possible'.[116] The reality, as Weiss also discovered, was that the prejudice of health personnel dominated their actions—to the disadvantage of the State's Aborigines.

As early as 13 November 1911 the Medical Department began involving itself in the treatment of Aborigines at country hospitals.[117] In this same month the Principal Medical Officer wrote to the Narrogin hospital to advise that tents were on their way for use by Aboriginal patients. The Chief Protector wanted to know why a separate ward was needed for Aborigines. By 1914, the Aborigines Department had built permanent wards but within two years these needed maintenance.[118] The responsibility for maintaining 'native' hospitals had consequently emerged as a problem. By then, A.O. Neville had been the Chief Protector for a year. He wrote to the Narrogin hospital objecting to paying for repairs on the 'native' ward.[119] The District Medical Officer, James. B. Lewis, wrote during November 1919 to advise that a large number of natives had been admitted to the hospital and placed in a portable frame tent at the rear of the hospital. He said they had been housed outside the main hospital because they were not clean. He added that their habits made the white patients uncomfortable. 'If materials were approved, the orderly could manage the construction. Otherwise the Police Department have a frame tent that could be used'.[120] The Medical Department wanted the old ward (erected at the Protector's expense) to be maintained by the Chief Protector together with an additional ward because of the increased numbers of Aborigines the hospital was taking. Neville noted on file that two small wards at the back of the hospital were intended for Aboriginal cases.[121] Neville wanted to know from the Medical Department whether the increasing number of Aboriginal patients meant there was no separate accommodation for them.[122] This inter-departmental disagreement disappeared fortuitously when the Carrolup reserve offered a refuge for sick Aborigines in cases of emergency.

During the period 1915–18 two new reserves had been established because Neville wanted to remove the Aborigines who had begun congregating in fringe camps on the outskirts of Perth. One was founded at Carrolup (near Katanning, 255 kilometres south-east of Perth) in 1915 and the other at Moore River (near Mogumber, 110 kilometres north of Perth) in 1918. Both reserves, it was thought, were far enough from the city to prevent Aborigines returning to town. These camps were populated mainly by unemployed Aborigines who had moved south from the Catholic mission at New Norcia, which had recently closed. Aborigines had been gathering around the fringes of small towns since the Aborigines Department had begun implementing its policy of closing

the missions and bringing their inmates more deliberately into the workforce. As people experienced the new freedom of fringe-camp life they learnt to prefer it and became reluctant to live under the strict rule of supervised missions and reserves. The Aborigines Department had fostered this trend, perhaps unwittingly, by encouraging land owners in the southern districts of the State to employ Aboriginal labour on their farms.[123]

As World War I intensified it drew white labour from the economy to enlist as fighting forces. This allowed Aborigines to fill the gap, and many subsequently found work in the southern cities as well as rural areas. Near Perth, Aboriginal domestics lived in fringe-camps located in bushland on the outskirts of the suburbs. These camps attracted most attention, and from 1916 a number of complaints were received from nearby white residents about conditions there. The Aborigines Department also showed concern when reports came in about epidemics of measles, bronchitis and pneumonia which were simultaneously spreading among the camps. In 1918 Neville instructed the local police to order Aborigines to shift their camps to the Moore River reserve.[124] Recurring respiratory infections were a hazard of fringe-camp life. In part they reflected the residents' inability to adapt to a more sedentary life in larger communities than they had been used to, as well as their poor economic circumstances. In part also, camp dwelling forced residents to live outdoors at times and, as a result, they were subject to the elements, which exacerbated their generally poor physical condition.[125] Then, soldiers returning from Europe brought back with them the 'Spanish' influenza, a worldwide pandemic which was to cause more deaths in a shorter time in Australia than any other epidemic before it.[126]

In late October 1918, federal authorities quarantined two ships returning from Europe via South Africa. The first was the *Charon Bay*, a passenger steamer and mail carrier carrying a large number of Fremantle residents. The ship entered quarantine on, 21 October 1918. It had arrived at Broome with many passengers on board who were seriously ill from 'Spanish' or 'pneumonic' influenza, also known as 'swine' influenza.[127] The Director of Commonwealth Quarantine Services assured the nation that diseases such as cholera and other infectious disease threats from Asia, should hold no fear for Australians on the mainland because they were in no immediate danger. The second passenger steamer was the *Mataram*,

which arrived in Darwin from South Africa on 22 October 1918 on its way to Sydney. The quarantine officials in Darwin directed the vessel to sail immediately to Brisbane because larger quarantine facilities were available there.[128]

The pandemic undoubtedly spread throughout Western Australia, but there is very little direct evidence of its impact on the State's Aboriginal population. At the time, Aborigines in Western Australia were not reported as suffering from the disease. Influenza was nevertheless causing considerable concern to Neville, as he indicated in his 1918–20 reports to parliament. No additional information about Aborigines was given by the Medical and Health Department, which published only aggregate data on Spanish influenza without differentiating between the racial origins of its victims. The pandemic of 1918–19 revealed characteristics different from earlier epidemics. One was its rapid movement across the world, south from Europe and America to South Africa, India, Australia and New Zealand. Before its arrival reports had reached Australia indicating that pneumonic influenza was killing vast numbers of people in many different countries, especially people with little immunity.[129] Strangely, those stricken were generally younger rather than older people. The mortality figures confirmed this: unusually, it was the strong, healthy and young adults who were most severely affected.[130] By contrast, among Aborigines most deaths were in the older age groups, particularly among those already weakened by other wasting diseases such as tuberculosis, venereal disease and pneumonia.

The influenza toll in Western Australia soon rose to 538 deaths among people of both sexes[131] out of a total population of 332, 732.[132] There are conflicting estimates of the numbers of Aborigines who perished. Neville maintained that the health of Aborigines in the southern region remained good,[133] and in his 1918–20 reports to Parliament he indicated that a total of only five Aboriginal deaths from influenza had occurred in 1918. No adequate health reporting system existed in Western Australia, and so information on epidemics was reported long after the event or not at all. In 1919, Neville reported that only 17 Aborigines had succumbed to influenza. A more recent 1985 claim puts the Western Australian mortality figure in 1919, at 150 Aborigines from both sexes.[134] The general population suffered most after May 1919, with a peak in July and a slow fall thereafter.[135] Commenting on his Department's work for the year ending 1918, Neville wrote that the pandemic affected Aborigines only to

the extent that 'a little' influenza appeared 'here and there'.[136] Unlike the reporting system in Queensland, which had the status of a legal death and disease register, the Western Australian reporting system came from protectors' reports, and only as estimates.

Neville repeated the words of the previous year in his next annual report to Parliament. 'The health of the natives throughout the State has been good,' he wrote.[137] His firm conclusion was that no epidemic of a serious nature had occurred among them.[138] It is entirely possible that deaths from influenza may have been misdiagnosed as pneumonia, given that medical personnel in America, Europe and Queensland had difficulty distinguishing between pneumonia and influenza.[139] The rise in deaths from influenza was swift in Western Australia by any measure, but it was not catastrophic, at least for Aborigines. In contrast to Queensland, the number of Aboriginal deaths from influenza in Western Australia appeared to be low. If this was the case, it reflected the effectiveness of the quarantine efforts of protectors, police, pastoralists and missionaries.[140]

The big health issue in Western Australia in 1919 was not influenza but the threat to whites of an apparent increase of leprosy among the Aborigines.[141] However, much of the fear was unfounded because only 22 confirmed cases of leprosy occurred there between 1898 and 1920. Leprosy had nevertheless been spreading from the Gascoyne area into the Fitzroy River region over the preceding decade.[142] As reports of increasing numbers of Aboriginal lepers circulated, white townsfolk in the Gascoyne, Pilbara and Kimberley districts feared for their safety. To protect the whites against infection, the police confined suspected victims on isolated and remote tidal islands, the practice adopted during earlier outbreaks. As a result, the first group of lepers from the Kimberley had been segregated on Barrett and Berzout Islands in 1908. From then to 1920 leprosy had continued spreading throughout the region.[143]

At the beginning of the decade Chief Protector Gale had had to cope with an epidemic of venereal disease and although he brought in a type of protection not envisaged by Walter Roth, he did involve protectors, missionaries and pastoralists more closely in the system of protection than at any previous time. Gale visited 'native' hospitals, ushered in the lock-up hospitals on Bernier and Dorré Islands, supported the national hookworm campaign, and involved his Department in caring, albeit in a rudimentary fashion, for lepers segregated on the islands in King Sound. One weakness

with Gale's administration was that some reforms introduced as a result of the Roth Royal Commission, for example collecting data on Aboriginal health, were allowed to lapse because of his particularistic concern with matters he regarded more urgent.

In 1915 important changes had been introduced which influenced the direction and substance of Aboriginal welfare in Western Australia for the next decade and a half. A new Chief Protector, Neville, presided over the introduction of segregated 'native' wards at country hospitals and the opening of the new 'native' hospital at Port Hedland. When the Spanish 'flu pandemic reached Western Australia it was impossible to know what its overall effect on Aborigines, was because comprehensive disease and mortality records were never kept, as they were in Queensland. Health services in the northern regions of the State began to develop[144] as the, flu pandemic subsided, and as leprosy began to dominate the minds of the Western Australian politicians and the settlers of the Kimberley and Pilbara regions. Austerity marked the way the State reorganised its protection policies and its management of its Aboriginal reserves. Austerity, too, was evident in the hookworm investigations as well as in managing the epidemics of leprosy and venereal disease. At the same time, the State's Aboriginal protection system began accepting ethnographic advice from particular pioneers in this field, most notably Daisy Bates and Walter Roth.

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17. *Ibid*., p.80.

18. *Ibid*., pf.

19. Fred Lovegrove, Superintendent Medical Officer, 'Annual Report of Lock Hospitals Bernier and Dorré Islands', in *Ibid*., pp.13-15.

20. Mary Anne Jebb, 1984 p.80; for evidence of this view, in Battye Library, Public Records, file 2425/2, Helen Lenihan, see footnote 142, p.87.

21. Daisy Bates, 1938 pp.97-98.

22. AN, 1/7, Acc. 2187, file 11/1932, 'Education and Domestic Training', some material on this file related to Bernier Island dated 16.5.12 (no folio numbers).

23. *Ibid*., pf.

24. Mary Anne Jebb, 1984, p.75; see also, AN, 120/4, Acc. 1003, file 82/1917, 'Health Act 1911-12, Amendments', p.folio 15; see also, the *West Australian*, 8 September 1919, p.5.

25. Mary Anne Jebb, 1984, p.79; see Protector of Aborigines, *Annual Reports*, WAVP, WAGP, Perth, 1911, 1912 and 1916.

26. Lovegrove, 'Lock Hospital Report', in Chief Protector of Aborigines, *Annual Report*, *Ibid*., pp.13-14.

27. Biskup, 1973, p.113.

28. J.B. Hickenbotham, 'Ulcerative Granuloma of the Pudenda in the Gascoyne District WA', in *Australian Medical Congress Transactions*, 1908, vol. II, pp.264-265, cited in Mary Anne Jebb, 1984, p.86.

29. Mary Anne Jebb, 1984, pf.

30. *Ibid*., p.77.

31. Hickenbotham, 1908, pp.264-265; see also, AN, 120/4, Acc. 1003, file 259/1905, 'Carnarvon, Dr Hickenbotham – suggests trip through Milinya for purpose of vaccinating natives', see memo to Dr Lovegrove on 1 May 1905, giving reasons for trip, which shows concern about the spread of primary and secondary syphilis among both white and Aboriginal in outlying rural regions.

32. Mary Anne Jebb, 1984, p.81.

33. AN, 120/4, Acc. 1003, file 2044/1918, 'Wyndham Road Board – Constitution of a Local Health Authority', see memos: 'from the District Medical Officer Arthur Adams to the Commissioner of Public Health Department Perth', dated 22 April 1918.

34. AN, 120/4, Acc. 1003, file 1959/1918, 'Darling Range Road Board – Local Board of Health'; see also, AN, 120/4, Acc. 1003, file 97/1919, 'Broome Local Health Board – Constitution of Road Board as Local Health Authority', pp.folios 1-20; see also, article in *The Medical Journal of Australia*, on Cabinet, April 1919, p.303, discussing approval of amalgamations of such bodies, folio 20.

35. AN, 120/4, Acc. 1003, file 6/1919, 'Quarantine and other Diseases Coordination of Commonwealth Powers re Quarantine', see letters from J.H.L. Cumpston Chief

Quarantine Officer to Everitt H. Atkinson, and from the Premier of Western Australia to the Acting Prime Minister of Australia.

36. AN, 120/4, Acc. 1003, file 888/1925, 'Interview with Dr Cecil Cook with Dr Dale', here Cook and Dale discuss changes to health system for diseased Aborigines including difficulties about building and locating lazarets and the incidence of venereal diseases.

37. AN, 120/4, Acc. 1003, file 630/1925, 'Leprosy in North West', see notes on outbreak of leprosy at Mt Shadforth, on the Fitzroy River, in the Kimberley district in 1918; see Davidson, 1978, pp.1-17.

38. AN, 120/4, Acc. 1003, file 579/1908, 'Treat Leprosy of Chinese patient raises protest by Derby Progress League, dated 17 June 1908'; see also, AN, 120/4, Acc. 1003, file 140/1908, 'Derby Leprosy Among Natives', this file also mentions infections from tuberculosis in Aborigines at Derby Hospital; but it also contains memos on directing police to assist in providing assistance to attend lepers, take them to island locations and assist doctors by bringing lepers from isolated islands in Kings Sound to Derby.

39. *Ibid*., pf.

40. AN, 120/4, Acc. 1003, file 82/1917, 'Health Act 1911-12', this file gives some background to the problems faced both by the Medical Department, the Protector of Aborigines, the State and the Commonwealth, and discusses the drafting of the 1911-12 Health Act; see also, AN, 120/4, Acc. 1003, file 1761/1907, 'letter from Acting Regional Medical Officer, Arthur Adams, dated August 28, 1907', this letter sets out the difficulties and frustrations that doctors had in dealing with the health system, the hospitals, the police and the magistrates regarding infectious diseases and calls for drastic action to implement treatment and stem the spread of a number of infectious diseases.

41. 'Derby Leprosy among Natives', in AN, 120/4, Acc. 1003, file 140/1908, see 'letter from Dr Cortis to PMO, dated 30 January, 1908'.

42. *Ibid*., see letter, 'Dr Cortis to PMO dated 18 February 1908'.

43. *Ibid*., see, 'letter from Dr Cortis to PMO dated 30 January 1908'.

44. *Ibid*., see reference in same letter 'Cortis to PMO'.

45. *Ibid*., pf.

46. 'Health Act 1911-12', in AN, 120/4, Acc. 1003, file 82/1019, folios 10-15.

47. On the question of the amalgamation of the Medical and Health Departments, see, 'Health Act 1911-12 Amendments', in AN, 120/4, Acc. No. 1003, file 82/1917.

48. Dr Maloney's Report, in 'Leprosy at Roebourne', in AN, 120/4, Acc. 1003, file 1262/1917, folio 43, dated, 1912, pp. folios 18-40.

49. Davidson, 1978, pp.98-100.

50. *Ibid*, pp.6-9, and pp.15-17.

51. 'Derby Leprosy among Natives', in AN, 120/4, Acc. 1003, file 140/1908, see note on file regarding building of lazaret at Derby, dated 25.5.1908.

52. 'Treatment of Chinese', in AN, 120/4, Acc. 1003, file 579/1908, see note by Theo H. Lawson, the President of Central Board of Health dated 25.4.1908, regarding lepers from Cygnet Bay, near Derby; see also, AN, 120/4, Acc. 1003, file 140/1908, entitled 'Derby Leprosy Among Natives', see telegram note from District Medical Officer (DMO) Lovegrove, dated between 26.2.1908 and 3.3.1908.

53. Suzanne Saunders, 1990, pp.169-170.

54. Davidson, 1978, p.95.

55. V.G. Heiser, 1914, pp.53-54.

56. *Ibid*., p.53.

57. *Ibid*., pf.

58. A. Johnston, 1915, p.285.

59. AN, 120/4, Acc. 1003, file 1262/1917, 'Leprosy Roebourne', see notes, folios 1-25, dated from 11.7.1908 to 14.11.1911, in particular notes from Gale to Under Secretary of Department of Fisheries, and long 1912 report on folio 43, by Dr Maloney about building of shelters for Aboriginal leprosy patients.

60. *Ibid*., folios 19-24.

61. Maunsell, in 'Leprosy at Roebourne', AN, 120/4, Acc. 1003, file 1262/1917', dated 15/11/1911, see 'Bezout Island – Visit by Dr Maunsell', on folio 2.

62. *Ibid*., folio 2, see 'Bezout Island – Visit by Dr Maunsell', on folio 2.

63. *Ibid*., pf.

64. *Ibid*., pf.

65. *Ibid*., folio 41.

66. *Ibid*., pf.

67. Gale, in 'Leprosy at Roebourne', AN, 120/4, Acc. 1003, file 1262/1917, dated 14.11.1911, see report, from C.F. Gale, Chief Protector of Aborigines to Under Secretary.

68. *Ibid*., folio 40.

69. *Ibid*., pf.

70. *Ibid*., pf.

71. *Ibid*., folio 42.

72. *Ibid*., pf.

73. *Ibid*., pf.

74. *Ibid*., pf.

75. *Ibid*., folio 43.

76. Davidson, 1978, p.17.

77. Gale, in 'Leprosy at Roebourne', AN, 120/4, Acc. 1003, file 1262/1917, dated 14.11.1911, folio 43.

78. William H. McNeill, 1976, p.50. The same form of treatment offered in the period from 1910 to 1940 continued until after World War II, but by 1950 new drugs offered a better prophylaxis than segregation, see R.G. Cochrane, 1947.

79. McNeill, 1976, p.164; see also, Suzanne Saunders, 1990, pp.168-169; see also, Suzanne Saunders, 1986, pp.1-33; see also, C. Cook, 1925; see also, J.H.L. Cumpston & F. McCallum, 1926; see also, M.J. Lewis (ed.), 1989, pp.207-218; Davidson, 1978, pp.94-97; Goldsmid, 1988 pp.81-89.

80. See Chief Protectors, *Annual Reports*, 1908-1920, used in the study by Cecil. E. Cook, 'The Epidemiology of Leprosy'.

81. Davidson, 1978; see also Mary Anne Jebb, 1984, pp.68-87.

82 1990, p.31; Ancylostomiasis duodenale was first recognised in 1838 by Dubini, an Italian physician, in a post mortem examination. The importance of the disease came to light in 1898 when Looss (accidentally) observed the penetration of the human skin by the hookworm larvae. The second type of hookworm was observed in 1902 by Stiles in the USA and he called this find, *Necator americanus*, and this is an African, Australasian and American species, while the former is located in Egypt, Europe. Australia has both species, see, in AA/1969/10, Item 17 I, 'Hookworm Disease and Control', pp.1-2.

83. 1990, p.31; see also, AA/1969/10/1, Item 17 K, 'Hookworm Disease', p.1.

84. Cumpston, 'Gastro-intestinal Diseases', in Lewis (ed.), 1989, pp.239-245; see also, AA/1969/10, Item 17 I, 'Hookworm Disease and Control', see, F.F. Longley, 1924, pp.1-7, this article reflects some of the concerns about rural health in Australia focusing on sanitation; see also, W.A. Sawyer, 1924, pp.1-6; see also, W.C. Sweet, 1924, pp.1-8.

85. AA/1969/10/1, Item 17 K, 'Hookworm Disease', p.1.

86. *Ibid.*, pf.

87. *Ibid.*, pp.2-5, see Figures, 1-4, which give the various stages of the metamorphoses of the hookworm.

88. *Ibid.*, pp.6-7.

89. *Ibid.*, p.7.

90. *Ibid.*, pf.

91. 1990, p.324; see also, Benenson, 1990, pp.219-220.

92. James A. Gillespie, 1991, pp.37-46; see also, J.A. Gillespie, in MacLeod and Denoon (ed.).

93. D.J.R. Snow, 1949, pp.68-69; see also, D.J.R. Snow, 1953, pp.49-51; see also, 1953, pp.67-75.

94. Goldsmid, 1988, p.43-44; note that areas in the plantation regions south from Cairns surveyed a number of institutionalised Aboriginal groups and some fringe-camp workers only. In Western Australia, Moore River and Catholic Missions near Broome and Derby offered the other sample group during 1918.

95. AN, 120/4, Acc. 1003, file 8297/1921, 'Hookworm Campaign – General Correspondence', see folio 13.

96. *Ibid.*, folio 1. These are 1921 facts but Cumpston confirms the program's development in Lewis (ed.),1989, p.239.

97. 'Hookworm Campaign', AN, 120/4, Acc. 1003, file 8297/1921, folio 1.

98. Lewis (ed.), 1989, pp.10-11, and pp.239-240.

99. 'Hookworm Campaign – General Correspondence', AN, 120/4, Acc. 1003, file 8297/1921, folio 13.

100. *Ibid.*, pf.

101. Gillespie, 1991, pp.36-42; see also, Fenner, 'Bancroft kindred' in Pearn and Powell, 1991.

102. A. Breinl, 'Ankylostomiasis', in *Transactions of Australian Medical Congress*, 1911, p.536.

103. *Ibid.*, pf.

104. Lewis (ed.), 1989, p.240.

105. 'Hookworm Campaign – General Correspondence', in AN, 120/4, Acc. 1003, file 8297/1921, folios 25-27.

106. *Ibid*., p.folio 28.

107. AN, 120/4, Acc. 1003, file 262/1902, 'Official Correspondence between WA and NSW on Health Procedure', this file refers to, among other things, epidemics and plagues and how other states dealt with epidemics among Aborigines; see also, AN, 120/4, Acc. 1003, file 34/1906, 'Kalgoorlie Hospital', see 'letter from Stanley Tratman, Secretary of government Hospital Kalgoorlie to PMO Perth, dated August 6 1906'; see also, AN, 120/4, Acc. 1003, file 292/1901-1902, 'Hospital treatment of "Aboriginals" Principal Medical Officer Claims', see 'letter from PMO to Chief Protector', dated 8 October 1902, p.folio 5; see also, AN, 120/4, Acc. 1003, file 282/1902, 'Death of Edward Whitworth in Peak Hill Lock-up Hospital', see 'letter from PMO to Under Secretary of Premier's Office re payment of burial, health and medical costs and fees. See also folios 2 and 3, re telegrams from Constable McGinley about treatment of a sick Aboriginal vagrant with infectious disease; see also, AN, 120/4, Acc. 1003, file 354/1904, 'Wyndham Hospital Payment of Fees', see 'memo from Dr Belgrave to PMO, re fees for sick and diseased Aboriginal Women', folio 5; see also, AN, 120/4, Acc. 1003, file 32/1906, 'Geraldton Hospital Fees Collection', see extensive documentation on fee payments and other costs for Aborigines at local rural hospital and sanatoria.

108. AN, 120/4, Acc. 1003, file 34/1906, 'Kalgoorlie Hospital "Fees Collection"', although there is no mention of Aborigines other files document the struggle to retrieve fee for service from white and Aboriginal paupers and from employees of pastoralists, folios 1-10.

109. AN, 120/4, Acc. 1003, file 459/1906, 'Re Medicine Chests for outlying Districts', see 'letter to Dr Hicks by PMO Lovegrove, on inquiry by H. Gregory from Edgar Owners and Company', dated 7.3.1906.

110. AN, 120/4, Acc. 1003, file 121/1906, 'Father Lyon Weiss, and Aboriginal treatment in hospitals and etc.', see 'letter from Father Weiss to the President and Medical Board of Western Australia', dated 25 September 1905 and 11 December 1905. The matters cover the right of hospitals, doctors and health staff to refuse treatment to sick Aborigines.

111. *Ibid*., pf.

112. *Ibid*., pf.

113. *Ibid*., pf.

114. *Ibid*., pf.

115. 'Health Act 1911-1912 Amendments', in, AN, 120/4, Acc. 1003, file 82/1917, folios 1-15.

116. 'Leprosy at Roebourne', in AN, 120/4, Acc. 1003, file 1262/1917, p.folio 40.

117. AN, 120/4, Acc. 1003, file 1325/1925, 'Narrogin Hospital: treatment of Natives', folio 65, see note on file about concern about the quality of treatment of Aborigines at Narrogin hospital dated 13 November 1911.

118. *Ibid*., p.folio 65, see reference, on 26 August 1916, to building of Narrogin Hospital Aboriginal Ward.

119. *Ibid*., see, Memo: from 'District Medical Officer to Perth Medical Officer of Medical Department', dated 7 November 1919.

120. *Ibid*., see Memo: 'Medical Department to Chief Protector of Aborigines', dated November 7, 1919.

121. *Ibid*., p.folio 70.

122. *Ibid*., p.folio 70.

123. Biskup,1973, p.154.

124. Anna Haebich, 1985, p.323.

125. *Ibid*., pp.324-333.

126. Burnet, 1953, pp.103-111; see also (Sir) F. Macfarlane Burnet, and D.O. White, 1972, pp.202-205; Goldsmid, 1988, pp.14-16.

127. Lewis (ed.), 1989, pp.319-320.

128. *The Brisbane Courier*, Tuesday, October 22, 1918, p.6.

129. 1990, p.505.

130. Lewis (ed.), 1989, pp.313-319.

131. *Ibid*., p.319.

132. Wray Vamplew (ed.), 1987, pp.26-27.

133. Chief Protector of Aborigines, *Annual Report*, WAPP, 1919, pp.3-6.

134. Anna Haebich, 1983, pp.323-333.

135. Lewis (ed.), 1989 pp.317-318.

136. The Chief Protector of Aborigines, *Annual Report*, 1918, WAGP, 1919, p.8.

137. The Chief Protector of Aborigines, *Annual Report*, 1919, WAGP, 1920, pp.6-7.

138. *Ibid*., p.7.

139. Burnet, 1953 pp.114-115; see also, Alfred W. Crosby, 1989, pp.10-11.

140. See reports in, Chief Protector of Aborigines, *Annual Reports*, 1918-1919.

141. Mary Anne Jebb, 1984, p.81.

142. AN, 120/4, Acc. 1003, file 630/1925, 'Leprosy in North West', see notes on outbreak of leprosy at Mt Shadforth, on the Fitzroy River, in the Kimberley district in 1918; see Davidson, 1978, pp.1-17.

143. AN, 120/4, Acc. 1003, file 579/1908, 'Treat Leprosy of Chinese patient raises protest by Derby Progress League, dated 17 June 1908'; see also, AN, 120/4, Acc. 1003, file 140/1908, 'Derby Leprosy Among Natives', this file also mentions infections from tuberculosis in Aborigines at Derby Hospital; but it also contains memos on directing police to assist in providing assistance to attend lepers, take them to island locations and assist doctors by bringing lepers from isolated islands in Kings Sound to Derby.

144. AN, 120/4, Acc. 1003, file 82/1917, 'Health Act 1911-12', this file gives some background to the problems faced both by the Medical Department, the Protector of Aborigines, the State and the Commonwealth, and discusses the drafting of the 1911-12 Health Act; see also, AN, 120/4, Acc. 1003, file 1761/1907, 'letter from Acting Regional Medical Officer, Arthur Adams, dated August 28, 1907', this letter sets out the difficulties and frustrations that doctors had in dealing with the health system, the hospitals, the police and the magistrates regarding infectious diseases and calls for drastic action to implement treatment and stem the spread of a number of infectious diseases.

5

Austerity, hookworm and leprosy: Social instability arising from poor Aboriginal health in Western Australia, 1920–30

In 1920 and again in 1926 the Western Australian Government reformed the administration of Aboriginal affairs. It changed the structure although the austerity that typified its protection policies continued. In the process, missionaries became surrogate protectors in the east and south of the State. In addition, the committee of the Australian Hookworm Campaign completed its final surveys in 1920, and the report on this project was made public in 1924. In the south and east of the State, the austerity measures prompted greater movement of Aborigines away from government reserves. This in turn called forth a new kind of missionary, one that in effect was a protector located in the fringe-camps. In the north, the Commonwealth began taking an interest in leprosy as international critics attacked the treatment available in Australia. For the first time, the Government began accepting ethnographic advice oriented towards Aboriginal administration.

In a new departure, the protection agency was split into two separate regions, one for the State's north and the other for its south. The northern region included everything north of the 25th parallel and east to the Northern Territory border, and encompassed the Gascoyne, Pilbara and Kimberley districts. The Chief Protector for this region, A.O. Neville, previously Chief Protector for the whole State, also became Secretary in charge of a new Department of the North West.[1] In the south, Aboriginal administration and protecting became the responsibility of Fred Aldrich, who had been the State's Inspector of Fisheries since 1911.[2] Under the departmental restructure in 1920 he was appointed Chief Inspector of Fisheries and Protector of Aborigines for the southern region. The fishing industry had an important stake in the southern waters, including whaling

and deep ocean fishing. Aldrich's Aboriginal protection region extended south from the Gascoyne, taking in all of the wheat belt, the eastern goldfields and the whole area south of Perth to Albany, and on to the South Australian border.[3] His general unfamiliarity with race questions, and particularly Aboriginal health, prevented Aborigines from getting to know him and enabled him to remain aloof from them while implementing the Government's austerity program.[4] Not surprisingly, when the administrative arrangements changed again in 1926, southern Aborigines still looked to Neville to correct the anomalies they had experienced under Aldrich.[5]

An important development of the early 1920s was the release in 1924 of the results of the hookworm survey. Although some survey teams focused on Aborigines, the survey was not specifically an Aboriginal program. Nevertheless results revealed high levels of parasitic infestation among Aborigines. A pilot survey begun in 1911 by the Australian Institute of Tropical Health had led to a further survey that began in 1919. Following funding from the Rockefeller Foundation, a national testing program began in October that year and continued until June 1924. The Australian Hookworm Campaign researchers, as the program became known, carried out a number of surveys of the Australian population to ascertain the location of major hookworm infestation. The survey team examined human fæces in sample populations in each state. Along with the search for the presence of hookworm, other parasites were also recorded. The results showed that of the 248, 721 Australians examined, 48, 256 or 19.4 per cent were infected with hookworm.[6]

According to W.C. Sweet, a contemporary observer, the highest infestation rates were in Aboriginal camps in the tropics.[7] In such camps the rate of infection was similar to that of Papua and New Guinea.[8] Some parasites depended on both the moist temperatures of the tropics and the insanitary habits of the population. Others were found in drier interior regions as well, and such parasites did not rely on the rainfall of moist tropical regions to spread, as was the case of hookworm.[9] Recent indications are that hookworm was never as serious as some medical administrators suggested. The parasite causes anaemia and can be fatal, but the kinds of parasites found in Aborigines at the time of the survey could be found in many other Australian populations, small and large.

J. Gillespie has recently argued that the hookworm project was a political

device presented to the Federal Quarantine Agency as a means of expanding into a fully fledged 'Public Health' Department, a goal achieved by 1920. Gillespie claims also that most of the parasites found among the Aborigines who were screened proved relatively harmless.[10] The real problem related to the complications arising from prolonged hookworm infestation. The worms could travel through to the bloodstream and on to the lungs and other organs. Internal bleeding followed and anaemia developed, thereby reducing the energy of the infected persons.[11] Throughout the world the social stigma of the disease caused it to be labelled as 'the germ of laziness'.[12]

The Australian Hookworm Campaign project was enthusiastically supported across Australia. It had already operated a number of pilot surveys extending back before the First World War. The Campaign commenced once more in Western Australia in April of 1921, when Dr Atkinson, the State's Principal Medical Officer, was notified by the head of the new Commonwealth Health Department, J.H.L. Cumpston, that hookworm existed along the north-west coast, several cases having been reported from Beagle Bay near Broome.[13] Cumpston was unable to say whether those infected were Aboriginal, but Atkinson confirmed that they were, and hookworm had been located in their mission communities.[14] The Western Australian results indicated that 308 or 10.8 per cent of the 2846 people surveyed were infected. Although this number represented only about half the national rate of 19.4 per cent,[15] it was sufficient for the State Government to agree to become involved in the national campaign to eradicate the disease.[16]

The District Medical Officer in Broome, Dr Hayes, asked Atkinson whether the Commonwealth wanted the 'stools' of Aborigines from Beagle Bay and 'half-caste' camps around Broome sent to Perth for testing, as suggested by the new Director of the national campaign, Dr Sawyer. The costs, he said, would be recouped from the Commonwealth. The expenditure was approved in July 1921.[17] Despite that, three years later Cumpston was writing to ask what action the State Government was taking about the endemic hookworm at Broome and Beagle Bay.[18]

On 24 August 1921 Sawyer wrote a memo to the Superintendent of the Moore River Aboriginal settlement (near Mogumber, 110 kilometres north of Perth), saying that, following a phone conversation with the

Chief Protector, they had arranged for an Aboriginal girl, Ruth Clinch, to return from treatment in Perth by train and that someone from the settlement should meet her at the Mogumber railway station.[19] The Superintendent was also advised that a Dr Baldwin would visit the reserve to investigate hookworm there and also at other places, including Laverton, 670 kilometres north-east of Moore River and 250 kilometres north of Kalgoorlie. In his reply the Superintendent advised Sawyer of the geographical movements of Aboriginal people who sometimes camped on his reserve. For example, he explained that Aborigines moved across the State when ceremonies were in process and often travelled for long distances.[20] In addition to the itinerant worker population from nearby New Norcia, Aborigines had settled at Moore River from as far away as Laverton. These people used the settlement as a safe haven when looking for work in the south.[21] The distances that these Aborigines were travelling indicated that they had acquired considerable geographical mobility. It also shows how quickly infection could travel from one group to another across vast distances.

In September 1921 Dr Sawyer wrote to the Manager of the Carrolup settlement (near Katanning, 255 kilometres south of Perth) to say that 7 per cent of the 300 Aboriginal adults and children there had become infected with hookworm. He also said that Dr Baldwin had notified him that Aborigines at the reserve were hosts to a number of other parasitic worm infections. These people had travelled from northern areas to work near New Norcia. From there they had moved south to Guildford near Perth, and then to other southern fringe and settlement camp locations. Notes on record show that health inspections took place as far east as Eucla in South Australia in the same period.[22] About 50 people were named in both the infected and itinerant category, among them were about 10 young children. Some of these people had been treated and had moved on only to be re-infected at other camp-sites, which demonstrated the difficulty in treating highly mobile individuals *en masse*.[23]

A July 1924 newspaper report about the Commonwealth's representations to the State Health Minister, H.B. Jarvis, indicated that health authorities had won the battle, at least for the time being, against hookworm infestation.[24] The hookworm campaign continued in other parts of the State and included examinations of Aborigines living both on government reserves and on government camp-site excisions.[25] These reserves, created

by the Chief Protector, were becoming permanent living places for some Aboriginal groups.

Although the Government continued to expand the supply of rations to newly established missions, it's austerity measures placed stress on protection agencies and presented problems of access by Aborigines to existing services. This in turn encouraged greater Aboriginal mobility away from established reserves and missions. The Aborigines' increasing mobility prompted the emergence of a new type of missionary, one that dwelt among them in their camps as *de facto* protectors. The Chief Protector began to supply rations and funds to missionaries to manage the Aborigines who had recently abandoned their bush life-styles. The two most notable regions where this happened were south-east of Perth, around Albany and Esperance, and the east central mining regions such as Leonora, Wiluna and Mount Margaret. In general, Aborigines of mixed-descent in the south lived either on privately leased sheep, wheat and cattle properties as labourers,[26] on missions and government reserves, or on government-owned fringe-camp sites. Their health conditions there were generally poor. In 1920 the residents at Moore River, for example, were variously suffering from scabies, pneumonia, influenza and tuberculosis. That year, an epidemic of influenza caused three deaths and the hospitalisation of 106 people.[27]

Nurses delivered primary care while the administration of public health remained with the Fisheries Department. Sixty years later a Moore River resident remembered that Aborigines had to be 'nearly dead' before a doctor would visit them. The same happened with a dentist. If any person suffered from toothache the Superintendent would take the tooth out.[28] At the same time, small family groups in the south, who became dissatisfied with institutional life on mission or government settlements, began moving in ever increasing numbers to fringe-camps. These were reserved lands set aside for use by fringe-camp dwellers and deliberately provided by the Government for that purpose. Such camps were in common use during the mid-1920s.[29] Migration to the fringe-camps was caused primarily by the implementation of A.O. Neville's 'native settlement scheme'.[30] One effect of this policy was that, in the south, unemployment throughout the 1920s increased for people of mixed-descent as they chased casual farm work. The Department vigorously pursued a policy of encouraging people to move into white society. As

people were released from the constraints of reserve and mission life, they moved in increasing numbers to the fringe-camps. The reserves were mostly occupied by those Aborigines who had either come west from desert areas for work or were migrants from the Carrolup settlement near Katanning. They had moved to the fringes of rural service towns from the missions and more remote government reserves, and then became casual labourers on soldier settlement and land development schemes after the First World War.[31]

Once on their camp sites, the Aborigines were left to fend for themselves. It was assumed that they brought with them a natural social order. There was also an assumption that hygiene and healthy living would be a part of their culture when relocated. Both assumptions proved wrong. Their health was affected by their circumstances and certainly by their pursuit of employment. Local white townsfolk regarded their camp sites as 'unsightly' and a 'menace to health'.[32] Although there was doubt about the actual evidence, local opinion was concerned lest social chaos resulted when Aboriginal farm workers, their families and 'undesirable' whites camped together. Further, in the camps there was a lack of authority which led to heavy drinking and fighting.[33] In 1924, the local Council at Kellerberrin, together with the local Medical Officer, told the Health Commissioner that Aborigines were making the local camping ground 'unhealthy' because they were camping too close to the catchment area of two government dams. The camps were without proper sanitation, which, according to the Shire Council, represented a threat to health.[34]

Despite some government resistance, the missionaries continued to find new ways of proselytising camp-dwellers. One way was to take on the mantle of advocate for the fringe-groups' problems by directly intervening between the government agencies and campers. Another was for the missionaries to live in the camps. There, they held religious gatherings and performed baptisms, weddings and burials whenever occasion demanded. Some became spokespersons for the campers in disputes with townspeople. Providing clothing for the destitute and food for the hungry campers was another service the missionaries provided. They also commenced child minding and some camps had their own schools. The missionaries also helped Aboriginal families in need of health care to communicate with the staff at country hospitals.[35] Migration from missions and reserves swelled the numbers of people living in fringe-

camps in the south. As their numbers rose, so did the spread among them of highly contagious diseases such as tuberculosis. Some children were removed to places like Moore River and the Swan River Mission in Perth to be closer to medical treatment. Other infectious diseases, especially influenza, proved more destructive.[36] Tuberculosis could wipe out whole families but influenza could remove an entire fringe-camp. During the 1918-19 Spanish influenza pandemic, 43 people among the southern reserve populations of about 1000 people died. Neville claimed, as he had done the previous two years, that in the southern region the health of Aborigines remained good, but the health reporting system was via protectors not trained for such a task.[37]

The spread of infectious disease among Aborigines and resistance by the health services to accept them as patients were two concomitant effects of the Government's austerity measures in the south. At Moore River in 1921-22, about 106 residents contracted influenza with three deaths resulting. In the same year, at Carrolup, some Aborigines died after the Katanning doctors refused them treatment. During the 1920s various camp dwellers complained to the Chief Protector about being refused treatment by district hospital medical staff. Such prejudice often forced Aboriginal patients to travel long distances before finding a doctor who would treat them. Another complaint about Katanning came in 1927. Aborigines rushed their sick relatives to Gnowangerup, where at least three subsequently died.[38] The local Road Boards were responsibile for running local hospitals, and they often opposed granting hospital access to the Aborigines. The Commissioner for Public Health had powers under the P*ublic Health Act 1911-12* to compel hospitals to admit Aborigines but local interpretation of the legislation always meant that hospital staff usually had the final say. Court magistrates, local police and protectors similarly failed in their duty to require that Aborigines be admitted.[39]

The austerity measures instigated everywhere by the Government in 1922 placed stress on the living accommodation at Moore River. The 1923 Annual Report of the Aborigines Department showed that about 400 inmates were living at Moore River. This was 1.5 times the 1922 figure of 261. A reduction in incurred costs from £7,711 in 1923 to £5,500 in 1924 was then imposed. The reserve management responded by reducing building maintenance, which in turn led to problems with vermin, water supply and a general deterioration in living conditions.[40] The Department's austerity measures prevented it from tackling the

overcrowding of dormitories, where large numbers of Aborigines were forced to sleep very close together. Economising by the Department, then, had created the conditions for rapid spread of infectious diseases among the residents. In adults, the diseases most commonly transmitted in this way were venereal diseases, influenza and tuberculosis. In children, the diseases were most often scabies and parasitic infections such as hookworm. The denial of access to hospitals exacerbated the illnesses resulting from overcrowding. The reluctance of the hospitals to admit Aborigines was to lead to a 25-year struggle between the Aborigines, the State health authorities and the local government bodies before Aborigines gained freedom of access.

Although fringe-camps had their origin around the turn of the century, their increasing use in the twentieth century may be dated from the closure of the government reserve at Carrolup in June 1922. The closure of Carrolup propelled people in two directions. The strong and healthy gravitated directly to fringe-camps, where the missionaries tended them if they became ill. The Chief Protector transferred the sick, elderly and younger residents directly to Moore River, which lacked proper health facilities. Carrolup had originally begun as a ration depot and refuge in the 1880s and by 1914 had then become a managed reserve. Its closure during the period when Aldrich was responsible for Aboriginal administration in the south resulted directly from the austerity measures he put in place. Its closure also ensured that sick and frail Aborigines would have to wait prolonged periods for treatment.[41] Meanwhile, the Aborigines who moved to Moore River believing they would be better off were sadly mistaken.

Many years after his retirement Neville recalled that relations between the Aborigines Department and health authorities had deteriorated throughout the 1920s. The clauses of the *Aborigines Act 1905* relating to health could not alone correct insanitary living conditions in the camps in the absence of adequate funding. Payment of medical expenses by the Aborigines Department, still in force in 1920, was the means by which Aborigines anywhere in the State were meant to obtain primary health attention. But this proviso did not guarantee access to care because of the shortage of hospital beds in country hospitals, which remained a continuing problem. Even when special arrangements for Aborigines were in place, there was no obligation placed on hospital staff and local doctors to treat these patients.

Hospitals with special wards for Aborigines often put white patients in them when beds in the general wards became scarce. Almost from the day he took up duty, Neville struggled unsuccessfully to keep health facilities open for use by Aborigines. The records reveal a long running battle between protectors and hospital administrators aimed at forcing the latter to admit sick Aborigines. In most cases the Aboriginal protection agencies paid for the erection of separate shelters for Aborigines, in some cases tents, at the rear of country hospitals. Even when Neville dealt directly with offending rural hospitals himself he could expect that they would disregard his remonstrations. At the same time, changing economic circumstances in the 1920s forced him to spend less on what, some argued, was a disappearing 'Aboriginal problem'.[42]

Not surprisingly, fringe-camp dwellers wanted the same health services as Aborigines living on the missions and reserves. Lance Williams, while relating his story of living on Gnowangerup mission during the 1980s, told Anne Haebich that 'in 1926 a tent was provided for Aboriginal patients at Gnowangerup hospital'.[43] When the reserve at Carrolup opened a clinic the tent was transferred to the reserve. Williams attended the school run by the missionaries at the time, and he recalled how, 'in those days, Aborigines were not allowed into the hospital at Gnowangerup'.[44] When other missionaries came into the camps 'they gave us a big sleep-out, a big canvas tent on a camping ground. My sister had an abscess on the brain then, just behind the ear, and you know they had to have the operation in this tent. The doctor, he was a German bloke, and matron and two nurses done it'.[45]

Further changes to Aboriginal administration occurred in 1926 when a new Aborigines Department was formed following the abolition, after only six years, of the Departments of North West and Fisheries. As part of a general increase in interest in Aboriginal issues, health featured prominently in the five years from 1925 to 1930. This did not mean an automatic acceptance by country hospitals of the need to allow Aborigines access to hospital and primary medical care, however. This matter remained unresolved. Neville wrote to the Secretary of the Medical Department about 'the large number of natives at Narrogin … requiring medical attention'.[46] He reminded him that Narrogin, a Government-funded hospital, had an obligation to treat Aborigines who sometimes needed treatment. He indicated further that it should revert 'to its original purpose, or some other arrangement [should] be made for the treatment at hospital of natives, and thus avoid unnecessary expense'.[47]

Two female missionaries of the United Aborigines Mission,[48] Misses Bradshaw and McRidge, became concerned at the poor education Aboriginal children were receiving[49] and they started a mission at Gnowangerup in January 1930. In the beginning the mission developed along similar lines to missions in other places. It started with a small bough shed school which had up to forty children attending within a few years. Classes were later moved to a small hall, which also served as a church, and a small hospital was erected. The Aboriginal families camped in different places. According to Lance Williams, they made 'little tin places made out of kerosene tins, used to go to the dump … cut up the tin and make a sort of tin place'.[50] This was a significant change in living patterns and in personal and group hygiene.[51]

The mission population at Gnowangerup grew rapidly and by 1928 there were one hundred Aborigines living there regularly. At the same time the camp was evolving into a little town, with its own store, school, hospital and camp-site. 'The women worked in Gnowangerup washing clothes for the white ladies at about 5 shillings for a whole day's washing, hanging it out, fetching it'.[52] They also did a lot of house work for the townsfolk.[53] These Aboriginal families differed from the usual repressed mission and government settlement groupings. More independent, they worked as kangaroo shooters, contract fencing workers, farm labourers and shearers. Many also earned money by felling trees to supply farmers with fencing posts.[54]

Political organisation by people of Aboriginal descent proved difficult to achieve. Various matters, often health-related, usually got in the way. In 1928 a group of mainly male Aborigines of mixed-descent took a political stand against the State Government, when, as a Perth newspaper pointed out, they banded together 'in order to obtain the protection of the same laws that govern the white man'.[55] The idea was the 'brainchild of a half-caste farmer from Morawa district, called William Harris, and a delegation led by him met with Premier Collier'. The delegation told Collier that they 'wanted to live up to the standards of the white man but to do so they needed to be exempt from the Aborigines Act, and allowed to live our lives in their own way'.[56] They owed their confidence to their Christian background. Various Protestant denominations, mainly the Salvation Army, the United Aborigines Mission and the Anglicans, had worked hard to convert fringe-camp people to their respective denominations. Such denominations fostered the emergence of a radical

group of Aborigines of mixed-descent who wanted equality with whites.[57] However, as a 'ginger' group for change, the Harris group failed to make much impact on either the Government or other Aborigines, who may have hesitated for fear of reprisal. The historian Anna Haebich, quoting M.C. Howard, an anthropologist who worked in the region 50 years later, has demonstrated that this delegation had little influence with either Aboriginal or white Western Australians. 'The emergence of autonomous Aboriginal political activity in the inter-ethnic field was discouraged by issuing exemption certificates to those deemed sufficiently acculturated', Howard found.[58]

Throughout the 1920s and 1930s tensions existed between Aborigines Department administrators and the various missions. In converting the Aborigines the missionaries tended to institutionalise them. The missions opened during the 1920s differed markedly from those established earlier. The newer missionaries acted as servants rather than tutors and had prescriptive dogmas to impart. In the southern region, 'all the old style church institutions had closed by 1921',[59] and this provided the churches with new opportunities for the evangelical proselytization of camp peoples.

Meanwhile, in Western Australia's north, two notable developments occurred in the Kimberley. One was an attack on the policy of isolating lepers; the other was a Commonwealth-funded leprosy survey of the Kimberley. The Kimberley had produced 28 leprosy patients out of the progressive state total of 35, most of whom came from the northern regions and were Aboriginal.[60] The preponderance of Aborigines among the lepers heightened the fears of white residents in remote northern towns such as Roebourne, Broome, Derby, Wyndham, Fitzroy Crossing and Kununurra. In the 1920s health authorities were forced to abide by the law and provide treatment, whereas in earlier decades the white residents, in collusion with the police, health and protection authorities, had simply shipped lepers out to isolated islands, as mentioned in the last chapter.

The protection legislation had always imposed an obligation on the protectors to provide medicines, medical attendance and shelter for sick, aged and infirm Aborigines.[61] We have already seen that this legislation created tensions between the Department and the health agencies.

Antagonism between the Health and the Aborigines Departments arose over treatment of Aboriginal lepers. This centred on the responsibility for providing food, shelter and land to erect hospitals and clinics, and on responsibility for the care of Aboriginal patients. Neville always assumed that once Aborigines fell sick they became the responsibility of the health authorities. Neville's inertia in relation to lepers perhaps arose from his failure to be able to guarantee Aboriginal health care in general. The health system operated in such a way that people paid for services either when receiving treatment or demanding a service. Payment must therefore come from the Aborigines themselves or the Chief Protector, employers, police or the courts. Aboriginal lepers suffered more than other Aboriginal patients because they lost all their liberties as soon as a positive diagnosis of their condition was made. The Chief Protector was powerless to help the lepers in the face of a more powerful Health Department,[62] which exercised almost unlimited power to apprehend and segregate Aborigines with leprosy (or other infectious diseases). The health agencies then expected the Chief Protector to pay the maintenance costs of Aboriginal lepers in custody.

In the early part of the 1920s very little change had occurred in screening practices and the collection of suspected leper sufferers for transportation to the nearest hospital or lazaret. Aborigines suspected of harbouring the infection were kept in custody until the pathologist's diagnosis was known. Those who were suspected of being infected were gathered from their distant bush camps by police disease patrols. Once in custody they travelled long distances (normally chained to each other) and were marched by foot or carried by bullock wagon to a central screening point, usually Roebourne, Broome, Derby or Wyndham.

Disputes persisted over the administrative responsibility to feed the lepers while they were travelling to the lazarets at Wyndham, Broome and Derby. The screening process, as the test samples went south to Perth and the results were returned, usually by radio, took weeks, during which time the suspected lepers still had to be fed. Their food was normally supplied either by private contractors, who sometimes worked in other government employment, or hotel kitchens in the Kimberley towns. If the tests proved negative, the suspects travelled home by themselves—a highly dangerous exercise. Such arrangements were harsh, and the infectious diseases legislation made little concession to humanitarian concerns.[63]

One of the Aboriginal Department's employees, F. Luyer, who attended leprosy patients as they came in from the bush in 1927, requested additional salary payments for feeding the members of the contingent. In November that year the Chief Protector approved the payment of five shillings for each leprosy patient he fed before their transportation to further destinations. On 27 November, Luyer wired the Commissioner for Public Health to request permission to build a shelter at the cost of £10. He also requested urgent action to maintain the security of the quarantine compound because some patients would be sure to escape.[64] His correspondence reveals the practical difficulties of operating a disease patrol in which a number of agencies held an interest.

The relevant legislation was the *Public Health Act 1886*, which allowed officials to isolate persons suspected of having the disease. As early as 1889 general statutes on leprosy existed, but leprosy was not a notifiable disease until the enactment of the Commonwealth quarantine legislation in 1908.[65] On the question of legislating for notifying infectious diseases, Western Australia followed Victoria, where legislation bestowed wide powers for isolating people suspected of being lepers.

Commonwealth reluctance in 1920, and the sudden upsurge of leprosy cases, tended to confuse the politicians and bureaucrats of State and Federal governments alike.[66] The confusion intensified because the Western Australia Government took a position that distanced itself from full responsibility for leprosy. The State felt that the Commonwealth held responsibility for controlling exotic diseases. Leprosy, in particular, was a disease that northern townsfolk believed came from mariners and pearlers, who were considered as foreigners. Doctors saw some strains of venereal disease as peculiar to Aborigines, where the body wasting appeared similar to leprosy; so it was that rural townsfolk believed that leprosy was a disease that mainly peoples other than whites contracted. The disease, many hoped, would not spread to white settler populations of the north-west.[67]

Segregation, even on humanitarian grounds, was never an easy choice for doctors, whether publicly or privately employed. Segregated hospitals already existed and had been in use to isolate venereally diseased Aboriginal patients since the late nineteenth century. In defence of the Western Australian medical system, they mistakenly applied models used by Europeans, mainly under epidemic conditions.[68] When the problem of

leprosy arose in the far northern areas of the State the solution appeared obvious.

Doctors and administrators did not appreciate it at the time, but leprosy was never very contagious. Rumours of an increase in the number of lepers therefore struck fear in the hearts of the medical profession and the public alike. Race prejudice ruled the placement of lepers in treatment programs. Chinese, Manilamen (Philippinos) and Aborigines were placed together in the same location; white patients were kept apart. Cook, in his 1922-24 study, drew the conclusion that the causes of the leprosy epidemics originated in the social conditions adopted by the few white pastoral workers who cohabited with Aborigines in the many fringe-camps of the northern towns.[69] Throughout the 1920s a number of small outbreaks did occur. These involved all races, but the majority were Aborigines. Even though the numbers of people contracting leprosy were small in the 1920s, the stage was being set for a huge increase in the next decade.

Increasing interest in leprosy arose from two sources. The first were the white settlers, who feared that some of them would soon become infected and join the leper ranks. Indeed, leprosy was spread to white society from Aborigines, gaining a foothold in the white community by 1920.[70] The upsurge in interest by the rural settler community was partly due to its spread among white townsfolk. The second source of interest was the Commonwealth, which expressed its intention of investigating the causes and prevention of leprosy as well as educating the public in matters of public health.[71] To complicate matters further, as early as 1918 the Wyndham Road Board had sought and gained approval from the Western Australia Government to act as the local health authority, an approval affirmed in law on 7 August 1918.[72] Parallel to this development, the Western Australian quarantine position was considered by the Federal Cabinet, which decided to list the matter of leprosy at the next Commonwealth and State Ministers' Conference.[73] During the following meeting, in January 1919, the Ministers discussed the question of coordinating Commonwealth and State powers in relation to quarantine and disease.[74]

In a memo written in 1920 to the Western Australian Minister for Health, Everitt Atkinson, the State Public Health Commissioner, pointed out that the Commonwealth authorities had responsibility for the isolation and

care of quarantinable diseases arriving in Australian ports by ship. The State authorities, by contrast, were responsible for diseases arising in the State.[75] Cumpston, the head of the newly created Commonwealth Public Health Authority, wanted something else. He proposed that in addition to its quarantine responsibilities, his agency should research the causes of disease and death, investigate methods of preventing disease, collect sanitation data and, finally, educate the public on issues relating to public health.

Cumpston also wanted the Commonwealth to subsidise States with any well-directed effort to eradicate disease and, using a system adopted in the United States of America, coordinate public health measures without jeopardising State sovereignty. Without exception, by October of 1920 the States saw in such moves a covert means of encroaching upon their powers. The Commonwealth had been subsidising Western Australian venereal disease programs from as early as 1907. The subsidies went directly into treating mostly Aboriginal sufferers. The Western Australia Government reacted to public fears by pressing the Commonwealth for subsidies to attend to the increasing number of lepers.[76] But these funds were to be spent on old methods of segregating sufferers from the public and transporting them away from Western Australia.

As the negotiations over responsibility for leprosy continued, an international controversy took public prominence. In the early 1920s Sir Leonard Rogers, a researcher into leprosy, and his co-worker, Ernest Muir, wrote a paper critical of the way Australia treated leprosy patients. Both men were leaders in the treatment of leprosy in India and Africa. At a conference of the Pan Pacific Science Congress in Sydney in 1923, Rogers argued that the policy of isolating leprosy patients deterred them from coming forward to be treated by medical practitioners.[77] Once confined to lazarets, the standard of lepers' treatment in Australia fell below that available in other countries. Rogers claimed that Australian policy had not been able to reduce the incidence of leprosy and new cases had been recorded each year, showing that the disease continued to increase.[78] Rogers believed that leprosy was reaching epidemic proportions in the Aboriginal populations of northern Australia.[79] At that time, Australia had a series of leprosaria located in a number of States. Western Australia had establishments at Roebourne, Broome and Derby; the Northern Territory had a facility on Mud Island; Queensland catered

for leper patients on islands off the coast of Cairns; and the New South Wales facilities were located in Sydney. In all instances, isolation remained the main form of treatment in 1920.

The Commonwealth's interest in the epidemiology of leprosy manifested itself when Dr Cecil Cook began a study of leprosy in Australia that resulted in a major report on the prevalence of the disease in northern Australia. Cook had been born in England in September 1897, the year in which J. Ashburton Thompson had published his prize-winning essay on the first Australian epidemiological survey of leprosy.[80] Cook's father, a doctor, had migrated to Barcaldine in Queensland, where he established a private medical practice. Cecil Cook studied medicine at Sydney University. On graduating in 1922, he was awarded the prestigious British Wandsworth Research Scholarship, a public health award, which he took up in 1924–25.[81] His research on the incidence of leprosy in northern Australia[82] was conducted in conjunction with the Commonwealth School of Public Health and Tropical Medicine in Queensland.[83]

Cook's report was among the first epidemiological studies of leprosy conducted in Australia since the 1890s. Cumpston later commented that his painstaking examination of the facts had characterised leprosy as an infectious disease caused by *Mycobacterium*. The disease was transmitted from one person to another by direct contact, under certain environmental conditions. Due to the problem of not knowing the medical histories of many who had come in contact with the infection it was impossible to know much about leprous infection in many Australian cases, largely because of imperfect observation and incomplete investigation. The disease seemed to appear among people who had harboured infection over a long period and possibly were a danger to their associates for much of that time. Many carriers harboured the disease but showed no outward sign of contagion. Leprosy was found to have been successfully diffused and had become endemic only in warm, humid climates.

The symptom, a thickening of the skin of the forehead, was less noticeable among infected Aborigines than among most Europeans. This folding of the forehead was attributed to the stimulation of resistance by the greater exposure to solar ultra-violet radiation. Cook surmised that leprosy was previously unknown amongst the Aborigines and early European settlers. He thought also that the disease had been introduced

from China and islands around the Pacific during the previous century through the importation of coloured labour into Australia from those countries. The disease then spread to white males through contact with Aboriginal women,[84] and then to others. It was through this process, he argued, that the disease had become endemic.[85] White females, Cook claimed, did not contract the disease until 1890, but the incidence among them had increased rapidly by 1925, when 23 white female cases were reported.[86] Between 1900 and 1921 the number of white Australian males who contracted leprosy had risen to 22, which tends to support Cook's conclusion that the disease came from Chinese mine workers and passed to Aborigines thence to white people.[87]

Cook made a preliminary investigation in 1922 and began his major project a year later. He travelled to the northern area of Western Australia, where he visited the sheep and cattle properties of the Ashburton, Fortescue and the Pilbara regions. He went on to Broome, Derby, inland along the Fitzroy River and north along the border to Wyndham and Forrest River.[88] He noted that the local leprosarium was housed in the old government buildings. He criticised the use of these dilapidated buildings and the lack of interest shown by the medical profession of the northern regions in improving them, improving the buildings as well as the lack of concern shown by the Government about the state of the buildings.[89] Cook's report was released in 1924 and published by the Commonwealth in 1925. One of his recommendations was for greater Federal and State coordination of funding leprosy treatment. At the same time he criticised the isolation of leprosy patients, but could see no immediate alternative.[90]

Only a few researchers in Australia worked on the study of leprosy, and those who did so conducted their inquiries mainly in the Pacific and elsewhere. An article appeared in a Western Australian newspaper, the *North West*, stating that, following the experiments, which lasted six months, the surgeons at the hospital where lepers were received claimed they had cured all cases treated with radium.[91] The article went on to quote an unnamed Collins Street (Melbourne) specialist with experience in treating lepers in Nauru. The specialist was quoted as saying the use of radium produced results and was a 'great step forward'. Further, the form of treatment up till then consisted mainly of isolation and strict hygienic practices comparable to those used in treating tuberculosis cases.

Chaulmoogra oil, with its various compounds, was the drug most used, and was given by injection. Other remedies were tried, but this oil appeared to be the only preparation which brought satisfactory results.[92] The lack of research in the Kimberley, as reported by Cook,[93] probably heightened local residents' anxieties.

The effect of Cook's study and recommendations on the Commonwealth Health Department was instantaneous. In June 1925, Cook reported to the Federal Government on a specific recommendation arising from his research. This was for the development of a lazaret on the Commonwealth-controlled Channel Island in the Northern Territory.[94] Cook pointed out that there were already eleven leprosy patients on the island, and that a Chinese man, Jimmy Ah Cup from Roper River, together with three Aborigines, Alick and Judy from Pine Creek, and Billy from Maranboy, were also living on the island. A Greek café proprietor from Darwin was isolated in his suburban home after being diagnosed as a leper. Cook's report argued that, while the Government waited for plans to be finalised for this mans removal elsewhere, there would be no special reason to condemn him to exile in a lazaret like the one at Darwin.[95] In the same report, Cook explained that in 1916 a lazaret had been created on waste land in Darwin harbour. This miserable locality had been the home of twelve lepers isolated there for some time. The inmates at this deplorable place included a healthy half-caste girl of four. No effort had been made to treat those Aborigines affected by leprosy with a view to its eradication. The diagnoses of many Aborigines were made by white bushmen or the local policemen, sometimes erroneously. Many notifications were free of the disease, and others actually suffering from it were overlooked altogether. Cook went on to indicate that the island was used exclusively to isolate Aborigines, and he scathingly criticised health authorities in Darwin. He urged action immediately because many Europeans were now becoming infected and accommodation had reached crisis point.[96]

On September 1925, Cumpston wrote to the secretary of the Department of Home and Territories in Melbourne stating that Cook's report had revealed that leprosy among the Aborigines was serious. Cumpston went on to argue that something should be done immediately and that he believed it was clear that three actions were imperative. First, a properly equipped leper station at Darwin. Second, the appointment of a Medical Officer with appropriate training and reliable personality to be placed in charge of the hospital. Third establish a lazaret on Channel Island the

when the quarantine regulations had been amended.[97] Cumpston tried to move too quickly, however, to get the lazaret going, and, in doing so, distorted Cook's objections to the Darwin site.

The lazaret established on Channel Island had two iron buildings. A doctor from the mainland visited once a week when weather permitted. When Aborigines were diagnosed as lepers the health officials shipped them straight to the island and left them to themselves. The condition of the island was regarded as sufficient for Aboriginal patients.[98] But the Bishop of Carpentaria, Dr Davies, and the Rev. H.E. Warren of the Church Missionary Society, had already brought the Church's contrary opinion to the notice of the Minister for Home Affairs. The Secretary of the Department of Home Affairs wrote to Cumpston and pointed out that temporary improvements were unacceptable. He agreed with Bishop Davies about the unacceptability of forcing Aboriginal and white patients to live under such poor circumstances. Ironically, despite the Bishop's protest, missions under his control continued to send patients to Darwin and many went straight to Channel Island.

Drs Cook, Jones and Norris of the Commonwealth Department of Health decided, on 9 October 1925, that leper patients identified at the Christian missions would be segregated at mission stations as a temporary arrangement. They would then be treated with medicines and medical direction from Darwin, to be supplied by the missionaries on the spot.[99] Mr Urquhart, the Administrator, Northern Territory, wrote to Cumpston earlier in the month about Dr Norris's view[100] that the lazaret on Channel Island was unfit for any patients not under supervision.[101] Despite the problems experienced in Darwin in 1925, Cumpston was planning to send Dr Elkington to report on the situation.[102]

The Western Australia Government responded to the Cook report by writing immediately to the Prime Minister, S.M. Bruce. His reply, in August 1927, drew attention to the Commonwealth's plans for establishing a lazaret at the Commonwealth quarantine station on Channel Island.[103] Bruce requested information from the State Premier, Philip Collier, on the numbers of Western Australian lepers he wanted to accommodated in Darwin.[104] Without answering this question, Collier responded immediately that as soon as the lazaret was finished he would send the Western Australian lepers there for treatment.

Seven years after his initial criticism of Australia's practice, Sir Leonard Rogers wrote a further critical paper in *The Medical Journal of Australia*. This time, he condemned Australia's approach to treating patients with venereal diseases and leprosy.[105] Writing in 1930, he was even more 'authoritative and persuasive' than earlier.[106] He criticised Cook's work, basing his comments on a decade of international research, the thrust of which was that Australia's treatment of leprosy was backward compared to world-wide developments.[107] Further, Rogers doubted Cook's assumptions that leprosy in Australia was as limited in its incidence as he had concluded in 1924.[108] He marshalled convincing data in these terms:

> In 1924 [Dr Cook] pointed out that, in spite of leprosy having been a notifiable and quarantinable disease for three decades, it was still as prevalent as ever in some of the States, and in his 1927 report he showed that the disease in Queensland, after declining between 1910 to 1919 from 83 to 42 steadily increased again from 1919 to 1927 from 42 to 77, especially among Europeans. He thought that leprosy was under control in New South Wales, but this is not altogether borne out by recent data, for in the seven years up to 1920 the total segregated cases varied between 20 and 24 and the yearly admissions averaged three; and from 1920 to 1927 the admissions numbered 26, an average of 3.25 and the decline in the total remaining to 17 at the end of 1927 was due to five repatriations and 15 deaths during that period.[109]

Rogers then attacked the segregation of 'poor lepers', who were compulsorily imprisoned for many years. 'In no other disease was treatment imposed with such penalty,' he observed.[110] Fearful of being diagnosed with leprosy, and of then being forced into incarceration, sufferers disguised their symptoms. The consequence was that the true volume of infection in Australia remained hidden and unknown. In short, according to Rogers, the cure for leprosy in Australia was counter-productive. The Australian approach, moreover, embodied racial prejudice against Asians and Aborigines.[111]

As for curing the disease, Rogers alluded to his experience in Calcutta and Hawaii. There, he said, it had been 'demonstrated that in early treatment stages of the disease out-patients could be cleared of all clinical signs of active infection'. These out-patients were 'rendered bacteriologically normal and uninfective by weekly injections of soluble preparations of the active parts of chaulmoogra and hydrocarpus oils'.[112] Reverting to statistics, Rogers claimed that he had treated 486 patients over a five year

period. Of this number, only 8 per cent of advanced cases had not responded to treatment while 38 per cent of those with moderate infection and 64 per cent of early stage infection had recovered. Modern methods of treatment, Rogers claimed, consisted of proper surveillance in which the patient's contacts would also be observed over time for signs of early infection and included in an early treatment program. This method could help to clear up the pool of infection within five years, before the new cases reached high infectivity, thus eliminating the sources of infection.[113] Rogers's methodology was, he argued, supported by pathological research which indicated that 'Hansen's bacillus is not always found in early nerve and skin cases'.[114] People in this category were best treated as outpatients he argued. Those with higher infectivity could be isolated, but only if skilled treatment was provided.

While these arguments were being propounded, another observer of Aborigines' customs, manners and daily lives arrived in the Kimberley. This was A.P. Elkin, Professor of Anthropology at the University of Sydney 1933–56, one of the few scholars who spent time in northern Western Australia during the 1920s studying the Aborigines of the Gascoyne, Pilbara and Kimberley districts.[115] Inevitably, Elkin had to confront the problems of Aboriginal health and its administration. The views he developed there were to have profound implications for government policy in Australia. They underpinned the protectionist and later assimilationist policies which most governments adopted during the 1930s. Like Walter Roth in an earlier era, Elkin was a scholar whose influence extended beyond the seminar room, particularly in Western Australia.[116]

Born in 1891, Elkin studied at both Sydney and London Universities, graduating from the latter with a doctorate in anthropology.[117] After arriving back in Australia Elkin did much of his early fieldwork in the area between the Gascoyne River and the Anglican mission at Forrest River, south of Wyndham, where the head missionary was the Rev. Ernest R.B. Gribble. Elkin (an ordained Anglican priest), was privately critical of Gribble's policy, practices and personality. Gribble's manner was authoritarian but he had proved fearless in exposing the massacre of Aborigines by police near Forrest River in 1927, when an unknown number of Aborigines had been killed and burnt.[118] Although Gribble had become a legend in mission circles and among white settlers in the

Kimberley, Elkin concluded that he was a 'reckless tortured tyrant, so oblivious to comfort that he lived on bush rations and expected everyone else so to do'.[119] According to Elkin, 'Gribble ran his world with megalomaniacal fanaticism.'[120] If the blacks stole his cattle, and they did, he went after them, unarmed and into the wildest country, to catch them. Gribble dealt summary justice, usually horsewhipping the culprits.[121] Elkin, astonished by what he had heard and seen of Gribble, viewed him as a contradictory mix of utopian ideas, defeatism and mean-spirited tyranny.[122]

Elkin endeavoured to put these views aside while he visited missions in the Kimberley. On his first field trips to the region in late 1927, he travelled by mission lugger with Gribble from Broome to Wyndham via Cape Leveque and Kings Sound to visit the missions at Port Georges and Walcott Inlet.[123] Once in the Kimberley, he travelled extensively. He described his experiences in his journals:

> Before I went to the Kimberley, my knowledge of individual Aborigines as persons was almost nil. My thoughts had not turned to their condition or the effects of contact on them. I had no humanitarian motive. My task was to record and analyse Aboriginal social organisation, ritual and mythology and to that task I stuck.[124]

On another occasion he travelled by steamer to Forrest River via Wyndham. He made numerous other trips around the Kimberley, either by foot, donkey or horseback. Travelling east along the Margaret River to Mt Frank and north via the Government cattle station at Mulla Bulla, he then went to Violet Downs near Turkey Creek and back to Halls Creek along the Ord River. Later, he crossed the Ord from its western side near Carlton Hill, travelling west to Wyndham, making diary entries as he passed the abandoned sheep and cattle stations of the north.

Elkin noted that Aboriginal labour was cheaper than white labour. Workers' diets consisted of some meat, bread, tea and sugar, some tobacco, and occasionally they were issued with clothing. They earned every penny of what they received, he wrote.[125] Similarly, he took an interest in sick camp people. After visiting one camp, he wrote:

> I rode out with the half-caste boy to this camp and had an interview with the old blacks. On the previous evening, one of them was very ill, and by way of remedy had grass string bound around his legs (thighs) upper arms

> and chest. This morning, however, it was all discarded except one bit from an arm. On my asking 'how sick-feller', he replied 'me sick-feller'; he was sitting up and having a drink. He took quite an interest and part in the talk about their marriage rules which followed. They take shelter during the day in a shade made from branches … The old sick fellow has since died.[126]

After a visit to the Beagle Bay Catholic mission Elkin described the people and buildings there. On the five hour trip he recorded his impressions of his fellow passengers:

> The other passengers were a sister from the mission (Irish), a Salesian brother going out on a short visit to Broome (Spanish), a black boy to open the gates and to go for help in case of trouble … Then there were two German mission brothers who said little … The sister was ready to talk and tell me plenty about the blacks and half-castes. She had been out there 21 years, [but the journey ended without further talk].[127]

He found buildings constructed of bricks manufactured on the reserve. According to Elkin they were of poor quality but they lasted longer than wooden buildings, which were attacked by termites. Government health authorities made no visits to monitor the health of the church mission establishments or their populations. District hospitals sometimes experienced overcrowding and tents located at the rear served as accommodation for Aboriginal patients at most hospitals he visited. Elkin became acutely aware of the number of specially segregated hospitals, something not present in the Hunter Valley of New South Wales, his home region. The number of Aborigines suffering from venereal diseases was also an unfamiliar sight. This, he noted, was a major responsibility of the Government, which was to subsidise hospitals that treated the sick and frail, and to give medicines to Aborigines affected by yaws, syphilis and gonorrhoea.[128]

Elkin observed an increase in these health problems during his time among the Kimberley Aborigines. The Chief Protector's annual reports to Parliament confirmed this trend, but claimed the increase was only a temporary aberration.[129] The number of patients admitted to the Port Hedland 'native' hospital in 1928 rose to 60 from 23 the previous year. A total of 11 patients remained from the previous year, making a grand total of 71. The number of cases of venereal disease stood at 25; 58 patients had gone home as cured, and 6 patients had died. Of the 71

patients admitted, 32 had contracted *Granuloma pudenda*, 17 had gonorrhoea but none had syphilis, and 24 had a variety of non-venereal complaints. Elkin was surprised to confront such an epidemic but thought the treatment that Aborigines were receiving was the most up-to-date available.[130]

Elkin's knowledge of sexually transmitted diseases was limited. The Government's health initiatives to arrest and control venereal diseases in Aborigines had been in place for some years. When Elkin observed that venereal disease was on the rise he failed to observe that two things were already happening. First, the medical regimes where draconian even if, as mentioned above, the Aboriginal patients suffering venereal infections were receiving the most up-to-date medication. Second, the incidence of venereal infection had begun falling in the late 1920s. The treatment for granuloma normally began with antimony tartrate—tartar emetic—given intravenously at weekly intervals. According to a 1928 report on the operations of the 'native' hospital by the Medical Superintendent, Dr Davis, a two per cent solution in distilled water made up the standard treatment. The method of application adopted by Dr Davis commenced with a 1 cubic centimetre dose to 6 cubic centimetres of diluted normal saline. The dose had to be increased weekly by 1 cubic centimetre up to a maximum of 8 cubic centimetres, which represents 2.5 grams of antimony tartrate, and, according to Davis, the dosage was never exceeded. As Davis indicated, the patients coughed a lot but did not vomit. Some patients, depending on the degree of infection, would require a second round of medication.[131] Even so, the duration of stay was longest for those suffering from syphilis, the victims of which were few. The forms of the disease presented were congenital,[132] of which there were several cases; plus two cases[133] of sexually transmitted syphilis.[134] None of these patients had recently been infected, but one of them, an older male with cerebral syphilis, died.[135]

At Moore River reserve, as Biskup has demonstrated, the settlement hospital opened later in the decade and was referred to officially as the Midland District Hospital. It consisted of a single ward with accommodation for male and female patients, 'including women in labour and patients with communicable diseases such as syphilis'.[136] The bathroom doubled as a surgery, and the same room was used occasionally for sick babies from the camps. These babies were often kept in the bath

tub to prevent them from wandering back to the camps. According to Biskup, 'the hospital had no resident doctor and relied instead on the services of the doctors at Moora and Mogumber and sometimes even Perth when epidemics of measles, mumps and influenza struck'.[137] This depot population rose to 150 in 1930 when Aborigines came in from nearby bush camps infected with influenza, from which five people died. Biskup and others reported that this was a group suffering from a range of health problems, and 'the State Psychologist, Miss Stoneman, states in her 1929 Annual Report that one hundred … children … were underweight for their age'.[138] It was possible for missionaries to decide to start a mission and rapidly attract an Aboriginal population. Services in the north were dealing with other, more exotic, infections that illicited wider public fear and a greater expectation of intervention by the Commonwealth Government.

Occupancy levels at the native hospitals—of which there were five between Wyndham and Moore River—always remained high. In 1929, for instance, the total number of patients admitted to Port Hedland totalled 54, compared with 68 the previous year of, whom 7 were 'incurables' from the previous year, leaving a total of 61 for 1929. Of those treated, 40 had been discharged as cured, four inmates had died and 17 patients were still under treatment. Dr Albert Davis of the Port Hedland Native Hospital wrote that:

> the activities for … 1929 suggest … that we are slowly … reducing the incidence of venereal disease among the native population … Fifty seven patients were treated compared to 71 the previous year. Of the 57 there were 35 suffering from venereal complaints, the remaining 22 being inflicted with various illnesses…All the venereal complaints were … granuloma.[139]

By 1930, venereal diseases among Aborigines could be described as being under control and although the method of isolation remained the same, the means of treating the disease improved.

In 1920, Western Australia restructured its Aboriginal protection administration, a change calculated to produce economies but one that unwittingly fostered an exodus of Aborigines from government reserves and old style church missions. At the same time, a new style of missionary ones without churches but only holding a bible and swag emerged in the fringe-camps in the southern areas of the State. In the north, as rumours

of an impending leprosy epidemic spread, closer public interest in disease gripped rural settler society. Leprosy treatment regimes became a subject of criticism from international experts. The professional anthropological study of Aboriginal society was beginning to influence politicians and administrators but, as we shall see, public opinion would also become an increasingly important influence on the administration of Aboriginal health.

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6

The great health panic: Leprosy, Aborigines, Church and State in Western Australia, 1930–40

The Moseley Royal Commission into the condition and treatment of Aborigines in Western Australia in 1934-35 was a landmark in the administration of Aboriginal affairs in the State. Coming three decades after an earlier landmark inquiry, the Roth Royal Commission of 1904–05, it set the stage for wholesale reform.

As we saw in the previous chapter, Aboriginal infectious diseases generated fear that pervaded relations between the Aborigines and the settler communities of the State's northern regions. The fears of each group differed. White rural populations everywhere feared that venereal disease would spread among them from local Aboriginal communities. In the north, leprosy became the main focus of settler fears. For their part the Aborigines feared institutionalisation, and being denied services white people took for granted. The prospect of being removed from their homelands to be incarcerated in disease management institutions, never to be seen again by their families, was for them very real. The mutual hostility between the institutions responsible for managing their health could only add to the Aborigines' burden of fear.

The tensions between Aboriginal groups, especially within those of mixed-descent,[1] were a further aspect of that burden. Such tensions mounted as their numbers increased, and they began migrating away from their reserves to live on the fringes of white society. That the Aborigines lived under stress became evident from the incurred injuries from frequent fighting, the antagonistic relations between men and women and the daily disputes between extended family groups. Couples with too many children, most often destitute, were forced to live in over-populated

camps. Such circumstances prevailed in the fringe-camps on the outskirts of Perth no less than in the camps on the periphery of regional centres. White townsfolk nearby worried greatly about the the heavy consumption of alcohol in the camps and the squabbles this often caused, especially after dark. Periodically, the ructions in the camps prompted campaigns for their removal. The tensions in the camps were particularly acute when sick and dying Aborigines were present.

By 1930, and despite years of concern, disease remained unchecked in southern Western Australia because the impact of government policies was to encourage the Aborigines to find refuge in the fringe-camps, where conditions were invariably unhygienic. The problem of fringe-camp hygiene persisted throughout the 1930s, as graphically reported in a series of articles for the *West Australian* newspaper in 1939 by Paul Hasluck, a journalist-historian (and later a Federal Cabinet minister and Governor-General).[2] Hasluck claimed that during the early 1930s the Health Department had openly refused to fulfil its duties, not only to destitute camp residents[3] but to 'half-castes' generally as well as the 'full-bloods', who remained concentrated in the north.[4] The responsibility for providing 'medical service care of indigent Aborigines'[5] remained with the Health Department throughout the 1930s, but the lack of cooperation between the Health and Aborigines Departments noted in the previous chapter continued. Frequent demarcation disputes over who should ensure that diseased, sick and injured Aborigines received care became one of the factors prompting the Government to establish the Moseley Royal Commission. The Chief Protector, A.O. Neville, generally opposed the Christian missions, but he and his missionary opponent, Mary M. Bennett, were united in their criticism of the Health Department, even if they were antagonistic toward each other.[6]

In the north, most medical professionals believed that by the end of the 1920s, except in the bush districts of the Kimberley, venereal disease had been brought under medical control. Dr Albert Davis produced figures to show that the numbers of people affected by granuloma had fallen slightly from 32 in 1928 to 27 in 1930. The incidence of other forms of sexually transmitted disease, notably gonorrhoea, had fallen more dramatically, from 17 to 3 over the same period.[7] Davis noted that some of the cases were recurrences and reinfections; others from remote parts of the district 'had so neglected themselves that a cure seemed hopeless'.[8] Bad hygiene

in the bush and fringe-camps, according to Davis, was the reason why curing the disease was problematic for some. He said that as long as poor hygiene prevailed, as it did throughout the 1930s, venereal disease would remain.[9] Resistance to change among the Aborigines, the bush people's stubborn clinging to their own customs and their general ignorance of western ideas of hygiene and disease, were further obstacles to improving Aboriginal health. The economic and social change induced by expanding white settlement required adjustments among the Aborigines that many resisted making. A parsimonious State and frugal missionaries were further ingredients in this mélange of factors militating against any rapid improvement in Aboriginal health standards.

Although fringe-dwellers did live in squalor, this was partly their own preference. Others may certainly have chosen cleaner environment, but camp people felt that certain advantages accrued to occupying living sites of: their own choosing. These included the absence of authoritarian reserve managers; being compelled to eat certain foods; and the new uncomfortable customs, such as bathing daily, sleeping on beds and using blankets. Similarly, their propensity to spend quickly what they earned through labouring meant that little money remained to pay for health care expenses. Their health, moreover, was something most fringe-camp people firmly believed was a government responsibility.

The Western Australian Government was also influenced by how the Aboriginal agencies in other States and the Northern Territory were taking Aboriginal customs into account. The Western Australia Government, according to the Protector's records,[10] was aware of what was taking place in other States, where more deliberate attempts were being made to raise the health standards of the Aborigines. The churches led the Government in taking more seriously the ideas emanating from cultural anthropology, and in endeavouring to bring these to bear on their management of the Aborigines' transition away from customary practice. In Queensland, a conference in the early 1930s made representations to the Commonwealth Government on developing general policy for Aborigines in which 'full justice' required 'full consideration of tribal traditions and customs', with appropriately trained field officers to interpret these.[11] Meanwhile, in areas south and east of the Gascoyne, Aborigines continued to leave the old style managed missions in large numbers. The Chief Protector's strategy for preventing Aborigines from moving between government reserves and places of employment worked

in one sense but failed in others. He thought this strategy would encourage Aborigines in the south of the State to integrate economically and socially into the wider society. This administrative thrust, together with the rising tide of disease among Aborigines, helped continue the squalor of the conditions in which most fringe-camps remained.

The reduced level of government care for Aborigines living in temporary camps in the south allowed missionaries with less prescriptive attitudes to fill the gap. As the number of Aborigines living in the camps rose, so did the prevalence of diseases resulting from bad hygiene and also chaotic social arrangements—lack of order, heavy drinking, trauma from fighting, marital break-down—that exacerbated poor health practices. In the north, unhygienic living sites created the conditions from which, most notably, the leprosy epidemic emerged in the 1930s. In 1934 the mounting crisis of Aboriginal health and living conditions forced the Western Australian Government to appoint another Royal Commission, Moseley's, which is discussed at length later in this chapter.

The growing Aboriginal population impelled government-mission relations into troubled waters. The missionaries, who came face to face with camp dwellers, were the first to appreciate the full extent of the Aboriginal health problem. When Frederick James Boxall, the Church of England Rector of Narrogin and a local protector of Aborigines, travelled between Kalgoorlie, Albany and Perth, he noticed that the number of half-castes had increased substantially. South of the goldfields railway line and west to the Coolgardie-Esperance track, there had been about 900 'half-castes' in 1905. By June 1932, their number had increased more than fourfold to 3,715. In the other direction, south of the railway and east to the South Australian border, the number there had been only 50 camp dwellers in 1905. In 1932 the number was 30 times that many, 1,536. In Boxall's home district he knew of an Aboriginal family with 20 children from the one father, most of whom had survived. Other families consisted of 14 members, Boxall wrote, and there were at least two with nine children each.[12] The survival of so many children created additional problems for the camps. There were far too many camp people and too few resources to enable them to be cared for adequately. Housing, feeding and clothing camp people became increasingly difficult, as did sending them to school and later helping them find jobs. The bulk of the camp population lived not in houses but shacks, tents and 'wurlies' (a Western Desert word for wind-breaks made from tree branches).[13] Such dwellings

had little or no furniture and people lived and slept on dirt floors covered only by sacks and old rugs. Some dwellings had a few utensils, and cooking was done outside the sleeping area in a bush fire-place.[14]

In 1931 and 1932, the great majority of Aborigines in the Narrogin district subsisted on government rations, which Boxall said cost 5 shillings and 6 pence (55¢) a week per adult.[15] A few received clothing and a blanket and the rest begged for clothing cast-offs from local whites. The State was hardly liberal with its rations, Boxall claimed.[16] At one location, called Geeraling, he counted between 70 and 100 Aborigines in a roadside camp on land that had never been declared an Aboriginal reserve.[17] There were no sanitary conveniences, and in summer the water in the well turned brackish. At the Narrogin camps in 1930 the occupancy levels fluctuated to between 25 and 150 people. The people at this camp lived on a reserve adjoining and overlooking the sanitary depot, with no water for bathing. Their drinking water came from a tap at the depot. The camp here, like others elsewhere, was devoid of sanitary arrangements.

At Wagin, Aboriginal casual workers camped on a traveller's resting place alongside the road. In addition, Boxall told the Commissioner that, at Katanning, Aborigines were living beside the rubbish pit and at Williams, only two portable toilets serviced between 70 and 120 people. As elsewhere, at Wagin water had to be supplied from a nearby property. Boxall took an officer from the Aborigines Department there in September 1931, when the reserve was completely under water.[18]

Boxall angrily described the camp people's predicament. Society should not allow these 'half-castes to pig it in wurlies in which father, mother, children and dogs curl in together', he said.[19] He pointed out that there was no privacy in the camps. The children consequently 'saw and knew too much'. In this regard they were worse off than the bush natives, and the morals of the latter were certainly higher than those who lived in the fringe-camps.[20]

Dr Keith McGinn, who treated Aborigines in the Quairading district, described their health circumstances. He claimed there had been a serious problem for many years.[21] According to McGinn, there were three major difficulties. First was hospital accommodation. The local hospitals were supposed to admit sick people of any colour, creed and station in life but

if Aborigines were admitted 'we would soon have only native patients'.[22] Second, 'in cases of severe illness, we have to admit them, but our hospital accommodation is limited, and admission of these cases often presents as awkward. We have a small wooden structure, large enough for one bed only, at the rear of the hospital, and where possible a sick native is kept there'.[23] Third, the habits and health of the Aborigines were so bad that they presented with infections such as 'scabies … lice … colds, influenza, bronchitis and pneumonia in winter'.[24] Venereal disease, however, was not among their ailments, McGinn observed. The camps, he said, should be stocked with surgical and medical supplies for dressing wounds, particularly at ration depots. In addition, proper sanitary conditions, such as well water and shower facilities, should have been provided to guard against skin and intestinal infection.[25] The conditions described by McGinn were fairly typical in the south, but in the north the health and protection agencies had even less effect in raising Aboriginal health standards.

In the early 1930s Beagle Bay, a Roman Catholic mission north of Broome, had a stable population of 282 people, including 134 children under the age of 14 years. There were 167 males and females of full-descent. The staff comprised two priests, five brothers and six nuns. The mission could have been regarded, even then, as a small township with church, cottages for the missionaries and a series of maintenance buildings, one of which was a blacksmith shop and another a brick-kiln. Livestock grazed in nearby fields and the beef cattle holdings normally totalled 3,500 head. Tropical fruit trees lined the perimeter of the vegetable gardens, which provided fresh food for the whole mission population for most of the year. Although Aboriginies were not required to work, many of the resident Aborigines worked for the mission, and the skilled jobs in the tannery sheds and the boot-maker's shop were held by the 'half-castes'. The children worked in the gardens, supervised by six adult Aboriginal women.[26]

Care for the sick was the responsibility of the Sisters of St John of God, nuns who were mostly trained nurses. The sisters conducted clinics for out-patients from a surgery constructed of locally made brick. There was also a special isolation ward for leprosy patients 'awaiting transportation to Port Darwin'.[27] It was this religious order that wrote to the Prime Minster about leprosy in November 1933 to offer its services at the leprosarium planned for Channel Island near Darwin. Sister Joseph, the

author of the letter and head of the St John of God convent in Broome, acknowledged that the hospital was a government institution and that the nuns must perform their duties under the instructions of the chief Medical Officer.[28] In fulfilling the role proposed by Sr. Joseph, the nuns would ask only for their 'food, medical treatment, and a yearly allowance for clothing and other little incidentals, also their fares to Darwin …[and] a fare south' for those who became sick.[29]

The offer was for four nuns to go to the Channel Island leprosarium. One was from Perth and the others from Beagle Bay, and the latter had extensive experience 'nursing the blacks'.[30] The Commonwealth replied to Monsignor W.M. Henschke in Broome, who in turn wrote to Sr. Joseph. The letter said that 'the Government …[was] unable at present to accept their offer'.[31] Dr Cecil Cook, an adviser to the Commonwealth, had prepared a report in 1925 on the suitability of establishing a joint lazaret facility in Commonwealth Territory. Now, as Chief Commonwealth Medical Officer in Darwin in 1934, he advised the Northern Territory Administrator that he 'wholeheartedly opposed … [the Sisters'] method of staffing however economical it may appear to be unless they accepted full responsibility for the leprosarium including the management, providing medical attention and arranging transportation is undertaken by the Order'.[32]

Further out in the bush, towards the southern tip of King Sound near Sunday Island, another Catholic mission was operating at Lombardina, and this mission fulfilled similar functions to the one at Beagle Bay. The Lombardina population of 82 men and women included a larger proportion of 'full-bloods', and there were similar numbers of people above and below the age of 14. The staff at the mission consisted of one priest, one brother and three sisters. The walls of the building were made of local timbers and the roof consisted of local brush thatching.[33] At Beagle Bay only the nuns normally cared for the sick, unless an epidemic occurred and then everyone helped.[34]

When working in their clinic the Lombardina nuns treated mainly coughs and colds, but sometimes gave out medicines. The more serious diseases included hookworm infestations and eye infections. Even though the mission faced the ocean and sea, bathing was a local custom, some communicable diseases persisted. Hookworm became endemic because of the contaminated soil on which the camp and mission people lived.[35]

Trachoma was usually present in the creche and among the older children. The boys and girls of school age slept on bunks in huge dormitories with dirt floors, and close body contact was unavoidable.[36] Leprosy was a problem at Lombardina and as those patients were identified and diagnosis verified by analysis in Perth, they went to the lazaret at Beagle Bay.[37]

Among northern bush-dwelling Aborigines, leprosy was spread both by contact with Asian mining labourers from the Northern Territory and by other Aborigines migrating across the border region for customary contacts.[38] Many of these people had almost no contact with the outside world and consequently knew little about sanitary habits under sedentary living conditions. Although hunter-gatherers avoided the propagation of some parasites through their low numbers and constant movement, as they began to settle in one location they began to experience the health hazards of congested communal living. Traditionally bush people slept close to each other and their hunting dogs to keep warm, which allowed transfer of parasites. When they switched to the sedentary lifestyle of permanent camps the parasites accumulated in and around the campsites, and infestation became much more likely. Once leprosy began infecting camp people two things complicated their circumstances: first, camper's clothes tended to make diagnosis difficult; second, campers living near pools of stagnant water also bathed in the water that they had to drink making for a dangerous cocktail. In the late 1920s leprosy infection among Aborigines increased sharply. The shipment of leprosy patients to the Northern Territory began in earnest and although it was never an easy procedure, the practice continued into the mid-1930s.

Treating Aboriginal leprosy patients became chaotic as the number of cases increased. The transportation of patients to Darwin was a particular difficulty.[39] In Western Australia the health and protection agencies developed a number of temporary holding compounds. Residents of the northern towns—Roebourne, Broome, Derby, Wyndham and Fitzroy Crossing—and the local pastoralists loathed the way authorities placed diseased Aborigines on the outskirts of 'their' towns. Discussions between the State and Commonwealth Governments went on incessantly from the mid-1920s, until they could both agree on the terms for the transportation and management of lepers being sent to the Commonwealth leper station in Darwin. Eventually, after long bargaining and discussion, 14 Aboriginal leprosy cases from Cossack and three

Kimberley people were taken by a coastal lugger to Darwin. Captain Scott contracted his boat, the *Colarmi*, to the Commonwealth.[40] He arrived in Darwin with his first batch of lepers on 10 October 1931.[41]

The Broome Road Board probably expressed a common belief among northern rural municipal authorities when in 1932 it wrote to the Health and Aborigines Departments about its concern that leprosy was infecting Aborigines in large numbers. A couple of surges in new cases had occurred in the late 1920s and the infection rate looked like rising further in the early 1930s. The Road Board told the Minister for Public Health on 20 July 1932 that five lepers would soon be removed to Darwin.[42] A year later, the Board again wrote to the Minister indicating that more cases had been located and that one, a 15 year old boy, was at a school in the south (possibly Perth).[43] The following year the Board protested that dormitory arrangements meant bedding down leprosy patients in the same room, regardless of sex. The Minister responded by saying that responsibility for the problem lay with the Commonwealth rather than with his own administration.[44]

The fears of the northern Road Boards (a form of local government) were confirmed as leprosy numbers continued rising in the Kimberley. Their worries were heightened further by an article that appeared in the *Sydney Morning Herald* in 1928 under the heading 'Australia's Problems in Tropical Areas'.[45] Its author, Dr Raphael Cilento, a Queensland medical and public health official, emphasised the future economic importance of Australia's tropical and sub-tropical north. He argued that since successful development would depend upon rigorously applied public health policies, medical services were an important part of all developmental activities. Appealing to imperial pride, he pointed out that the tropical portion of Australia made up the largest tropical possession within the British Empire[46] and that both hookworm and leprosy were the aftermath of the use of 'coloured labour' in Queensland. These maladies, he claimed, represented the most serious outbreaks of tropical disease in Australia's medical history. Across the north of Australia the two diseases had become endemic. Leprosy, he claimed 'had been introduced by the Chinese, who poured in when the country was opened'.[47] (This was not entirely true.) He went on to say that the conditions Australia confronted had occurred within a period of twenty years and that the Australian Institute of Tropical Medicine had been opened at Townsville to deal with the problems incidental to the establishment of a healthy white population in

the tropics.[48]

Early in January 1933, discussions over the transportation of lepers from Western Australia to the Northern Territory continued between the Commonwealth Department of Health and the Western Australia Public Health and Aborigines Departments. During these discussions the possibility of purchasing a launch for this express purpose was mooted, but no action was taken.[49] Soon after, an offer was submitted to the State Health Minister from a Mr F. Redfern of Broome to transfer the lepers from all ports in the north to Darwin for £1,250 annually. One month later the Broome Road Board again wrote to the Minister for Public Health in Perth, drawing to his attention the prevalence of leprosy in the district. The Board urged the Minister 'to provide periodic inspections by a medical man of the Kimberley area,'[50] and recommended that Dr Hayes, the Broome District Medical Officer, be appointed to undertake the task. Dr Atkinson, the Chief Medical Officer, contacted Hayes immediately to ask him if he would 'accept responsibility to undertake the examination of the natives'.[51]

Later that year the Minister wrote to the Broome Road Board saying that his Department had spared no expense in attempting to cleanse Western Australia, and the Kimberley in particular, of lepers. The Department's efforts, however, were hampered by Captain Cockrane's early departure from Broome to Darwin. Dr Hayes was notified that the launch could only take eight patients and that Cockrane had not called at Derby, where lepers were awaiting transport. Dr Cecil Cook, now the Director of Commonwealth Health in the Northern Territory, was asked to get an explanation from Cockrane of why he had failed to stop at Derby. One reason for the concern was that there was a build-up of leper patients at towns specified as transit points for collecting lepers. The Chief Protector wrote to the Under Secretary for Health on 26 October 1933, advising him that five confirmed lepers and an unspecified number of suspected lepers had camped outside the native hospital fence at Derby and that he feared others would be attracted to the site.[52] The boats took months to collect their human cargo, travel to Darwin and return. This meant a build-up of patients, which in turn exacerbated townspeople's fears. While all this was going on leper suspects and patients had to be managed in the small, uncoordinated, over-crowded disease compounds.

In resolving such difficulties, inter-departmental demarcation disputes were usually a factor. This could be seen in the correspondence of the local Aborigines Department employee at Derby, Franz Luyer, who attended to the new leper patients as they came in from the bush. His pay and conditions were rather poor and he had made repeated requests for increases in his rates of pay. Once more he had made a request to the Chief Protector for an increase in wages for feeding and generally keeping the lepers awaiting transit to Darwin under surveillance in the compound. He also asked for more money to look after the growing camp population. The Aborigines Department thought it would be better if the Health Department could handle the matter. Dr Hodges of the Health Department was reluctant to move either on the wages or accommodation question, and argued that funds would be wasted if diagnoses did not confirm infections.[53]

The job of feeding, sheltering and securing lepers never proved to be easy. Luyer often became the object of derision among local townsfolk for attempting to provide comfort to the compound inmates. They also demanded that he secure the compound to protect town residents. On 27 November 1933, Luyer wired the Commissioner for Public Health for permission to erect a shed at a cost of £10 to shelter prospective leper patients. His request was for urgent action because some patients were sure to escape.[54] A few weeks earlier, the Chief Protector had notified the Aboriginal adviser in Derby, that all the camp people would be transferred to the lazaret near Darwin and this had made the Aboriginal people suspected of having leprosy uneasy.[55]

No improvement occurred either in the coordination of the screening of leprosy patients or the quality of their transportation. The two governments, Commonwealth and State, hesitated, both because of costs and their differing underlying philosophies. The problem lay partly in the way responsibility was divided among a number of government departments. The transport of patients nevertheless continued, and on 26 January 1934, the Department of Public Health received a letter from Mr R.A. Bourne quoting for the transport of 25 lepers to Darwin at a cost of £350 a month. The Department asked Dr Hayes to inspect the lugger for its suitability and seaworthiness. On 30 January another offer came from Gregory and Company for the schooner *Eva*, at a cost of £30 a month plus insurance on the vessel plus a per voyage cost of £1,500.[56] While the

two governments dithered over the competing tenders, other problems remained unresolved.

On 14 March 1934, the Perth newspaper, the *West Australian*, made an effort to allay the concern of northern townspeople. It published an article which made the point that, while people in the towns were naturally concerned about Aborigines contracting leprosy, and usually referred to it as a 'foul and a most loathsome disease', in actual fact these terms were only applicable when 'to the disease itself was added, the dirt and septic processes of uncleanliness, and the squalor of the leper's surroundings forced upon the victim'.[57] The writer went on to say that 'leprosy was no more foul or loathsome than syphilis and a number of other diseases'[58] and that just as science had swept away fears of syphilis 'so it would do the same for leprosy'.[59] This article appeared at the same time as the detection of a leprosy case in Perth itself.

White patients unfortunate enough to contract leprosy were confined to Wooroloo Infectious Diseases Hospital near Perth, but the Aboriginal victims were confined north of the 25th parallel, or what some called the 'leper line', which in Australia runs west–east from Carnarvon to Bundaberg.[60] A comparison of the living conditions of the two types of patients is instructive.[61] In Wooroloo the rooms were comfortable if small, and each had its own fireplace. The food was described by an elderly woman patient as excellent and staff did most of the cleaning and also provided a wide range of other services. Wooroloo was near the sea, and in such pleasant surroundings the patients could occupy themselves by reading, sewing, doing their own washing and ironing, and entertaining their visitors. In 1934, the consensus was that they were contented.[62]

Aboriginal conditions in the north-west were vastly inferior. Many patients were left stranded in either bush and cattle camps or were not picked up by medical screening. Travelling protectors or disease patrols conducted by police on contract identified cases and were paid by the head for the number of suspected Aboriginal lepers they brought in from the bush. Aborigines would sometimes emerge from the bush to confront horrified pastoralists, protectors, police or the local residents of peripheral country towns. In one instance, near Mount Shadforth, there was

> a male native with his face eaten away, who looked like a horrible skeleton. There was no flesh on the face and no skin on the forehead and for some inches below the chin, and the ears were … missing. There was only bare bone to be seen. The jaw and teeth were exposed owing to the

> absence of the lips. The eye lids were exposed, and when the eyes were moved the strings (muscles) could be seen working. There were sores all over the neck, scalp, arms and body.[63]

When Aborigines did get attention they were normally chained by the neck and, even in the late 1930s, were walked or taken by wagon for long distances before they received treatment.[64]

In towns, the Aboriginal patients were crammed into very small shelters or compounds which they were not allowed to leave, sometimes for months on end, while they awaited transport to Darwin. On 9 January 1935 the Broome Road Board informed the Health Minister that lepers diagnosed near Broome had 'no place to be put'.[65] The real cause rested with the Broome Hospital's refusal to admit leprosy patients, and as a result the lepers were kept at a distance from other hospital patients.[66] The Road Board Secretary at Wyndham (650 kilometres north-east of Broome and 550 south-west of Darwin) notified the Health Department that a number of lepers had been seen there.[67] The Broome Road Board received the information that an Aboriginal woman held at the Wyndham hospital for six months had contracted leprosy and later transferred to Darwin.[68] Two Aboriginal men from the Wyndham gaol were also diagnosed with leprosy, but both escaped to the bush.[69] Such events left white townsfolk uneasy.

The member for Kimberley in the Western Australia Legislative Assembly, A.A.M. Coverley, had expressed local peoples' unease. Born in the south-west of the State, Coverley had migrated north some sixteen years earlier. In his evidence to the Moseley Royal Commission, Coverley said that

> events have proved that leprosy is gaining ground … in the Kimberley. Six or seven years ago the Road Board members resigned in a body as a protest against the inactivity of the Government towards leprosy … To prove that the disease is increasing, there are about 30 cases awaiting transport to the Darwin leprosarium at the moment.[70]

Coverley observed that one of the difficulties was that no medical practitioners travelled around inspecting Aborigines, and that medical clinics had to be built to support the work of practicioners.[71] In addition, the 'native' hospital at Derby lacked sufficient room to take lepers. Many diseased natives in the Derby area lived along the coast and did not come in contact with townspeople, and no effort was made to do anything with them. When medical aid was provided, the white townsfolk wrongly

assumed that they were running the risk of infection. Medical authorities publicised the fact that leprosy was not as contagious as people believed. Most townsfolk remained unconvinced. They believed that the sooner the lepers were removed, the better.[72] Aboriginal concerns were dealt with by keeping lepers beyond the town limits. Coverley feared the possible escape of lepers from the disease patrols. He was critical of the Chief Protector on the grounds that suspected lepers were allowed to camp near the towns while they awaited transport to Darwin, and control over the movement of lepers was so lax that many did escape.[73]

Even without leprosy, white and Asian townsfolk held a deep-seated fear of Aborigines, particularly of those who escaped from the compounds. They suspected most Aborigines of being diseased. Government neglect stirred their resentment, as did the idea of mission development. Their fears were intensified by the bottleneck of suspected leprosy patients living in the town compounds. A 1934 article in the *Melbourne Herald*, 'Silent Menace Of The North', by Ion L. Idriess, the popular historical novelist, captured the prevailing mood of fear.[74] What bothered most whites of Western Australia's north was that leprosy might become epidemic among them as well as among the Aborigines.[75] They worried greatly lest leprosy could be spread among them by vectors such as flies, mosquitoes and fleas.[76]

Fears like these inflamed the townspeople's attitudes towards the missions, which they felt propagated the disease. At the Kunmunya Presbyterian Mission, the head missionary, Rev. Love, rejected such beliefs. He thought that the most serious medical complaint his mission faced was granuloma. Love, like most other commentators on the Aborigines, believed this form of venereal disease was peculiar to them. To his knowledge, there were no cases of syphilis or gonorrhoea at Kunmunya.[77] As far as he was concerned, the existing system of missions was the only way of undertaking the 'philanthropic work' of tackling the Aboriginal health problem. The missionaries, he said, had dedicated their lives to the service of the Aborigines, and the church had a reservoir of trained and qualified people on whom it could draw.[78] After saving Aboriginal souls, the first duty of the mission was to care for the sick.[79]

The Presbyterians serviced several populations in the Kimberley, including Fitzroy Crossing, where they began building a hospital.[80] The Australian Inland Mission (AIM, the Presbyetrian mission organisation) had been

planning to introduce its flying doctor services to Western Australia. Although this was a popular idea with other missionary agencies, notably the United Aborigines' Mission (UAM, a non-denominational agency at the revivalist and fundamentalist end of the Protestant spectrum), the UAM was often in conflict with the Chief Protector.[81] Local protectors of Aborigines were consequently discouraged from direct contact with the UAM.

In spite of the Chief Protector's general prejudice against mission expansion, so great was the demand for medical services that in the 1930s the UAM pushed ahead with the provision of hospital services for the pastoralists. Greater levels of illness certainly arose from the concentrations of indigenous people on the missions, which unwittingly helped spread communicable diseases to both cattle property and town fringe-camp populations. White and Asian settlers already had a public health structure in the towns but the isolation of cattle properties caused a demand for primary care which, in turn, required an Aboriginal hospital system. The UAM moved to meet the social as well as the religious need.[82] Mr F.S. Bray of the Chief Protector's office received a letter from the mission in July 1934 indicating that the UAM station at Morgans had begun erecting a bush hospital. The mission was seeking financial help from the Chief Protector, and asked 'whether the Department would assist on a pound for pound basis'.[83]

The hospital had already opened when the mission superintendent wrote saying the building consisted of a two ward hospital measuring 40 by 14 feet. The plans included nurses' quarters of three rooms and a maternity ward. The UAM itself intended spending £250, and wished to employ only trained nurses. The need existed because of the 300 Aborigines who now lived within the sphere of UAM influence, and 200 of them were already consuming supplies from the protector's 'indigent rations and medicines'.[84] The protector wrote that 'serious cases are sent to Leonora and the Aborigines Department usually meets any transport expenses'. He acknowledged that the mission at Morgans did good work, but thought it relied too heavily on support from the Aborigines Department. His Department carried in the bulk of indigent food supplies and medicines and monetary assistance for attending to the needs of individuals. The mission would have been in serious straits if it was not for the work of the protectors. Bray seemed peeved that the missions seldom gave credit to the Government for contributing to their success.[85]

In a note for his file Bray described the Morgan's missionaries as 'persistent beggars and the more it gets from the Government the more it wants'.[86] He cited the case where the mission had received a large consignment of medicines from Neville, which the missionaries had used without acknowledging the Department. The mission, he said, 'unblushingly asked for more medicines and drugs far beyond the generosity of the department'.[87] This conflict between the Chief Protector's Office and the missionaries in the field centred on the question of who the Aborigines should trust and rely on—church or State.

Bray recorded his opinion that the Chief Protector's office was working to solve the Aboriginal health problem, and there was consequently little reason for the missionaries to be defensive in their dealings with the Department.[88] He wrote that there had been no earlier instance where the Government had approached missionaries to fulfil a State function, and so a precedent for assistance should not be created in this instance. The Aborigines Department had already appealed to the Lotteries Commission of Western Australia for financial assistance for a settlement hospital at Moore River. Bray indicated further that the Lotteries Commission had responded with a cheque for £500. On the question of the hospital development at Morgans, he was certain that the local Member for the Legislative Assembly, Mr Nulsen, and other friends of the mission, would make favourable recommendations on the mission's behalf. The staff at the mission had already risen to 16 missionaries and there would be pressure to expand further eastwards if more support was given.

Expansion of the UAM sphere of influence over the daily lives of Aborigines proceeded without encouragement from the Aborigines Department. Its activities, however, soon came under the spotlight of prolonged official examination. This process began on 23 February 1934, when the Western Australian Parliament established a Royal Commission to investigate 'the social and economic conditions of Aboriginals and persons of Aboriginal origin in or from native camps'.[89]

As commissioner, the Government appointed Henry Doyle Moseley. Moseley, a Perth stipendiary magistrate, had earlier been Resident Magistrate at Carnarvon, where he had become familiar with 'the Aboriginal problem'. He must have impressed the government with the work he did for this, his first Royal Commission because he was later

appointed to lead three other royal commissions in the 1930s and 40s, on mental health, money lenders, and housing. Moseley's Terms of Reference required him to report on the social and economic conditions of Aborigines, the laws relating to Aborigines and persons of Aboriginal origin, their administration, and allegations appearing in the Press since 1930 about the ill-treatment of Aborigines in Western Australia.[90]

The missionaries in the southern areas of the State felt victimised by the Aborigines Department. The view they presented to Moseley was that they were, perforce, obliged to attempt to fill the gap left by a receding State in caring for camp-dwellers. That Moseley did pay some attention to their views was apparent in his report:

> There is one aspect of the native's life which require[s] attention—the question of medical treatment. Those in charge of pastoral properties and Missions do all they can to care for sick natives: it is obvious, however, that their ability is limited. Each of the stations and missions which I visited carried a supply of medicines suitable for the treatment of ordinary every-day ailments, but serious epidemics occur when something more than household methods are necessary.[91]

Mosely singled out the condition of the southern Aboriginal settlements for particular comment. These, he said, displayed a level of squalor that had been generally overlooked by Western Australian society. He observed that Government-operated establishments could not be praised. For example, the 'compound' at Moore River consisted of a set of dormitories which had become dilapidated and so over-crowded that people slept on the verandah. 'Dr Maunsell of New Norcia, who frequently visits, …agreed … that the dormitories are vermin ridden … making disease eradication impossible,' he pointed out.[92] The hospital, Moseley wrote, 'is a substantial building, but two additional wards are necessary'.[93] The nursing sister told him that a labour ward was necessary, and that there was no isolation ward for children with syphilis, who were allowed to mix freely with other children. In addition, the main ward housed both men and women.[94]

In his own submission to Moseley the Chief Protector, A.O. Neville,[95] addressed such problems with the proposal that: 'in order to provide for proper medical, surgical, and hospital treatment for Aborigines and half-castes who become ill or injured or affected by any disease while in the service of employers, it be made a condition of every permit that a fee, to

be fixed by regulation, be paid by the employer into a special fund to be controlled by the Minister, and that the proceeds of the funds be utilised to provide the cost of such medical, surgical, and hospital treatment'.[96] Moseley himself suggested a permit system to supply rations, clothing and a range of reforms relating to providing medical treatment to sick bush people.[97]

The health of Aborigines featured prominently in Moseley's report. During the inquiry he had questioned the State's Public Health Commissioner and the Principal Medical Officer, Dr R.C.E. Atkinson,[98] about a number of problems outlined by other witnesses during the Commission's hearings. Atkinson's evidence spelt out his Department's difficulties in dealing with the problems canvassed in Parliament and the press.[99] He said that many difficulties arose because of the way the bureaucracy managed government business. This had a direct effect on the way leprosy patients were treated. The transportation of lepers out of the State was conducted by his own department, the Aborigines Department and the Commonwealth Department of Customs and Shipping, all of which played a part in transporting lepers to Darwin. Atkinson tried to convey to Moseley the reality of the lepers' isolation and their transportation in small boats.[100] Similarly, he criticised the missions and protectors for the isolation methods adopted in handling lepers.[101] In answering Moseley' criticisms, Atkinson said he believed his department was humane, but seemed anxious to shift the responsibility from the State to the Commonwealth, as leprosy was a question of the 'national interest'. With this in mind, Atkinson indicated that he had raised this issue at a recent meeting of the Federal Health Council in Canberra.[102] Atkinson, it seemed, wished to make the Commonwealth a scapegoat for the State's shortcomings in caring for Aboriginal lepers.

Neville for his part was in his element in giving his evidence. He said that the health of Aborigines in the south-west of the State had 'deteriorated very much'.[103] In his view, 'the natives had learned to enjoy certain amenities of life and they wanted to be near the centres of civilisation'.[104] He added that pastoral activities took all the land and no land had been left for Aborigines to camp upon. In the southern part of the State, despite the fact that the Department had catered for campers by creating 50 camp-sites, many of these camps lacked basic health facilities such as

ablution amenities, fresh water supplies and toilets.[105] The Department, he said, was

> not in a position to install such supplies on account of the financial situation. We do our best. In some of the areas we are carting water to camps. Sanitation is another difficulty. We have had certain structures erected, but very often the natives do not use them, and [they] are few and far between. From the departmental point of view it is … advisable to have natives near town in order to avoid costs of transport of supplies when we have to feed them … to ensure medical attendance to be applied if possible, to arrange for expectant mothers.[106]

Neville also explained that the physical fitness of Aborigines in all parts of the State presented 'a gloomy picture'.[107] By contrast, 'in the north, except where introduced diseases are evident, the bush natives are a healthy virile people. Their condition varies according to whether the seasons are good or bad'.[108] On cattle stations the condition of Aboriginal workers was generally good. The wives and children of workers were fed by the majority of stations, and their diet consisted 'of meat, bread, tea and sugar … [though] at least one medical man in the north [had] informed … [him] that the majority of the natives in his district ... [were] suffering from malnutrition ... due to the sameness of the diet'.[109] Some stations provided cooked food and others the basic ingredients for Aboriginal workers' families to cook their own meals. One major problem was that while people worked the cattle, they would not hunt for food but happily ate what the station provided. When they moved back to the bush, however, they did eat their customary bush foods.[110]

In southern areas of the State such as the goldfields, Neville claimed, 'we find that most of the Aborigines are reduced to dependence on government rations'.[111] The people issuing the rations were either protectors, police officers or local white people approved by the Department. Throughout the State there were 74 government ration depots. On reserves and cattle stations owned by the Government the diet was better than elsewhere because stock and gardens provided more balanced nutrition on a continuous basis.[112] Also in southern regions the monthly rations normally amounted to two kilograms of meat, five of flour, two of sugar and 400 grams (about three packets) of tea. The issue included tobacco, mainly to smokers but, Neville was quick to point out, this was carefully watched because it was a cost to the Department which

Aborigines themselves should shoulder. He added that rations were intended as 'a standby and were never meant to develop as a "hand-out" as well as replace bush foods as the staple food of the people'.[113] Although reliant on advice from outside, Neville had no hesitation in putting the view that the natives throughout the southwest and the eastern goldfields area suffered from malnutrition and weakness brought about through poor diets and their low resistance to powerful diseases.[114]

Neville told Moseley how, even on reserves operated by the Government, airborne transmission of infection proved unavoidable. In his view, the cause was the way Aborigines were forced to live too close together:

> The children in the southern areas, … suffer[ed] from the effects of cold and sickness, probably brought about by the lack of clothing … This has the effect of making the whole family huddle together in a small ten feet by six … structure with probably every crevice closed up, their heads under the blanket and in those conditions the whole family are breathing in filth and germs all the time.[115]

Under the circumstances, the medical costs to the Aborigines Department always remained considerable.

Neville went on to explain what his Department had done to restructure primary health care arrangements. Doctors subsidised by the Aborigines Department were expected to attend to indigent natives, and 'where they do we have to pay them for their services'.[116] In the past, 'native wards' had existed but now these had all been absorbed by hospitals. 'As for hospital accommodation, there is practically none for natives in the south'.[117] The Moore River reserve hospital was expected to cater for all the sick Aborigines in the Midland region.[118] In the southern and eastern goldfield areas no hospital was available for natives. There were only a few government hospitals left and they were nearly all operated by committees hostile to allowing Aborigines to enter as patients, even though the hospital was subsidised by the Medical Department.[119] According to Neville the hospitals run by committees were loath to accept native cases and it was, in fact, impossible to find accommodation for maternity cases. There were in the country, he said, certain good women, matrons and nurses, were are willing to help, and who went out into the native camps to look after those cases. The native today was not the native of 50 years ago, said Neville, and some of the native women suffered intensely from

childbirth. They had lost all the old stamina of the black and they had considerable difficulty in bringing children into the world, possibly because of their mixed-blood.[120]

Neville never explained how he had arrived at this speculative conclusion, but no one could deny his experience in travelling the State to observe the people under his department's care.

Warming to his exposition of the Aborigines' plight, Neville proceeded to describe the fringe-camps. The camps, he said, were a sorry phenomenon because 'camp life as it existed was bringing [the Aborigines] lower and lower … The old tribal laws have broken down and there is nothing to check the [actions of] young men and women'.[121] The social erosion was the cause of two policy problems for his department, Neville said. First, there was a problem in encouraging young Aboriginal bushmen to leave the main group to pursue work in other parts of the State, without which factionalism and lawlessness would result. Second was the deplorably low level of camp morality, seen in the factionalism and fighting in the camps, and in the incest and brutality to which younger camp residents, especially the women, were subjected. The camps, in short, were a nightmare, representing a complete breakdown of social order.[122]

Neville's strictures against the dysfunction of the fringe-camps was aimed partly at Aborigines, but more particularly at a parsimonious State and its institutions. State institutions had customarily displayed prejudice towards the plight of the Aborigines, he averred.[123] His main complaint was that he reported to government each year about the problems his department confronted, but lacked funding and support for changes to the legislation. He was right on both counts because his departmental funding had been systematically reduced since 1920 and, apart from various departmental structural rearrangements, no changes had been made to the *Aborigines Protection Act* since 1906.[124]

In the period 1935-40 the Government endeavoured to implement the recommendations of the Moseley Royal Commission. One of its first responses was to appoint Dr Albert P. Davis, a specialist in public and tropical health, as the first District Medical Officer assigned exclusively to attend to the health of Aborigines. He had graduated from Melbourne University with medical and science degrees in 1923. In 1934 he had

qualified in tropical health from the London School of Hygiene and Tropical Medicine. By 1935, soon after his term as District Medical Officer at Port Hedland had ended, the Commonwealth appointed him as a travelling medical inspector. His new responsibilities consisted of surveillance and inspection of Aborigines in the Pilbara and Kimberley regions. One of his first tasks was to establish two hospitals, at Broome and Wyndham, and to construct a leprosarium near Derby.[125]

Another early task for Davis was to travel around the Kimberley towns, pastoral properties, missions and government reserves to inspect Aboriginal health. He took with him Rev. Love of the Mowanjum Presbyterian mission, whose knowledge of Aboriginal language and culture he valued. Davis and Love commenced a leprosy survey of the coastal regions between Derby and Wyndham. When they visited Kunmunya they 'found an alarmingly high proportion of venereal disease, as well as leprosy. Love was thankful to learn … that the leprosarium was shortly to be built near Derby and all the natives contracting the dreaded disease would be able to be treated and kept until they were free of it'.[126] When Love had given his evidence to Moseley a year earlier he had been adamant that no leprosy existed at Kunmunya, but he feared it might come. Davis's inspection uncovered large numbers of people with venereal disease at the missions that Love managed. Once leprosy was diagnosed in a mission, the local Road Boards, together with the country hospitals and District Medical Officers, became involved. As some idea of the full extent of leprosy among Aborigines became known to the public, fears of a leprosy epidemic gripped the white townsfolk across the entire north of the State.

The main reason for this terror about leprosy was that Aboriginal lepers were being brought into the coastal towns in increasing numbers from a wide area of the Kimberley hinterland. Large groups were left for long periods in towns. Patients came into the rural outposts and towns and remained there exposed to the gaze of townsfolk. Large numbers of lepers seemed to be concentrated in transit towns like Broome, Derby and Wyndham, but this was largely an illusion driven by fear. In the four years, 1936–40, the Kimberley contributed 133 new leprosy patients out of a total of 192 new patients Statewide. The following table summarises the onset of the leprosy epidemic in Western Australia.[127]

Table 6.1
Leprosy in Western Australia, 1898-1940

Year	Males	Females	Total	Percentage increase
1898–1920	16	6	22	—
1921–1930	25	10	35	59%
1931–1935	111	50	161	360%
1936–1940	105	87	192	19%

Source: W.S. Davidson, 1978, pp.124-127.

As this table demonstrates, the absolute numbers involved in the epidemic were low but the crisis appeared to be much greater because of the huge increase in the rate of infection between 1931–35, when the number of diagnosed cases blew out by 360 per cent. The social, economic and cultural arrangements in the northern towns made infection of prospective new cases seem much easier to townspeople than it was in reality. A further reason for the continued unease among the white and Asian townspeople was that the situation at the 'native hospital' at Derby, as described by Davis, was 'chaotic'.[128] Moreover, Davis's criticism of the Aborigines Department staff was further adding to the alarm. He had pointed out that the leper compound was managed by Luyer and his wife on behalf of the Cheif Proctector of Aborigines. These two people had no medical training and operated more out of compassion rather than skill. Their brief appointment at the Cossack quarantine facility was hardly experience enough to manage a lazaret under epidemic conditions. Davis was angered by the staff's lack of experience in managing lepers, but the Department was powerless in such an isolated region to attract trained staff, more especially when it had to rely on a parsimonious government for such 'extravagance'.[129] The explosive increase in the number of leprosy patients confirmed the urgency of the situation that Davis was depicting.[130]

While the leprosy epidemic unfolded in northern Western Australia an event of international significance for leprosy treatment occurred in Sydney. A view had developed that the Commonwealth should encourage

States to develop segregated centres for treating Aboriginal lepers, isolating them from the rest of the population.[131] This became part of the Commonwealth's approach when Cumpston, Cilento and Cook addressed the International Pacific Health Conference in Sydney in September 1935.[132] The continuation of such a policy appeared odd, considering Sir Leonard Rogers' long-standing criticisms[133] and Cecil Cook's own well-known objections.[134] In Western Australia, meanwhile, the Government continued to expand the number of lazarets in the north as the number of lepers increased.

Political opportunists who contributed in one way or another to the complexity of the health and politics of the Kimberley region, continued to criticise the Chief Protector and the Government. On 11 June 1936, a member of the Legislative Assembly, J.J. Holmes, sent a report to the Minister for the North West, F.J.S. Wise. This report referred to the increasing numbers of patients being received at the Broome hospital. Holmes said that

> all governments—National, Country and Labour—were equally liable for the alarming spread of leprosy in the Kimberley … The Commissioner of Public Health was charged with the care of the white residents in this State, and the Chief Protector of Aborigines is charged with the care of the Aborigines.[135]

Holmes complained to the Minister about the Broome Road Board, which held responsibility for general health services to the Kimberley region. The Road Board's failure to act resulted from the fact that no common understanding existed between health workers and the Board about what health really meant. Holmes hinted at this when he claimed that

> the local health authority … the Broome Road Board, have definitely set their face against persons suffering from leprosy being allowed to remain within the boundaries of the Broome township. The district Medical Officer at Broome is opposed to having them in the hospital which is situated at the centre of the town, and where white and coloured patients, and out-door patients, receive medical attention … The departments preferred to say that the Broome hospital grounds is the place for leper subjects to be held until moved to Derby or elsewhere.[136]

Holmes went on to express his concern that all patients at the Broome Hospital were obliged to use the same seats and conveniences while

waiting for treatment. This, he remarked, would spread infection. Furthermore, maids and cooks were all employed from the Aboriginal compound across the road from the hospital and that was another health hazard.[137]

An appreciation of the legislative changes which sprang directly from the Royal Commission are crucial to understanding why the State Government and the missions were unable to agree on strategies for handling Aboriginal health problems and living conditions. The first important change, as mentioned above, was the appointment of inspectors.[138] As we have seen, Dr Davis took on the role of travelling health inspector. The second was that the State modified its legal understanding of who it now regarded, officially, as an 'Aborigine'.[139] The new definition created by the revised legislation considered all people of Aboriginal descent as Aborigines except 'quadroons' (people of one-eighth Aboriginal descent) over twenty-one who neither associated with nor lived after the manner of Aborigines. However, any person could lose that 'exempt' status through designation by a court.[140] The other important section in the legislation was the inclusion of the right of the Government to detain compulsorily for an 'examination and treatment' any Aborigine 'afflicted with disease'.[141] Neville had argued painstakingly before the Moseley Royal Commission for all these legal changes, and he had explained to the Commissioner why they were needed. Similarly, he had explained that he needed wider powers, and that the old Aborigines Department should become a Commission administered by Commissioners.[142] With the passage of the new legislation Neville gained all the powers he wanted. These enabled him not only to regulate mission development but also to deal with the problems posed by an expanding white rural industry and deteriorating Aboriginal health. Such powers nevertheless proved difficult to exercise.

Without elaborating on the growth and development of the Flying Doctor Service, it is sufficient here to observe that the Australian Inland Mission was a prime mover in its development. The service declared that it had a specific role, which was to provide a health service for rural white farmers and isolated pastoralists.[143] The antagonism between the smaller mission societies and the Chief Protector may be understood better if it is appreciated that Neville concurred with that role, and resisted mission pressure for the service to cater for Aborigines as well.

Moseley's Royal Commission had proposed a special arrangement covering the costs of medical fees for Aboriginal families working in the pastoral and coastal marine industries.[144] The new *Native Administration Act 1936*, which followed on from the Royal Commission, provided powers for the State Government to issue periodical 'regulations'. In July 1937

> the government gazetted further regulations of the Natives' Medical Fund, and required employers to contribute £2 annually with respect to every Aborigine permanently employed. At the same time the British Medical Association agreed to lower the doctors' fees for Aborigines covered by the fund, and the Medical Department reduced hospital charges for members of the fund.[145]

Neville had generally been above criticism by pastoral interests until this scheme came into force, when the regulations struck opposition both inside and outside of Parliament.

Finally, in the wake of the Royal Commission, the Chief Protector endeavoured to licence mission workers. This proposal antagonised individual missionaries and missionary organisations alike but it also rallied the support of local political representatives. So great was the reaction to Neville's proposal that, as Biskup commented, 'the missions and the churches must have taken the department by surprise, for it decided not to enforce the regulations'.[146] The government-mission conflict persisted. The Aborigines Department reasserted its authority, with detrimental effects for its relations with both Aborigines and the missions. These were to last into the post-war era.[147]

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Notes

1. I use the term 'people of Aboriginal descent' because not all people who had some mixture of Aboriginal descent were regarded, or regarded themselves, as 'Aborigines' until the gazettal of the *Aborigines Act Amendment Act 1936*; see also, Rowley, 1970, pp.250-254, and pp.290-315; see also, O.A. Neville, No. 7, 1948, pp.3-13, and O.A. Neville, 1948, pp.274-290; for aspects of legislation, see McCorquodale,1987, pp.95-98.

2. See Paul Hasluck's articles in, Paul Hasluck, 1939; see also, Paul Hasluck, 1988, pp.1-65; see also, Paul Hasluck, 1953; see also, Paul Hasluck, 1977, Chapter 17, pp.202-227.

3. Hasluck, 1977 p.220; but see also, Anna Haebich,1985, p.410.

4. Hasluck, 1977, pp.202-206.

5. Anna Haebich,1985, p.410.

6. A.O. Neville, 'Transcription of Evidence', in, *Transcripts of the Royal Commission Appointed to Investigate, Report, And Advise upon matters in relation to the condition and Treatment of Aborigines*, Battey Library, Perth Western Australia, AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), pp.595-651, (this document will here after be cited as 'Transcripts of Royal Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934)); see also, Mary M. Bennett, 'Transcription of Evidence', in, 'Transcripts of Royal Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), pp.246-248, and, pp.255-295.

7. *Ibid*., p.4.

8. *Ibid*., p.5.

9. Paul Hasluck's articles in, Paul Hasluck, 1939, see also, Hasluck, 1977 pp.215-220.

10. A.P. Elkin, 1947, pp.182-203, also quoted in Rowley, 1970 pp.294-295.

11. *Ibid*., pf.

12. 'Fredrick James Boxall, Rector Narrogin', in, 'Transcripts of Royal Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), p.189.

13, *Ibid*., pf, and is a term which Boxall actually uses.

14, *Ibid*., pf; see also, Biskup, 1973, pp.91-169; see also, Anna Haebich, 1985, pp.483-566.

15, Boxall, 'Transcripts to Royal Commission', p.189.

16, *Ibid*., pf.

17, *Ibid*., p.190.

18, *Ibid*., pf.

19, *Ibid*., pf.

20, *Ibid*., pf.

21, 'Keith Edward McGinn, medical practitioner Quairading, Transcript of evidence to Royal Commission 1934', in, 'Transcripts of Royal Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), p.232.

22. *Ibid*., pf.

23. *Ibid*., pf.

24. *Ibid*., pf.

25. *Ibid*., p.233.

26. Otto Raible, Chief Supervisor of the Roman Catholic Church in the Kimberley Division, in, 'Transcripts of Royal Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), pp.132-141.

27. *Ibid*., p.133.

28. AA, 659/1, Item 45/1/2887, 'Copy of one page letter from Sister Joseph of Convent of St John of God, Broome, dated 3.11.33'.

29. *Ibid*., pf.

30. *Ibid*., pf.

31. AA, 659/1, Item 45/1/2887, 'One page letter written by W.M. Henschke to H.G. Brown, dated 2 July 1934'.

32. Confidential (two page) 'Report from Dr Cecil Cook, Chief Medical Officer of the Commonwealth in Darwin, to His Honour The Administrator of the Northern Territory, Darwin, dated 5 March, 1934', in AA, 659/1, Item 45/1/2887.

33. Otto Raible, Chief Supervisor of the Roman Catholic Church in the Kimberley Division, in, 'Transcripts of the Royal Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), p.132.

34. *Ibid*., pp.133-134.

35. AN, 120/4, Acc. 1003, file 8297/1921, 'Hookworm Campaign – General Corro', folios 222-228; see also, AA, 1969/10/1, Australian Hookworm Campaign, see, Lewis (ed.), 1989, pp.239-245; see also, F.F. Longley, 1924, pp. 1-7; see also W.A. Sawyer, 1924 pp.1-6; see also, W.C. Sweet, 1924, pp.1-13.

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37. Otto Raible, 'Transcript of Evidence to Royal Commission 1934', pp.132-135.

38. Cook, 1925, pp.27-45; see also, P. Moodie, 1970, p.151.

39. AN, 120/4, Acc. 1003, file 79/1932, 'Leprosy in North West', see letter from Prime Minster to WA Premier dated March 1930, this letter talks about transportation arrangements of leprosy patients to Darwin and where the PM told the WA Premier that his Government would have to make provision for the transport.

40. Davidson, 1978p.32.

41. *Ibid*., p.33.

42. AN, 120/4, Acc. 1003, file 360/1927, Leprosy in North West, 'Broome Road Board', see memos dating back to July 1927, re labour and leprosy; see also, AN, 120/4, Acc. 1003, file 116/1934, 'Leprosy – Summary of Indicators In North West and Transfer to Darwin', folios 1-21 and folios 26-91.

43. *Ibid*., folios 33-34.

44. *Ibid*., pf.

45. Newspaper article in *Sydney Morning Herald*, entitled, 'Australia's Problem in Tropical Australia: Dr Cilento's Address, Tropical Colonisation', in AA, 1928/1, Item 635/38.

46. *Ibid*., pf.

47. *Ibid*., pf

48. *Ibid*., pf.

49. AN, 120/4, Acc. 1003, file no. 360/1927, 'Leprosy in North-West'.

50. AN, 120/4, Acc. 1003, file no. 116/1934, title, 'Leprosy – Summary of incidents in Nth West, and Transfer to Darwin', folios 1 and 21.

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53. *Ibid*., folio 21.

54. *Ibid*., folios 41 and 53.

55. *Ibid*., folio 25.

56. *Ibid*., folios 90-91.

57. Australian Press Cutting, in AA, 659/1, Item 45/1/2887, see *West Australian*, Perth WA, 'Native Lepers, Misconception about Disease', dated 14 March 1934, p.5.

58. *Ibid*., pf.

59. *Ibid*., pf.

60. Davidson, 1978, pp. 104-105.

61. AN, 120/4, Acc. 1003, file No. 683/1934, 'Leprosy – Case of Mrs Z'; see also, AN, 120/4, Acc. 1003 file no. 1765/1923, 'Leprosy in North-West'; see also, AN, 1/7, Acc. 993, file no. 3/1936, 'Leprosy among natives in the North-West'; see also, Libby Peebles, 1992, pp.20-24.

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72. *Ibid*., p.406.

73. *Ibid*., p.407.

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103. A.O. Neville, Chief Protector of Aborigines', dated, 12.3.34, in, 'Transcripts of Royal Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), p.7.

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107. *Ibid*., p.9.

108. *Ibid*., pf.

109. *Ibid*., p.10.

110. *Ibid*., pf.

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112. *Ibid*., pf.

113. *Ibid*., p.11

114. *Ibid*., pp.11-12.

115. *Ibid*., p12.

116. *Ibid*., p.13

117. *Ibid*., pf.

118. *Ibid*., pf.

119. *Ibid*., pf.

120. *Ibid*., pf.

121. *Ibid*., pf.

122. *Ibid*., pp.13-14.

123. *Ibid*., p.14.

124. Biskup, 1973, pp.273-282, Biskup detailed catalogues of funding both from Government to the Aborigines Department, which was nearly stable from 1915 to 1934 and detailed grants from the Chief Protector to Missions, which actually fell from 1915 to 1934; for legislative changes see, McCorquodale, Aborigines And The Law, pp.95-98.

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126. Maisey McKenzie, *The Road To Mowanjum*, Angus and Robertson, Melbourne, 1969, p.98.

127. Davidson, *Havens of Refuge*, pp.124-127.

128. *Ibid*., p.57.

129. *Ibid*., pf.

130. *Ibid*., p.58.

131. AN, 120/4, Acc. 1003, file 116/1934, 'Leprosy — Summary of incidents in North West and transportation to Darwin', see report dated 12 October 1932 by R.W. Cilento, on Aboriginal Survey, 'Report to The Director General of Health Canberra', p.7.

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135. J.J. Holmes (Member of the Legislative Assembly WA), Report on Broome Hospital, Leprosy and Treatment of Aborigines', in Davidson, 1978, pp.156-164, see quote on p.156.

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140. *Ibid*., pf; see also, Hasluck, 1977, pp.22-27.

141. *Ibid*., pf.

142. A.O. Neville, 'Transcription of Evidence', in, A.O. Neville, Chief Protector of Aborigines', dated, 12.3.34, in, 'Transcripts of Royal Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), pp.595-686; Neville gave evidence in May 1934, when the Commission began hearings, and then again in December of 1934. The December hearings appear to be special sittings to answer problems for Commissioner Moseley posed by other witnesses. Moseley handed down his report early in 1935.

143. Maisie Mackenzie, 1990, pp.17-103; see also, AA, 1658, Item, 614/2/1, Pt 1-4, 'Medical Services General – Flying Doctor Service General, 1947-1961'. These files are not comprehensive but have pamphlets and some memos of interest only; see AA, 1928, Item 715/8, Section 1, 'Northern Territory Medical Services Katherine Darwin'. These files have data on Royal Flying Doctor Service (RFDS), and the Rev. Frank Flynn, the initiator of the RFDS.

144. A.O. Neville, 'Transcription of Evidence', in, 'Transcripts of Royal Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), pp.1-7; see also, *Report of the Royal Commission appointed to Investigate, Report and Advise upon matters in relation to the condition and treatment of Aborigines*, Vol. I, WAV&P, 1935, pp.23-24.

145. Biskup, 1973, pp.170-178.

146. *Ibid*., p.174.

147. *Ibid*., pp.174-178.

Readers should be aware that the following images may cause distress.

Readers are reminded that if members of some Aboriginal communities see names or images of the deceased, particularly their relatives, they may be distressed. Before using this work in such communities, readers should establish the wishes of senior members and take their advice on appropriate procedures and safeguards to be adopted.

Plate 1: Local Aboriginal crew members of the Rita, a Kimberley supply boat: left-right are Ikey, Teddy and Jacky, 1916. (From the Basedow collection, AIATSIS)

Plate 2: Young 'full-blood' Aboriginal women of the King Leopold Ranges, Western Australia, about 1916. The woman in the centre, aged about 20, is suffering from ulcerating granuloma of the pudenda. (From the Basedow collection, AIATSIS)

Plate 3: A man, aged about 45, from the Port George IV area of the northern Kimberley region, Western Australia, suffering an osteoma (bone tumour) of the right leg, about 1916. (From the Basedow collection, AIATSIS)

Plate 4: Effects of yaws or syphilis: a youth aged about 15 from the Port George IV area of the northern Kimberley region, Western Australia, suffering the wasting of facial tissue common in advanced treponema infections, about 1916. (From the Basedow collection, AIATSIS)

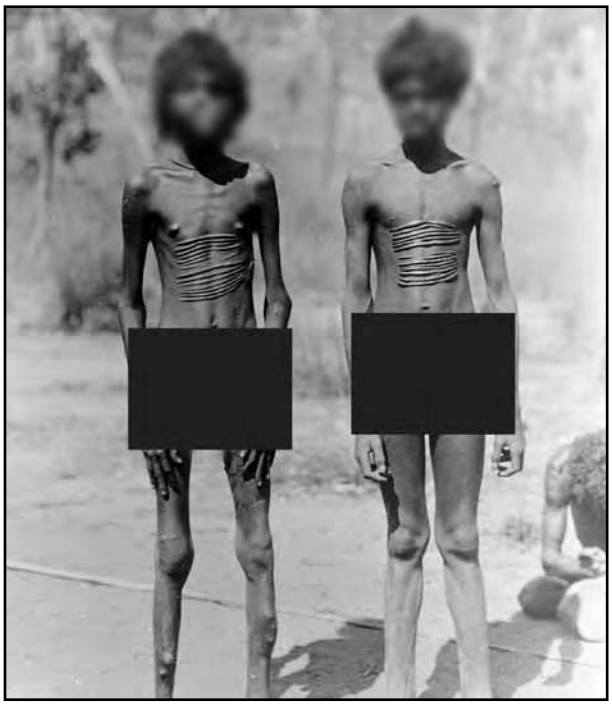

Plate 5: The youth on the left is the one shown in Plate 4. He is suffering leg ulcers as well as the loss of facial tissue; the youth on the right is suffering genu valgus (knock-knees) and flat feet, about 1916. (From the Basedow collection, AIATSIS)

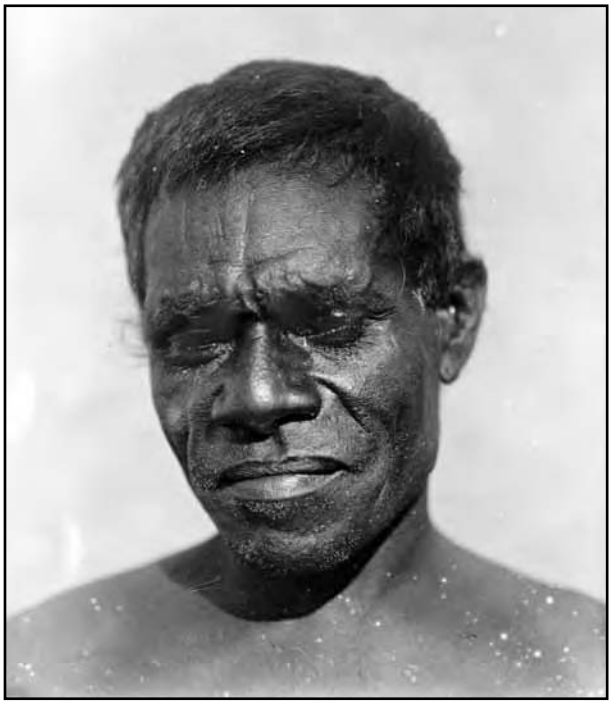

Plate 6: Early stages of leprosy showing a man from Sunday Island, Western Australia, 1916: the thickening of the eyebrow tissue is a symptom of the early onset of leprosy. (From the Basedow collection, AIATSIS)

Plate 7: Aboriginal female lepers carrying water to the kitchen at Napier Downs station, Derby, Western Australia, 1916. (From the Basedow collection, AIATSIS)

Plate 8: Chinese cook and female Aboriginal assistant at Napier Downs station, Derby, Western Australia, 1916. (From the Basedow collection, AIATSIS)

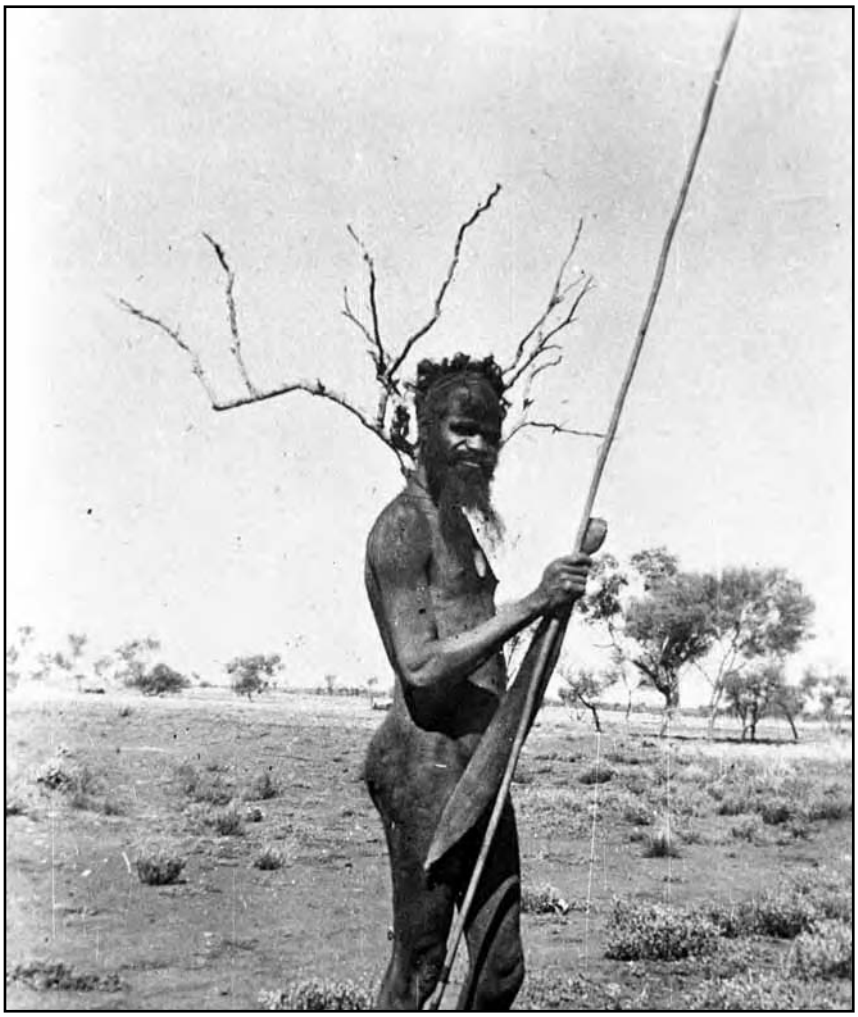

Plate 9: A 'bush' Aboriginal close to white settlement, his legs and buttocks show scarring from burns due to sleeping close to fire, circa *1928–32.(From the Brainwood collection, AIATSIS)*

Plate 10: Boy showing facial wasting caused by yaws, 1920. (From the Basedow collection, AIATSIS)

Plate 12: An Aboriginal man from Alligator River, Northern Territory, aged about 30, showing the facial nodules typical of advanced leprosy, 1920. (From the Basedow collection, AIATSIS)

Plate 11: An Aboriginal woman, aged about 60, from Pine Creek, Northern Territory, showing the effects of leprosy and its complete destruction of the nasal septum and depressed tip of nose; paralysed lips, strong naso-labial fold and drooping eyelids, 1920. (From the Basedow collection, AIATSIS)

Plate 13: A 40year-old Aboriginal man from Port Darwin, Northern Territory, with the fingers on both hands reduced to stumps as a result of advanced leprosy, 1920. (From the Basedow collection, AIATSIS)

Plate 14: An Aboriginal man and woman, Tony and Frank, in the aged people's fringe camp, Barambah, Queensland, circa *1928–32. (From the Brainwood collection, AIATSIS)*

Plate 15: Government nursing staff, Barambah, Queensland, circa *1928–32. (From the Brainwood collection, AIATSIS)*

Plate 16: A community photograph of the children at Barambah, Queensland, circa *1928–32. (From the Brainwood collection, AIATSIS)*

Plate 17: Government-built cottages at Barambah, Queensland, circa *1928–32. Note the small size of the cottages, which might have housed six people or more. (From the Brainwood collection, AIATSIS)*

Plate 18: Older housing at Barambah, Queensland, circa *1928–32, possibly for people living away from the main settlement. Note the 'gunyah' in the right foreground, probably for older people. (From the Brainwood collection, AIATSIS)*

Plate 19: A group of elderly Aboriginal men outside the old men's dormitory, Barambah, Queensland, circa *1928–32. The man lying centre foreground is said to be 'waiting to die'. (From the Brainwood collection, AIATSIS)*

Plate 20: A group of Aboriginal women and children outside the western fringe camp at Barambah, Queensland, circa *1928–32. Such camps were usually for elderly or sick people who preferred that type of accommodation to the Western-type housing available elsewhere on the reserve. (From the Brainwood collection, AIATSIS)*

Plate 21: A group of Aboriginal men beside a fringe bush camp in a clearing about 1.6 kilometres from the Lockhart River mission, North Queensland, circa *1924. (From the MacFarlane collection, AIATSIS)*

Plate 22: A group of Aboriginal men and women in front of the mission house, Cowal Creek, Queensland, circa *1924. (From the MacFarlane collection, AIATSIS)*

Plate 23: Aboriginal men stand in front of a bush hut near the Lockhart River mission, North Queensland, circa *1924. (From the MacFarlane collection, AIATSIS)*

Plate 24: Margaret, the Aboriginal house mistress at the Lockhart River mission, North Queensland, with a group of the schoolgirls for whom she was responsible, circa *1924. The girls had probably been removed from the main group of residents at the mission to receive schooling. (From the MacFarlane collection, AIATSIS)*

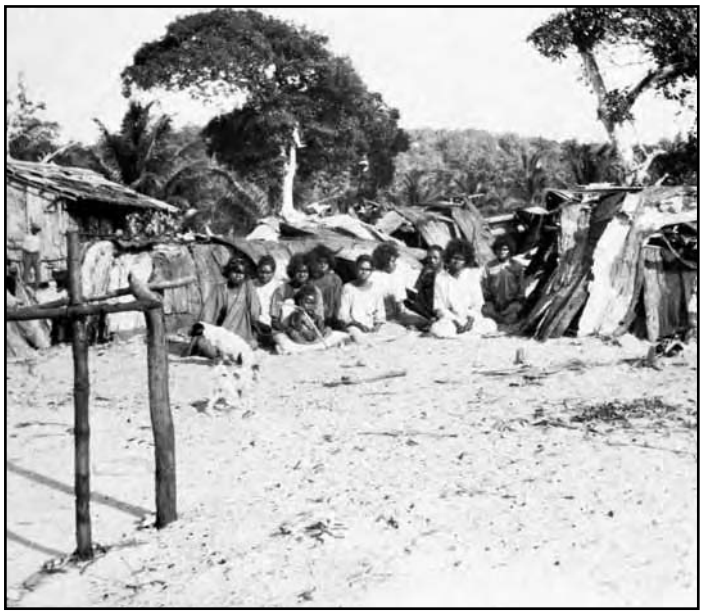

Plate 25: A typical fringe camp of the Lockhart River mission, North Queensland, circa *1924. (From the MacFarlane collection, AIATSIS)*

Plate 26: A beach fringe camp near the Lockhart River mission, North Queensland, circa *1924. A family group sits front left. Note their dog, front right. Dogs were for protection against intruders, useful for hunting and for keeping warm at night (From the MacFarlane collection, AIATSIS)*

Plate 27: A group of Aboriginal residents outside the church of the Peel Island leper colony, North Queensland, circa *1928–32. (From the Brainwood collection, AIATSIS)*

Plate 28: An Aboriginal funeral at Barambah, Queensland, circa *1928–32. As the death rate from tuberculosis and other respiratory infections rose, such sights were common at Barambah and other Aboriginal settlements. (From the Brainwood collection, AIATSIS)*

Plate 29: Aboriginal men queue for service at the Barambah, Queensland, store on 'order day', circa *1928–32. (From the Brainwood collection, AIATSIS)*

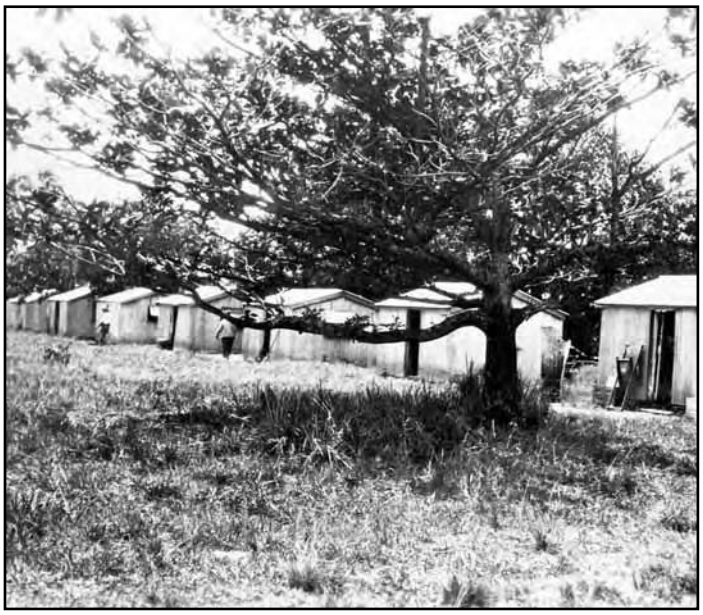

Plate 30: The Aboriginal men's huts at the Peel Island leper colony, Queensland, circa *1928–32. The colony was segregated: 'blacks' (Aborigines, Torres Strait Islanders and Pacific Islanders) were sent to the Peel Island colony; Europeans and Chinese went to Phantome Island. (From the Brainwood collection, AIATSIS)*

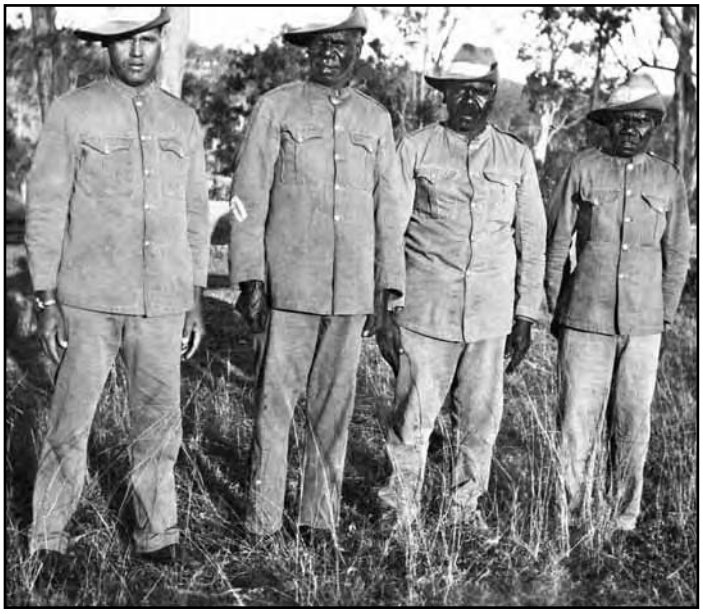

Plate 31: Aboriginal ('Native') police at the Barambah government reserve, Queensland, circa *1928–32. These men were employed under Queensland's Aborigines Protection Act of 1927, their main purpose being to service the 'native' courts at Barambah and to apprehend people who committed offences against the Act. (From the Brainwood collection, AIATSIS)*

7

Protection and disease pools: Aboriginal health in Queensland 1900–10

After four chapters focusing solely on Western Australia, we must now return to Aboriginal population health in Queensland.[1] Contemporary historians have tended to depict Aboriginal-settler history in Queensland pre- and post-1900 under all-embracing terms. Thus, 'dispersal' is the metaphor commonly used to depict the pre-1900 phase and 'exclusion' for what came afterwards. Such broad terms, however, cannot adequately summarise the manifest complexity of events extending over many decades. Many historians nevertheless favour these terms.[2] Few apart from Rowley[3] have attempted to consider Aboriginal demography in all its nuances when 'writing back' the Aborigines into Australian history.

The last phase of white settlement in Queensland began around 1900 and lasted until just after World War I. All that was left to settle was the hinterland of the Gulf of Carpentaria and Cape York Peninsula. In addition, there were sparsely settled pastoral areas along the New South Wales border, west from Roma to Cloncurry and in northern South Australia (now the Northern Territory). Land settlement there inevitably impacted upon the Aboriginal population. How large that population was is a matter of opinion. Those best placed to make estimates were the protectors and missionaries working in such remote regions.[4] Scholars, however, have been peculiarly unwilling to rely on their word. Instead they have followed Charles Rowley,[5] J.P.M. Long[6] and Dawn May[7] in believing that there were huge numbers of Aborigines living in the bush beyond white settlement.[8]

At this point we need to introduce Archibald Meston (1851–1924), one of the most influential of commentators on Aboriginal affairs in the colonial era. Meston was a journalist, civil servant and explorer who was

born in Scotland and came to Sydney with his parents in 1859. In 1874 he went to Queensland to manage a plantation on the Brisbane River. From 1875 to 1881 he edited the *Ipswich Observer* and represented the Rosewood electorate in the Queensland Legislative Assembly. An early interest in exploration led him to conduct a survey into the Bellenden Ker Ranges. In 1894 the Colonial Secretary commissioned him to 'prepare plans for improving the lot of Aborigines in Queensland'.[9] This work was incorporated into Queensland's *Aboriginal Protection Act 1897*. When the Act was implemented Meston was made Protector of the Southern Region of Queensland, a position he held until 1903. More than anyone before, Walter Roth (see previous chapters) and Archibald Meston took an interest in the well-being of Aborigines and travelled more extensively than most protectors. Meston's impact on protection policy had a lasting effect on the operations of both government and mission protection agencies.[10]

Without having explored very far into the Gulf country, Meston's travels had convinced him that large numbers of Aborigines with little or no contact with whites were still living their traditional lives in the thin wetland strip of the Gulf coastal region.[11] He believed they needed to be protected from their generally disastrous relations with whites, Asians and South Sea Islanders, and that they would be safer if they gathered together on reserves and were excluded from the towns. [12]

Populations in central and far western Queensland had only been estimated. By 1900, Aboriginal 'remnants' in the southern areas around Brisbane and west to Blackall who had not been killed off or died from diseases had taken up permanent residence on pastoral properties, ultimately vacating their traditional living places. They had been replaced as the dominant population by white settlers migrating south and west. The native police had played a part in eliminating some Aborigines but this punitive force was small and its activities restricted to the Great Dividing Ranges and the coastal strip between Brisbane and Cairns.[13] How many Aborigines remained in Queensland by the turn of the century could only be guessed at. As explained in earlier chapters, people of mixed-descent were included in the census from 1901 and all other national censuses.[14] As a result of the distorted means of estimating the total Aboriginal population, Commonwealth and State census officials appeared to accept the population decline from 26, 670 to 17, 967 in the period 1900–40.[15]

In 1900 the settler population, as estimated by the Registrar General, totalled 502, 415. The Aboriginal population was 6670 (3862 men, 2808 women). These estimates referred only to those people 'engaged in industrial pursuits, or as living in fixed abodes, and who had abandoned the nomadic … [environments] of the ordinary Aboriginal'.[16]

By 1900 pastoral settlement extended from Brisbane west to Dalby, Roma and Charleville, then north from Brisbane to Coen, west of Cairns, but remained south of the Cape York region.[17] Attempts to both extend settlement to Cape York and christianise Aborigines had failed in the 1860s.[18] With the abandonment of the outpost near the tip of Cape York at this time, the task of missionising the Aborigines in this region also had to be postponed until the 1890s and later.[19] As the Queensland settler economy and population grew, so did the need for the Government to protect Aborigines rather than leave the State's interests in the hands of missionaries alone. Archibald Meston made himself an advocate for Aborigines, and the Government quickly seized upon his ideas about protection.

Meston saw Aboriginal ill-health as a consequence of starvation, ignorance and superstition. In 1900 he reported that

> all the minor ailments afflicting European communities are met with among the Aboriginal population, though what with ignorance and superstition, want of proper care and nourishment … their effects are not easily … [removed]. At Cloncurry five deaths took place last October during the epidemic of a disease resembling measles, while at Urindangi, in April … thirteen deaths occurred from influenza and dysentery; in other cases, the rations supplied assisted in saving many lives.[20]

Wherever Meston travelled, he saw Aborigines who appeared to be wasting from tuberculosis and syphilis. It was a relief to him to find pockets of the population who had escaped veneral disease, though where syphilis existed it had long-term infectious effects because of the lag between infection and the emergence of its symptoms.[21] Meston also suspected that the mouth to mouth sharing of native tobacco (*pituri*)[22] was aslo a cause of the spread of syphilis. Treating syphilis was difficult because 'the semi-civilised blacks take medicine neither constantly nor regularly',[23] and they sometimes drank the whole bottleful. If the sick person saw no cure within a short time, Meston said, then they regarded both doctor and medicine as 'no good'.[24] Local remedies of western

medicine were used by protectors and police on the one hand, while on the other, Aborigines in the camps used sorcery and witchcraft.[25] So numerous were the cases of syphilis, and so 'foulsome' were the sufferers who roamed the district that Meston created a lock hospital about eight miles outside of Cooktown, 'where any such really bad cases could be treated'.[26]

Yet, Meston's views were somewhat contradictory for he also objected to diseased or sick Aborigines being indiscriminately collected up and 'removed to reserves'.[27] This was not only objectionable as 'a matter of justice'[28] but also impractical because of the numbers of Aborigines with infections.[29] For diseased Aborigines living too far from medical attention, Meston encouraged police and local protectors to give relief, including rations and tobacco, 'and so help them make their last days on earth a little more bearable'.[30] Even in 1900 government medical officers had the duty of attending to sick Aborigines, with these doctors also supplying medicines paid for by the Government to police, mission stations and anyone willing to take responsibility for caring for sick Aborigines.

Partly for his own convenience, Meston created the Deebing Creek depot where he could treat the sick and diseased people. He could then bring doctors, rather than do battle with hospital officials for beds. One consequence of this was that such camps became an alternative to placing Aborigines in hospitals.[31] The problem with this solution was that once a holding place was created for sick Aborigines it soon became overcrowded.[32] Meston's forcefulness in such enterprises contrasted with the methods of Walter E. Roth, who was still a student in England when Meston was at the peak of his influence.[33]

In Queensland, Walter Roth, like Daisy Bates in Western Australia, was the first ethnographer to record from Aborigines a wide range of their customary beliefs about disease and health. He gathered his information from across Queensland. Unwilling to accept the say-so of other public officials, Roth sought a scientific means for understanding Aboriginal society and culture. He believed that the new discipline of social anthropology should inform government policy;[34] and by documenting traditional ideas on health, healing and sorcery he added to this body of knowledge.[35]

Roth had studied at Oxford with Baldwin Spencer, who later became

Professor of Biology at Melbourne University. They continued for a time as ethnographic colleagues after Roth came to Australia in the 1890s.[36] Roth was still working as an ethnographer at the turn of the century. He described the belief that sorcerers could strike at an enemy by inflicting diseases and accidents to doom the victim beyond recovery. Such superstitions, he believed, accounted for the difficulty in halting the spread of venereal disease, making medical treatment almost impossible because people could not see the link between cause and effect.[37]

Roth was amazed at the complexity of Aboriginal belief about sorcery no less than by their ability to explain all events through its effects. Often, if the sick felt themselves getting weaker they assumed they were the victims of sorcery and then accepted their fate.[38] They also believed that people who became the targets of sorcerery could be identified by their strange behaviour.[39] On the other hand, even if sick people healed quickly sorcery was still assumed to have worked. The origin of the sorcery however might now not be revealed, and the sorcerer responsible, could escape. Roth also found that magic played an important part in exerting social control: death from sorcery awaited the breakers of custom.[40] In addition, sorcerers were thought, by Aborigines, to be able to cause accidents as well as illnesses. These sorcerers, it was belived, had special kinds of capacitiies to make patients believe that the dead could re-appear. Even events such as thunder and lightning were taken as signifying evidence that sorcerers were at work.[41]

The source of the sorcerers' supernatural powers came from the objects they carried in small leather bags tied around their waists. They and their patients believed that, as well as using the contents to practise 'black' magic, they could work 'white' magic to alleviate pain and bring about cures. Diseases of all kinds, whether observable or not, had only one name, *'turrwan'*.[42] The sorcerers, or 'doctors' as Roth reluctantly called them, had a powerful position of influence throughout Queensland no matter what methods they used. Aborigines believed that their powers affected everyone, except other more powerful sorcerers. Roth took the opportunity of discussing such beliefs with customary medicine-men, or doctors, but he probably only learned a fraction of the mysteries of their craft.[43]

Roth recognised that the power of Aboriginal belief in sorcery—'superstition'—had ramifications for the effectiveness of Western medicine

in healing diseased Aborigines. Aborigines' understanding of sicknesses and the efficacy of remedies could not be separated from their belief in sorcery. Blindness from trachoma, for example, was believed to have resulted from disobeying ceremonial practice or breaking 'taboos' rather than from infection.[44] Even children could be implicated in their relatives' illnesses if they unwittingly ate the wrong foods or obliviously became the agents of the sorcerers.[45] Roth's research went some way towards explaining why European medicine could hinder rather than promote healing among Aborigines in the face of the competing belief systems. Aborigines, he said, were unwilling and unable to reconcile their superstitions with the strange ideas of European medical science. Roth held the idea that it was import for people such as police, missionaries and protectors had an understanding of Aboriginal belief systems. All such people, he believed, should develop an understanding of the Aborigines' view of life and the environment. Ideas about hygiene were even harder for Aborigines to assimilate, most probably because of the time lag between setting up a new dwelling place and the onset of infectious disease. Roth travelled widely across Queensland and he entered many Aboriginal camps that he believed both held great danger for residents health and held potential difficult problems for Aborigines and white society as well.

Protectors occupied an arbitral position between Aboriginal labour and the property owners. This was resented by the latter, who saw protectors as agents for Aborigines rather than as serving a public interest in scrutinising agreements drawn up under the 1897 protection legislation. By 1900, however, the weaknesses of the legislation in being able to deliver care to destitute, sick and aged people were obvious to Roth. He believed that pastoralists, Chinese traders and foreign mariners were abusing the protection legislation. He pushed for greater powers to be given to protectors to force employers to comply with the agreements they made with Aborigines. The private property owners and pastoralists took every opportunity to complain. His main suggestion for amending the legislation was for the creation of a hierarchy of protectors, with a Senior Protector appointed to supervise a number of deputy protectors, all of whom would ultimately be answerable to the Chief Protector.

Roth proposed two processes for regulating relationships between the pastoralists and Aborigines. Both involved the creation of registers. One register was to control Aboriginal labour relations, the other was to record information about Aboriginal disease and mortality. The employment

register allowed protectors to keep a record of all people employing Aborigines. It indicated which pastoralists had to renew their agreements with Aborigines each year. New restrictions were imposed on the amount of time land owners and merchants could employ Aborigines or remove them from the protection of the State. Employers had to record in the register all transactions, such as wages paid to Aboriginal employees as well as gifts of rations, and detail the blankets and other articles given to Aboriginal workers and their families, and account for any new agreements they made with Aboriginal contracted labour. Police and protectors were also given wider powers to over-ride the authority of local hospital staff and their managing committees in order to force them to give access to health care for sick and diseased Aborigines. If Aboriginal workers were indentured, their health accounts had to be covered by graziers.

The new protection legislation established a number of health reforms.[46] It forced protectors and health officials to record all Aboriginal deaths in an official register. Nowhere in Australia in 1901 was there a system for keeping registers of the number of Aborigines who had died from natural causes, injury at work, infectious diseases, from violence in the camps or at the hands of Chinese, Kanaka or white settlers. In Queensland the protectors were required to file annual returns on Aboriginal deaths, even if they had no powers backed by legislation to compel employers, missionaries or mining and market gardeners to report Aboriginal deaths and the causes of deaths. Roth's proposals were aimed at correcting that discrepancy.

Legislative powers already existed in the 1897 protection legislation, but although Parliament accepted suggestions to tighten employment relations it failed to allocate additional funds to implement Roth's strategies for monitoring Aboriginal mortality and disease. The amendments which were legislated did two things: they made administrative changes to centralise the Aboriginal population and gave protection to Aborigines throughout the whole of western and northern Queensland. The additional protectors provided more information on what was occurring at a distance from Brisbane. Protectors reported more fully on the needs facing Aborigines and on what they believed was necessary to address these. Protector Quilter's annual report of 1900 to Home Secretary Tozer, for example, advised that in his district of Cloncurry there were several camps with a total of 71 Aborigines (39 men, 32), of whom 21 were under agreement.[47] Quilter's report also indicated that 11 Aboriginal

workers were under agreement at Cork and Brighton Downs.[48] Protectors now had power to feed and protect starving, sick and destitute Aborigines, even if some isolated protectors chose not to exercise these powers. Quilter was one who didn't. He wrote that he refused to issue some Aborigines with rations and blankets because he believed 'that they would come to expect it'.[49] The reforms nevertheless brought greater relief to Aborigines in the old pastoral regions of the west and the newly settled areas of the Cape and Gulf regions, and also gave support to missions which had previously concentrated on teaching children to read, write and count.[50]

At the same time, the new powers enabled protectors to move Aborigines from the fringes of western country towns, and in 1901 about 401 males and females were removed from fringe camps to ration depots near Brisbane: the latter were Durundur, 30 kilometres from Caboolture, and Deebing Creek, 10 kilometres north of Ipswich. Camp people were not the only ones to be moved to eastern relief depots. Police sent those Aborigines arrested for petty crimes into the custody of the Southern Protector, Meston. The largest groups of Aborigines forcibly removed numbered between 33 and 63. Some of the people removed suffered from alcoholism, some were lame, crippled or paralysed, blind, old and infirm. Some people had been fed for some years and needed medical attention.[51] Following the legislative changes, a protector reported to Meston that

> medical treatment was arranged and medicines sent for sick Aboriginals in various parts of the West. I sent one packet of medicine to the care of Sergeant O'Connor, at Boulia, in the far North West. Blacks whose ailments … [could not be treated were] removed to the coast, where they could be treated properly. These include four blind Aboriginals and three permanent cripples.[52]

The new legislation did little to benefit fringe-camp Aborigines in western parts of the State, particularly dependent sick and ageing individuals. Although many Aborigines suffered sickness and the effects of aging, police protectors moved such people eastward to ration depots simply to force them out of the area rather than because they were disabled.[53]

Protection thus became an excuse for moving people across the State. The usual justification was that Aborigines had to be protected from the ravages of white settlement and from themselves.[54] Aboriginal belief, built on traditional customs and attitudes, proved unable to cope with the

change. It failed to convey an understanding of the adjustments needed when moving from one form of dwelling place to another, including the need for hygiene when living permanently on one small area of land. Settlers were not able to see what was happening and could not appreciate that crowded and polluted dwelling places created conditions for the rapid transmission of disease. It was almost inevitable that, as Roth observed, there would be an increase in the number of people dying from respiratory diseases in particular.[55] Roth noted that consumption (tuberculosis) accounted for eleven deaths in 1901, three of the women being wives of the same man. At Yarrabah, four people died from it, making an accumulated total at the missions, of 24 deaths from tuberculosis between 1893 and 1901. While this was only an average of three deaths each year, it was a sign that living in larger concentrations aided the spread of tuberculosis. Many of these people, according to Reverend Gribble, were near death on arrival at the mission.[56] Tuberculosis was killing Aborigines in relatively large numbers, and by 1902 appeared to be endemic.[57]

Sedentary living increased the infectious pool for adults, but even more for children. Children suffered everywhere that Aborigines lived. Roth tried to raise public interest in disease among the Aborigines, particularly tuberculosis and venereal disease, each of which was affecting young children. The dilemma that Roth faced in providing health care was that he lacked the legislative power to act effectively. This remained a difficult issue. For example, Topsy, 'a little girl, twelve years of age, from Magoura Station, suffered with syphilis. The station owner brought her to Normanton where [she was] joined by her sister in the local camp'.[58] Roth reluctantly sent the children directly to Mapoon mission. His report to the Minister indicated that he asked Galbraith, the protector there, to

> report as to the ability of the sister to provide Topsy's wants. He [Roth] did not care to trespass too much on the kindness of the Mapoon Mission people, to whom we have already sent diseased half-caste children; and if, ultimately, it may be desirable to send her there, I think it only fair that the superintendent be consulted beforehand.[59]

At the same time, many people from Thursday Island were reported to be suffering from syphilis. They presented with numerous leg and body ulcers and were taken to the mainland for treatment. On those mainland mission stations seven 'cases of ankylostomiasis existed … and a few deaths from phthisis had occurred. In the Gulf missions tubercular and venereal diseases have claimed a few victims'.[60]

As Chief Protector, Roth wrote to the Society for the Prevention of Consumption to ask for help. He gave a general description of the disease among Aborigines living on missions in the Cape York region.[61] He met with Dr Hirschfield to discuss the large numbers of Aborigines who were contracting the disease on the bêche-de-mer boats. 'Phthisis', or some similar pulmonary disease, was widespread in the area and Hirschfield sent printed material to the various missions to advise how lay missionaries could diagnose, treat and carry out surveillance of the disease. Tuberculosis sufferers went to the same camps as people with venereal and other infectious diseases. The Cooktown and Cloncurry hospitals refused to treat patients diagnosed as carriers of venereal diseases. As a result, many people suffering from other maladies where wasting was obvious, were also refused entry,[62] and were forced to remain in camps nearby.

Such camps acted as pools of infection and they retained diseased people of all kinds. Aborigines of full- and mixed-descent came from missions and pastoral properties looking for medical care. They stayed for long periods of time at the depots and bush camps, waiting for follow-up medical attention. People suffering from sexually transmitted diseases lived crowded together, and pregnant females were frequently among their number. These circumstances intensified the dangers of these living sites. Protector Galbraith complained that

> [from] all parts of the district comes the same tale: venereal and ophthalmia … [The sick are held in] outside places away from civilisation … there is … [no] freedom from disease. There is no way of combating this evil, except by quarantine: to point out my reasons for same would only mean reiterating your arguments to bring forward facts that you are obviously acquainted with.[63]

There were probably many deaths from disease at stations like Yarrabah (on Cape Grafton near Cairns), Mapoon (on the Batavia River), Weipa (on the Embley River), and Hope Valley (at Cape Bedford near Cooktown), but there was no legal requirement to record these deaths.

In 1902, Roth wrote to the Registrar-General's Department seeking information on the prospect of recording Aboriginal deaths. The Registrar-General replied that 'births and deaths of full-blooded aboriginals are not registered, whether residents at mission stations or elsewhere'.[64] Births of half-castes, he added, 'are registered only when certified to by the white parent, and the matter of civilisation would be considered when deciding whether or not the death of a half-caste should

be registered'.[65] This view of the proper ambit of registration complicated the question of who was responsible for protection and who could be protected. Similarly, it confused people in the bodies operating ration depots and isolated missionaries engaged in protection. In addition, because protection agents sometimes had difficulty determining who was regarded as an Aborigine, there was confusion when putting protection policy into practice.

Cost was always a constraint in tackling disease among the Aborigines. Hospitals needed to cover the costs of servicing the sick but the Chief Protector had to justify expenditure on relief and health care to Parliament. Hospitals had the responsibility of treating sick Queenslanders, but only those paying for the service. On this matter, Roth reported to the Minister that 'a letter had been sent to the Cloncurry and Cooktown Hospitals about the department refusing to pay charges for Aboriginal paupers. Aborigines classified as not in legal employment had the right to claim pauperism'.[66] Aborigines employed under the protection legislation had legal cover through their employers but those living on protection stations, reserves, camps and missions had no legal health cover. What normally happened during epidemics, such as occurred in 1904, was that 'the fever-stricken blacks'[67] at Cape York, relied almost solely on the compassion of the local protector, Bennett, who 'sent across rations and medicine',[68] but despite this some men died.[69] Thus, in 1904, missionaries living on remote settlements and caring for sick Aborigines had to rely on the generosity of protectors whenever epidemics occurred, or whenever injuries from accidents were suffered.

Access and medical costs were a continuing dilemma for health workers who treated sick Aborigines. For example, doctors had discretion in accepting sick Aborigines as patients. If Aborigines did come to their surgeries for treatment and could not pay, the doctors redirected them to hospitals. When they arrived at the hospital they either recieved immediate attention or were dispatched to government relief depots. Sometimes hospital staff would not allow them in to hospitals and would send them to bush camps on the fringes of town to await treatment and follow-up treatment. Some were refused treatment altogether. In 1904, for example, the Rev. Gribble, Superintendent of the Yarrabah Mission, wrote to the Chief Protector asking if the Cairns hospital 'had the right to refuse entry' to Aborigines.[70] Gribble was told that 'the matter was entirely in the hands of the various hospital committees'.[71] Gribble's action was prompted by Dr Browning of Taroom, who charged high fees.

Those Aborigines who could not pay the doctor went to the Cairns hospital, which might also refuse them treatment. They were then forced either to go back to the doctor or remain untreated. Although no information exists on the treatment prescribed by Dr Browning, but Browning sent the bills to Gribble, who forwarded the accounts to the Chief Protector. One bill sent to the Chief Protector was for £20 for a sick female Aborigine named 'Sissey Queenslander'. Browning later reduced the fee to £10/5/.[72]

Roth had to battle with hospitals to open them up to sick Aborigines and he also had running disputes with the hospitals that sought payment for servicing Aborigines. The most disturbing of these incidents were those where hospitals staff exercised their discretion to refuse sick Aborigines access to country hospitals. Sometimes sick Aborigines were simply left at hospitals. They might be turned away but if the illness was serious they might be admitted and their accounts forwarded to the Chief Protector. The Chief Protector then had to decide either to dismiss the request or to pay the bill. Roth reported to his Minister that he had refused to certify one voucher tendered by a medical officer because 'a pauper native, with a fractured arm'[73] had been admitted into the subsidised government hospital at Boulia.[74] The practice, and expectation, was that government-subsidised hospitals gave sick Aborigines free services. This custom, however, was not always followed, partly because of the difficulty of hospital staff having to decide who was an Aborigine, and partly because many of the people classified as Aborigines by protectors and hospital staff might not accept this categorisation.[75]

The following year, Roth returned from conducting his Royal Commission into the conditions of Aborigines in Western Australia (which the previous chapter examined). The Member for Cook in the Queensland Legislative Assembly, John H. Hargreaves,[76] raised complaints about Roth in Parliament. He alleged that F.T. Briggs, a local landowner and constituent of Cook electorate, had made a statement to him that 'the protector refused to attend a blackfellow who was seriously ill'.[77] Briggs further accused Roth of not acting 'when requested to do so by the landlord of Gregory Downs Hotel'.[78] In the same debate, the member for Carpentaria, James Forsyth,[79] made other complaints about Roth.[80] Forsyth, the Member for Carpentaria, criticised the actions of the protector in connection with the removal of a half-caste boy named Harry from Lawn Hill Station to Mapoon, and also stated that the

protector had declined to visit a girl at Burketown who was ill.[81] Other politicians complained about Roth in his last years of tenure. The Member for Clermont, for example, accused him of removing a number of ethnographic specimens from an Aboriginal camp in his electorate.[82] Roth was further criticised for selling the material to the Sydney Museum and retaining the proceeds of the sale. Roth denied the charges and indicated that any payment from Sydney was directed to camp people. As Chief Protector, Roth felt obliged to intervene in these exchange transactions as a way of protecting Aborigines from exploitation, which the legislation he controlled was meant to prevent. The ultimate purpose of the complaints against him by land and labour interests was to restrict his power and eventually remove him from office.[83]

Roth survived these political attacks but had to contend with some administrative problems of his own making. He reported that on a visit to Barambah he had noticed a number of sick natives with skin diseases. Also, one woman suffered from 'a fallen womb, a source of great pain to her'.[84] Similarly, there was a man 'with sores on his neck, face and body and there were some depot residents suffering from venereal disease'. A number of cases, he said, were 'pitiful and the distress of the parents over the illness of their children was painful to witness'.[85] Roth tried to arrange for a doctor and the Government Medical Officer to visit the relief depots. He said that the present arrangement was to send sick natives to Maryborough hospital—an expensive and unsatisfactory option which was pursued only when cases became critical and other people in the camps became infected.[86] Roth retired in September 1906 because of illness, but before he did so, Samuel Lipscombe, the Superintendent of the Barambah relief depot near Murgon, complained to him that he had not sent the medicines promised a month earlier to service the relief depots under his responsibilities as a protector. Lipscombe wrote that he needed the medication urgently because 12 patients under his care were suffering from syphilis.[87]

After Roth's departure his more humanitarian approach gave way to a less enlightened administration. As described, Roth had tended to leave people with incurable infections close to their homes. The new administration took a different view because the Protector's Office renewed its interest in two aspects of Aboriginal life that became a continuing source of concern—venereal disease and the increased number

of hunting dogs in camps. Richard B. Howard, the Acting Chief Protector, wrote to Lipscombe indicating that the 'natives' known to be suffering from venereal disease 'must at once be removed to a camp in one place at a distance from all other natives'.[88] Howard suggested that a building be erected away from the general depot population and 'enclosed in a fence of several barb wires with a proper gate and lock; a building of say three metres by six would perhaps be sufficient to house the incurables'.[89] A further suggestion was that another hut be built outside this compound for people with other illnesses.[90] In addition, two Aborigines from the depot should be selected to act as supervisors, keeping patients in and other depot residents out. The gates, Howard suggested, would be locked each evening and those people coming and going were to be scrutinised thoroughly.[91] This was the very first of a type of specialised construction which Howard referred to as 'The Hospital'. Before the construction of disease compounds, these structures were used to segregate diseased Aborigines from other inmates, and were the only specialised buildings constructed for the care of sick Aborigines. Such buildings could only be found on government and mission relief depots.

When Aborigines were brought to these relief depots they were usually accompanied by their camp dogs. The depots consequently became overpopulated with dogs. Roth had allowed inmates to keep their dogs for protection, hunting and for warmth on cold nights, and he had encouraged people to camp behind the shelter of branches, or windbreak, in their traditional way. When Roth retired, officers of the Chief Protector's Office moved to clear all dogs away from the government depots. Howard then wrote to Lipscombe on 8 December 1906 asking him to 'destroy all diseased and useless dogs'.[92] Such action by protectors was justified on the grounds that domestic dogs harboured parasites which complicated other ailments. It was mostly the children and women who suffered as a result of campsite infestations. Camp dogs also bred out of control but they were important in helping catch kangaroos, a staple bush food for Aborigines. Moreover, campsites in isolated locations, sometimes at long distances from homesteads and towns, were subject to attack either by other blacks or by white settlers, and the dogs offered some protection. They served to warn camp occupants when outsiders were approaching, and could attack unwelcome visitors. Howard's order for the destruction of the dogs caused deep concern and disrupted depot peoples' lives for a long time to come. Harsher, and more authoritarian, management was to follow.

The earlier idealism of protecting Aborigines faded. A new utilitarianism took its place. Politicians and even Church leaders and protectors thought that the State protection policy should produce large numbers of Aboriginal labourers, thereby ensuring that white settlers would support this policy. Aborigines, they hoped, would replace Pacific Island labour. It was a vain hope, however, destroyed by Aboriginal ill-health, as large numbers of sick Aborigines each contributed their own burdens of bacteria, viruses and parasites to an accumulating pool, which guaranteed that Aboriginal labour would never become a major factor of production.[93]

Diseases such as venereal disease and tuberculosis had been common complaints, and now leprosy, too, entered the pool of infection. Leprosy had not been endemic among Aborigines of Queensland in either pre- or post-contact groupings[94] until the 1930s, and the first Queensland case appeared in 1868 among indentured Kanaka labourers from Melanesia and Fiji.[95] Reports of infected Aborigines began reaching Brisbane during the 1890s.[96] For example, Roth noted the existence of the disease when he wrote in 1899 that, 'during the past twelve months two Aboriginal lepers have been discovered—a man on the Pennefather River, and a woman at Georgetown'.[97] The first record of a medical identification, the source of which was unknown, came in the first decade of the twentieth century.[98]

Notwithstanding the confusion of the causes and effects of leprosy on the indigenous population during the period before 1900, Aborigines in regional districts had certainly been infected with leprosy. For example, two cases came from Etheridge, five from Cape York Peninsula, and one each from the Ingham, Innisfail and Rockhampton regions. The total fell to seven in the period 1900–05, but rose sharply to 22 in the period 1905–10. In this latter period most lepers came from areas in central and northern Queensland. Leprosy was spreading among Aborigines but the spread was slow due partly to government intervention. In part also, it was due to the relatively small number of Aborigines living on mission and government depots for any length of time. Only one leprosy case came from Cunnamulla during the period, 1895–00; single leprosy patients came from Mackay, Ayr and Cunnamulla between 1900–05; only one patient, from Moreton Bay, presented from southern Queensland in the period 1905–10.

By this time, the health authorities in Queensland had begun to deal with leprosy infection in the Kanaka labour force,[99] from which it spread to Aborigines. As the condition first became obvious among plantation workers and Aborigines, Parliament amended the legislation on infectious diseases to make leprosy a notifiable disease, but made the mistake of doing so only in urban areas. The legislation therefore failed to halt infection spreading among isolated Aboriginal settlements. In any event, there was no regulatory body to compel the detention of infected people.[100] The records of leprosy infection in Queensland identified people by sex and disease but not by race. It is possible, therefore, to use regional leprosy prevalence figures extracted from Dr Cecil Cook's Queensland leprosy study. It should be noted, however, that the data used was only an approximation. It is known that by 1895, 82 people were infected in Queensland with one form of leprosy or another. A slight fall occurred in the period to 1905, but because more Aborigines were presenting with leprosy the figure had risen to 84 by 1910.

Chief Protector Roth reported with optimistic trepidation a high level of cooperation existed between other government officials in tackling leprosy. For example, in 1904 the Department of Home Affairs reported that the protectors 'had no legal power to deal with a wife of a suspected leper, Sam Weegeegan'.[101] The man was a South Sea Islander from Buderim Mountain, and the Chief Protector suggested that he be dealt with under the *Leprosy Act, 1894*, rather than the Aboriginal protection legislation. 'Subsequently, if necessary a home could be found for the gin and child'.[102] The Goonda Asylum received the man, following his transfer from Georgetown on 4 July 1904. The responsibility for caring for the wives and children of non-white patients, it was almost always assumed, fell on the State government. In another instance Walter Roth wrote in May 1904 that owing to the death of 'a gin "Dolly" during her confinement at Oakley Creek, Constable Kenny of eight mile native police camp, Cooktown, had to bring up the twins by bottle'.[103] Roth expressed his appreciation of the policeman's humanity directly to the Police Commissioner. At the same time, he indicated that rations were allowed to be distributed to sick Hector and his Gin in the Roma camp because of their condition and Mr O'Brien, the local protector, sent medicines to this camp and over to the sick blacks at Red Island.[104] Leprosy and venereal infections were on the rise, possibly due to the inexperience of protectors and hospital staff who were unable to diagnose such diseases accurately. Aborigines who harboured infection were left in camps near urban country towns, and the mission system was so isolated

that patients were more or less left to their own devices. In Kanaka and European cane cutting labour camps and in Aboriginal fringe-camps, exotic diseases persisted long after they had disappeared in the rest of the community.[105]

An institution with major responsibility for keeping Australian society disease free, was the Australian Institute of Tropical Medicine.[106] This organisation came under the administrative umbrella of the Sydney University, and quarantine and public health considerations were the impetus for its creation.[107] Townsville became the site for the Institute, which soon developed an interest in the Northern Territory and Papua New Guinea. The Institute depended on public subscriptions for its financial survival and focused on malaria and tropical diseases relating to quarantine rather than on venereal disease and leprosy among the Aboriginal labouring and fringe-camp groups of Queensland. Its main interest was promoting public health as a scientific discipline in Australia.[108] It consequently did little to help sick and diseased Aborigines gain access to hospital, or to focus its research on Aboriginal public health dilemmas.[109]

The devastating effects of ill-health on Aborigines, mostly associated with the adoption of camp living, remained little understood or studied. Fear of disease occupied the minds of some people with an interest in northern development and there were those who feared that white settlers could not settle the northern and inland reaches of a vast vacant land.[110] The reluctance of health officials to treat Aborigines was certainly a problem of understanding some ailments such as venereal diseases and leprosy, but in large part it was health officials prejudices and fear of bush peoples habits and manners. In small part too, it was the level of training of medical and nursing staff.

Except perhaps for the lock-up hospitals, Queensland's general health system was unable to administer health care to Aborigines.[111] The regional hospitals, as the records reflect, were operated as if settlers were the only clientele expected. Aborigines probably made up by far the largest group of inmates in the lock-up hospitals.[112] The first lock-up hospital in Queensland was located in Brisbane in the mid-nineteenth century, but because records of the Aborigines sent to it were haphazard the number treated there is unknown.[113] Many of those who ended up there were probably prostitutes, because police records attest that various Aboriginal women were engaged in prostitution in the period 1900–10 and earlier.[114]

Aboriginal prostitutes who harboured venereal infections were moved first to southern ration depots such as Barambah, Taroom and Duaringa. With a large number of diseased Aboriginal prostitutes congregated at these institutions, the Government was forced to increase the number of depots. Although it was difficult to screen for sexually transmitted diseases in prostitutes, the existence of the disease among them was a sufficient excuse to move them away from northern towns and into southern depots. At the same time, the growing incidence of tuberculosis, venereal disease and influenza assisted the growing demand for mission services, and for relief depots. If none existed, these people were then sent as patients under police escort by car and train from as far away as Cooktown on Cape York and from Cloncurry in the west to lazarets and sanatoria near Brisbane. The difficulties for both police escorts and the Aboriginal patients are now hard to imagine.

Police acted as surrogate health workers from 1900 until the early 1930s as they fulfilled their role as escorts. Aborigines suffering from leprosy, tuberculosis, venereal disease and other medical conditions became a familiar sight around the fringes of Queensland country towns and plantation service depots.[115] The lack of facilities for treating and dealing with Aboriginal prostitutes, was directly responsible for the build-up of Aboriginal groups around settlements; and this in turn created the impression that all Aborigines were derelict, diseased or destitute. As white settlement intensified in the first decade of the twentieth century the State government seized every opportunity to continue centralising and 'civilising' Aborigines.

The Queensland Government stopped issuing free rail passes in the period from 1903-5. The police had been issuing free rail passes as a way of moving Aborigines from rural regions. Police regarded ration and relief depots and mission stations as holding centres for disparate Aboriginal populations who had become a liability. To move Aborigines expeditiously from one place to another, the Acting Chief Protector agreed to cover the costs of Aborigines being escorted by police, thereby putting the practice on an official footing.

Movements of Aborgines by police, in 1904 ration and relief depots were operating as recieving places like Deebing Creek, Barambah, Durundur, Yarrabah, Cape Bedford, Mapoon and Weipa. Of these establishments, the missions were 'year by year becoming a greater assistance to the State in

dealing with the pauper aboriginal waifs and strays, adults and children, on the most economic lines. Two new missions … opened along the coast, on the Archer and Mitchell Rivers, under the control of the Presbyterian and Church of England respectively'.[116] Deebing Creek, Durundur and Barambah had one committee to manage all three depots. The Committee consisted of ministers of religion and various other public spirited people, and employed a Mr Tronson as superintendent of all three.[117] The Church of England operated a mission station at Mitchell River on Cape York and a relief and ration depot at Yarrabah near Cairns. Revs. Gribble and Chase were employed as superintendants by the Church of England.[118]

For example enforced centralisation of Aboriginal people by police required more missions. Cape Bedford (the name of which was changed to Hope Vale) opened in 1904 and maintained a total population of about 98 men and women. The Lutheran missionaries there could not raise additional funds to admit more Aboriginal inmates so they limited the population to about that figure. Hope Valley was about 20 kilometres from Cooktown by boat, and the Queensland Government covered the cost of a small boat. The Lutheran mission society responsible for running it had its head office in Germany (in Neuendettelsau, a small Bavarian village), with the Australian operations headquarters located near Adelaide in South Australia. The health of the small population at Hope Valley remained good during 1904. Serious disease and health problems were either not observed or unknown in this coastal location since the German missionaries had arrived in the area in 1885.[119] The Lutherans also had interests at Mapoon and Weipa, and they began developing a new settlement on the Archer River. The reconstitution of the reserves of Mapoon, Weipa and Yarrabah took place on 14 July 1904, after which they were to be used as 'reserves for the use of the Aboriginal inhabitants of the State'.[120]

Many Aboriginal venereal disease patients were transported to country towns by police (males and females) from other, more distant rural locations. As a result, it was not just their own demand for health care which brought Aborigines to congregate around rural hospital centres. Aboriginal lepers were similarly escorted by police. If from northern regions, they travelled thousands of kilometres to the southern lazarets.[121] Enforced movement of Aborigines or transportation of them by police

meant sitting on trains for up to six or seven days. This police responsibility became a long-running matter of contention between the Police Department, the railways and the Chief Protector. Roth's toughness of mind as Chief Protector usually paid dividends, especially with police, but sometimes the tough approach failed and he then had difficulty in arranging for sick Aborigines to be transported to hospital towns. [122]

The movement of leprosy cases from depots to lazarets by police intensified as Stradbroke Island lazaret became the first hospital to receive an Aboriginal leprosy patient.[123] The patient was escorted there from the north of the state by police using a special rail concession, the destitute person's rail pass. In 1905 the Commissioner of Police issued a circular dealing with the transportation of such people. This stated that the Home Secretary had directed officers in charge of police stations to authorise the issuing of free rail passes to people urgently in need of hospital treatment, provided that they produced a medical certificate.[124] This was not a measure designed for Aborigines, but was adapted to meet police needs for a short period. In November 1905 Roth wrote to the Under-Secretary for Home Affairs complaining of rising costs. What began as a free service began to cause admin problems. The administrative practice was round-about, involving protectors contacting the local police constables, who would then contact the Chief Protector of Aborigines for the rail passes to be issued and charged to the Chief Protector's office.[125]

The Police Department then normally issued rail passes to travelling patients. On one occasion it issued a pass to an Aboriginal woman travelling from Narrang, about 100 kilometres south of Brisbane. The woman discharged herself from hospital and subsequently became very ill. She then had to be re-admitted to the Brisbane hospital.[126] Because of the problem of organising free travel for Aborigines, the police refused her a second free rail pass despite her worsened condition. Police were reluctant to hold sick Aborigines in custody lest their condition deteriorated. When the newspapers heard of the sick woman's predicament they attacked the police for their lack of compassion and apparent negligence. The police then complained to their Commissioner because they feared what might happen to people confined in watch-houses while stricken with a highly infectious disease. They were probably also afraid that they themselves might become infected.[127] The Commissioner re-issued 'circular number 335' on 20 November 1905, saying that the issuing of rail passes to sick indigent persons in need of

special hospital treatment 'does not apply … [to] Aboriginals'.[128] Possibly motivated by fear of leaving Aboriginal patients in or near concentrations of white populations, the police skirted around their instructions by inventing other means of transporting Aborigines away from their districts to southern relief depots and institutions.

The responsibility for getting Aborigines into hospitals and then paying for their treatment continued to present problems for the protectors in the period 1906–10. Thus Roth's final report for 1906 indicated that 'various hospitals assisted in alleviating the suffering of sick natives, whilst the Aboriginal missions and settlements … provided permanent homes but I regret the disputes about the cost of treating Aboriginals in hospital'.[129] At the remote town of Camooweal, about 165 kilometres north-west of Mount Isa, the hospital administration made a claim for treating an Aboriginal man named Tommy who had a broken leg. The account was forwarded to the Chief Protector for payment. Another case involved the Nanango Hospital, which treated Aboriginal paupers and sent the account to Roth. In most cases where hospitals were subsidised by the Government, the Chief Protector refused to pay the costs. Under these circumstances the hospital had to absorb the costs. This approach pushed the hospitals into adopting a policy of treating only those Aborigines whose bills were paid by employers.[130]

Although there was no specifically identifiable Aboriginal health system outside the protection legislation for employees, Roth succeeded in bringing better administration to the relief of Queensland's Aborigines. His greatest disappointment was his failure to gain better access to hospital for Aborigines. The hospital committees were to remain in control of rural hospitals beyond the 1940s, and while they retained control Aborigines had little ability to enter hospitals on request. A further disappointment for Roth was that Aborigines' hygiene problems continued to prevent a general improvement in their health.[131] Hospital staff in most country towns refused to accept diseased Aborigines, who were then confined to disease-camps away from the townspeople. The hygiene problems generated in the fringe-camps that were used as temporary accommodation for people awaiting follow-up medical treatment became worse as a result of this practice. The Aborigines forced to live in fringe-camps permanently simply had to accept the appalling conditions which these 'disease-camps' offered. Deliberately created for the convenience of hospital staff and local doctors, such-camps were

strategically located outside towns away from the public gaze. Aborigines continued to suffer communicable diseases and serious problems that, in the absence of decent hospital access, necessitated the maintenance of the disease-camps.[132] It was the most vicious of vicious circles.

In 1909 Queensland's Northern Protector of Aborigines observed that venereal disease existed in most districts.[133] One case of granuloma came to the notice of a protector at Port Douglas.[134] In the same year, Reverend Brown of the Moravian mission at Weipa reported that a dispensary had been opened in July to attend to the widespread venereal disease problem, which was the worst ailment suffered by Aborigines. The dispensary consisted of a clinic with a room attached where sores and wasting wounds could be dressed, and where sick people could receive attention instead of being treated, as previously, in a building used to keep garden equipment.[135] Despite the optimistic assumption that venereal disease was declining by 1910, the Brisbane General Hospital had treated six cases of granuloma from Barambah of which two people had been returned to their homes near Ipswich, cured. At Taroom, the local general practitioner treated 450 Aborigines and, of these, six presented with venereal disease. Similarly, doctors at Charleville, Hughenden, Normanton, Herberton, Innisfail, Port Douglas and a fringe-camp called Turn-off Lagoon, all reported treating cases of venereal disease. Of those living at Barambah two deaths occurred due to venereal infection, and the medical practitioner treated three other cases of the disease. Barambah had become a holding place for sick Aborigines from all over the State and was attracting high numbers of people who only came there to die.

Despite the depressing trends in Aboriginal health, many Aborigines had successfully assimilated into the pastoral and rural economic milieu of the period. Many Aborigines were contracted to work on properties under the protection legislation and took their families away from the government depots and mission stations. These people worked in an inter-dependent relationship with their employers and sent their children to local primary schools. When seasonal diseases such as trachoma struck, whole rural communities often became infected, white as well as Aboriginal.[136]

In the early period of the decade 1900–10, trachoma and hookworm infestation were diseases that, like venereal disease, leprosy and

tuberculosis, determined people's social acceptability. Trachoma[137] was treated more seriously in Queensland as a blinding disease than it was in Western Australia. Once trachoma reached epidemic proportions in the general Queensland rural society, Government concern turned to medical action. A series of seasonal outbreaks eventually prompted a major survey. This was conducted jointly by the Queensland Department of Home Affairs and the Commission for Public Health. The screening of the rural population by itinerant teams of trained nurses and an ophthalmologist proceeded, with the intention of locating the infected populations.[138] As in a later period in Western Australia, trachoma in Queensland came to Aboriginal communities as settlement spread into their environments, and as they moved into the proximity of white settlements.[139] Wide-spread reports of trachoma among Aboriginal fringe-camp groups became commonplace, though this epidemic came to light first among the white rural population. In the 1907 survey, no mention of either Aborigines or half-castes appeared because neither group existed as a readily classifiable ethnic or racial entity.[140] Many half-castes lived on pastoral properties in and around rural towns. The Commonwealth acknowledged Aborigines as being people with half- or more Aboriginal descent and considered them British subjects, as mentioned in chapter two.[141] On the other hand, people of half or less Aboriginal descent were not considered Aborigines. The number of half-castes attending either the mission or State schools was substantial and totalled 8,480 (4,475 males, 4,005 females).[142]

The report on ophthalmia tabled in the Queensland Parliament on 11 March 1908 gave details of all cases identified since 1907. It paid particular attention to state school children in Charleville, Tambo, Blackall, Isisford, Longreach, Barcaldine, Aramac, Muttaburra, Winton, Hughenden and Richmond.[143] Two doctors, M.D. and W.F. Taylor, (a husband and wife team), had conducted a survey between October and November 1907. In Tambo 91 per cent of the school population had active trachoma, and in Blackall, Isisford and Muttaburra the infection rates were above 90 per cent. Barcaldine, Aramac, Winton, Hughenden and Richmond all had rates of infection in the mid- to high-80 per cent range. The lower rates in the latter reflected their proximity to permanent water. The closeness to permanent water normally allowed for hot water for bathing and for washing clothes and bedding. Where this facility was absent it was more difficult to maintain hygiene, which in turn allowed human hosts to harbour, and flies to spread, the infection. The total number afflicted with trachoma amounted to 1740 people.[144]

In discussing the causes of the disease, the Taylor's wrote that the dryness of the air, the periodic rains and the onset of long grass, accompanied by the increase in bush flies, combined to cause, or at least to prolong, trachoma. The dust storms that followed hot spells caused eye irritations that often led to infection and then conjunctivitis. The infectious pool might begin with only one infection, carried to a healthy eye by means of flies. Aborigines could not escape this mode of infection. As Ida Mann later discovered in her Western Desert studies, there were genetic differences between white settlers and people of full-descent, but Aborigines of mixed-descent did not inherit the genetic ophthalmic protection of their Aboriginal forebears.[145] The eye team did not report their results along racial lines, nor in as technical a way as Ida Mann.[146] The Taylors reported that in acute cases of ophthalmia they found a discharge of pus from between the lids, flies being the active carriers of contagion from the diseased eyes to the healthy ones. Flies settled in swarms on children's discharging and infected eyes, then spread the infections quickly to other children. Once disturbed, the flies would infect healthy eyes, and so on until a whole school became a centre of infection, with the parents, too, becoming infected.[147] Of the people most affected, all lived and slept in small houses that confined the occupants to the one sleeping area.

In describing the characteristics of the infection in western Queensland, the Opthamologist identified two varieties of trachoma, each different to those occurring in other countries. The differences appeared to be 'superficial vascular keratitis pannus' (lumpy blood vessel tissue[148]) or ulceration of the cornea, a condition not uncommon in Queensland and elsewhere.[149] Further, other conditions such as 'papillary hypertrophy' (many small lumps with swelling of the surrounding tissue[150]) were a very common result of the disease in Queensland, varying from mere roughness of the palpebral or eye lid conjunctiva to numerous large lumpy granulations.[151]

Taylor thought that after someone had contracted trachoma, mass infection occurred easily 'once the fly season arrives'.[152] Old scarring appeared on eye lids of most people he examined. Unfortunately Aborigines on distant pastoral properties, government reserves, missions and in fringe camps awaiting hospitalisation missed out on Taylor's survey. As early as 1902, Chief Protector Meston had moved people from the southwest regions of the State close to the Northern Territory border to

places nearer the coast where hospital treatment was available for blind bush people.[153] Roth's reports made no mention of ophthalmia in the early part of the decade nor other protectors in the period from 1908 to 1910.[154] This was not unusual. Many of the government relief depots were situated along the coastal areas where temperatures tended to be lower. In addition, coastal regions had a higher rainfall, and water was plentiful enough for the regular bathing that reduced infection rates. Similarly, people's diet and closeness to medical attention in coastal areas prevented infection occurring at the rates common among the western rural populations, who were subjected to prolonged and regular seasonal drought.[155]

As white settlement in Queensland expanded out from Moreton Bay, a depletion of the Aboriginal population as argued above occurred with increasing pace. By the time Meston observed the numbers of surviving Aborigines, he was only able to conjecture what their estimated size might be. If large numbers of Aborigines had existed, which was unlikely, many had either been killed off or died from disease. From 1900 to 1910, their small residual numbers had begun to be moved to government ration depots, mission stations and the southern sanatoria. A decade passed before the reforms introduced by Meston and Roth came into effect, but medical practitioners, hospitals and depot management bodies were generally unwilling to grant proper access to sick and diseased Aborigines and the depot structures were managed under a system of compassion rather than professionalism. When Bleakley became Chief Protector he began constructing a generally compassionate system of caring for Aborigines where none had existed previously. The period 1900–10, however, saw a general rise of infectious diseases among Aborigines, venereal disease, tuberculosis and leprosy being the most common. Reports of Aborigines being infected with diseases were numerous, but difficulties in making accurate diagnoses perhaps made the problem seem worse than it actually was. Where people had ugly, ulcerated wounds exacerbated by the long wait for treatment, diseases like leprosy, tuberculosis, venereal diseases, yaws and hookworm spread easily. Trachoma surveys most certainly serviced the Aboriginal rural working population by granting them a measure of protection against blindness, but trachoma was only one infectious disease among the many that were afflicting Queensland's Aborigines. And, as the next chapter shows, new types of infectious diseases were emerging by 1910.

For full references see Bibliography

Notes

1. Torres Strait Islanders have been omitted from any analysis because of the paucity of source material, and in the period of study this ethnic group was not identified until 1932. Apart from an inquiry in that year on fishing in TI, primary archival sources are limited.

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3. See the following modern Queensland historians: Ross Fitzgerald, 1982, pp.204-262; see also, R. Evans, K. Saunders, K. Cronin, 1975; Dawn May, 1994.

4. See also, F.A. Hagenauer, 'Notes of a Missionary Journey to North Queensland 1885', published with 'Report of the Aboriginal Mission at Ramahyuck, Victoria, 1885'. This report was located in the Victorian Public Records Series (PRS) 1856-1873, among items classified as Registered Inward Correspondence to Surveyor-General, Board of Land and Works, located in the Public Records Office of Victoria, see index Australian Archives and the Public Records Office Victoria, *My heart is breaking*, Victorian Regional Office, AGPS, Canberra, 1993, see p.15 and p.19.

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6. Long, 1970, pp.4-5, and see also, pp.91-98.

7. Dawn May, 1994, p.13.

8. Long, 1970, pp.91-136.

9. S.E. Stephens, 'Meston, Archibald', in Nairn and Serle, *ADB*, Vol. 5, pp.243-244 (this entry contains a corrigenda published in ADB Index, Vols 1-2, p.313, referred to 'Archibald Meston' file, ADB, RSSS, ANU, 1994); see also, Archibald Meston, 'Report on the Government Scientific Expedition to Bellenden Ker Range, 1889', in *Annual Report of the Department of Agriculture, Queensland, 1889-1890*; see also, Queensland Parliament, 'Report on the Aboriginals of Queensland (by Special Commissioner, Archibald Meston), 1896 Queensland Legislative Assembly, Votes and Proceedings (QLAV&P), 1896, Vol. IV, pp.723-170; Archibald Meston, 'Report on the Aboriginals of Queensland: Special Commissioner under instructions from the Queensland Government, to The Honourable Horace Tozer, Home Secretary', in Queensland Legislative Assembly Votes and Proceeding, 1896, Vol. IV, pp.723-740.

10. Long, 1970, p.94.

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12. Long, 1970, pp.94-95; see also, recommendations by Meston, 'Meston Report', pp.13-14.

13. G.W. Rusden, *1897*, Reissue of 2nd ed., Melbourne, 1908; see also, N. Loos, 1982, pp.22-27; see also, J.B. Gribble, *A Plea for the Aborigines of New South Wales, Jerilderie, 1879*; see also, Gribble, *Black but comely, or Glimpse of Aboriginal Life in Australia, London c1884*; see also, 'Report from the Commissioner appointed to Inquires into the Employment and Protection of the Aboriginals in the District of Mackay, and 'Generally to Inquiries into what steps can be taken to Ameliorate the Condition of Aborigines of Queensland',

in QLAV&P, 1874; see also, 'Report on the North Queensland Aborigines and Native Police', in QLAV&P, no. CA, 10, 1897, this report paralleled the new Queensland Protection legislation of 1897; see also, F.A. Hagenauer, 'Notes of a Missionary Journey to North Queensland 1885', published with other material, 1885; see also, G.C. Bolton, 2nd impression, Canberra, 1970; see also, A Laurie, 1959; see also, Rowley, 1970, pp.157-186; see also, Long, 1970, pp.92-96; see also, Meston, 'Meston Report', *op.cit.*, pp.1-2.

14. Commonwealth of Australia Constitution Act 1900, (63 and 64 Victoria, c12), in John McCorquodale, 1987, p.3 and see p.9, and see also, reference p.201, to Geoffrey Sawer, 'The Australian Constitution and the Australian Aborigines', in the Federal Law Review, Vol. 2, 1966, pp.17-36; see also, J.A. La Nauze, 1972, pp.67-68.; La Nauze agrees with both Smith, *The Aboriginal Population* 1980, pp.20-21, and Geoffrey Sawer, 'The Australian Constitution', pp.17-36 (and I presume McCorquodale even though he does not consult La Nauze) when he says that, 'Although the origin of the section was a good deal more complicated than is implied by Geoffrey Sawer in his article ... [quoted above] he is completely justified in holding that it had no relevance at all to the taking of the census'. La Nauze, as I explained in chapter 1, was correct to argue that the cause of the problem lies in the section's location in the Constitution.

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16. J. Hughes, *The Queensland Official Year Book, 1901*, QGP, Brisbane, 1901, p.62.

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22. D.J. Mulvaney, 1975, p.111.

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25. *Ibid*., pf.

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28. *Ibid*., pf

29. *Ibid*., pf.

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40. *Ibid*., p.28 (para 114).

41. *Ibid*., p.30 (para 122).

42. *Ibid*., p.30 (para 121).

43. *Ibid*., p.28 (para 115).

44. *Ibid*., p.37 (para 150).

45. *Ibid*., p.37 (para 151).

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113. Lewis (ed.), 1989, pp.256-262. Leprosy was the only disease, up to 1910, recorded by races, and only on an *ad.hoc.* basis.

114. Kay Saunders, 1982, pp.99-110; Dr Roth, in his *Annual Report 1900, op.cit.,* hinted that hospital Committees had refused services to Aborigines suffering from diseases; see also, Kay Saunders, 1982 who cites Police letter books which reveal that police complained to the Chief Protector for Aborigines about hospitals refusing to receive Aboriginal patients suffering from venereal diseases at the following hospitals: Maryborough, Gympie, Nanango, Prosopine, Atherton, and Hughenden hospitals. See also, R. Evans, 1982, pp.58-59.

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8

A fading hope: improving Aboriginal health in Queensland, 1910–20

The original high hopes for Queensland's protection policy were fast fading by 1910. Continuing infection, much of it spreading from the government disease camps, had marked the preceding decade. By the late 1910s the worldwide pandemic of Spanish or pneumonic influenza ensured that any short- or medium-term 'fix' was beyond reach. As discussed in an earlier chapter, the pandemic lasted from early 1918 to the end of 1919 and perhaps later, killing more than 20 million people worldwide and perhaps 12,000 in Australia.[1] Of these 1,030 were Queenslanders, 315 of whom were known to be Aborigines, representing 30 per cent of the State death toll. Worse was to come, however, because by 1920 greater contact between Aborigines, whites, Asians and Pacific Islanders brought new health challenges, including a wider range of respiratory and parasitic infections.

The belief that reserves could segregate Aborigines from outside influences was proving wrong. Protection had been introduced to prevent opium being supplied to Aborigines by Asian mine workers. Settlers and visitors to Australia harboured infections which spread quickly among Aboriginal groups. Starvation forced people to the ration depots and women into prostitution as a means of earning cash. To cope with police action against the numbers of prostitutes being removed from country towns, hospital workers sent Aboriginal patients to government and mission depots or to fringe-camps outside of town limits. Aboriginal population growth continued and exacerbated poor health conditions. Finally, the Government created three new ration depots to cope with the numbers of Aborigines on the move.

The opening of such depots was initially due to the efforts of the protectors in the period 1890-1910. After 1910, the poor condition of

diseased Aborigines required that new depots be opened. Archibald Meston's enthusiasm in documenting the Aborigines' physical, social, cultural and economic conditions said something about everyone's concerns for what was happening to indigenous people in the face of the expansion of white settlement. In addition, Walter Roth created a vigorous administration which attempted to arrest the depressed morale under which indigenous people struggled.[2]

Once the processes of protection began operating more effectively under W.E. Roth, the Aboriginal population of both full- and mixed-descent grew. The number of 'full-bloods' rose only slowly because of the demographic problems they experienced during the nineteenth century. The population of mixed-descent Aborigines grew more quickly; and as the Government brought more of them together on reservations and incorporated them into the State's health and relief programs, they thrived demographically under the protection policies. As in Western Australia, some observers had difficulty understanding whether the Aboriginal population was increasing or disappearing. There was continual confusion between enumerated and estimated Aboriginal populations in Queensland. Adding to the confusion, changing definitions and interpretations of Aboriginal identity clouded understandings of who the people of full-, half-caste and other degrees of mixed-descent were.

The enumerated total of Aborigines of full-descent increased from 6670 in 1901 to 8687 in the 1911 census. At the same time, the people of mixed-descent increased from 951 to 2508.[3] The growth of the latter resulted from cohabitation between the 'full-blood' men and the 'half-castes' as well as between Aboriginal females and various white, Asian and Pacific Islander men. This sexual contact resulted in an increase in the numbers of 'half-caste' children. Moreover, the rising number of children taken from camps to institutions resulted from this population increase.[4] It is impossible to explain the dynamics of the full-blood Aboriginal population because of the paucity of recorded information, but it is possible to say that, after the previous imbalance in favour of males, a change occurred from 1901 and the balance was somewhat restored. It was becoming obvious in the early part of this period that the survival of younger Aboriginal women was improving because in these younger age groups there were now only marginally more males than females. Aborigines were apparently cohabiting more with each other than with peoples of other races. This meant that endemic venereal disease was

largely confined to the Aboriginal community, though the transfer of infections also continued among Asians and Kanakas (Pacific Islanders brought to Queensland as indentured labourers).

Venereal disease appeared to be one cause of death which could be handled by keeping white people away from Aborigines. The removal of Aboriginal prostitutes from service centres where whites settlers, Asian fishermen and Kanaka cane plantation labour congregated became a major strategy in some locations. One explanation for the spread of venereal disease is that the health authorities themselves were partly responsible because they sent Aborigines to depots and disease camps, where they infected other Aborigines and members of other groups with whom they had sexual contacts. In addition, hospitals refused to treat venereal diseases for reasons of prudery and to avoid offending other patients sensibilities. Furthermore, health workers experienced difficulty in determining what particular 'wasting disease' had been contracted by Aboriginal patients' needing medical attention. Few establishments existed at this time where leprosy, tuberculosis and venereal infections could be managed effectively. And while some islands in the Torres Strait were converted into leprosaria, the Pacific Islanders and Asian seamen made up the majority of inmates. If Aborigines suffered from these infections they went back to their bush homes, where they tended to infect other family members. Despite such set-backs, knowledge of Aboriginal health was about to be improved because in 1910, the Office of the Chief Protector of Aborigines put into operation a register of recorded Aboriginal deaths by disease.

In 1907, the first 'Death and Disease Register' was established in accordance with Section 2, Clauses (xii)–(xv) of the regulations of the *Aboriginal Protection and Restriction of the Sale of Opium Act 1897*.[5] This legislation instituted the recording of Aboriginal deaths.[6] Although the resulting data was incomplete and varied in quality over time, it was still possible to draw useful conclusions about the pattern of Aboriginal mortality. When Aborigines died from disease, their entry into the Death and Disease Register was a complicated exercise. Under normal conditions the certification of the death of people of other races by police, health workers or medical practitioners was reasonably simple. Great difficulty existed, however, for someone determining the cause of death of a deceased Aborigine. In most cases, the isolated places where Aborigines usually died was a factor. Certification had to be made by

various untrained people because medical advice was not available, so it is not surprising that the entries in the register often gave inappropriate reasons for Aboriginal deaths.

The registration process required protectors from all around Queensland to send information to a central register located in the Chief Protector's Office in Brisbane for entry in the register. Richard B. Howard was still the Chief Protector of Aborigines when this occurred.[7] In 1910, he travelled extensively to all locations where the Government and churches operated relief depots and ration stations to inform them of the administrative changes.[8] The visits made to the north 'showed that the last year was a fairly healthy one for Aboriginals'.[9] For the first time since the Chief Protector's office began operating, he was able to give some indication of the incidence of chronic diseases among Aborigines and the number of deaths resulting from those diseases.[10]

Howard's report drew attention to the venereal disease problem. In 1910, six female Aborigines went to the Brisbane General Hospital from Barambah. Dr Junk of Wondai, who now visited Barambah once a month, reported to the Chief Protector that two of the women came back to Barambah cured of venereal infection, while four had been pronounced incurable.[11] In addition, 27 people had died at Barambah during 1910. This was from a notified State total of 61 deaths from disease.[12] Two of the 27 Barambah deaths resulted from venereal disease. In the whole of Queensland only three other deaths were attributed to venereal disease, though in other parts of the State syphilis was commonly observed and of those identified many suffered from external sores or ulcerated limbs.

Venereal diseases were not a notifiable disease under the *Infectious Diseases Act of 1892*. In 1911, the Queensland Parliament amended *The Health Act 1900–1911*, sections 124 to 129 of which now included powers to remove and detain in hospital people suffering infectious diseases. These sections were primarily designed to deal with people who had no proper accommodation.[13] There is no reason to believe that the legislation was designed to imprison Aborigines, but it empowered police to detain and remove Aboriginal women to hospital for treatment.[14] Once police had removed prostitutes, other Aborigines could be removed to nearby camps or missions and relief depots. Thus the legislative powers for removal already conferred by the 1897 protection legislation were now reinforced by the health legislation.

In Queensland, venereal disease was a general health problem rather than an exclusively Aboriginal problem. In a few Aboriginal groups, particularly in the north, there was no trace of the infection, but for southern women having or wanting children great problems arose. This was evident in a report of a Mapoon missionary:

> The health of the mission inmates has been satisfactory, and a great contrast is observable between those who have gone through the mission routine and those who were not so fortunate. The former are healthier and comparatively free from disease, and the women are in consequence more prolific. Six births and … [eight] deaths took place on and near the station during the year. Most of the deaths were the result of tubercular and venereal diseases, and the latter is still very prevalent among old blacks.[15]

Polygyny was practised mainly by the older generations and, as implied above, Christianity had had a great impact on the mission residents, who had abandoned their earlier habit of multiple wives and sexual partners.

Interpreting what health authorities, legislators and health workers meant when they spoke about venereal disease was as much a problem in Queensland as it was in Western Australia. Sexually transmitted diseases such as syphilis could be mistaken for other diseases which caused open wounds and pussy lesions.[16] Because these issues were unresolved, the capacity of the Aboriginal population to develop immunity to either viral or bacterial infections remained uncertain.

In 1912, the Queensland Health Commissioner hoped that venereal disease could be eradicated by parliamentary action. 'The difficulty will, it is hoped, be overcome when Executive authority is obtained for the gazetting of the new Venereal Diseases Regulations,' he wrote.[17] Syphilis, he pointed out, could be treated if it was identified quickly enough, otherwise treating the long term effects was expensive. Moreover, if left untreated, the cost to society was greater because lunacy might be the long term effect.[18] The issue in Queensland was becoming a matter for concern because in the metropolitan area alone, 1477 people between the ages of one and 60 years were infected in just one year.

Among Aborigines the disease had also become a major problem. The results were birth defects, infertility and long term wasting of male and female genitalia.[19] As soon as police suspected that Aboriginal women

were harbouring sexually transmissible diseases they sent them south to ration depots or under escort to sanatoria in Brisbane.[20] Doctors at Charleville, Hughenden, Normanton, Herberton, Innisfail, Port Douglas and Turn-off Lagoon all reported cases of venereal disease they had treated. Of those living at Barambah two deaths were due to venereal infection, and the medical practitioner there treated three other cases of the disease. This relief depot became a holding place for sick Aborigines from all over the State and held a high number of people sent there only to die. In 1910, the protectors reported that of 61 Aboriginal deaths throughout the State, 27 took place at Barambah.[21]

In the north of the State, 'wasting infections' were also reported during this period. On Thursday Island—a centre to which diseased mainland Aborigines as well as Japanese, Chinese, Filipino and Pacific Islander mariners were sent—it was reported that a high incidence of venereal disease existed among these groups. Similarly, on the mainland too, various 'body wasting' conditions existed where open sores disfigured the victims. Some of these infections were possibly tuberculosis or yaws and were responsible for the majority of Aboriginal deaths reported from coastal regions in 1914. Venereal diseases accounted for 19 of the deaths. As the Chief Protector reported, 'venereal disease, principally gonorrhoea and syphilis, [prevailed] in some districts, particularly the "gulf country", the coastal districts and the far west'.[22] Due to the high levels of illness caused by venereal disease, the Government considered opening a lock-up hospital on Fitzroy Island near Cairns, but World War I forced a postponement.[23] In 1919 venereal disease was still a concern for protectors and missionaries in some locations. The Chief Protector's official reports observed that

> venereal disease was reported in the Gulf country, the Peninsula, the Torres Strait, and far west; and in the last area phthisis was also noticeable … In some communities upwards of 9 people received long term treatment for the effects of venereal diseases, and in some cases low births in some Cape York settlements remained a concern.[24]

New government reserves had been created to cater for people being moved from the fringes of cattle property homesteads, rural towns and hospital grounds. Such reserves were controlled by the Chief Protector's office. J.W. Bleakley, who had been Deputy Chief Protector from 1911 and was then appointed Chief Protector in 1914, reported that between

1914 and 1917, 434 Aborigines had been moved to Hull River, and 256 arrived there the following year. In March 1918 the new settlement was destroyed by a cyclone and work had already begun on new buildings as new Aboriginal residents were being moved there from Greater Palm Island.[25] Social problems generated by mining development on the Hull River, together with the problem of Chinese providing opium to Aboriginal men and women as payment for sexual favours, led to the mass migration of Aborigines into the mining camps. In 1919, Bleakley indicated that the existence of venereal infections, endemic in camp people, was a major problem. Many Aborigines worked not for money but for alcohol and opium, and whole families worked for miners in exchange for 'grog' and opium. From this came epidemics of sexually transmitted diseases which plagued the Aborigines thereafter.[26] A common theme of government reports during this period was the prevalence of venereal infections, particularly in the Torres Strait and the far west; and in the last area phthisis was also widely reported.[27]

Venereal diseases among Aborigines in Queensland caused 116 deaths in the period 1910–19.[28] The data reveals a steady increase in the numbers reported as dying from venereal disease, which rose from six to 19 in the period 1910–14. No administrative system was devised to keep abreast of how many Aborigines were contracting the disease, and health authorities in general were never explicit about the full extent of sexually transmitted diseases during this period.[29] The number of deaths nevertheless gives some idea of the scale of the problem. Earlier in the decade the Queensland Parliament was unable to gain public support for including venereal disease on the list of notifiable diseases, the reason being that it was commonly viewed more as a moral than as a medical problem. Moreover, the mobility of Queensland's mining and plantation workers made sexually transmitted diseases among them difficult to control.[30]

Because of the vague public perceptions of what conditions sexually transmitted diseases included, even as late as 1917 venereal disease remained only a 'reportable' disease (one generally agreed by doctors) rather than a notifiable disease (one that the law demanded be reported) under the State health legislation.[31] Infected Aborigines living in isolated regions were sent under police escort to either the Brisbane infectious diseases sanatoria or to the relief depots at Taroom, Barambah and Palm Island. Palm Island by this time had become a place of detention for

people contravening the protection legislation, but it also acted as a screening depot for leprosy, tuberculosis and other 'wasting' diseases.[32]

Health officials in regional centres worried greatly about Aborigines harbouring social diseases such as hookworm and respiratory infections. Hookworm was less important as an infectious disease but attracted political prominence as a State, Commonwealth and international interest, and consequently became an issue for the administrators of Aboriginal people. The cooperative international effort to eradicate hookworm continued into the 1910s and 20s, although it was interrupted during World War I.

In Queensland, the areas of endemic hookworm infestation corresponded to regions of heavy rainfall, mainly in tropical and sub-tropical regions, where the eggs have sufficient warmth and moisture to hatch. The districts of greatest infestation were those around Charleville, Longreach, Hughenden, Rockhampton, Ayr, Bowen, Mackay, Ingham, Innisfail and Cairns.[33] The Australian Hookworm Campaign research identified these areas as being ones with an 'Aboriginal problem'. The Campaign's report said there was no doubt that limited hookworm infestations existed in Aboriginal groups prior to white settlement., Papuans and Malays were most likely to have spread it further. With white settlement 'the "natives" have been gathered into … fixed localities, such as missionary settlements and cattle stations,'[34] where conditions 'were ideal for the spread of hookworm disease; in certain areas the hookworm rate among them on first examination was 90 per cent and afterwards 50 per cent'.[35] Thus, if immediate eradication occurred where the eggs hatched and the Aboriginal hosts were given effective treatment, serious long-term benefits followed.

The hookworm report observed that 'the Aboriginal settlements acted as centres for the spread of hookworm disease to Europeans, and … they still present a problem'.[36] In 1911, researchers located hookworm in North Queensland.[37] Dr Anton Breinl pointed out that the disease occurred among children of the Townsville, Ingham, Innisfail and Cairns areas.[38] In the period April 1918-September 1919, the International Health Board of the Rockefeller Foundation provided money and personnel to carry out hookworm surveys in the coastal area from Cooktown to Townsville, where 22, 844 people were screened. Of this number, 4605 people were infected—an infection rate of 21.1 per cent;[39]

992 Aborigines were examined, and their infection rate was 81 per cent. The differences in the infestation rates between one area and another closely matched 'the amount of rainfall in the several districts, and it reflected the amount of soil pollution prevailing in the various communities'.[40] Following these results, the hookworm campaign developed into a national program, as will be seen in the next chapter. This development was also covered in an earlier chapter.[41]

Leprosy was a more disturbing hygiene problem than hookworm. By 1910, the Commonwealth *Quarantine Act 1908* had been extended to cover leprosy, but only so as to prevent infected people entering Australia. Leprosy by then had already taken hold as an endemic disease in some northern areas of Australia.[42] Amendments to the State's *Public Health Act, 1884* made notification of leprosy mandatory, forcing health workers to report on patients suspected of harbouring leprosy. But the legislation applied only to urban areas, leaving the rural population beyond scrutiny. Not surprisingly, the legislation failed to halt the spread of infection among isolated Aboriginal missions, camps and reserves. The Board of Health had the legislative power to compel the detention of the infected but lacked a regulatory body to control the disease over a geographical area as large as Queensland.[43] Reports indicated that as a consequence, leprosy had spread quite quickly among isolated Aboriginal groups.

Between 1895 and 1900, 13 new cases of leprosy among Queensland Aborigines were reported. This number increased to 35 by 1910. Among explanations for the increase were the growing influence of protectors, the vigilance of missionaries, interest in Aboriginal labour by pastoralists and the growing proximity of Aborigines to townships. Such factors increased the likelihood that infected Aborigines would be detected and reported. In the next decade, reports of the incidence of leprosy among Aborigines became proportionally greater than among the general population. Between 1895 and 1925 the number of recorded cases of leprosy in the wider population fluctuated, peaking in 1915 at 84 cases. During the six years between 1915–20 the number of Aboriginal cases fell to 56. All new cases were now coming from northern Queensland. In the southern areas of the State no new cases presented in the 15 years between 1910–25, suggesting that the disease had now become a North Queensland phenomenon.

Respiratory diseases killed Aborigines right across the age and sex range.

The first entry made in the 'Aboriginal Disease and Death Register' in 1910 was for an Aboriginal man from Barambah by the name of Finigan, who died from pneumonia.[44] The range of diseases from which Aborigines died in Queensland in the decade 1910–20 included pneumonia, venereal disease, senile dementia, tuberculosis, influenza, kidney disease and various other complaints categorised as 'other diseases'. Throughout the period, pneumonia remained a constant problem. In 1910, 18 people died from pneumonia; after that the number declined until 1918, when the mortality rate from pneumonia began to rise again.[45]

The epidemics appearing periodically in Queensland affected only parts of the population, and this was true for both Aborigines and other Queenslanders.[46] Many small family groupings living on isolated northern and western pastoral and mission lands escaped the influenza epidemics altogether, and as a result may not have acquired immunity against later epidemics. Those Aborigines who were born after the influenza epidemic of 1895, or who escaped infection during later outbreaks, failed to acquire immunity.[47] The reason is that influenza strains appear every three or four years and some indigenous groups were either too young or too isolated to have been infected, and therefore developed no resistance to the later strains. This could possibly explain the reports of groups of Aborigines suffering from influenza that continually appeared in mostly secondary protectors' reports at the turn of the century, and why some were affected as they came closer to white settlement during the various epidemics between 1895 and 1918.[48] Such contemporary reports are problematic because they often lack clarity about the epidemic events that present-day investigators prefer, because this broader reporting draws accurate conclusions about the causes of particular epidemics.[49]

At this point we need to reconsider the 1918-19 worldwide pneumonic influenza pandemic to appreciate its impact on Queensland's Aborigines. In 1918, a million or more American troops were sent to France. Between August and mid-September 1918, a strain of either the 'Spanish' (pneumonic) influenza, also known as 'Swine Fever', killed 1500 of the troops before they left America. Even larger numbers of the troops left their homeland already infected, and they became ill and died en route. As a consequence disease infected soldiers from both sides of the conflict met in battle.[51] From the front it spread to the civilian population on the continent, then to England and Spain, killing large numbers of people in

both countries. Not since the 'Black Death' the bubonic plague pandemic of the fourteenth century, had an epidemic inflicted such catastrophe on Europe.[52] At the end of the war the epidemic travelled back to England and America and then on to South Africa before entering Australia by October 1918.[53] By now a pandemic, it had then killed 1600 people in London and Manchester already.[54] By then, the disease had also reached New Zealand, spreading rapidly throughout the country.[55]

As a number of people were already suffering respiratory diseases when the pandemic reached the Aboriginal populations in Queensland, it is difficult to assess accurately the extent of the impact of the pandemic among them. Table 8.1 indicates the number of people suffering from pneumonia, tuberculosis and non-Spanish influenza, each of which were killer diseases among Aboriginal people.

Table 8.1:
Aboriginal deaths in Queensland 1910-1919

	1910	1911	1912	1913	1914	1915	1916	1917	1918	1919	Total
Male deaths											
Pneumonia	10	10	12	7	6	2	6	5	21	14	93
Influenza	1	1	1			3	1	4	29	174	214
Consumption,	2	3	7	9	12	1	10	5	15	6	70
Nephritis	1	2	1	2	11	17					
Sub-total respiratory	13	15	20	16	20	6	17	15	67	205	394
Venereal diseases	3	4	8	6	11	7	6	4	7	4	60
Senile decay	5	6	9	16	8	5	14	9	17	2	91
Other diseases	5		3	3	5	5	19	9	18	8	75
Sub-total other diseases	13	10	20	25	24	17	39	22	42	14	226
Total male deaths	**26**	**25**	**40**	**41**	**44**	**23**	**56**	**37**	**109**	**219**	**620**

Table 8.1 cont.

	1910	1911	1912	1913	1914	1915	1916	1917	1918	1919	Total
Female deaths											
Pneumonia	8	3	4	9	6	5	10	4	6	9	64
Influenza			4	1	2	1	11		9	103	131
Consumption,		4	3	2	12	3	8	7	12	3	54
Nephritis									1	5	6
Sub-total respiratory	8	7	11	12	20	9	29	11	28	120	255
Veneral diseases	3	2	8	9	8	8	6	4	5	3	56
Senile decay	2	2	3	7	1	8	8	8	8	8	47
Other diseases	5	3	1	5	8	1	10	5	12	6	56
Sub-total other diseases	10	7	9	17	23	10	24	17	25	17	167
Total female deaths	**18**	**14**	**20**	**29**	**43**	**19**	**53**	**28**	**53**	**137**	**422**
Total Aboriginal deaths											
Pneumonia	18	13	16	16	12	7	16	9	27	23	157
Influenza	1	1	5	1	2	4	12	4	38	277	345
Consumption,	2	7	10	11	24	4	18	12	27	9	124
Nephritis	0	1	0	0	2	0	0	1	3	16	23
Sub-total respiratory	21	22	31	28	40	15	46	26	95	325	649
Veneral diseases	6	6	16	15	19	15	12	8	12	7	116
Senile decay	7	8	9	19	15	6	22	17	25	10	
146Other diseases	10	3	4	8	13	6	29	14	30	14	131
Sub-total other diseases	23	17	29	42	47	27	63	39	67	31	385
Total Aboriginal deaths	**44**	**39**	**60**	**70**	**87**	**42**	**109**	**65**	**162**	**356**	**1024**

Source: *Queensland State Archives*, Series No., A/58973—58974, 'Death Registers—Where, Cause, 1910-1936'

As the table suggests, pneumonia was a persistent killer of Aborigines, and occurred most seriously among people already located in depots and the hospital camps on town fringes close to where sick white people were being brought to hospitals. Over the decade 1910–19, it accounted for 15 per cent (157 out of 1034) of Aboriginal deaths in Queensland.

In the nine-year period between 1910–18, a total of 678 Aboriginal deaths (401 males, 277 females) were recorded as being from infectious diseases. Of these, those dying from influenza totalled 68 (40 males, 28 females) or only 10 percent. The tally in 1918, however, was 38 (29 males, 9 females) or treble the number in any preceding year (see Table 8.1). This upsurge probably reflected the early results of the arival in Queensland of pneumonic influenza, although this is difficult to establish since the only deaths recorded were of people in institutions (hospitals, doctors' clinics, and government and mission depots and reserves) and those under work contracts of employment. Despite that, what is remarkable about the upsurge in the influenza death rate is its explosive increase in 1919 as a direct result of the pandemic. As the table above demonstrates, deaths from influenza leapt from 38 in 1918 to 277 in 1919, more than a seven-fold increase in just one year.

Deaths from tuberculosis (also called 'consumption' and 'phthisis', depending on who was registering a death) also rose over the nine years 1910–18, from 2 in 1910 to a peak of 27 in 1918. Apart from 'senile decay', it was second only to pneumonia as a killer of Aborigines. Indeed, as Table 8.1 indicates, having caused 115 out of 678 deaths 1910–18, its mortality rate was higher than that for both venereal disease (109 out of 678 deaths) and influenza (68 out of 678). The high incidence of tuberculosis and the other major repiratory diseases—pneumonia and influenza—possibly conditioned the authorities to anticipate high Aboriginal mortality from respiratory complaints so that, when the influenza pandemic struck with full force during 1919, people expected that many Aborigines would die. The mortality rates from pneumonia and tuberculosis consequently set a base line for the expected death rate from pneumonic influenza.

The dramatic impact of the pandemic on Queensland's Aboriginal population is summarised in Table 8.2 below. As the table indicates, from only four Aboriginal deaths (4 males, 0 females) from influenza in 1917, the number increased 92 times to 277 (174 males, 103 females) in 1919.

Table 8.2
Aboriginal deaths in Queensland from influenza during the period January 1917 to December 1919, by sex and month

Month	1917			1918			1919		
	Male	Female	Persons	Male	Female	Persons	Male	Female	Persons
Jan	1	0	1	1	0	1	1	2	3
Feb	0	0	0	0	0	0	0	0	0
Mar	2	0	2	8	6	14	0	0	0
Apr	0	0	0	2	0	2	26	5	31
May	0	0	0	1	1	1	40	31	71
Jun	0	0	0	5	1	6	37	16	53
Jul	0	0	0	0	0	1	5	9	14
Aug	0	0	0	0	0	0	26	27	53
Sep	0	0	0	5	0	5	5	3	8
Oct	0	0	0	3	1	4	34	10	44
Nov	1	0	1	2	0	2	0	0	0
Dec	0	0	0	2	0	2	0	0	0
Total	4	0	4	29	9	38	174	103	277

Source: *Queensland State Archives*, Series No. A/58973-58974, 'Death Registers – Where, Cause, 1910-1936'.

The spread of the pandemic across mainland Australia was initially contained for two basic reason. First, the wartime quarantine restrictions were kept in place as the disease came closer. Second, as the troop and passenger ships from Europe arrived they were quarantined immediately. Anyone who was either suspected of harbouring the infection or confirmed as an influenza carrier was removed to the Commonwealth quarantine stations located at each major seaport. Bureaucratic hair-splitting confused the situation somewhat because these people were not regarded as having yet reached Australia. This distorted both the time when the pandemic was officially recognised as having arrived in Australia and when the first case on Australian soil was diagnosed. In Queensland, the State Government amended the *Infectious Disease Act, 1900-1917* to include pneumonic influenza as a notifiable disease.[56]

It appeared from the beginning that this outbreak would affect Aborigines in the same way as the white population. Influenza was not an alien disease to Aboriginal groups but this new strain was particularly virulent, especially among weak and undernourished people. On 22 October 1918, Sergeant Quinn of Rockhampton

reported 'the death of a half-caste named Butcher at Comet from influenza'.[57] Apparently Butcher had arrived at Rockhampton several days before his death. According to *The Brisbane Courier*, Butcher had come from the Springsure district to attend the local races. He remained at Comet for a few days before catching the disease and dying soon after. Quinn stressed that he had attempted to send Butcher back to his relations near Emerald, but his death had followed too swiftly.

At the beginning of May 1919 the number of Queenslanders who had died of pneumonic influenza stood at 49, and by the end of that month about 650 people had been hospitalised. In Queensland, the hospital system proved unable to cope with cases of influenza infection. *The Brisbane Courier* reported that at Charleville, influenza was still spreading in the district and 'the Parish Hall has been fitted up with many beds'.[58] Hotels and theatres closed, inoculations took place everywhere, and appeals for bed linen went inter-state, as did the State Health Minister's requests for assistance from hospital nurses. This was the general situation in early 1919; meanwhile a more dangerous predicament was developing among the Aboriginal populations of the ration depots, reserves, labour camps and fringe-camps. As the death rate rose sharply, pleas for help were soon going out from the government depots and the missions.

The reported Aboriginal deaths from influenza in Queensland had never risen above 11 per year until 1916. In 1918 the number of Aborigines dying from pneumonic influenza throughout Queensland reached 38 (29 males and 9 females), as noted in Table 8.2. The imbalance of male over female deaths is difficult to explain, but it should be remembered that Aboriginal male workers in the cattle industry lived closer to normal white society than their families did. As a result, as they fell ill with the 'flu their employers immediately despatched them either to public hospitals or directly to relief depots near the coast. As the depot and mission populations increased, the number of reported deaths rose sharply in early 1919 to 277 (174 males, 103 females). These numbers followed both the Australian and the world-wide trend of deaths from pneumonic influenza. The total fell then progressively to 28 deaths in 1920-22 and none in 1923. The true numbers of deaths from the pandemic were most probably higher than reported because some of the early deaths would have been wrongly entered in the death registers as 'pneumonia', or as 'bronchitis-related infections'.[59]

There has been an extensive debate in the medical literature about the incidence of influenzal infection and the immune responses among Aborigines. The historical and anthropological literature in general accepts that the effects of influenza, including the pandemic of 1918-19, were catastrophic. The truth is that we simply do not know how Aborigines responded to influenza. Queensland was the only Australian State that maintained a death and disease register from which accurate assessments can be construed. In other States some confusion exists about the extent to which pneumonic influenza affected the Aboriginal populations. Most groups of Aborigines in rural areas and in bush camps had small populations and were isolated long distances from white settlements. Although few reports exist of the actual effect of the pandemic among them, it is probable that their small numbers made it unlikely they would develop immunity to new strains of disease. It is also possible that some groups missed contracting the infections altogether due to their isolation. For most Aborigines who were infected with the influenza virus, the probability of infection was heightened by their centralisation at missions, depots and confined living areas, which served as reservoirs for infection. The next influenza attack after their arrival at the relief depots ensured that inmates became ready-made targets for infection. Their generally low nutritional levels predisposed them towards infection from influenza, as did their polluted and over-populated dwelling places.

At the time the pandemic arrived, reports were flooding in from around the State about respiratory infections. At the Mitchell River Mission on Cape York, a number of adults had been reported as suffering from forms of tuberculosis. Cloncurry people were said to be suffering from bronchial pneumonia combined with influenza. Diseased Aborigines were transported from all over Queensland to relief depots, complicating the general picture of respiratory infections. As the graph below suggests, an epidemic of pneumonia was already in progress when the Spanish 'flu arrived, and Aborigines came to relief depots to be treated for one respiratory infection or another. Some went directly to hospitals at Rockhampton, Mitchell and Burketown suffering from complications of tuberculosis. Some sick people from the pastoral properties were delivered directly to hospital by the white property owners, but once there, hospital staff moved them to hospital disease camps or directly to government relief depots at Duaringa, Barambah and Taroom.[60]

A general gathering of people with serious respiratory disease already existed at the depots prior to the onset of the influenza pandemic. The number of Aborigines dying from combined respiratory infections had increased at least a year in advance of the pandemic reaching Australia. This phenomenon is clearly shown in the graphs below (Figures 8.1 and 8.2). The main impact of the pandemic was delayed until 1919, having been successfully, albeit temporarily, contained by the coastal quarantine stations. It became obvious in the south in February 1919, and peaked in August.[61] The quarantine barriers had proved effective, at least in the short term, in arresting its spread, including to Aboriginal groups in Queensland.

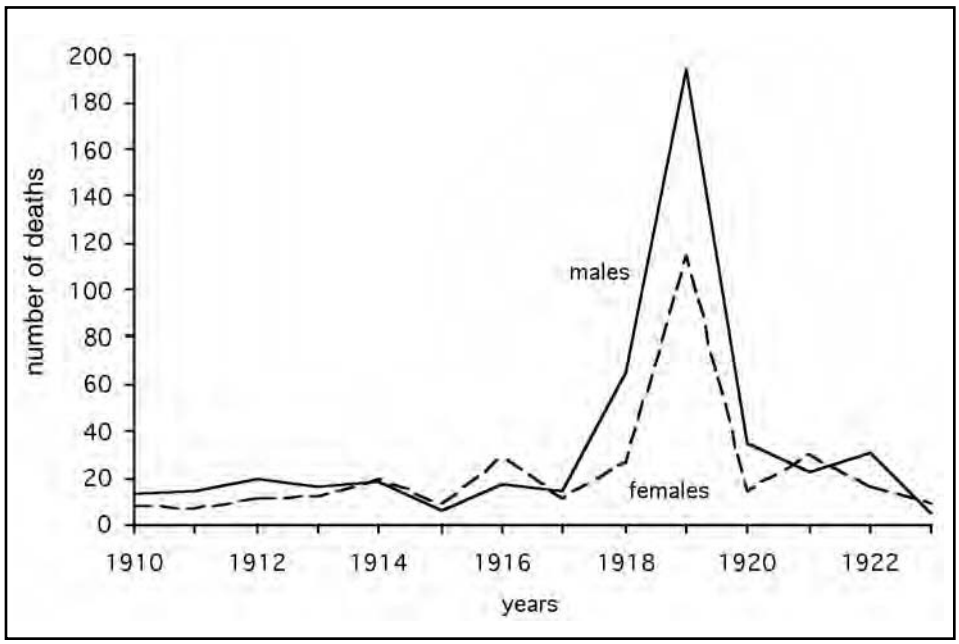

Figure 8.1: Aboriginal deaths from respiratory diseases in Queensland, 1910-1923
Source: Compiled from Table 8.1.

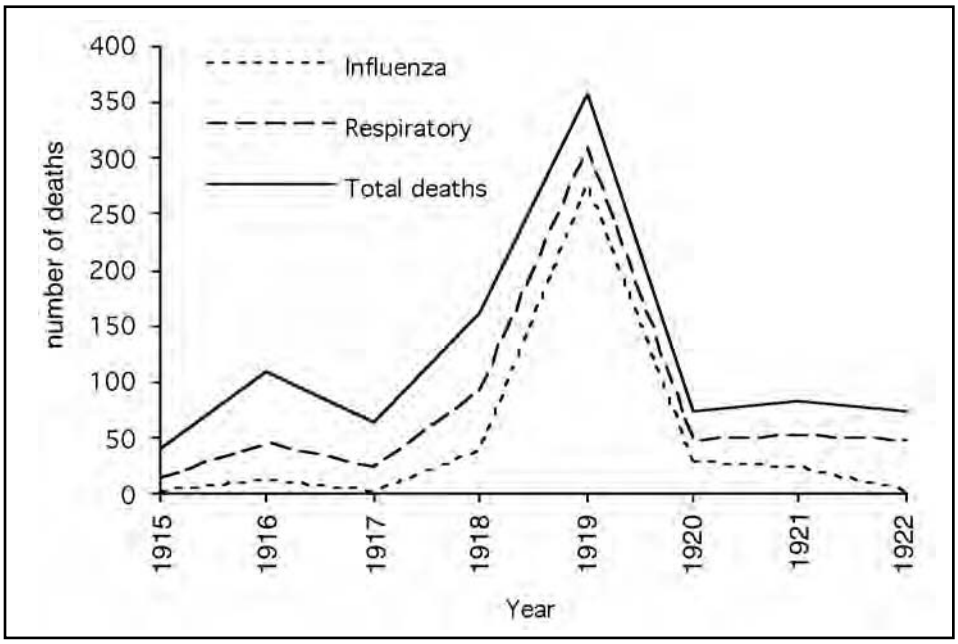

Figure 8.2: Aboriginal deaths from influenza in relation to total deaths from respiratory diseases in Queensland, 1910-1923. Source: Compiled from Table 8.1.

In Queensland, the pandemic had arrived first at the main seaports of the middle and southern coast and had then moved inland to urban and rural regions. Initially, it affected white people then began affecting Aborigines, coming for them on top of the epidemic of pneumonia described above. The difference for the Aboriginal victims of influenza was that, unlike the whites, they were taken to disease compounds on the government depots, fenced areas resembling huge wire cages built with 9-metre high wire mesh fence and topped by barbed wire to prevent entry and escape. The huts at the relief depots were made of weather-boards with fire-places built outside for cooking meals. These compounds, constructed a decade earlier as places for punishing people infected with venereal disease, were now utilised to isolate the influenza victims from the other relief depot inmates.

Aborigines who became ill were often influenced by traditional beliefs about death, and as a result, when large numbers of inmates died many other inmates reacted by escaping the compounds for refuge in the bush.[62] On 8 June 1919, the Rockhampton *Morning Bulletin* reported that

Dr Junk, a general practitioner from Murgon, had attended sick Aborigines at Barambah at the request of the Home Department. He said there was a 'state of panic at the dire effects of the epidemic which influenza caused among the natives at the settlement'.[63] Junk also reported that 596 natives had became infected with influenza, of whom 69 (24 males, 45 females) had died. Most of the dead were aged, infirm or diseased.[64] Junk said that he had found old people running about in a panic, and as a result some of the weakest of the older people died immediately. He noted that of those who had died later, many died of simple 'funk', or grief and panic. 'There can be no doubt as to the result of this fatalistic creed among Australian Aborigines,' he observed.[65] Junk went on to report that two waves of infection had occurred. During the first wave, about 10 of the white staff suffered infections while caring for sick inmates. During the second wave, a similar number of white and Aboriginal staff came down with the disease. He observed that a 'notable feature of this disease was that there had been no deaths among the children'.[66] It is not possible to say why they were not infected by the adults. Neither Junk nor the Chief Protector's records indicated how long the children had been at the depot. Possibly, as at the Palm Island reserve, they escaped the impact of the pandemic because of their distance and isolation from the mainland.

The pandemic certainly caused general chaos. Such large numbers of deaths occurred with each outbreak that disposal of the dead became a major problem. Burials took place immediately. The worst periods were the months from March to October 1919, as the next graph (Figure 8.3) shows. At Taroom, for instance, the number of infections was high from April, and the numbers esculated until 10 people died in the last few days of June. Their burials took place in one ceremony on 29 June. Similarly, on 10 October 1919, at Mareeba, near Cairns, 14 deaths occurred and the burials again took place in one session.[67] The dead among Aborigines of full-descent at the relief depot went directly to the depot graveyards. At Yarrabah and Purga missions, and at the various camps around Cairns, people of full-descent went to the cemeteries at the government relief depots and missions, while people of mixed-descent, including those exempted from the *Protection Act 1897*, went to public cemeteries.[68]

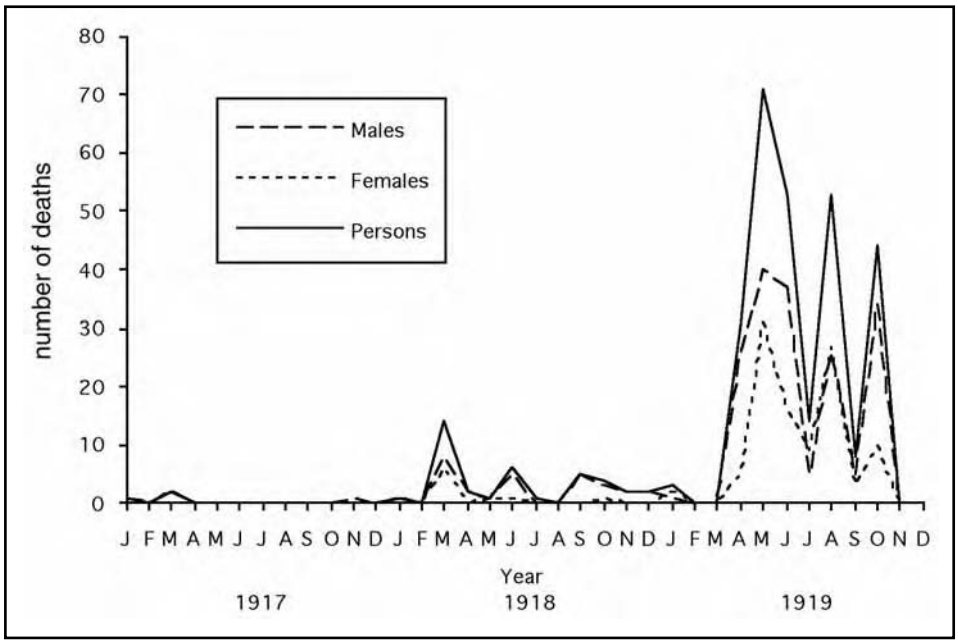

Figure 8.3: Aboriginal deaths from influenza per month and by sex in Queensland during the period January 1917 to December 1919. Source: Compiled from *QSA*, Series No. A/58973-58974, 'Death Register–Where, Cause, 1910-1936'.

By late 1919 the influenza pandemic was receding among the general population, but in the Aboriginal relief camps it appears to have lingered into 1920. Although there was no major outbreak of other respiratory diseases, this could have represented a return to the normally high seasonal incidence of pneumonia. It is also possible that the larger pastoral groups and hospital fringe-camps harboured and sustained the infection into 1920. That it continued among Aborigines was a reflection of their physiological and social circumstances. The American historian A.W. Crosby has argued that indigenous populations were at risk during epidemics because they had not 'had contact within the lifetime of their oldest members with the disease that … [attacked] them and [were] therefore immunologically defenceless'.[69] This is the 'virgin soils' theory, and the pneumonic influenza pandemic of 1918-1919 supports this hypothesis.

The number of Aborigines who perished from the disease remained high for almost a year after the incidence of the disease had subsided in the white community. J.W. Bleakley mentioned in his annual report for

1920-21 that Aboriginal mortality remained above normal throughout these years.[70] Depot and fringe-camp populations in Queensland lived in mostly small isolated groups in the bush, at some distance from urban populations capable of harbouring that particular strain of influenza and becoming immune to it. If Aborigines were at a disadvantage by being unable to deal immunologically with new infectious diseases, they were not the first to fail in this way.[71] The difference between the traditional dwelling sites where Aborigines were born and had lived for most of their lives and their new camp environment was that the people from the bush then lived under totally new hygiene and social conditions. Large numbers were gathered in common or mass living areas in camps or on pastoral properties. When sick Aborigines migrated or travelled away from their homes to seek treatment, their exposure to new pathogens and new social environments led directly to poor health. Their physiological system was unable to cope with the infections confronting them. Under the new circumstances in which the sick found themselves, in places where they faced an additional range of exotic viral and bacterial infections, good health was almost impossible to maintain.

In contrast to the quarantine and isolation measures implemented everywhere else, the pandemic moved to Queensland and sick indigenous people were brought to government and mission depots. Once there, they found themselves in a place where the pandemic was already established and they soon became infected, the disease killing mostly the very young babies and the weakened aged. As it did it caused cultural chaos, which in turn affected a whole range of Aboriginal peoples' social relationships[72] and led to rapid social change. It eroded traditional Aboriginal social relations by forcing people to travel long distances for treatment into unfamiliar missions, reserves, relief depots and hospital camps. Older people were commonly despatched to the depots from pastoral properties and from fringe-camps near coastal towns, which could help explain why so many older Aborigines became infected and perished soon after they arrived at their new places of residence. Many of those transported to the large population centres simply lacked the immunity and the strength to fight potent new infections such as pneumonic influenza. At the same time, sick and dying Aborigines who were brought to depots were unable to understand the nature of the danger with which they were confronted. Nor could sick bush people adapt quickly to a physiological threat from beyond their experience.

In the period 1910–20, the increasing incidence of venereal disease, tuberculosis, leprosy, hookworm and influenza highlighted the need for change in health delivery services to Aboriginal groups. Authorities searched for answers as more Aborigines were moved to government reserves from cattle properties for care and protection. Government officials, politicians, church leaders and even the State Governor worried over explanations and solutions for the Aboriginal predicament.[73] Reform to the Aboriginal health care system was about to be introduced, a topic we will consider in the next chapter.

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5. McCorquodale, 1987, p.55; see also, A/589526, 'Registrar of Acts, 1897-1934'; this is a book in which all legislation in the period was recorded by the Protector's Office in the Under Secretary's Department, see folios 77-99, and section 2(xii), of the Regulations to the 1897 Act, 'The employer shall provide every reasonable facility in the event of illness of employee or any accident occurring to an employee for such employee to obtain medical attention or medicine, and no charge shall be made against any wage due to the said employee for medical attention or medicine without the approval of the local protector;

> (xiii) The employer shall provide all provisions ... and medicines;
>
> (xiv) In the event of illness of an employee under eighteen years of age, or of any accident occurring to any such employee, the employer shall at his own expense provide such employee with the necessary medical attention, medicines, and maintenance during illness or state of infliction to the satisfaction of the local protector;
>
> (xv) The employer shall forthwith report to local protectors in writing, the desertion, illness or death of any employee.

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22. Chief Protector of Aborigines, 'Annual Report', 1919-1914, in particular, see 1914, p.9.

23. *Ibid*., pp. 9-10.

24. *Ibid*., p.6 and their mention of 9 people admitted to lock-up hospital, which was a hospital for sufferers of venereal cases; see also p.8, for evidence of native birth control.

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26. Chief Protector of Aborigines, 'Annual Report', 1919, p.6.

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28. *QSA*, Series A/58973, file no., 58974, with title, 'Death Registers – Where, Cause', 1910 to 1936, see entries for years 1910 to 1920, (see Appendix 8, see Table 8.1).

29. Allan M. Brandt, 1987, pp.2-51.

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32. Chief Protector of Aborigines, 'Annual Report', 1920, p.6.

33. AA/1969/10/1, Item 17 K, 'Hookworm Disease', p.16.

34. *Ibid*., p.17.

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9

Protection and segregation: the motive forces in improving Aboriginal health in Queensland, 1920–30

The decade 1920–30 was important for Aboriginal health in Queensland. The results of the hookworm surveys carried out along the central Queensland coastal districts between 1918 and 1923 were published. The reforms introduced throughout the 1920s transformed the old style ration and relief depots into permanent, settled, segregated Aboriginal townships, providing a basis for improving health standards. One reason why such townships were created was to ensure that Aborigines married and produced children only among themselves. Another reason was to help Aborigines feel 'contentment and comfort'.[1]

The post World War I phase of the national hookworm campaign ended in 1924. This phase became entwined with the growth of ideas about public health, from which came ideas about Aboriginal 'betterment'.[2] Aborigines by now were widely perceived as being in need of 'improvement'. Not only that, but as surplus labour they could productively assist during postwar reconstruction.[3] One approach to 'improvement' was to ensure that Aborigines coming into the labour camps were free of infectious diseases which could threaten the rest of the work force. The notion that hookworm was a 'disease of laziness' had to be dispelled immediately. The national hookworm campaign therefore targeted Aborigines as the group most vulnerable to hookworm infection and consequently the group among whom the disease had to be treated first. As previous research among indigenous groups had revealed, the rate of infection was high among Aboriginal groups. The report claimed that practically all indigenous groups of north Queensland were affected by hookworm.[4] Some had extremely high rates of infestation.

One researcher found a 100 per cent infection rate among Aborigines at Yarrabah, a mission near Cairns. Three years later, the survey found an infection rate of 75 per cent in the two settlements of Aborigines on Palm Island.

By 1924, the data collected by the National Hookworm Campaign was released to the public.[5] Selective material was presented to show what the incidence of the disease was only among some Aboriginal groups,[6] but it indicated that

> with white settlement the natives were eventually gathered into more or less permanent groups in fixed localities, such as missionary settlements, and cattle stations, and these altered conditions were ideal for the spread of hookworm disease. In certain areas the hookworm rate among them on first examination, was found to be over 90 percent, while 50 percent and over was usual. These Aboriginal settlements have acted as centres for the spread of hookworm disease to the European, and as a matter of fact, they still present a problem.[7]

The problem extended to those Kanaka, Chinese and white populations who failed to construct 'privies' at their place of residence and whose habit was to defecate close to their houses.[8]

Although the campaign lasted well over a decade, its final stages commenced in August 1920 and lasted until 1924.[9] It followed a preliminary campaign conducted by the Queensland Hookworm Campaign under Dr S.M. Lambert. The final report indicated that the population was a shifting one, which meant that a number of mass treatment visits became the normal eradication strategy.[10] Aboriginal settlements, the report stated, resulted from the inability of Aborigines to live in comfort among the white population, although in some cases they had been placed in settlements for misdemeanours under the protection legislation. The report claimed the settlements were like 'a home, a benevolent asylum, and a reformatory'.[11] The Aborigines surveyed at the Ingham Aboriginal reserve displayed an infection rate of 70.4 per cent out of a population of 92 people.[12] Although very young children had been infected, throughout the population of Aborigines tested older children and young adults appeared to have the highest rates of infection.[13]

At Barambah near Murgon in the south-east of the State, the rate was clearly much lower than in the north. At Barambah, 142 people presented

with hookworm infection from a population of 602, or 24 per cent.[14] Barambah had begun as a relief depot and, in the space of little over a decade, its residents had become an institutionalised population. The reason for the disparity between Barambah and the northern settlements may have been that such southern settlements had already been treated with chemicals. Phenyl was sprayed on the ground surrounding the toilets and urinals. In addition, most houses on depots and most public facilities, including the disease camp areas, were sprayed with the disinfectant by pressure pumps. Even the relatively low infection rates of the south suggest that the image of the Aborigines portrayed by the 'betterment' movement was over-optimistic, if not idealised.

A total of 1079 Aborigines were living in this district not including the Barambah population of 602. A further 426 Aborigines lived in fringe-camps near Murgon (a farming service town close to both Barambah and Taroom Aboriginal ration and relief depots). Another 51 Aboriginal workers of the district had no specified dwelling place.[15] The incidence of hookworm infection by age and geographical distribution revealed that the highest infection was in the age group between 6 and 18 years, most of whom lived in the fringe camps.[16] At the reserve, however, the figures revealed that 62 people in the 6-18 age group were infected, or about 10 per cent of the total population. In the camps, out of a total of 417 only 6 were infected. The survey teams tabulated the results, correlating them with the rainfall and climate,[17] but in the last instance the numbers were 'too small for any importance to be attached to these groups'.[18]

J.C.S. Elkington, the new Director at the Institute of Tropical Medicine, indicated in 1923 to Cecil Cook, the Commonwealth Quarantine Officer in Darwin, that hookworm constituted a 'menace to white people' in the Northern Territory and Queensland, and would consequently require all available funds for a considerable time.[19] Cilento, the new Director of the Division of Tropical Hygiene, had a different view of treatment. The public, which consisted of both white migrant labour and the permanent white population, had to be educated. His view was that

> the new hookworm campaign was basically educational. Illustrating pamphlets in Maltese, Italian were distributed in the community and lantern light slide lectures were held to demonstrate…[the need] for clean sanitary habits. Hookworm nurses and inspectors visited schools and other public places. There were laboratories in most centres for

> testing samples of faeces for the presence of hookworm eggs … It was difficult to collect faeces from sugar farmers … among whom domestic sanitation was appalling … [they] had little or no English, lived in poverty in squalid hovels and kept to themselves.[20]

Cilento obviously understood workers' habits in the cane cutting districts.[21]

To inform the treatment of Aborigines, the State Health Commissioner had a two-day follow up survey conducted among the various Aboriginal groups, and this

> took in Dunwich, Myora and Amity Point. The survey commenced on 14 August and persisted until 16 August 1924, and the numbers [of people previously infected] examined in Dunwich was 309, and of these only two cases were found positive, and these men were aged 52 and 75 respectively. This showed the previous treatment… [to be] very successful. At Myora 24 cases were examined… [and] 15 harbour[ed] hookworm.[22]

The difference between the Dunwich and Myora figures was remarkable. Bleakley, the Chief Protector, believed that if the attempt to eradicate the disease was to succeed in the long term then Aborigines had to stop walking around barefoot and should wear 'some foot-covering'.[23] Cumpston had suggested that the Institute of Tropical Medicine should become a central testing agency for use by medical practitioners of the north. Cilento had changed the research orientation of the Institute from a preoccupation with disease conditions to preventive medicine or, as he put it, 'from sickness to health'.[24] He knew that 'by the early twentieth century the aetiology and cure for hookworm infestation had been well understood'.[25] The hookworm surveys also found high levels of infestation among some migrant groups. In the original investigation in three North Queensland districts, of 1339 Italians examined, 32 per cent showed hookworm infection. In a group of 221 Spanish people the rate was 29.1 per cent. In a sample of 12,318 British Australians, however, the rate was only 15.3 per cent, while among 112 Pacific Islanders the rate was 30.3 per cent. By contrast, in a group of 393 Aborigines the rate of infestation was 62.1 per cent.[26]

Those leading the development of public health tended to overstate the threat of hookworm in Australia. There was a concern that the effects of the disease on Aborigines was to create a permanent pool of infection which would always pose a threat to the broader Australian population. Cilento was one who held this extreme view on this subject. In his diary entry for 17 December 1917, prejudice tinged with compassion was apparent:

> My Aboriginal patient was in a meanly built cottage… As the car drove down it was greeted by scores of mongrel dogs… Their furious barking brought natives old, young and middle-aged, black, yellow and almost white to every door and window… The home of the sick woman was floored with mud and stamped hard…The living room was crowded with waiting gins… The bedroom was smaller dirtier and similarly floored and roofed with bags that bulged with many a hint of vermin and dirt.[27]

A.T.Yarwood, who published a paper on Cilento in 1991,[28] found his views both prejudiced and naïve.

Sanitary conditions in the cane plantation regions had been poor and as a result, most plantation workers became infected. The same was true for the Aboriginal communities. Sanitary closets were not extensively provided because of the costs of installation. In the mid-1920s Bleakley had difficulty in showing that the Aboriginal population was increasing on reserves. However, populations were increasing in the fringe camps and information on their size was never properly collected. The demand for toilet facilities was never accepted as a legitimate health need. The final report of the, Hookworm Campaign concluded that the main cause of the spread of the hookworm disease was a lack of proper latrines. Further, it argued that those people not already infected would eventually become victims by coming in contact either with infected material such as polluted soil or through direct contact with other humans and animals.[29]

Temporary relief depots and places of segregated detention possessed human waste systems described as 'primitive'.[30] What this meant was that of all the hundreds of campsites and scores of homes occupied by Aborigines in the various depots, settlements, missions and fringe-camps, only six had privies.[31] Customary practice prescribed that people simply defecated and urinated where they stood, slept and ate, or in the bush nearby.[32] Researchers reported that the ground around Aboriginal living

sites soon became polluted. The constant use of the dwelling site as a repository for human excreta made this inevitable. Even where toilets had been constructed they were allowed to overflow and pollute the surrounding areas for some distance.[33] The Queensland protectors were paradoxically placed in this situation: they wanted to leave people alone but at the same time expected that Aborigines should heed public views on health standards. Realistically, however, to expect people who had so recently emerged from bush life to use latrines was a vain hope. No amount of State tuition could persuade reserve inmates to use them regularly.

Two hookworm inspections took place in the period 1920–23, and the second revealed a vast improvement over the results of the first. For example, at Purga mission near Cairns the first inspection had revealed a 70.4 per cent infection rate, but the second inspection showed it had fallen to 45.9 per cent. The latter figure was still too high, however. Despite the 24.5 per cent improvement, the infection rate among Aborigines was two or three times higher than among other groups.[34] Other Aboriginal settlements showed improvement too, but their infection rates also remained unacceptably high. Palm Island, which had an infection rate of 66.2 per cent at the first inspection, fell only by 9.3 points to 56.9 per cent on the second. As mentioned earlier, a similar small improvement occurred at Barambah, where the initial rate was 25.0 per cent, falling by 4.7 points to 20.3 per cent at the second survey.[35] In the places were the sanitation improved a reduction in infection rates occurred, but even when sanitation improved and treatment was administered other factors, such as the continued pollution of the living areas ensured high levels of infection. Aboriginal camps had no sanitation whatsoever and so in these locations the rates of infection sometimes increased.[36] As at Barambah, improvement generally came because the government acted deliberately to reduce the risk of infection by providing toilets, cleaning the surrounding polluted soil and disposing of human waste.[37]

In the whole-of-Queensland survey, as reported by W.C. Sweet in 1924,[38] 167,290 people (blacks and whites) were screened. Of this number, 15,472 (or 9.2 per cent of all surveyed) were infected with hookworm. The Queensland infections amounted to 6.2 per cent of the Australian total screened, which was 248,721. The highest rates in Australia were

among the Aboriginal groups of Cape York, where tropical conditions were similar to those in the Pacific Islands.[39] Following the screening and treatment program a permanent control plan was devised which was put into operation in January 1923. The Australian Hookworm Campaign employed sanitary engineers to inspect sites identified by the surveys as 'hookworm polluted'. Their strategy was to carry out surveillance of infected sites and ensure that the public was being educated about the complex nature of 'soil pollution'. In addition, the engineers had to consult with local government authorities, who then followed up on the engineering advice. The data collected by the engineers of the Hookworm Campaign Office went to the Queensland Health Department for follow-up treatment and surveillance work.[40] No mention was made in the final report about what the States ought to do about follow-up or continuing surveillance.

Except for continuing work among Aboriginal camp groupings, the Australian Hookworm Campaign completed its work at the end of September 1924. The Campaign had national responsibility for monitoring control measures but its diagnostic laboratories were limited by the funds it received. Although it planned in 1925 to have a number of laboratories located around Australia to continue the survey and treatment program, in practice this proved difficult to achieve. No further action on hookworm occurred either in Aboriginal institutions close to rural service towns or in the more isolated Christian missions.[41]

Bleakley was still the Chief Protector and his reputation as an authority on Aborigines had grown.[42] His views on protection favoured segregation and the allocation of reserved lands for that purpose. Both these objectives were central to the policies of his administration. But despite his attempts to segregate Aborigines from the wider society, outside influences still penetrated his protective net in the form of contact between Japanese mariners and Aborigines. The Japanese maintained fishing communities in the Solomon Islands, and when they came south to harvest fish they lived in various locations along the Queensland coast for extended periods. An unknown number of these mariners set up camps or lived in cottages built by Australian fishermen on islands off the coast of northern Queensland. They also stayed for long periods in the hundreds of estuarine locations on the Queensland coast itself. They were mainly men, although a number of Japanese women were brought in between 1907

and 1910. Many of the Japanese fishermen took on Aboriginal women as labourers, concubines and even as 'articles' of exchange. Venereal infections must have been passed between Aboriginal women living close to or with the Japanese and other Asian mariners. No comprehensive record of venereal infections among these fishermen exists, nor were comprehensive records among Aborigines kept either by protectors or medical practitioners. The 'Death and Disease Register'[43], however, did record the number of Aboriginal deaths from venereal diseases.

Anxiety by Queensland fishermen and Commonwealth Customs agents about cohabitation between Japanese men and Aboriginal women prompted the Chief Protector to inspect the Aboriginal reserves and campsites along the Queensland coast annually.[44] The transfer of communicable diseases between Aborigines and the Japanese was a matter for concern to the protectors and government agents alike. Speculation about the presence of foreign fishermen led to rumours that they were spreading venereal diseases among Aborigines. Articles on Japanese sailors periodically appeared in the newspapers of coastal towns, and such articles were placed on record in the files of customs officers. Although no correspondence passed between the customs authority and Bleakley, he probably received information from customs officials in Cairns. Early in 1922, an article appeared in the *Cooktown Independent*, expressing concern about the prospects of 'the white man being gradually deprived of his hold on the fishing industry along the coast'.[45] The article went on to say that 'Asiatic fishermen are not only multiplying in numbers, but… are masters of the natives of the land'.[46]

A number of Japanese sailors were under surveillance by the Home and Territories Department in 1920. Skippers of luggers hired by Nippon Yushen Kaisha Co., a Japanese fishing company with bases in Thursday Island, New Guinea and Hong Kong, all employed Japanese contract seamen.[47] Seamen such as Niro Nagasaku, Wahichi Nakashiba, Hachiro Wooi, Kichizo Goto and Yonemmatsu Nishakawa all fished along the Australian coast for many years and had long contact with Aboriginal men and women. F.N. Gabriel, a Customs Officer in Cairns, reported that Japanese luggers rested in inlets and were 'in and out of ports after dark without hindrance'.[48]

The Japanese mariners knew well all the coastal inlets and bays from

Mackay to Thursday Island. They sheltered regularly in these waters even though, 'no attended lighting existed' between Cape Grafton and Cooktown.[49] Similarly, no guiding lights existed along the 1,000 kilometres of coastline between Cooktown and Goode Island.[50] The sailers would leave their luggers, sometimes for weeks, trek inland to Aboriginal missions and live there undetected by either mission or government authorities. An Aborigine informed Gabriel that on 2 July 1922 'plenty of Japanese boats' had come to Port Stewart near the Daintree River and had stayed 'a long time'.[51] They had brought 'plenty of food and grog and the Japanese got plenty of gins'.[52] There were many drunken brawls between the Aborigines and the Japanese, and the Japanese took the drunken Aboriginal men and women away on the boats.[53] At Port Stewart, temporary thatched huts served as accommodation for six or seven Japanese sailors. In addition, the sailors used huts built by white men as a haven from rough seas. Dr Elliott of Cooktown advised Gabriel that the Japanese had received treatment for both syphilis and other less dangerous forms of venereal disease.[54]

Although the courts deported him once, the seaman Nakashiba disappeared into the bush for over a year. Then Gabriel 'discovered him at Yarrabah mission building boats for the mission'.[55] Nakashiba received no wages from the mission, which supplied the material for the boats.[56] Gabriel said that Nakashiba told both Rev. Smith and Captain Brewster (the Harbour Master at Cairns) that he owned a cattle property at Cow Station, inland from Cairns.[57] Another report by Gabriel[58] indicated that a Japanese named Miyagawa had opened a store at Cooktown to supply food to the boats arriving there. Miyagawa came originally from Cairns as an employee of P.J. Doyle, a merchant, selling wines and spirits to Japanese mariners. According to Gabriel, Miyagawa came under notice for illegally selling alcohol to Aborigines and was fined £100 for doing so. In addition, Dr Elliott had him under surveillance because he said that 'men and women suffering from syphilis still continue to arrive at Cooktown from Coen'.[59]

The rising incidence of venereal disease caused overcrowding at the Cairns hospital and the health camps.[60] Hospital staff had to use tents to house the venereal disease victims who came for treatment. In Cairns, the Customs officials accommodated both the sick and diseased Japanese and Aborigines in the 'alien' stockade. This practice was also adopted by the

medical officers, who held emergency powers under the infectious disease legislation to do so. Such accommodation remained unhygienic, although repairs were gradually undertaken. In Cooktown, the alien cells at the hospital were otherwise known as the 'Aboriginal venereal disease and leprosy stockade'.[61]

In June 1922 Gabriel received a letter from F.W. Hayes of the Land Office in Cooktown, who wrote about

> obtaining authentic information [about] the Japanese Bêche-de-mer fishermen along the Queensland coast [who] are cohabiting with the Aboriginal women. I am in a position to state emphatically that they do, and have been indulging in the practice for years.[62]

Hayes wrote that he planned a trip to northern Cape York soon and would not be back for about three months. He would attempt to get more proof if requested.[63] In a memo to Gabriel N.A. Pollock, the northern district inspector of customs, advised that Hayes was in contact with him about Japanese cohabiting with Aboriginal women and that he expected the police patrol to arrive soon 'with seven Aboriginal women afflicted with syphilis contacted allegedly from Japanese. Pollock [said] he thought the Japanese were operating in a region along the coast from Cooktown north to Port Stewart, a distance of about 300 kilometres north of Cooktown'.[64]

In the period 1923-29 Bleakley's interest in the condition of hospital facilities concentrated on the quality of health care at depots such as Taroom and Barambah and on the prevalence of leprosy among Aborigines. The development of better quality health care at the depots depended variously on the reserve and local hospitals, the Aboriginal hospital attendants, the nursing staff, the visiting medical officers, and the reserve managers and their wives (known as female protectors). The medical officers had the power under the *Public Health Act 1911* to admit Aborigines into local district hospitals or to create emergency holding depots, as happened during the influenza pandemic. Better care of the depots was important because most, but not all, local hospitals refused to accept Aborigines suffering from infectious diseases, particularly venereal disease, leprosy, tuberculosis and infectious skin complaints.

During the 1920s primary health care for Aborigines consisted largely of the first aid box maintained by untrained depot staff. Emergencies were

attended to by medical practitioners, who travelled long distances to attend to sick Aborigines at the relief depots. In most cases the bush fringe-camp offered the best compromise for all concerned. For the doctors it provided a way of keeping sick Aborigines near the hospitals for follow-up treatment. For Aborigines it served as a respite from strict hospital matrons, and provided a level of comfort not available in hospitals. For the white townspeople the fringe camps were distant enough to protect their sensibilities and keep the possibility of infection well away from the town. What had begun as an emergency measure gradually gained acceptance as permanent practice. It was therefore most convenient to dispatch Aboriginal patients to bush camps to await treatment, but they sometimes went with aliens—mainly Chinese and Japanese—to police lock-ups.[65]

The alternative destination for Aborigines was relief depots like Barambah and Taroom, to which large numbers of sick people were sent from all around Queensland. In 1924, Bleakley reported that an outbreak of influenza had caused some deaths and left many people sick at Mapoon on the Cape. Severe outbreaks of influenza, followed by pneumonia and pleurisy, occurred at the Barambah and Palm Island settlements.[66] Similarly, at the Taroom settlement an outbreak of measles in the autumn left many serious cases of pneumonia in its wake.[67] Venereal disease, too, brought people to central points for treatment and continued to incapacitate people, sometimes beyond a full calendar year.

Bleakley continued making trips north each year to inspect at first hand how protection policies operated. In 1925 he wrote that

> venereal disease [was] … most evident in the Gulf and east coast districts, but isolated cases were treated at a number of district hospitals. Four cases were at Normanton Hospital, and a similar number in the Torres Strait Seaman's Hospital, while eighteen cases from Palm Island Settlement, mostly new arrivals from mainland districts [received treatment] in the Townsville Hospital. Venereal cases coming from the Peninsular [and treated] under direction of the government medical officer were kept in the compound of the old Cooktown gaol.[68]

The Church Mission Society owned and operated some of the rural and coastal hospital establishments, but under the *Public Health Act 1911* such institutions were ultimately controlled by the Queensland Health Commission. These arrangements often confused the health issue because responsibility remained divided.

The number of Aborigines treated in district hospitals throughout Queensland in 1925 totalled 406 people of both sexes. According to Bleakley, all missions gave direct clinical and in-patient treatment. At Barambah 941 sick inmates received some form of treatment, of which 246 received treatment in the hospital compound. At Taroom 645 patients received treatment from the hospital and, of these, 70 stayed as in-patients.[69]

Recruitment of hospital trained nurses was always from among personnel from outside the district, and once employed at the depots the nurses worked under a series of State regulations,[70] including those of the *Public Health Act 1911*, the *Aborigines Protection Act 1897* and the *Public Service Act 1922*.[71] Medical practitioners, that is, visiting medical officers, billed the Chief Protector for their fees. However, they, came under the control of public health and medical legislation. They undertook to make weekly visits to inspect the hospitals and to treat sick Aborigines at the ration depots (which were now becoming known as Aboriginal settlements). Once on the depots they performed minor surgery, prescribed drugs and gave other treatment and follow-up care for patients. In addition, they could consult on the telephone or, if they wished, have patients brought to their private surgeries. They were able to admit patients either to local hospitals or send them to sanatoriums and hospitals such as the Brisbane General Hospital or the Diamantina Sanatorium. In addition, they advised reserve managers on the supervision of settlement and village health conditions, and carried out the health surveys that then formed part of their annual reports to the Chief Protector.[72]

White townspeople generally abhorred the practice of white men having sexual relations with Aboriginal women. Townspeople believed that Aboriginal women were the original source of venereal diseases and that their white male partners would bring the infection into white society. It's not known when venereal diseases were passed on to Aboriginal people. In any event, white people were highly fearful of this infection because they knew of its social effects. Alternatively Aboriginies did not fear the effects of the disease. On the one hand, Aboriginal groups could not see the infection nor was the disease life threatening. On the other hand, the disease was barely under control but mostly, protection kept white men away from cohabiting with Aboriginal women. In addition, the number of Aborigines who died from venereal causes was small during the 1920s. In the five year period 1920-24, only 18 Aboriginal men and 10 Aboriginal women died from venereal diseases.[73] A possible reason why more

Aboriginal males were dying of these disease, than Aboriginal females was that the transmission of infection was partly congenital and partly coming in from outside Aboriginal social groupings. Protection policies were designed to prevent white and other males from conducting sexual liaisons with Aboriginal females. The government policy, therefore, began to become more effective, except for the contact with Asian sailors (which was, as described, difficult to control). White men had generally begun to bring their own women to live on isolated properties and in country towns.

Most settlers, including the Chinese males, had been segregated from contact with people of either full- or mixed-Aboriginal descent through the protection legislation. Segregation took place more rigorously under the more forceful policy management of Bleakley, who firmly believed in keeping the races separate. In the next five years, 1925-29, only 12 Aboriginal males and 9 females died from venereal diseases.[74] The decline from the previous five-year period reflects the assiduity with which Bleakley fulfilled his responsibilities. Further, protection was reshaping the kinds of other diseases Aborigines contracted.[75] Protection policies allowed the Chief Protector (and the Courts) to move people from one institution for Aborigines (i.e., reserve or industrial training centre or mission station) to another. This enforced migration meant that where infection was endemic, as with tuberculosis, then the infection remained in the group until the removal of those who were infected. Until that happened, all camp residents remained vulnerable. The following graph (Figure 9.1) shows that respiratory infections—pneumonia, influenza and tuberculosis—caused the deaths of 235 Aboriginal men and 166 Aboriginal women during the decade 1920-29, and almost no cure existed. Of these deaths, 110 were from pneumonia and a further 110 from influenza, of which there were possibly three different strains. The first strain was probably a lingering form of Spanish Influenza,[76] which killed 52 people in the two years between 1920-21. Another wave of influenza arrived in 1924-26, with a further epidemic in 1929.[77] In this period there was still no knowledge of the differences between either the various strains of periodic influenza viral attacks, or between pneumonia and influenza.

For Aborigines who died from disease, entry of their death into the Death and Disease Register was not necessarily a straightforward exercise. Under normal conditions certification of the death of a white person or someone of mixed-descent by rural police, a health worker or a medical

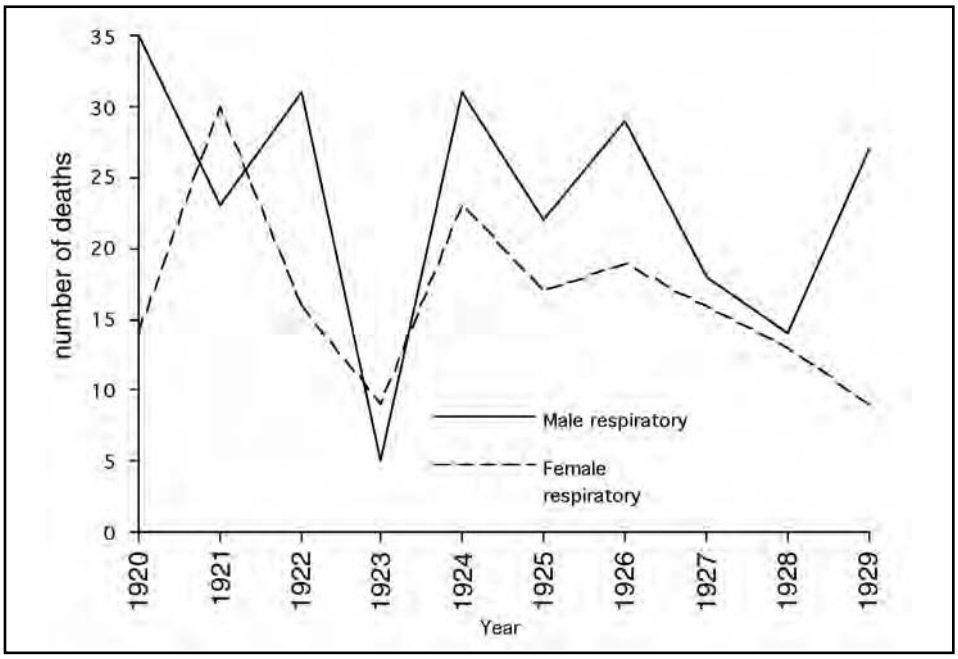

Figure 9.1: Aboriginal deaths from respiratory diseases in Queensland by sex, 1920-1929. Source: Compiled from Table 9.1.

practitioner, was reasonably simple. Great difficulty existed, however, for someone making a determination of cause of death of a full-descent Aborigine. In most cases, problems existed because of the isolated locations where the Aboriginal person died. Certification usually had to be made by untrained people because medical advice was not available, so it is not surprising that the entries in the medical certificates often gave inappropriate reasons for the deaths.

Recognition or diagnosis of diseases was difficult for health workers. Pneumonia, as in earlier epidemics, became confused with influenza, so the information about Aboriginal deaths can only act as a guide. In the period 1920–29, for instance, 77 Aboriginal males and 33 Aboriginal females died from pneumonia, while 64 men and 46 women were said to have died from influenza. We cannot be sure of the details because the two diseases were often confused. It is interesting to note that while, influenza deaths fluctuated the recorded deaths from pneumonia increased, with exactly the same number of deaths from each—110—over the decade, as Table 9.1 (below) indicates.

Table 9.1
Aboriginal deaths in Queensland, 1920-1929

	1920	1921	1922	1923	1924	1925	1926	1927	1928	1929	Total
Male deaths											
Pneumonia	6	4	7	2	7	11	9	10	8	13	77
Influenza	19	15	2	0	7	0	10	0	1	10	64
Consumption,	10	4	22	3	17	11	10	8	5	4	94
Sub-total respiratory	35	23	31	5	31	22	29	18	14	27	235
Nephritis	1	2	1	0	1	1	0	11	1	1	19
Venereal diseases	2	8	1	5	2	4	3	5	0	0	30
Senile decay	5	4	12	2	15	12	20	17	7	10	104
Other diseases	9	1	4	2	24	30	27	39	19	32	187
Sub-total other diseases	17	15	18	9	42	47	50	72	27	43	340
Total male deaths	**52**	**38**	**49**	**14**	**73**	**69**	**79**	**90**	**41**	**70**	**575**
Female deaths											
Pneumonia	1	2	1	1	4	2	4	7	6	5	33
Influenza	9	9	1		10	3	7	1	3	3	46
Consumption,	4	19	14	8	9	12	8	8	4	1	87
Sub-total respiratory	14	30	16	9	23	17	19	16	13	9	166
Nephritis		1	0	0	0	1	0	1	0	0	3
Veneral diseases		1	0	3	6	2	1	4	1	1	19
Senile decay	1	2	2	2	5	8	8	10	7	9	54
Other diseases	6	6	5	6	22	22	20	36	20	26	169
Sub-total other diseases	7	10	7	11	33	33	29	51	28	36	245
Total female deaths	**21**	**40**	**23**	**20**	**56**	**50**	**48**	**67**	**41**	**45**	**411**
Total Aboriginal deaths											
Pneumonia	7	6	8	3	11	13	13	17	14	18	110
Influenza	28	24	3	0	17	3	17	1	4	13	110
Consumption,	14	23	36	11	26	23	18	16	9	5	181
Sub-total respiratory	49	53	47	14	54	39	48	34	27	36	401
Nephritis	1	3	1	0	1	2	0	12	1	1	22
Veneral diseases	2	9	1	8	8	6	4	9	1	1	49
Senile decay	6	6	14	4	20	20	28	27	14	19	158
Other diseases	15	7	9	8	46	52	47	75	39	58	356
Sub-total other diseases	24	25	25	20	75	80	79	123	55	79	585
Total Aboriginal deaths	**73**	**78**	**72**	**34**	**129**	**119**	**127**	**157**	**82**	**115**	**986**

Source: *Queensland State Archives*, Series No., A/58973–58974, 'Death Registers–Where, Cause, 1910-1936'

The increasing number of Aborigines dying from tuberculosis was a cause for concern. In the period 1910-18, the number of Aborigines dying from tuberculosis or similar 'wasting' diseases had increased from two to 27, and then to 36 between 1922-24.[78] After that the number fell to 5 in 1929. Apart from the efforts of the Queensland Tuberculosis Association, a private tuberculosis prevention body (which acted as lobby group for sufferers), no real efforts were made to combat the spread of the disease. The reasons for the increasing numbers of Aboriginal deaths lay in the manner in which the Queensland Government managed its protection policies. Centralisation of disparate small bush populations would have spread infection rapidly in government reserves, missions and ration depots.

As relief depots evolved into permanent dwelling places, those who lived there also began developing new forms of social relations: they were indeed coalescing into communities.[79] The protection and religious policies allowed more permanent marriage relationships to be created. With these came a wider range of diseases not experienced under the earlier social relations. Two types of diseases rose to prominence during this period: diseases related to ageing, including illnesses resulting in deaths by 'natural causes', and diseases resulting from urban living. The first type, mainly leading to deaths from senility and ageing, increased from 1920, when six Aborigines died from such causes, rising to 28 in 1926. More relevant to this period were deaths from 'other' causes. These rose from 15 to 46 in the five years between 1920-24, then peaking at 75 in 1927 before dropping to 58 in 1929. It is not possible to discuss this category in detail because the information is so limited. Many deaths were recorded by pastoral employers or by medical, protection and mission, staff who were simply unable to specify the actual causes of death. In some cases it was death from a natural cause, in others it was a complex of causes, such as work related accidents, fighting, snake bite or being trampled by horses.[80] There are limited data on infant deaths.[81] Epidemics of measles and typhus (that is the parasitic infection from lice and fleas which produces fever) are occasionally recorded together with many entries of dengue and malarial fevers. As happened during previous epidemics, Aborigines were sent to central points for treatment and subsequently suffered more than they needed, despite being under medical supervision.

In the period 1920-29, Bleakley attempted to improve clinical care at the government and mission depots. He tried new approaches to Aboriginal health services in protective institutions. Typical of these was the system in place at Barambah. The Barambah management, an interdenominational body set up to administer health care to the sick and suffering, helped create a new kind of community. The clinic became necessary because of the number of Aborigines dying of disease and starvation following their displacement by early pastoral development. As Bleakley's 'protection with segregation' policy gained acceptance, new forms of communal daily life emerged. The pneumonic influenza pandemic of 1918-19 demonstrated the weaknesses of the rudimentary health service of the depots. The health clinic at Barambah developed from the segregated compounds staffed by 'nurses'—some of whom were untrained and were employed mainly for their religious convictions, while others did have formal nursing qualifications. The latter type began to be employed by the Chief Protector from hospitals, and were supervised by local general practitioners or by visiting medical officers. These clinics were also serviced by Aboriginal orderlies who were supervised by both trained and untrained nurses. In turn, these health workers were supervised by medically qualified general practitioners on contract to the Chief Protector. The following events, beginning in the mid-1920s ,show how these institutions coped as well as some of the problems faced daily by the staff.

The events began on 21 January 1926, when Bleakley wrote a memo to the Under-Secretary of the Home Department saying that 'an Aboriginal woman, Maudie King, died suddenly after "taking a bad turn"[82] from asthma and a heart complaint while on her way to the Barambah hospital'.[83] She began feeling ill 70 metres from the clinic. An Alex Lander came to the clinic to fetch a stretcher but was prevented from doing so by Matron Little. Maudie's condition deteriorated and she died.[84] This caused consternation among the Aboriginal inmates of the depot. A large meeting occurred between irate relatives and other inmates at Barambah following the incident. Statements were collected from all Aboriginal and other witnesses. Most, according to Bleakley, concluded that 'the nurses evidently unaware of Maudie's true condition … treated the request too casually'.[85] Bleakley saw no wilful callousness in the staff members' actions, and did not think Matron Little had been purposely unkind. 'Natives, too, are difficult to deal with at times when sick', Bleakley

added, 'and are superstitious and mulish, and necessary discipline is often regarded as harsh'.[86] Life for inmates was often mundane but sometimes traumatic. The staff sometimes became alienated because of their closeness to the Aboriginal inmates, from whom they were unable to escape. The Superintendent at Barambah, W. Porteous Semple, and the Chief Protector realised some of these problems.[87] In a petition issued from the protest meeting, inmates explained their dissatisfaction to the Chief Protector about the services received at the Barambah store and medical clinic.[88]

The issue did not end there. In March 1929 a baby girl, Maudie Bell, died from syphilis and heart failure at the Barambah settlement clinic.[89] She was only seven months old.[90] Earlier that month another child had died, which had heightened Aboriginal and settlement management's sensitivity to the problem. But the outside world was also sensitive to Aboriginal infant deaths. Matron Little was charged with 'alleged neglect by refusing to admit a baby to the hospital'.[91] Dr Junk examined the baby on Wednesday 6 May, recording that the baby was only teething and its illness was consistent with that condition. Another medical opinion was obtained and the baby was sent to hospital immediately because of 'the advanced stage of pneumonia gripping the child'.[92] The baby died that afternoon and Dr Junk maintained that nothing incompatible existed between his earlier diagnosis and the subsequent development of pneumonia. Bleakley asked for Matron Little's resignation.[93] Little's resignation brought the events to a close, and other kinds of health problems began to take priority. These examples, however, give some idea of the health difficulties faced on a daily basis by health workers, administrators and inmates.

Aboriginal deaths from respiratory infections made up a large part of some of the problems with which depot, reserve and mission staff had to cope. In general, the types of administrative problems exposed above did contribute to some deaths but the problem was much larger. Aboriginal deaths from respiratory infections in the period 1920-29, as entered in the Death and Disease Register,[94] suggest that deaths from pneumonia, influenza and tuberculosis were of most concern to the health professionals and the protectors. Aboriginal males died in greater numbers from pneumonia and influenza than females, though the totals in each case were close (see Table 9.1 above). Confusion over diagnoses probably meant that the numbers were not accurate in each category: each could

well have been either higher or lower. Tuberculosis increased almost to epidemic proportions in the mid-1920s if judged from deaths alone, and also exacerbated other respiratory infections.[95]

As noted above, two waves of influenza struck during the period 1924-26, with a further epidemic in 1929 that drove deaths from respiratory infections upwards.[96] The reasons for the increase lay in the manner in which Aborigines began living in larger sedentary groups and using the houses with limited space and ventilation provided by mission and government authorities. The Queensland Government's protection policies and practices were also part of the problem. As Aborigines went south for reasons of protection, illness or offences against the protection legislation they spread the diseases among people not previously in contact with such infections. This was especially true of people who came from Cape York to work in the south and who lived for the first time in centralised settlements. With them came hygiene-related infections such as leprosy.

Although leprosy had been eradicated from the southern groups it could be transported by cattle and rural labour. In Queensland in 1920 there were 31 lepers, mostly Aborigines, though their numbers also included Torres Strait Islanders, Kanakas, Europeans and Asians. This figure was lower than the 35 in 1910. The number rose to 36 Aborigines in 1925, so it was obvious that leprosy was not about to disappear.[97] The regions from which the new cases came were all in the north. A number of towns in the north such as Bundaberg, Innisfail and Ingham provided one leper each, and two came from Cardwell. Leprosy had therefore become a disease of the north: no further new cases were reported from the southern areas of the State after 1925.[98] By that year two leprosaria, one at Fantome Island and another at Peel Island, had been established to house lepers. The numbers of people admitted to Peel Island fluctuated during the mid-1920s and rose to 47 new cases in 1928.[99] Although no new cases were reported in 1929, the reason might have been the secrecy with which this whole issue was managed by the Queensland health authorities and the inability of the health regime to locate and track down the source of infection. This was not a simple problem and it persisted well into the next decade.

Dr Raphael Cilento endeavoured to describe the problem in one of his reports. He wrote that when the Kuranda (Mona Mona) Reserve started in 1914, the majority of the Aborigines brought there belonged to the

Mareeba tribe, a closely knit group.[100] A few others came from as far north as the Gulf region and some from Mossman, and a large number had been born in fringe-camps and had grown up close to white settlement, knowing no other life.[101] The first case of leprosy reported among Aborigines in the region 'was an old woman, Nellie, who died in 1916'.[102] According to native accounts this woman's toes 'looked as if they would drop off', she was covered with sores, and she was avoided by other natives'. Her principal contacts and relatives [were] known and she [had] no known descendants at the settlement'.[103]

Other cases cited by Cilento clearly showed the need for greater awareness of maintaining control of the infected patients as well as the likelihood of the disease spreading to other Aborigines. In a comprehensive report to the National Health and Medical Research Council in 1925, Cecil Cook outlined some of the complications of the problem. He referred to the problem of 'surveillance and contacts', then outlined the context of treating lepers in Queensland.[104] It should be possible through efficient 'prophylaxis', he said, to eradicate the disease in spite of the problems presented by the heat and humidity of the climate.[105] The problems were inadequate surveillance of suspected victims, inadequate investigation of patient contacts, and poor control of lepers discharged after treatment.[106] Tracing contacts meant searching for Aboriginal families, which was an arduous task and sometimes impossible, even in the coercive protection institutions.[107] It meant full investigations into clinical histories of other members of families. Aborigines did not have 'households' nor simple 'family connections' as white society understood these. An Aboriginal family sometimes involved upwards of 15 small extended families spread over a 30- to 80-kilometre radius. When lepers were relocated they were sent from their place of residence by missionaries or protectors. Many had no knowledge either then or later of the size of their family. The lepers were travelling hundreds of miles under police custody by train or motor vehicle to the coastal island leprosaria.[108] These difficulties made it impossible for doctors to contemplate releasing Aborigines, on the basis that they would not return for follow-up treatment.[109]

Another complication in developing a treatment regime for Aborigines was that doctors believed there was a hereditary link among patients who

became infected with leprosy.[110] If there was a 'hereditary factor', or even a suspicion of this, then a large number of Aborigines needed to be involved in tracing the causes. Cost factors already plagued attempts to provide primary and secondary health care to Aborigines, and this made it even less likely that stringent leprosy follow-up systems could be implemented. Family members lived cheek by jowl with one another, so large numbers at one living site could readily be infected by a single carrier.[111]

As noted in earlier chapters, by 1925 Cook had produced a major epidemiological study of leprosy in northern Australia.[112] In a later document[113] he revealed that no new discoveries had been made since the mid-1920s.[114] Segregation, Cook admitted, was the most successful means of treating and limiting the spread of leprosy among Aborigines. He wrote that 'leprosy amongst Aborigines was more easily controlled by segregation than was the case amongst whites, probably because the precautionary measure was more effectively applied'.[115] The blame for the break-down of the leprosy treatment in the early 1920s could not simply be laid at the feet of the Aborigines, nor the difficulty of treating them because of their unpredictable social and cultural habits. Cook felt that the medical profession were to be blamed because they lacked the necessary training. He wrote that 'the medical question revolved around the idea that untrained medical practitioners could not detect the symptoms of leprosy, and medical officers failed to understand the level of infectivity of leprosy'.[116] Individuals, Cook added, 'suffered from the prospects of losing a livelihood if detected, particularly if they had to provide for a family, and fear of separation from… [their family] members'.[117] In 1927 Cook thought it reasonable to assume that an improvement in the pattern on the spread, and treatment, of leprosy was occurring,[118] but he was mistaken.[119] In the following year, the numbers of lepers among Aborigines began to increase dramatically.[120] Some of the new lepers were at the Mona Mona reserve at Kuranda.[121] One person, a man named Tommy, died when his feet became infected. Tommy was thought to be about 40 years of age. According to Cilento, the feature of this case was that Tommy had a contagious disease but was never isolated from fit inmates. Cilento wrote that Cyril and Roy, two of Tommy's sons, had been taken by ministerial order to the Peel Island lazaret, but his only grandchild was still at the settlement and was in danger of infection.[122]

Other relatives were later diagnosed as lepers and removed to Peel Island.[123] Hookworm, venereal disease, respiratory infection and leprosy continued to be the greatest health risks to Aborigines.

Following the flu pandemic a phase of their reform took place, despite all this lebrosy numbers increased during the period between 1930 – 1940, as shown in Chapter 10.

For full references see Bibliography

Notes

1. Chief Protector of Aborigines, Annual Report, 1913, p.17, in *QPP*, 1914, Vol. III, pp.1011-1030; see also, Long, 1970, p.97; see also, Bleakley, 1961, pp.166-180.

2. National Library of Australia (NLA), mfm NX 643, '*Daily Mail*', May 22, and 12th June, 1919, see article, 'Justice for our Aborigines', and 15 June 1919; see also, NLA, mfm NX 643, '*Courier Mail*', dated 19 June 1919, letter to the editor; and see also, interview with Premier Theodore dated 12 June 1919; see also, NLA, mfm NX 640, 'Standard', dated 12 June 1919; see also, NLA, mfm NX 190, '*Cairns Post*', dated 12 June 1919; see also, NLA, mfm NX 190, '*Telegraph*', dated 12 June 1919, and also, '*Courier Mail*', dated 20 June 1919.

3. Chief Protector of Aboriginals, Annual Report, 1919-1920, in *QPP*, 1920; see also, Long, 1970, pp.96-97, (Long talked about the scheme but makes no elaboration); see also, Dawn May, 1994, pp.104-123, (Dawn May makes no mention of the Betterment Scheme or the Betterment Movement).

4. Chief Protector of Aboriginals, Annual Report, 1919-1920, p.6, in *QPP*, 1920, Vol. II, p.233.

5. A/A, 1969/10, Items, 17 I, 17J, and 17K, 'Hookworm Disease and Control', see, W.C. Sweet, 1924, pp.1-13.

6. Cumpston, 'Hookworm', in Lewis (ed.), 1989, pp.241-245, this is a much shorter version summarising the period of operations and outcomes, but for more detail see the archival material cited above and Sweet, 1924, pp.1-13; see also, Gillespie,, in McLeod and Denoon, 1991, pp.64-87.

7. A/A, 1969/10/1, Item 17K, 'Final Report of the Australian Hookworm Campaign', pp.17-18.

8. *Ibid*., see copy of letter, 'From A.E. Wilkinson Town Clerk of Cairns to Dr J.H. Waite, of the Australian Institute of Tropical Medicine', dated 27 August, 1918.

9. A/A, 1969/10/1, Item 17K, 'Final Report of the Australian Hookworm Campaign', p.55.

10. *Ibid*., pf.

11. *Ibid*., pf.

12. *Ibid*., p.57 (a) on cover sheet, form 133; but see also, p.61.

13. *Ibid*., p.57 (a).

14. A/A, 1969/10/1, Item 2E, 'Relief and Control Of Hookworm Disease In Queensland, Australia', pp.1-17, see Table 5, p.10.

15. *Ibid*., see Table 5, p.10.

16. *Ibid*., p.12.

17. Cumpston, in Lewis (ed.), 1989, see Table 113, p.242.

18. *Ibid*., pf.

19. Gillespie, in McLeod and Denoon,1991 p.86. Gillespie also cites this letter and quotes more extensively from it, see A/A, letter from Elkington to Cook, 18th August, Series No. CRS, A1928/495/21, Canberra.

20. Fedora G. Fisher, 1994, pp.45-66.

21. *Ibid*., pp.45-66, and see p.138; and see also, Geoff Burrows and Clive Morton, 1986, pp.78-80; see also, A/A, 1969/10/1, Item 2E, 'Relief and Control Of Hookworm Disease In Queensland, Australia'.

22. Chief Protector of Aborigines, Annual Report, 1924, p.16, in *QPP*, QGP, Brisbane, 1925.

23. *Ibid*., p.16. Bleakley stated his scepticism that little support of the hard work already applied would be forthcoming.

24. Fisher, 1994, p.46.

25. Gillespie, 1991, p.66-86; Gillespie also cites this letter and quotes more extensively from it, see A/A, letter from Elkington to Cook, 18th August, Series No. CRS, A1928/495/21, Canberra.

26. Douglas Gordon, 1974, p.111.

27. Cited in A.T.Yarwood,, in MacLeod and Denoon, 1991, pp.47-48. Quote is on p.48.

28. *Ibid*, pp.54-60.

29. A/A, 1969/10/1, Item 2E, 'Preliminary Report, No 73871, on the work for the Relief And Control Of Hookworm Disease In Queensland, Australia, From April 17 to August 28 1918, by J.H. Waite, MD, State Director', p.11.

30. *Ibid*., p.14.

31. *Ibid*., pf.

32. Sweet, 1924, p.9.

33. *Ibid*., see Table VI, pf.

34. *Ibid*., Table VI, pf.

35. *Ibid*., Table VI, pf.

36. *Ibid*., p.10.

37. *Ibid*., pf.

38. W.C. Sweet, 1924, p.1.

39. *Ibid*., pp.3-4; see following articles cited by Sweet, J.H. Waite, 'Preliminary Report on Ankylostomiasis in Papua', in *MJA*, Sept 15, 1917, p.22; see also, S.M. Lambert, 'Intestinal Parasites in North Queensland', in *MJA*, April 23, 1921, p.332.

40. Sweet,1924, pp.11-12.

41. *Ibid*., p.12.

42. Ian Howie-Willis, 'Bleakley, J.', in Horton, *1994*, pp.134-135; see also, Raymond Evans, 'Bleakley, John William', in Nairn and Serle, pp.325-326.

43. *QSA*, Series No. A/58973 – 58974, 'Death Registers – Where, Cause, 1910-1936'.

44. *QSA*/58853, 'Venereal – Aborigines General', see also, papers marked 'Aboriginal VD Camps – Cooktown', dated 6 August, 1925.

45. *Ibid*., pf.

46. Along Our Coast – 'White Fishemen Out-Rivalled – How Asiatics Coax The Natives', *Cooktown Independent*, June, 1922, in news clippings in Australian Archives Series No. A 1, 1923/14083, Home Territories File No. 23/6432 – 'Japanese Cohabiting'.

47. Report: to The Chief Clerk, Home And Territories Department, by Inspector F.N. Gabriel, Collector of Customs, Cairns, in Home and Territories file 23/6432, 'Japanese Cohabiting', in AA Series A/1, 1923/14083, pp.1-6.

48. *Ibid*., p.4.

49. *Ibid*., pf.

50. *Ibid*., pp.5-6.

51. *Ibid*., pf.

52. *Ibid*., p.2.

53. *Ibid*., pf.

54. *Ibid*., pf.

55. *Ibid*., p.5.

56. *Ibid*., p.6.

57. *Ibid*., pf.

58. AA Series A/1, 1923/14083 – 'Japanese Cohabitation', in 'Progress Report relating to suspicious movements of Japanese between Mackay and Port Stewart', dated 19/12/1922 (this is a one page report).

59. *Ibid*., pf.

60. *Ibid*., pf.

61. *QSA*, Series, No. A/58863, Item No. 36/688, 'Hospital Boards Generally', see 'letter dated 21st April, 1933 from Acting Under Secretary, Dept. Public Works', p.1; see also, 'letter from Cooktown Hospital Board to The Under Secretary Home Secretary's Office, dated Nov. 21st, 1933', p.1; see also, copy 'telegram, From Cooktown Hospital Board to Under Secretary, dated 21/11/1933, re contractors to repair accommodation for aliens'; see also, letter, 'Cooktown Hospital Board to Under Secretary, Home Secretary's Department, re repairs to stockade for Aboriginal VD and leprosy patients, dated 17th October, 1934', p.1; see also, 'letter from Chief Protector O'Leary to Under Secretary Home Department re proposed removal of cells from Cooktown hospital, dated 7th February, 1935', pp.1-2; see also, 'letter from Chief Protector O'Leary to Under Secretary Department of Health and Home Affairs, dated 25th February, 1936', pp.1-2.

62. *Ibid*., AA, Series, A/1, file, 23/6432, see, 'letter from F.W. Hayes to Gabriel, Customs Office Cairns, dated 21 June, 1922', p.1.

63. *Ibid*., pf.

64. *Ibid*., see, 'Memo, N.A. Pollock, Nth Dist Inspector to F.N. Gabriel, Customs to Collector of Customs, Cairns, in 'Re: Japanese cohabiting with Aboriginal Women, dated June 8th', 1922.

65. *Ibid*., *AA*, Series, A/1, file, 23/6432; see also, QSA, A/45263, 'Inquiries for Health and Home Affairs', 1881-1959, see notes dated 1920 to 1926; see also, QSA, A/45275, 'Epidemics', dated 1926; see also, QSA, A/45359, 'Dimantina Hospital 1912 to 1942'; and file, 'marked chronic diseases', 1911 to 1930; and finally, file marked 'Public Health Inquiries', 1900 to 1940'.

66. Report upon the Operations of Certain Sub-Departments of the Home Secretary's Department, p.3, in *QPP*, 23rd Parliament, 1925, Vol. I, pp.1089-1155.

67. *Ibid*., p.3.

68. *Ibid*., pf.

69. *Ibid*., pf.

70. *QSA*, Series No. A/58677, 688/1928 – 2030/1929, – 'Sickness', see papers on enquiry by Charles David O'Brien, Police Magistrate, Bundaberg, into administration at Barambah, entitled 'The Public Service Acts, 1922 to 1924'.

71. *Ibid*., pf; see also, document entitled 'Duties and Emoluments of Officers On Settlement and Island Reserves, Queensland Aboriginal Department'; see also, document entitled, 'For Information Of Applicants For Position Of Matron, Barambah Aboriginal Hospital'.

72. *Ibid*., see document named, 'Suggested Duties Of Visiting Medical Officer Barambah Settlement'.

73. *QSA*, Series No. A/58973 – 58974, 'Death Registers – Where, Cause, 1910-1936'; see folios dated 1920 to 1924.

74. *Ibid*., see years from 1920-1930.

75. Bleakley, 1961, pp.170-178, and see also, pp.194-200.

76. Brown, et al., 166, pp117-119; see also, C.H. Stuart-Harris, 1970, pp.850-851; see also, N.R. Grist, 1979, pp.163-164; see also, F.B. Rodgers (editorial), 1968, pp.2192-2194.

77. See Table 9.1 in Appendix 9.

78. See Table 9.1 in Appendix 9.

79. Long, 1970, pp.176-188.

80. See column for causes of death in, QSA, Series No. A/58973 – 58974, 'Death Registers – Where, Cause, 1910-1936'.

81. There are problems in the Register with this category, but some cover infant mortality data which includes neonatal (data on deaths occurring in the first four weeks of life), postneonatal (or deaths in the first year of life), perinatal material (or data on stillbirths and of first weeks of life). In this register, however, some limitations do exist with the data on infant mortality because sometimes details, such as sex and exact age, are not always mentioned.

82. This is a coloquialism used to indicate when someone suddenly became ill from

mostly an unknown cause.

83. *QSA*, Series No. A/58677, 688/1928 – 2030/1929 – 'Sickness', see letter from 'Chief Protector Bleakley to Under-Sec., Home Dept., dated 21st January 1926'.

84. *Ibid*., p.2.

85. *Ibid*., pf.

86. *Ibid*., pf.

87. *Ibid*., see draft complaint headed 're: Miss Little – Matron Barambah', attached to draft unsigned Memorandum dated 14th January 1927, from Dr Junk to Chief Protector, re Matron Little. I am unsure whether the two go together, but they revolve around the same issue, and were together on the file, *QSA*, Series No. A/58677, 688/1928 – 2030/1929, – 'Sickness'. See draft typed letter: 'from Dr Junk to Chief Protector Bleakley, dated 15/1/27'. See draft Memo: 'Chief Protector Bleakley to both W.P. Semple (Super Barambah) Dr Junk (VMO, Barambah), dated 12th January 1926 with attachment of complaints about Matron Little. See typed (apparently typed copy of original for ease of reading scrawly hand writing in Department) 'letter dated 15/1/1927, from Dr Junk addressed to Chief Protector Bleakley, Brisbane'. See hand written letter by Edith M. Lock, dated, 18th August, 1927, in *QSA*, Series No. A/58677, 688/1928 – 2030/1929, – 'Sickness'. See letter 'From Edith M. Lock to The Superintendent Barambah Murgon, dated 12 November 1927'. See letter 'Edith M. Lock to Superintendent Barambah, dated 28th February, 1928', p.1, in *QSA*, Series No. A/58677, 688/1928 – 2030/1929 – 'Sickness'. See 'memo dated 29th February, 1928, from Superintendent Barambah to Chief Protector Brisbane', p.1, regarding further deaths and raising the Barambah residents protest; see two paged Petition dated 16th February, and signed by a number of Barambah residents; see also, 'memo from Superintendent Barambah to Chief Protector Bleakley dated 11th March', going over events mentioning Aboriginal protest against hospital and store keeper and deaths.

88. *QSA*, Series No. A/58677, 688/1928 – 2030/1929 – 'Sickness', see 'memo from Chief Protector to Superintendent Barambah, dated 6th March 1928'; see also, letter from Chief Protector Bleakley to Under-Sec., Home Department, dated 28 Jan 1928', in *QSA*, Series No. A/58677, 688/1928 – 2030/1929 – 'Sickness'. See, 'letter dated 20th January, from Chief Protector Bleakley to Under-Sec., Home Department', p.1. See also 'Letter from Chief Protector Bleakley to under-sec., Home Affairs, dated 21st May, 1928', *QSA*, Series No. A/58677, 688/1928 – 2030/1929, – 'Sickness'.

89. *Ibid*., see 'Medical Certificate of Cause of Death', which states primary cause of death as cardiac failure, and gave as a secondary cause of death, 'pneumonia'.

90. *Ibid*., see hand written 'memo from Matron Little to Superintendent Barambah, dated 8.3.1929'.

91. *Ibid*., see 'Extract from letter of Visiting Justice to Barambah Aboriginal Settlement on 13th and 14th May 1929', see note by Chief Protector at bottom explaining the circumstances to the Secretary of the Home Department.

92. *Ibid*., pf.

93. *Ibid*., see notes below by Protector Bleakley dated 11.6.1929, and notes above the

text of the charge sheet by the Secretary of the Home Department dated 2/7/1929.

94. See column for causes of death in, *QSA*, Series No. A/58973 – 58974, 'Death Registers – Where, Cause, 1910-1936'.

95. Brown, et.al., 117-119; see also, C.H. Stuart-Harris, 1970, pp.850-851; see also, N.R. Grist, 1979, pp.163-164; see also, F.B. Rodgers (editorial), 1968, pp.2192-2194.

96. See Table 9.1 in Appendix 9; see also, The Chief Protector, Annual Report, 1930, p.1.

97. Cook, 1925 pp.76-185; Cumpston, 'Leprosy', in Lewis (ed.),1989, pp.208-212 and see Table 100, p.213, pp.420-430.

98. Lewis (ed.), 1989, p.208.

99.A/A 1928/1, Item 690/8/106, 'NH&MRC Grants – Cilento', see graph attached to 'memo: Report from Cecil Cook of School of Public Health and Tropical Medicine', dated 19 June, 1940, pp.1-7; see also, Lewis (ed.), 1989, 99, pf.

100. (Sir) R.W. Cilento, Director-General of Health and Medical Services, and Professor of Social and Tropical Medicine, Queensland, 'Preliminary Progress Report on Leprosy In North Queensland', in, A/A1928/1, Item 690/8/106, 'NH&MRC Grants – Cilento', pp.1-4.

101. *Ibid*., p.1.

102. *Ibid*., pf.

103. *Ibid*., pf.

104. *Ibid*., see 'memo: Leprosy in Queensland, Section 11', p.8.

105. *Ibid*., p.1.

106. *Ibid*., p.5.

107. *Ibid*., pf.

108. *QSA*, A/44722, 'Conveyancing of Police and Prisoner and Aborigines', this file deals with matters from 1921; see also, *QSA*, A/44746, 'Transporting Aboriginal Prisoners: 1926-1951', this file has some detail on the transporting of sick Aborigines from 1926-1951; see also, *QSA*, A/44832, 'Conveyancing of (1) sick indigents (2) destitute Persons (3) unemployed: 1893-1959'; see also, *QSA*, A/45399, '(1) Sickness of, and Accidents Happening to, Persons Confined in Watch House, (2) Persons Suffering from effects of meeting with Accidents when taken into custody'; see also, *QSA*, 45253, 'Destitute Persons: Free Rail Passes to Sick Indigents in need of special treatment'.

109. A/A1928/1, Item 690/8/106, 'Leprosy in Queensland, Section 11', pp.5-6.

110. *Ibid*., p.6.

111. Cilento, 'Preliminary Progress Report on Leprosy In North Queenslnad', in, A/A1928/1, Item 690/8/106, 'NH&MRC Grants – Cilento', p.1.

112. Cook, 1925; this was the result of an investigation in northern Australia during 1924-25, as a Wandsworth Research Scholar from the London School of Tropical Medicine; see also, Lewis (ed.), 1989, pp.207-219; for other biographical information see, John Pearn and Mervyn Cobcroft (eds), pp.87-100.

113. *AA* Series A1/1, Item 1935/2301, 'International Conference', pp.1-88', in

Commonwealth Department of Health (CDH) file 35/2301, see also letter from Cumpston, dated 12 March 1936, pp.1-2.

114. *Ibid*., pp.22-31.

115. *AA*, Series A659/1, 44/1/657 – 'Leprosy', see Cecil Cook, (Wandsworth Scholar), Report On The Establishment Of A Joint Lazaret At Darwin', dated June 1925, p.2; then see his statement in, 'International Conference', 1935', in 'CDH file 35/2301', p.31.

116. *AA*, A/192811, 690/8/106, NH&MRC Grants, see, 'memo from Cook to Director of SPH&TM, dated 5 September 1929', p.1-6.

117. *Ibid*., p.1.

118. *Ibid*., pf.

119. *Ibid*., see graph on p.7, depicting a dramatic increase in the numbers of lepers for 1928.

120. Cilento, 'Preliminary Report On Leprosy Nth Qld', *op.cit*., pp.1-2.

121. *Ibid*., p.1.

122. *Ibid*., pf.

123. *Ibid*., p.2.

10

Depression, migration and segregation: Aboriginal health in Queensland, 1930–40

The transformation of the Queensland Aboriginal population between the censuses of 1901 and 1933 was dramatic. The latter census surprised most observers in that all the different racial and cultural groups comprising the 'Aboriginal' population were now observably sustaining themselves. The means of defining who the Aborigines were in 1933 were adjusted and this meant that membership of the total group defined as Aboriginal had to increase. With the increasing numbers of Aborigines came the economic depression of 1929-32, which dominated life for most Australians, including Queensland Aborigines. It impacted on them with increasing severity as drought affected the pastoral industry, making Aboriginal pastoral labour almost totally redundant. That in turn affected the relations between the Chief Protector and Aborigines as he sought to provide for their social, economic and cultural welfare. These factors also influenced the disease patterns among Aborigines and the health systems designed to care for them.

In Queensland, the public health structure consisted of public hospitals which were either under the control of local hospital boards[1] or the control bodies administered by local commissions.[2] On Aboriginal reserves and missions health administration was the responsibility of the missionaries and the personnel working in clinics on government depots (or, as they were becoming known, 'Aboriginal settlements').[3] This was the general structure the indigenous people faced as their style of living and their habits changed. Technological improvements in communications, including telephones, wireless and air transport all helped reduce the isolation of Aborigines no less than for rural white pastoral families. Although there were still problems about transporting sick Aborigines around the State, mission stations in most locations were

fairly readily able to contact medical aid. An institution that became important in Aboriginal health during the 1930s was the Queensland Ambulance Transport Brigade (QATB), or State Ambulance Service. The QATB was a cooperative organisation supported financially by its members' subscriptions. When subscribers became ill and incapacitated they were guaranteed transportation to hospital by the ambulance services, and even from huge distances such as along the coastal regions to Thursday Island where the sick came by boat. The Queensland ambulance organisation approached the Chief Protector about the possibility of membership being extended to Aboriginal groups. The service was a voluntary one, and did not discriminate in taking Aborigines when called to do so.

During the late 1920s the pastoral industry in Queensland had maintained a high demand for Aboriginal labour, despite prolonged drought and the onset of economic depression.[4] By 1930, however, the depression had deepened and was widening into the rural sector, and this caused wide-spread unemployment among Aboriginal rural workers.[5] This mass redundancy of Aborigines meant that Aboriginal workers had to remove their families from the refuges they enjoyed on freehold and leasehold lands in the western and northern parts of the State, and that in turn affected the missions, government reserves and fringe-camps that had to take the bulk of this displaced population.[6]

As Aboriginal pastoral workers' incomes dried up, rural Aborigines relied increasingly on government assistance. This brought more Aborigines under the control of Aboriginal settlements, both missions and government reserves. As Bleakley, the Chief Protector, and others explained, the protection legislation provided for funds to be deducted from Aboriginal incomes and transferred directly to a trust account managed by the Chief Protector. The Chief Protector then reinvested the money in interest-bearing Commonwealth bonds, which provided funds to pay for the welfare needs of the State's Aborigines.[7]

A further impact of the Depression was that the rise in the number of Aborigines on government and mission settlements forced State authorities to re-define who the people were who now made up the Aboriginal population. Many Aborigines of mixed-descent not previously living on government reserves or on mission settlements now moved there as permanent residents, and began to participate in industrial

programs operated by the Chief Protector. They then became permanent recipients of government and church relief. The Depression changed both the nature of the Aboriginal population and the Government's Aboriginal protection policies. That in turn had a trickle-down effect on Aboriginal patterns of illness and mortality.

By 1933, the Aboriginal population had increased from 5261 'full-bloods' and 951 'half-castes' in 1901 to a total of 15,676. The four-fold increase forced government services, including the Chief Protector's Office, to adapt. The government services generally changed from temporary relief programs into permanent protection services. The Chief Protector's office, as seen in earlier chapters, usually over-estimated the total Aboriginal population, and in 1932 it put the number at 17,706.[8] Six years later, in 1938, a 'Report On the Office Of The Chief Protector Of Aboriginals', produced by the Chief Protector's office itself, said that 1707 people of full-descent were living a nomadic life. In addition, there were 2657 people of full-descent who had settled on missions. The report classified some Aborigines as 'detribalised' people of full-descent, of whom there were 560 living in bush camps. An additional 500 people from this group could be found at town camping sites or in other reserves around the State. A further 1310 people were on pastoral properties as dependants of workers, and of these 225 were receiving direct departmental relief. The largest number of full-descent Aborigines, 1496, were living on government settlements. About 390 of this group were in church-run mission settlements and government depots, including Yarrabah (Anglican), Palm Island (Government) and Mona Mona (Lutheran). The population of the last three settlements consisted of workers from cattle stations or people occupied in some other form of rural employment, of whom there were 2130 men, women and children.[9]

The report then outlined people of mixed-Aboriginal and other racial descent, whom it called 'half caste' Aborigines. Of this group, 50 were what the Department described as 'living in Aboriginal conditions'.[10] Then there were 360 in employment on cattle and sheep stations, a further 457 in other forms of employment, and 800 men, women and children who were dependants of the pastoral workers. Finally, 1422 lived in government settlements and 946 in mission establishments.[11] A small number of people subsisted in bush camps beyond the daily reach of the

Chief Protector's Office. The number of people who relied on services provided by the Protector's Office in one way or another amounted to 15,010 people of both 'full-' and 'half-caste' descent.[12]

This figure was the most realistic yet produced by the Chief Protector and was considerably lower—by a margin of 2700—than that given in 1933 and also lower than earlier inflated figures. The estimates had fallen progressively, as mentioned in previous chapters, from 26,670 in 1901 to 22,508 in 1911 and 17,104 in 1922 before rising to an inflated final total of 17,967 in 1933. The 15,010 mentioned in the previous paragraph was not a public figure but represented a much more realistic total than had previously been published.

The health services received by Aborigines living in government reserves, fringe-camps and missions had to be modified to meet the changing demographic and economic circumstances. The administration previously based on protection then had to adapt its practices on Aboriginal communities because such communities were not only growing rather than diminishing, but were also becoming a racial as well as a social and political grouping. Among the measures adopted was ensuring that depots had direct access to general practitioners and their surgeries on a contractual basis. Where possible, these doctors were supported by fully trained nurses employed by the State. The creation of the Royal Flying Doctor Service in the mid-1930s also improved contact between isolated Aboriginal groups and the medical system.

In the period 1930-35, reports of the number of Aborigines dying from killer diseases such as pneumonia, tuberculosis and venereal disease continued increasing. Reported deaths from pneumonia rose from 24 in 1930 to 38 in 1934, before falling in 1936 to 17 deaths—a 123.5 per cent improvement over the previous two years, as Table 10.1 demonstrates.

Table 10.1
Aboriginal deaths in Queensland, 1930-1936

	1930	1931	1932	1933	1934	1935	1936	Total
Male deaths								
Pneumonia	14	15	18	21	22	16	12	118
Influenza		3	1	12	3	1	1	21
Consumption,	4	15	14	8	19	10	11	81
Sub-total respiratory	18	33	33	41	44	27	24	220
Nephritis		2	1	3				6
Venereal diseases	2	5	13	9	13	7	3	52
Senile decay	24	38	28	21	20	50	24	205
Other diseases	17	36	52	32	27	29	24	217
Sub-total other diseases	43	81	94	65	60	86	51	480
Total male deaths	**61**	**114**	**127**	**108**	**104**	**113**	**75**	**700**
Female deaths								
Pneumonia	10	11	16	11	16	14	5	83
Influenza		3		6	2	6	1	18
Consumption,	6	11	17	18	15	19	8	94
Sub-total respiratory	16	25	33	35	33	39	14	195
Nephritis		2				1		3
Veneral diseases	3	9	12	11	11	2		48
Senile decay	13	14	14	18	18	36	15	128
Other diseases	12	27	42	33	22	19	14	169
Sub-total other diseases	28	52	68	62	51	58	29	348
Total female deaths	**44**	**77**	**101**	**97**	**84**	**97**	**43**	**543**
Total Aboriginal deaths								
Pneumonia	24	26	34	32	38	30	17	201
Influenza	0	6	1	18	5	7	2	39
Consumption,	10	26	31	26	34	29	19	175
Sub-total respiratory	34	58	66	76	77	66	38	415
Nephritis	0	4	1	3	0	1	0	9
Veneral diseases	5	14	25	20	24	9	3	100
Senile decay	37	52	42	39	38	86	39	333
Other diseases	29	63	94	65	49	48	38	386
Sub-total other diseases	71	133	162	127	111	144	80	828
Total Aboriginal deaths	**105**	**191**	**228**	**203**	**188**	**210**	**118**	**1243**

Source: *QAA*, Series No., A/58973 – 58974, 'Death Registers – Where, Cause, 1910-1936'.

Males reported as dying from pneumonia consistently outnumbered the females, a phenomenon for which there is no ready explanation. By contrast, female deaths from tuberculosis appear to have outnumbered the male. The most likely explanation is that tuberculosis was partly a disease of the 'creche'. That is, women were most vulnerable because they slept in confined spaces huddled together with lots of children, all breathing the same air. The following graph (Figure 10.1) shows the differential trends in male and female deaths from respiratory diseases. The Aborigines reported as dying from tuberculosis rose from 10 in 1930 to a peak of 29 in 1935 before dropping back to 18 in 1936. Aborigines notified as dying from venereal disease rose from 5 in 1930 to 24 in 1934, and then fell to 18 in 1936. No female figures could be located for the period beyond 1936, but the inference is that deaths from venereal disease reached a high point in 1935 and declined thereafter.

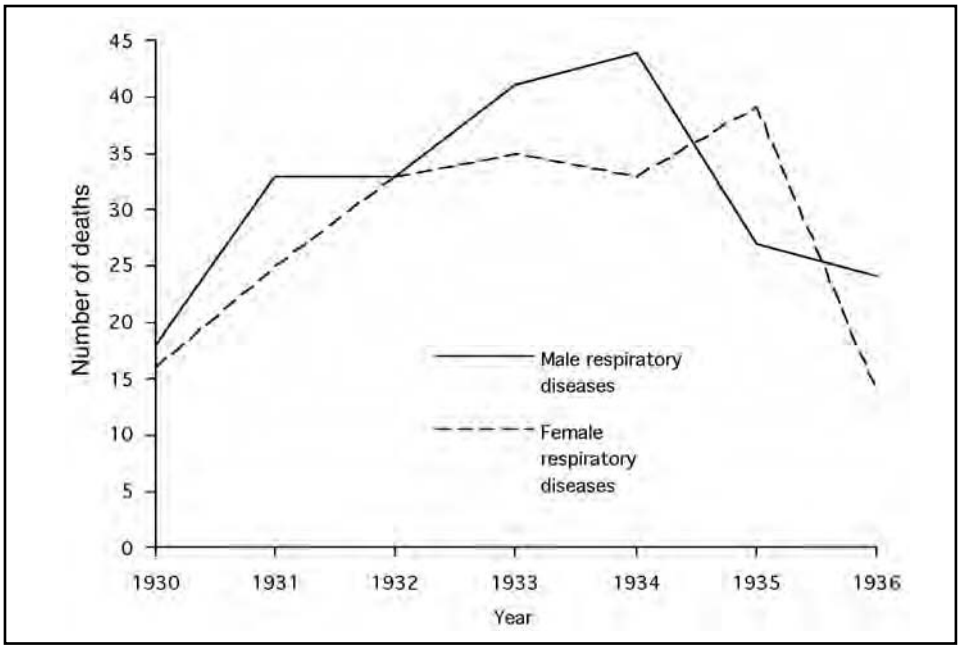

Figure 10.1: Aboriginal deaths from respiratory diseases in Queensland by sex, 1930-1936. Source: Compiled from Table 10.1

There had been a long term decline in tuberculosis in the general population. At Federation in 1901 tuberculosis deaths occurred at a crude rate of 89 per 100,000, but between 1921 and 1925 the rate had dropped

to 62 per 100,000;[13] it continued falling well beyond the period of this study.[14] The number of reported deaths among Aborigines, as seen above, fluctuated widely between 1920 and 1936, generally rising throughout the 1920s, peaking in 1934 and subsequently falling.

Up to the 1930s separate infectious disease hospitals were established in most States to deal with tuberculosis.[15] In Queensland, tuberculosis was classified as a notifiable disease in 1904 and a body set up by public spirited individuals to fight the disease made efforts to stem its spread among Aborigines in 1902.[16] A medical officer, Dr Eleanor E. Bourne, was appointed to inspect the Queensland schools for tuberculosis and other diseases. Since the first decade of the century school children were screened for tuberculosis and other illnesses. Not until after World War II, however, did tuberculosis vaccinations become widely available in Australia. The Koch vaccine, 'tuberculin', the form used most in Australia, was introduced in the 1920s. In France, Albert Calmette and Camille Guérin had produced a successful vaccine. These two scientists

> worked together for 13 years from 1908, attenuating bovine bacilli to create the vaccine, culturing their bacilli on ox bile and potato. After years of animal testing they began human trials in 1921, and in 1923 announced confirmation of a safe vaccine, effective in infants for up to three years and probably longer.[17]

Tuberculosis had probably become endemic among the Aborigines in the northern tropical areas of Queensland long before 1930.[18] Since the turn of the century Aborigines (a term which included Torres Strait Islanders until 1932) were known to suffer from tuberculosis, and could have benefited from a vaccination because they were dying from the disease.[19] No attempt was made to vacinate them until after World War II.

The incidence of such ravaging infections, as well as other diseases and illnesses, began rising once Aborigines from the cattle and pastoral stations moved to what became government Aboriginal settlements, missions and fringe-camps. The number of government settlements did not increase in the south during this period but their resident populations expanded. With this growth came higher incidences of a range of illnesses, included under the heading 'other diseases'. More deaths were notified as work related and due to violence between Aborigines themselves. These categories of reported deaths were beginning to emerge during this

period. Under 'other diseases' are also included diseases such as typhus, typhoid, swamp fever, measles and some deaths not identifiable. New types of diseases, already mentioned, began to enter the record during the 1930s. Notified deaths due to lifestyle diseases such as diabetes and heart disease formed the most numerous, however.[20]

Although official leprosy figures were not available,the incidences of leprosy in general were decreasing. Nevertheless, in indigenous groups the disease appeared to be on the increase but surveillance systems could not help to settle the problem. Reports claimed that leprosy had spread to a number of Aboriginal populations in the northern part of the State. Table 10.2 shows the comparative leprosy infection rates in Queensland and Western Australia between 1900 and 1925.

Table 10.2
Queensland and Western Australian leprosy Totals, 1900-25

Period	Queensland	Western Australia
1900-1905	67	2
1905-1910	84	18
1910-1915	56	8
1915-1920	57	6
1920-1925	31	17

Source: J.H.L. Cumpston, in Lewis (ed.), pp.207-219, and W.S. Davidson, 1978, pp.124-127.

As the table indicates, leprosy was a more serious problem in Queensland An important change relating to leprosy was that it was becoming a killer disease. Deaths of Aborigines from leprosy began to enter the Aboriginal Death Register during the 1920s. Previously it was thought to be a disabling disease only, but its rising mortality rates disproved that theory. Reports suggested that leprosy in Queensland had spread from its early locations around the Rockhampton region and moved to other locations. The confidence which some administrators and medical workers had in thinking they could contain it by monitoring Aboriginal patients proved false. Some people thought of applying methods of disease controls to

Aborigines as were used with white urban patients, but this failed. As Cecil Cook mentioned in his reports to the National Health and Medical Research Council, strict monitoring was the plan.[21]

In a report read at the fifth session of the Federal Health Council in March 1931, Dr Raphael Cilento reminded participants that a resolution from the previous conference had called for the adoption of a system of recording all new cases of leprosy in Queensland. This system had now been implemented, he said. The collected data would be reported to the director of the Division of Tropical Hygiene of the Commonwealth Department of Health. All of this effort was to contribute to better understanding of the epidemiology of leprosy and to better administrative control of lepers in Australia.[22]

On the same subject, very little had changed in the way of treating lepers or of knowing what the patterns of distribution were in the early 1930s. Cecil Cook, speaking at the Second International Pacific Health Conference held in Sydney during September 1935, could add nothing new to his previous report of his work in the mid-1920s.[23] Both Western Australia and Queensland still practised segregation as the primary treatment for leprosy.[24] The main difference between the two States was that Western Australia had many Aborigines living beyond government contact whereas by 1930 Queensland Aborigines were almost fully maintained on missions and government settlements. Even so, leprosy control proved difficult to administer in Queensland because of the scattered and isolated locations of the missions and those groups in contact with missionaries. This reality was contrary to Cilento's assurances in 1931 that an adequate management system was in place.[25]

Although the Queensland figures on leprosy were falling, Cecil Cook advised the Medical Research Council in 1927 that, based on his own unpublished information, leprosy was increasing and that 'the prophylactic system in Queensland had failed'.[26] Cook was unable to explain the increase in leprosy in 1927, but he pointed out that 'no proper regular system of surveillance and re-examination of contacts existed … [and] patients often received premature discharge without returning … to their homes'.[27] That meant some people either never went home or did so years later. Cook believed also that the system of screening for leprosy was failing among Aborigines because 'untrained medical practitioners could not detect the symptoms of leprosy, and medical officers failed to

understand the level of [its] infectivity'.[28] Further, 'individuals suffered from the prospects of losing a livelihood if detected, particularly if they had to provide for a family, as well as fear of separation from … family members'.[29] He regretted the failure to contain the disease, since 'it might have … been hoped that conditions today might reveal an improvement in procedure'[30] for containment of the disease.

Cook believed that in New South Wales, in contrast to his news on Queensland, the disease had been eradicated because of the energetic and thorough application of care and follow-up practices by the State Health Department. He feared that leprosy might now be on the increase in the north of that state. It was rumoured that some of the Queensland Aboriginal labour migrated south for seasonal work. In doing so, the workers could subsequently become infected by Aborigines from New South Wales. When these new carriers returned with full-blown leprosy they would enter Queensland lazarets as a cost to Queensland tax payers.[31] Cook claimed that records of admissions to the Peel Island lazaret showed an increase in the number of lepers, and without evidence he offered southern Aboriginal migration as a cause. He went on to say that the number of reported new cases of Europeans contracting leprosy was increasing and was a worrying feature of the general increase.[32] He and others believed that the results of his 1925 study had enabled a plan of action for combating the disease to be implemented in New South Wales. He went on to assert that 'the environment in the damp Queensland coastal regions should have prompted vigilance',[33] but no epidemiological study had occurred since his own in 1925.[34]

Writing later in the decade, the Chief Quarantine Officer noted that as early as 1930 leprosy had 'continued its insidious course, and the slow but continual discovery of new cases, particularly in the Rockhampton area, represents perhaps the most pressing problem of the moment'.[35] He was discussing the general reported spread of leprosy in Australia, a matter raised later at a meeting of the Federal Health Council in 1931. The Commonwealth Government, some thought, was best placed to research the incidence of leprosy and its spread.[36] Close surveillance, as Cook had suggested late in the 1920s, appeared to be the preferred strategy. Close monitoring of suspects, and regular reporting on the progress of patients and their families, together with the close cooperation between State health agencies, was required. In Darwin at this very time such methods were already being practised.[37]

At a 1932 conference on the problems facing Australia in the tropics,[38] Cilento emphasised the point that adequate medical services were an important part of developmental activities in those regions.[39] He argued that Australia with its dependencies had 'the largest tropical possession in the British Empire'.[40] This took account of the Northern Territory, Papua, New Guinea and the Pacific island possessions, which were greater in total area than any single imperial dependency in the African and South American tropical areas. Institutions such as the Australian Institute of Tropical Medicine had been created in order to eradicate many of the diseases introduced between 1860 and 1900. At the same conference, Dr H.E. Molesworth endeavoured to explain his belief that leprosy was an example of the 'operation of natural selection'.[41] He postulated that the disappearance of leprosy from parts of Europe related directly to the medieval regulations, better housing and nutrition and the depopulation of Europe following the Black Death. The conference did not dismiss these propositions, but recommended intensive investigation of the factors which aided the spread of leprosy, and of its distribution and control measures in Australia.[42]

A month after the conference, Cilento wrote to Cumpston, Commonwealth Director-General of Health, pointing out that he had prepared an itinerary for a proposed examination of Aborigines suspected of being infected with leprosy. He had prepared the schedule in consultation with Bleakley, who had helped arrange visits to missions, government settlements and distant Aboriginal camps.[43] Cilento arranged to travel between October and November 1932. He wanted to visit Townsville, Cairns and the Atherton Tableland regions before returning to Brisbane.[44] Cilento advised Cumpston that a number of people around Rockhampton were also suspected of being infected. These people now showed signs of leprosy and were younger members of the same family of a person whom he had identified in the late 1920s as having leprosy. The original contact had been removed to an institution at Aberfield, near Moto.[45]

Briefly, the circumstances of this case were that an Aboriginal man had been identified as having contracted leprosy but he had never been isolated. As a result, two of his sons contracted the disease and were sent by ministerial order to Peel Island.[46] In other Aboriginal depots used as disease camps, whole families were infected and this case was no different

from earlier reported ones. The patient lived with his children, who also produced grand-children who had also become infected. Another distant relative of the patient, a man named Barney, was the father of three (two girls aged 19 and 23, and a boy of 21) who were all admitted to Peel Island a year earlier. Another relative among this family group had also been sent to Peel Island, and this man was the first Aboriginal person to be scientifically diagnosed as contracting leprosy at Mona Mona.[47] All of these cases were members of the local Kuranda people, and many of them had married into peoples from as far north as Cape York who had been brought down to the Mona Mona government depot. People from the northern country also came to Mona Mona for other reasons and entered the pool of infection by what might be described as forced migration for health reasons. In any event, the first cases, as previously mentioned, appeared to be from the Kuranda Ranges, and this batch of leprosy cases was identified by the Health Department as the 'Kuranda series'.[48]

The surveillance structures put in place at the turn of the 1920s and 1930s to diagnose leprosy, yaws and tuberculosis were not easy to put into practice. Aborigines suffering from these diseases were removed from the places they wished to settle. Similarly, when health workers came to observe the infections in the bush the lepers' lesions were often matted with soil and bodily fluids and could not be diagnosed immediately. Isolating family members within certain cattle and sheep properties was a further complication.[49] In a report entitled 'A Brief Review of Leprosy in Australia and its Dependencies', Cilento stated the dilemma:

> When the question of the Aboriginal was investigated, the problem was seen as complicated. The native habit of changing their names repeatedly further disguised relationships already marked by the haphazard use of terms brother, father, uncle, cousin, etc. Their complete dread of white society's medicines, made … [Aboriginal patients accept] surgical possibilities ... in hospitals utterly impossible … [It was only possible] to contemplate … complete segregation for all Aborigines diagnosed with leprosy.[50]

This report appeared in the records of the seventh session of the Federal Health Council, held 20-22 March 1934. Cilento used this venue to further claim that it was 'utterly untrue' to assume that Aborigines would cooperate like white persons. Aborigines, he argued, feared the unknown, which often controlled their responses. Anything outside their experience in the way of medicines frightened them and, as a consequence, they

would not return for follow-up treatment nor would their relatives give them up to authorities.[51]

Evidence from the report revealed that eight lepers from a number of settlements had been isolated on Peel Island. These were Aboriginal patients who came from Mona Mona and were discharged from Peel Island as cured. They belonged to the same family and the closeness of their relationship suggested that the pool of infection was confined to one family.[52] This was a further complication which arose in monitoring the progress of notified cases of infection among Aborigines. A survey of the whole of the Mona Mona settlement commenced in November 1932 and it showed that two people had died from leprosy, a woman in 1916 and a man in 1928. Similarly it indicated that another male, Billy, had been sent to Peel Island in 1925.[53] The team conducting the screening found 20 females and 3 males who presented with 'suspicious skin conditions requiring re-examination from time to time'.[54] In the same year, but only a few months later, the team found 5 females and 6 males in this same category, and listed them for checking every six months.[55] In the period from 14 July 1934 to 23 March 1935, several of the males were diagnosed as positive. These patients included one suspicious patient deemed positive in 1932. By ministerial order all were dispatched to Peel Island.[56] The following year two females, Violet and Edith, who had been considered suspects in 1932, were identified as positive leper cases. Both women left for Peel Island in September 1936.

In the following year, a National Health and Medical Research Council (NH&MRC) grant of £1,000 allowed a mass screening program of all Aboriginal residents to take place at Palm Island, Yarrabah and Mona Mona. The subsequent report claimed that the researchers took swabs from all people aged five years and over.[57] Cilento sent his Minister a memo on 23 March 1937 to report the results of the confidential screening exercise at Palm Island, Yarrabah and Mona Mona.[58] By 1937, the Mona Mona population had grown by only 23 to a total of 207 since an earlier survey in 1932.[59] The Mona Mona population of 207 (96 males and 111 females) revealed only 11 suspected cases of leprosy.[60] This figure was surprising given the urgency expressed in Cilento's letter to the NH&MRC on 28 October 1938.[61] A year earlier he wrote in his report on Mona Mona, that he had

> inspected all the natives with particular reference to leprosy. Six registered as suspect lepers from the swabs obtained from them. Of these, three proved positive, namely Elsie Hunter, Myrtle Hunter and Roy Hobson and steps have been taken to remove these persons to Peel Island. A list of their intimate contacts and relatives and also those of Lindsay Baker, now at Peel Island, Mable Green and Gilbert Martin should be made out by the Superintendent, and careful watch kept for skin lesions in these or other people. They should be examined at least twice a year and preferably every six months for five years for early evidence of leprosy.[62]

Cilento was clearly perturbed about the suspected spread of leprosy, and his concern was the spread of infection among both Aboriginal groups and the wider white society.[63]

Cecil Cook's 1940 report looked at the wider incidence of leprosy among Aborigines in Queensland in government depots, lock-up hospitals and missions.[64] Working from records compiled by Dr Croll (a medical researcher employed by the State government), Cook could only account for 50 lepers. This number consisted of 25 cases at Palm Island, five at Fantome, two at Yarrabah, eight at Mona Mona, five at Woorabinda, two in the Torres Strait, one at Normanton and, finally, two at Mapoon.[65] Of the 30 lepers that Croll had located on Palm and Fantome Islands, Cook saw only 18 people with leprosy. One of them showed signs of leprosy on the lower section of the leg with no skin change. One case showed cherry type lumps opposite other nodes consistent with early leprosy. Some people also presented with a tinea (fungal skin infection) in various forms and swelling of the nose and ear lobes, the body parts that often reveal early signs of infection.[66]

Cook was critical of Croll's data, but the figures had been double-checked by Dr Johnson of the Queensland Health Department. In 1939, Croll found and reported 201 suspected leprosy specimens that he had taken from 57 patients. The eight reserves, depots and settlements mentioned above had the greatest prevalence of leprosy out of a total of 21 known locations where Aboriginal groups congregated. Between 70 and 100 per cent of all people were inspected at the 21 settlements, but only 18 swabs resulted in positive leprosy identification; however, 16 of these subsequently produced no reading when checked by Dr Johnson.[67]

In 1940 the Peel Island leprosarium was converted into a lazaret for whites only. Fantome Island and a small part of Greater Palm Island became segregated as a temporary detention and screening depot for

Aborigines exclusively. Despite his earlier claims that a surveillance and treatment system was in place, Cook noted that no proper record keeping existed and reported that this was a great handicap to the health authority's capacity to keep track of lepers.[68] Very little information was available to rural medical practitioners when and if they were presented with a patient and the doctors had to make the original diagnosis. Cook was critical of this ignorance in the profession because the number of Aboriginal leprosy patients was increasing. More specifically, however, was the fact that the big increases were occurring in the white population and, according to Cilento and Cook, the need to separate Aboriginal from white patients was advisable because of the racial prejudice of white patients.

In 1934 a new Department of Health and Home Affairs took control of the Office of the Chief Protector of Aborigines.[69] Before then the Secretary for Home Affairs had maintained control of the office. Cilento became the first Director General of Health and Medical Services for Queensland on 28 April 1935, and subsequently carried out extensive surveys among Aboriginal missions and government settlements. Cilento's views on Jews and Aborigines later became a matter of controversy but, in his own defence, he argued that he did try consciously to channel his department's resources to tackle Aboriginal health problems systematically. In doing so, however, his chief obstacle was the parsimony of both the Queensland and Commonwealth governments, which prevented him developing a Statewide Aboriginal health strategy.[70] As a result, it was virtually impossible for him to provide better primary and preventative health services for Aborigines, or to improve on the limited knowledge of the poor health of the State's Aborigines.

Some health programs in Queensland did fortunately come to Aborigines in rural towns and on pastoral properties. One instance was the program to combat trachoma, which became a public health threat, mainly in rural Queensland, in the 1930s. Like hookworm, trachoma was a disease resulting from poor hygiene practices, and subsequent infections were readily passed from one person to another. According to Dr Rogers of the Queensland School Health Program, poor hygiene in toilets at home, using dirty personal handkerchiefs and wearing articles of dirty clothing formed the main sources of infection. Another source was flies. Flies landed on the infected eye, and quickly transferred the diseases to others in close contact with the infected person. Treatment required a trip to the

local doctor or nurse, if available. Alternatively, children could see the part-time ophthalmic officer who visited the schools twice yearly. School instruction in eye health and the dangers of eye disease was also a preventative measure, with some beneficial effects.[71]

The school-oriented programs involved numerous Aboriginal children, many of whom by the 1930s were going to country schools run by the Education Department as well as to schools on Aboriginal settlements such as Woorabinda (previously Taroom), Cherbourg (or Barambah) and Yarrabah. In addition, the School Medical Program officers visited mission settlements as far north as Cooktown and even Mornington Island in the Gulf of Carpentaria.[72] At the beginning of the period the Wilson Ophthalmic School Hostel opened in Brisbane, and was located close to city-based eye specialists who could quickly treat rural patients infected with trachoma or whose eyes became damaged by trachoma. Many children, including many Aborigines from camps, reserves and missions, who failed to respond to normal treatment in their home towns were sent to this institution.[73] In 1932 Dr P.R. Patrick, the medical officer of the School Medical Program, toured the areas of infection and remote islands, and he chose many of the first intake of patients of the government-funded eye hostel.[74]

Once in the hostel the children received free treatment and tuition in health and hygiene. The average length of stay was initially two years, but this was reduced. Patrick wrote that since the 1912 survey, three further surveys had been conducted in the years before the 1930s. The rate of infection was reduced from 20 per cent to 3 per cent between 1912 and 1940. The severity of the disease, Patrick believed, had been greatly reduced because of the regular local inspections and treatment, support from local general practitioners, education in hygiene and finally the opening of the Ophthalmic School Hostel. By the 1940s, 71 country towns were included in the State-wide school health inspection round. At least 5417 children were inspected, and this included many in Aboriginal camps or, as Patrick called them, 'way-side camps'.[75] Patrick wrote that although trachoma was present in most parts of Queensland, it was mostly found west of the Great Dividing Range. Although it was difficult to quantify, the prevalence of trachoma in Queensland appeared to be higher among 'less hygienic sections of the community'. The disease had no respect for person, race or class and most rural people were vulnerable

during an epidemic. 'The lower standard of hygiene is no doubt the reason for its greater prevalence in the coloured children,'[76] Patrick wrote, 'but a low standard is not confined to the coloured folk'.[77]

The vice-president of the International Organisation Against Trachoma, according to a memo written later to the Director General of Health, wrote to the Prime Minister's Department in February 1934 asking for details of the presence of trachoma in Australia.[78] Cumpston wrote back saying that trachoma did exist in Australia and had done so since the early days of colonisation, but the medical profession now believed it to be a condition of decreasing importance.[79] Cumpston thought the disease had practically disappeared from urban coastal regions of Australia. In most States however trachoma still existed but had consistently disappeared as housing and living conditions and diet improved.[80] The disease was confined to dry and dusty areas of western and northern Queensland and Western Australia. In all States except Victoria, trachoma was no longer a notifiable disease but it still remained a public health problem in Queensland. School inspections continued there and coastal retreats were sometimes provided for children suffering infections.[81] Trachoma became more of a social stigma in rural society rather than a major health risk, although it persisted well past 1940.[82]

Since the onset of the Depression, Aborigines had adopted a highly mobile pattern of living while looking for work. This was not associated with traditional practice but arose from economic necessity. Changes in technology were bringing the Australian economy, and in particular the general health system, much closer to once distant and isolated Aboriginal communities. The Queensland health system in 1930 consisted essentially of a primary health service built on access to general practitioners, with a tier of hospitals in urban and rural centres. This system included services to Aborigines in hospitals for infectious diseases and mental illnesses. Although medical practitioners needed a stable population of potential patients to survive on a fee-for-service-basis, they essentially clustered around and often became dependent on hospitals.[83] The structure then was a public hospital-based health system in which hospitals were managed by Boards of local citizens and medical representatives determined hospital policy. As might have been expected, fee-for-service was the principal source of doctors' incomes, but the other sources of income included government subsidies and fund-raising by the local

community hospitals, which mostly used private general practitioner services. Some hospitals were managed by a government-appointed Commission rather than by local Boards.[84] Finally, there were private hospitals which were mostly located in prosperous agricultural regions and in urban areas near the coast.[85] According to the General Review of Medical Services a major deficiency of this structure was that doctors tended to lose their professional skills because of isolation and an absence of continuing in-service training. Isolation in rural towns often kept doctors out of touch with new developments in medical science and technology.[86]

In 1936, those hospitals which were operated by Boards came under amended legislation through the *Hospitals Act 1936*. This legislation provided for the grouping of hospitals in adjacent areas under the control of District Boards. By July 1940, some 21 of these District Boards around Queensland were controlling 32 hospitals.[87] Each Board consisted of a Chairman and from four to nine members. The Board membership was drawn from local government authorities, interested local residents who raised money from public donations to the hospital, and a government representative.[88] Each year the Government made grants of £10 per occupied bed to each hospital from its 'Golden Casket' lottery fund. Grants were made to 'base hospitals' in larger towns such as Cairns, Rockhampton and Townsville, all of which received special grants for buildings and other purposes. At smaller port towns such as Cooktown quarantine arrangements had to be supported by local hospitals. Such support grants helped to cover the costs associated with the detention of aliens and servicing people with infectious diseases, including poor foreign sailors and indigent Aborigines unable to pay their hospital bills.[89]

In Queensland, there were 22 hospitals not controlled by hospital Boards. In these establishments, local committees made decisions about operating policies but left repairs and maintenance to committees which raised funds for that purpose. The local committees largely focused on access rules, staffing conditions, operating budgets and hospital fund-raising for expansion programs. The number of members was fixed by the hospitals themselves and some members were elected by subscribers while others took their place as government appointees.[90] The committees could raise money but not through loans, and the government contributed a guinea (£1.10.0) for every £1 raised by the hospital. Like the public hospitals, profits from the Queensland Golden Casket Art Union were used to fund

grants of £10 per bed, or approximately half the amount needed to operate these hospitals. In addition, there were private hospitals and maternity hospitals.[91] Aborigines were treated in almost all subsidised hospitals but, as with privately operated institutions,the hospital reserved the right to refuse entry to those who could not pay for its services. The publicly-funded bodies sometimes refused people access because they wanted to protect their white patients from Aborigines or from poor white vagrants. Some hospitals also thought that Aborigines could be treated at the relief depots, to which they sent their Aboriginal patients if such settlements were nearby.[92]

In 1928, the Australian Inland Mission's Flying Doctor Service began operations from a base at Cloncurry in western Queensland. Although its headquarters was in Melbourne, the real nerve centre was Cloncurry.[93] Cloncurry and Charleville each had base hospitals, and most patients were flown there. In 1935 these two hospitals were equipped with X-ray machines by the Commonwealth Government. With this equipment it was possible to screen patients for both tuberculosis and cancer.[94] These services became available to those Aborigines who were in contact with missions, reserves and country towns.[95]

Other ambulance services were provided by the Queensland Ambulance Transport Brigade. In January 1931, Mr Browning of the QATB wrote to Bleakley asking for financial support. The reason was that

> considerable assistance had already been given to Aboriginals and now the subsidy was being reduced to three shillings and six pence in the pound. The protector of Aboriginals should contribute to their costs as some of the Aboriginals had expressed a willingness to contribute but could not do so without his permission.[96]

Browning went on to tell Bleakley that the QATB had attended 40 accidents involving Aborigines and 90 Aborigines were transported to hospitals in the Tully and Ravenshoe areas and surrounding station properties. Fourteen of these cases were serious and a total of 928 miles had been travelled without payment.[97] This QATB Committee was anxious to know if consent could be given to recover some of the costs if Aboriginal families could contribute to the fund. Bleakley replied in July 1933, saying he agreed with the idea of encouraging Aborigines who held paid employment to contribute to the organisation if they wished. Many

employers were responsible for their employees and they, too, should be approached. Bleakley, however, felt no need to draw funds either from taxpayers or from Aboriginal people's savings as a contribution to the service.[98] At the same time, more clinics and reserve hospitals were built on the settlements as the number of unemployed Aborigines living on government settlements increased.[99]

On Aboriginal reserves and missions, primary health care was based on health clinics managed by general practitioners located in nearby towns and staffed by professional nurses with support from Aboriginal employees.[100] The contract doctor could visit at regular intervals or as needed. Most Aboriginal mission stations along the northern coast of Queensland were operated by either Anglican or Lutheran churches. In most cases the Bush Nursing Society of Queensland provided the nurses employed in the mission clinics. These nurses were usually posted to regions isolated from general practitioners.[101] Such isolation meant that the nurses had to rely on police protectors to transport Aborigines to base hospitals and sanatoria, which were sometimes located hundreds of miles away.

Some patients, particularly those with mental illnesses, were difficult to transport. By 1933, complaints came to Bleakley's notice about the way police were continuing an old practice of moving people away as unwanted vagrants by organising free rail passes to shift them out of town.[102] The incident arose as a result of an insane Aboriginal person receiving press coverage in *The Brisbane Courier*. The circumstances recounted by the newspaper were that the patient was transported by police in a train from Townsville to Brisbane. The Police Union complained to the Commissioner of Railways, M.J.W. Davidson, about forcing police to transport sick Aborigines and prisoners in the normal compartments used by other passengers. The union argued that the Railway Commission should put an extra carriage on the train for transporting insane or dangerous passengers under police escort.[103]

That was not the end of the issue, for in January 1935 a Senior Sergeant Howard wrote a memo to the Railway Commissioner saying that in escorting

> insane patients, or Aboriginals suffering from venereal disease or other contagious disease, the practice adopted here was to phone the District Superintendent for Railways at Cairns on the day previous to the

> escort leaving, giving full particulars … and … if the escort consisted of insane patients, or Aboriginals suffering from contagious or infectious disease they would be sent forward on a goods train … A special carriage … [usually] provided the space to convey lepers, insane patients and others, and that this carriage … [could not] be attached to the mail train but … [had to] go … by goods train.[104]

The Secretary for Railways, G.A. Murton, replied soon after, saying he was not aware of any problem in transporting insane patients from Cairns to other places. Moreover, Murton pointed out that 'it was distinctly unfair for Aboriginals to be placed in sleeping berth apartments on the 266 up from Cairns to Townsville and then to ask other people to get into these compartments at Townsville and occupy them to Brisbane'.[105] Murton went on to say that the Railway Commission had received no application for either the insane or Aborigines to travel to Townsville, and he saw no reason why an extra carriage was needed.[106] In November 1935 L.E. Toohill, a police inspector, wrote to the Commissioner for Railways about an insane Aborigine from Palm Island who had been refused travel by mail train from Cairns to Townsville.[107] The difficulty continued for three years until W.L. Lipp of the Cairns police office declared that he was

> of the opinion, [that] the Railways Department … [could not] legally refuse to convey any insane or Aboriginal by mail train. If a relative of an insane patient purchases the ticket, the Department cannot refuse to convey that patient, neither could they, nor do they, attempt to prevent an Aboriginal from travelling by this train.[108]

The argument ended there, but health issues continued forming a major part of reserve managers' reports to Bleakley. Between January 1933 and March 1935, seven people were removed from Woorabinda to Palm Island with leprosy.[109] Some people with limited infection received treatment, or were possibly screened for diseases, at Palm Island. These people were sent to leprosariums or kept at Palm before being cleared to return to their homes. If they harboured dangerous infections they were detained under either the Aborigines protection or health and infectious diseases legislation. If people living on relief depots, missions or government settlements were identified as carriers of leprosy then they could be removed immediately on confirmation. Sometimes confirmation came from local hospitals and at other times from Brisbane. Either way, it was usually a slow process that could take months.

Patients from the Cape went first by boat to Cooktown, and then either received further treatment there or were transported further south to depots. While they travelled they were bedded down in aliens' wards or quarantine compounds. In April 1933, J. Collard of the Home Secretary's Office, the Department in charge of government works, wrote to the Minister for Agriculture, F.W. Bulcock,[110] about repairs to the Cooktown hospital buildings. The quotation for the repairs was £640.14.0. Collard said that repair to the buildings remained a matter for the hospital to deal with, and that the Department of Works would only pay for new structures.[111]

In November 1933, Collard wrote to the Cooktown hospital board indicating that the building repairs related to the alien's ward which was in a state of disrepair.[112] He said further that if the building was demolished the aliens, including Aborigines, would be accommodated in the general wards. On the same day the Chairman of the hospital Board sent a telegram to the Under-Secretary of the Home Secretary's Department in Brisbane to say that work had commenced on repairing the aliens' ward. It was to be demolished and would leave no accommodation for aliens unless a new building replaced it. He also suggested that the front portion of the aliens' ward would be allowed to remain.[113] At the end of the month the matter was sent to the Department of Public Works to consider what action could be taken.[114] That was not the end of this matter because on 7 June 1934 Collard visited the Cooktown police station, where the old alien's ward was located.[115] He found that the walls of the compound were falling down[116] and that Aborigines suffering from leprosy and venereal disease were being placed in the police cells while awaiting transit by launch at Cooktown.[117] Many of these people had already been transported from Cape York on their way to the Fantome Island leprosarium via the health screening depot at Palm Island. Bulcock consulted Inspector Sydes of the Department of Works and arranged to re-erect a new compound on the hospital grounds and demolish the old building at the police station. The Minister felt that 'the presence of these infected natives in close proximity to police officer's quarters, and the cells of white civilian offenders was wholly undesirable'.[118]

In the meantime, the Home Secretary and Chief Protector had each visited the site. Nothing happened before October 1934, when the

Secretary of the Cook Hospital wrote on behalf of his board to the Under-Secretary of the Home Secretary's Department. He complained that there was insufficient room for Aboriginal patients and that the work should proceed immediately.[119] In January 1934, the District Supervisor of the Department of Works had assessed the site for both the removal of the old cell and the erection of a new 'room stockade' at a total cost of £334.16.0.[120] This meant removing the wooden cell from the police station at Cooktown and erecting a stockade in the hospital grounds—a simple, straightforward task. In addition, Sydes recommended that the wall be dug to a depth of 18 inches 'to prevent blacks from scratching their way out'.[121] The following month, the deputy Chief Protector, Mr O'Leary, wrote to the Under-Secretary in the Home Secretary's Department about the matter.[122] He made the point that he had received no advice about who was to pay for the structure. He said that the expenditure involved should be charged to Aboriginal standing accounts, the funds to which the project could be 'legitimately charged'.[123] Since the structure would mostly benefit the Police Department, the local protector felt that they should be consulted about the costs.[124] In mid-1935 building plans and specifications were passed between the Home Secretary's Department and the Department of Works, but nothing was decided that year.[125]

In February 1936 O'Leary wrote a memo to Bleakley saying that while on his way to Thursday Island he had stopped at Cooktown, where he had drawn the hospital secretary's attention to

> an apparent misunderstanding by the local hospital committee regarding the isolation ward recently removed from the police station site …. The secretary of the hospital committee and others were inclined to argue that patients admitted to this ward, i.e., venereal disease or leprosy cases, were under the control of the Protector of Aboriginals who was responsible for their general care … support and treatment as ordered by the medical officer.[126]

O'Leary believed that the hospital patients should remain the responsibility of the hospital until cleared of disease or infection, irrespective of the nature of their complaints.

In correspondence at this time O'Leary alluded to another problem. He said that the Cooktown Hospital Committee claimed that the nursing staff objected to attending Aborigines with either leprosy or venereal

diseases. In addition, this hospital had no Aboriginal staff to attend sick Aborigines. In the past Bleakley had paid a subsidy to the hospital for Aborigines to be employed to clean and attend Aboriginal patients. This subsidy had been withdrawn during the Depression, after which the nursing staff had to do the work. O'Leary recommended that the department undertake to pay the wages of a suitable native married couple to be obtained from Palm Island settlement to look after and give treatment to the patients in the isolation ward.[127] These employees would be under the supervision of a matron and they would feed patients from food prepared in the hospital kitchen. The status of this Aboriginal couple would be equal to ward attendants and they would be employed as such. O'Leary said he felt sure the hospital would accept these arrangements.[128]

With regard to the building, O'Leary said that the proposed new building would be unsuitable for the accommodation of Aboriginal patients. There were only two cells and an enclosed front verandah with a high galvanised iron wall. No exercise yard was planned, and in the heat of the tropics the compound would be unbearable. The Cooktown Hospital secretary discussed these views with O'Leary and agreed with him. In addition they both insisted that it would be better to raise with the Department of Works the possibility of expanding the yard by about 20 to 30 metres. The yard, O'Leary suggested, should be made large enough to allow for shade to fall across the yard from nearby trees and 'thus provide relief from the insufferable conditions in the building when humidity rose, and for patients to exercise in the open air'.[129] Inter-agency agreements like this would prove to be important because the new legislation passed by Parliament in 1934 was just beginning to provide greater control by the Chief Protector over the health and social conditions of Aborigines, whose number by legislative fiat now included both people of mixed- and full-descent.[130]

Later in February 1936, Bleakley wrote to the Department of Health and Home Affairs pointing out that he had never taken up with the Minister the problem of how the new infectious disease compound at Cooktown would be staffed, nor how the patients would be fed or who would be responsible. He said O'Leary had discussed a plan to meet these contingencies with the secretary of the Hospital Committee. Now that the building was completed, the Committee's attitude had shifted. It now

claimed that 'the responsibility for the treatment of Aboriginal patients [was] no longer one for the hospital but one for the local protector'.[131] Bleakley accepted that the hospital secretary was possibly talking about Aborigines confined in the cells normally used by police for Aboriginal prisoners. He was adamant, however, that the attitude of his Department was that if Aboriginal patients required treatment, no matter whether they were accommodated in the compound or in the hospital ward, it was the hospital's function to provide any necessary treatment.[132] Bleakley's stance may have been at odds with the general attitude of other government agencies, but it was appropriate for an official like him to be concerned with improving the health and social conditions of Aborigines under the desperate economic circumstances caused by the Depression. Bleakley believed that O'Leary's recommendations in February 1936 were reasonable and that the Department should make an offer along such lines.[133]

Bleakley defended his portfolio interests strongly and this was reflected in the changes made to the protection legislation. The changes in 1934 had made it possible to appoint missionaries as protectors of the Aborigines on their missions. S.E. McKay, Superintendent at the Weipa Mission, was appointed as a protector in the district of Somerset. In addition, W.F. McKenzie, Superintendent at Aurukun, and J.W. McCullough, Superintendent at Mitchell River, were all given greater powers as protectors.[134] Following these appointments, other superintendents of government and mission establishments thought that they should also be appointed as protector; Bleakley agreed and made a series of new appointments on 22 August 1934. Among this batch were the Palm and Fantome Island superintendents, the Lutheran missionaries at Mona Mona and Cape Bedford, and the government settlement managers at Woorabinda, Cherbourg, Purga and Yarrabah. In addition, the police magistrate at Townsville and the visiting justice to Palm Island were also made protectors. The reason given for these appointments was to minimise the chance of outsiders interfering with Aborigines.[135] As far as policy was concerned, the objective was meant to keep costs of policing to a minimum. Increasing the number of protectors also meant maintaining the policy of discouraging racial miscegenation, which aimed to ensure, first, that Aborigines of mixed-descent married and had children within their own grouping, and, second, that the 'full-blood'

groups remained intact by being isolated from the influences of white culture. Policies with respect to the care and protection of Aborigines were organised within the departments, and so 'outside interference' could be avoided. During the period 1936–37 the Queensland public began to demand a greater political say in the way the Chief Protector was managing affairs relating to Aborigines.

As already described, the Chief Protector's Office was placed under the Department of Health and Home Affairs in 1934. When this change occurred, Bleakley was required to report directly to his Minister rather than to Cilento, the departmental head, on the operations of his office. These arrangements changed in 1938. Bleakley's first report to Cilento outlined the policies from 1914, when he had assumed his Chief Protector's responsibilities, to the late 1930s. In that time, the health policy had been to 'provide accessible machinery for medical treatment and relief, take measures for the discovery, prevention, isolation and treatment of disease and the promotion of better health conditions in the interest of the European as well as the Aboriginal community'.[136] It was clear to him from his recent visit to northern missions that the missions ought to be given greater support in managing their operations.[137] Bleakley drew attention to the fact that at all locations where Aborigines had been concentrated there was evidence of a serious lack of financial resources. The shortage of capital was due particularly to the slump in charitable contributions and the increase in maintenance costs.[138] An equally serious reason for Bleakley's concern was the depletion of traditional Aborigines' food sources, as a result of which 'nomads' were sending their children to missions and reserves and also drifting from their bush living sites to the fringes of white settlements in increasing numbers.[139] Although it was not possible to quantify this at the time, the population of people of both full- and mixed-descent had grown substantially, increasing the missions' dependence on government aid. Unemployment and an increasing population rendered the missions' task doubly onerous.[140]

Under the new circumstances of working together, Cilento and Bleakley adopted similar points of view. In a report to his Minister in March 1937,[141] Cilento wrote that 'settlements are large concentration camps where natives are isolated from the white population and where any education or training they receive is relatively valueless due to lack of outlet'.[142] He was convinced that the real problem among Aborigines was

largely medical. What this meant was that it was a problem encompassing 'all aspects of welfare from diet to working hours and working conditions'.[143] This view represented a movement away from the colonial policy of protection and towards one of total control based on health. Not only that, it envisaged a system of apartheid because, as Cilento observed, 'the developmental scheme put forward some years ago … that a native state should be built up on the Torres Straits, Cape York Peninsular, Palm Island axis, with gradual concentration towards this axis of true native stock, and gradual dispersal from it of near-white stock, is the only solution that is a progressive one'.[144] He actually doubted whether such a scheme could be properly implemented under the present departmental structure and protection policy. He was, nevertheless, certain that the plan he was proposing was necessary to 'solve the native problem in a way that … would] be to the advantage of the native … and prevent conflict between white labourers and coloured'.[145]

As Cilento's responsibilities for the protection of Aborigines grew he made a field trip to inspect some of the missions, in particular the once Lutheran, and now the new Seventh Day Adventist, mission at Mona Mona. His main purpose was to carry out a health inspection of the Aboriginal population there. Once at the mission, he commented on the isolation of the settlement and the state of the roads in the wet season. After conducting the medical screening of most of the Aboriginal population, he found six cases of suspected leprosy. Of these, two females and a male gave positive swabs. Cilento took immediate steps to have them removed to Peel Island. He also prepared a list of their intimate contacts and relatives. He knew, from his earlier research, of other Aborigines who were already at the leprosarium from this mission and asked the Superintendent to do as he had done in the past and collect information on the contacts and relatives of suspected lepers. He further added that the mission population should be examined annually for further spread of the disease. In addition he located three cases of venereal disease, each of which showed suspicious signs of old infections. This suggested that there could have been a latent source which could appear at later investigations.[146]

This mission was ill-equipped to carry out the monitoring which Cilento had previously advocated with regard to leprosy surveillance because it lacked medical facilities and the missionaries only had experience in first

aid. Most medical conditions were simply left to take their course, and that in turn meant that emergencies would inevitably arise. Whenever anything serious happened the sick were taken either to Cairns or Mareeba. A store of standard medicines was kept at Mona Mona but this settlement was extremely poorly equipped, Cilento wrote, and needed better stocks of medicines if only for routine ailments and medical disorders. In addition, no materials were available to deal even with something as simple as minor cuts and injuries from accidents.[147] The conditions at Mona Mona were also present at other missions and so Cilento recommended that all Aboriginal stations should carry minor medical supplies.[148]

Poor medical facilities at Mona Mona, Yarrabah and Palm Island were not the only deficiencies in these settlements. At all three, the inmates suffered from poor diet. Of the three missions, Mona Mona had the least deficient diet even though the population there ate no meat. Cilento concluded that their food was unable to 'compensate for the absence of haemoglobin, iron and copper salts and other materials present in meat, and the diet … [would] not be satisfactory until some adequate substitution … [was] made'.[149] Whichever way Cilento turned anomalies appeared to which no easy solution was available.

In Queensland in the decade 1930–40 the Aboriginal population was deeply affected by the catastrophic economic depression of 1929-32. This forced people accustomed to living on sheep and cattle properties to migrate to mission and government reserves. The combined burdens of economic depression, population increase, changing definitions of Aboriginal identity, an evolving pattern of reforms of Aboriginal settlements, together with new patterns of disease, poor health servicing and hygiene practices created many stresses for all concerned. As a result, the health structure and the system of protection entered a set of circumstances where all three were brought to breaking point.
Despite changes in technology which brought Aborigines and other patients closer to better health care and ambulance services, problems persisted with the escort system used to bring Aborigines from remote regions for some time to come. The method of escorting Aborigines across the State by police acting as surrogate health workers had commenced at the turn of the century. This practice suggested that both the Chief Protector and police went to some trouble to care for sick Aborigines, yet the idea of moving people around the State by force, and

making them travel thousands of miles for health treatment, now appears draconian. The official means for handling indigenous disease, health and healing in Queensland improved the Aborigines' living conditions—as the increases in population and the declining rates of some infectious diseases attest. Other newly emerging diseases, however, joined the killers—leprosy, tuberculosis, pneumonia—and then persisted among Aboriginal groups.

For full reference see Bibliograph

Notes

1. These local hospital boards consisted of health staff, who worked for the hospital and local residents nominated by locally-based organisations.

2. These local commissions were bodies appointed by the State Government. The hospital staff made up the membership of the local commission of the hospital.

3. 'General review of existing Medical Services in Northern Australia', p.4, in *Australian Archives*, (AA), Series No. A/431/1, Item, 46/2123.

4. Bleakley, 1961, pp.172-177; see also, Dawn May, 1994, pp.104-146.

5. Bleakley, 1961, p.177; see also, Rowley, 1971, pp.48-49.

6. At the same time the 'Aboriginal Station Hands Award' was suspended, which aided this mass migration of Aborigines away from pastoral properties, see Bleakley, *1961*, p.177. For more detail on this event see Dawn May, 1994, p.121-130; see Rowley, *1970*, pp.48-66; Long, 1970, pp.98-99.

7. Bleakley, 1961, pp.166-177.

8. 'Aboriginals General', see in this file, 'Report On Inspection Of The Office Of The Chief Protector Of Aboriginals, dated, 24 August, 1932', pp.1-34 (this figure appears on p.1), in *QSA*, A/58856, Item 36/9457 and 37/2324.

9. *Ibid*., see 'Report On The Office Of The Chief Protector Of Aboriginal, dated 25 May 1938', pp.1-13.

10. *Ibid*., p.1.

11. *Ibid*., pf.

12. *Ibid*., pf.

13. F.B. Smith, 1993, pp.408-422.

14. *Ibid*., p.408.

15. *Ibid*., pf.

16. W.E. Roth, Annual Report Of The Northen Protector Of Aborginals For 1902, *QPV&P*, CA. 6-1903, QGP, Brisbane, 1903, p.14; see also, Chief Protector Of Aborigines, Annual Report, 1901-1904; QV&P, see also, *QSA*, A/58853, 'Venereal – Aboriginal General', see notes under Aboriginal VD Camps – Cooktown which go back to turn of century; see also, *QSA*, A/44681, 'Chief Protector's Corro', see Dr Roth's Progress Reports 1904-1906.

17. F.B. Smith, 1993, p.408.

18. *Ibid*., p.408.

19. *Ibid*., pp.408-410.

20. 'Death Registers – Where, Cause', 1910 to 1936, in *QSA*, Series A/58973, file no. 58974, and see deaths from 1930 to 1936.

21. Cook, 1925, pp.76-185; see also, Cumpston, 'Leprosy', in Lewis (ed.),1989, pp.208-212, and see, Table 100, p.213, and see also, pp.420-430; see also, 'NH&MRC Grants – Cilento', see graph attached to 'memo: Report from Cecil Cook of School of Public Health and Tropical Medicine' dated 19 June, 1940, pp.1-7, in AA Series No. A 1928/1, Item 690/8/106.

22. Cook, 1925, for Western Australian data see, pp.45-75, and for Queensland, pp.76-197.

23. 'International Pacific Health Conference, 3-6 September 1935', in *AA* Series No. A1/1, 1935/2301, the document may be found on pp.1-88, in Commonwealth Department of Health (CDH) file 35/2301, see also, 'covering letter from J.H.L. Cumpston dated 12 March 1936', pp.1-2.

24. Susanne Saunders, 1990, see also Saunders,1986, unpublished BA (hon.) thesis, Murdoch University WA, 1986, and subsequently published with some modification by NARU, NT, 1988; see also, Rogers, 1930, pp.525-527; see also Rogers, 'Pacific Health Conference 1930', p.31, in CDH, file 35/2301.

25. Cook, 1925, pp.74-197; see also, Lewis (ed.), 1989 pp. 207-210; see also Cecil E. Cook (Wandsworth Scholar), 'Report On The Establishment Of A Joint Lazaret At Darwin', dated June 1925, p.2, and then see his statement in, 'International Pacific Health Conference, pp.1-88', in Commonwealth Department of Health (CDH) file 35/2301, p.31, in AA Series No. A659/1, 44/1/657 – 'Leprosy'.

26. 'Cecil Cook, Memo to Dir., SPH&TM, dated 5 September 1929', in *AA* Series A/192811, 690/8/106, 'NH&MRC Grants', p.1.

27. *Ibid*., p.1.

28. *Ibid*., pf.

29. *Ibid*., pf.

30. *Ibid*., pf.

31. *Ibid*., pf.

32. *Ibid*., pf.

33. *Ibid*., pf.

34. *Ibid*., p.1, see also, 'Preliminary Report on Leprosy In North Queensland: by Sir Raphael Cilento to the NH&MRC', June 1938, pp.1-4.

35. *AA*, Series No. A/1928/1, Item 635/38. 'Report from Chief Quarantine Officer (General), Steamship Blgs, Eagle Street Brisbane, to Director General Of Health, Canberra', dated 10 September, 1938.

36. *Ibid*., p.1.

37. Ralph Doherty, in J. Pearn and M. Cobcroft, 1990, pp.87-94; see also, S. Saunders, 1990; see also, Ellen Kettle, 1991, pp.86-131; see also, press cutting on this file of, *The*

Sydney Morning Herald, (SMH), 19 Aug, 1932, article entitled, 'Medical Science, Australia's Problem in Tropical Areas,
Dr Cinento's Address: Tropical Colonialism', in AA, Series No. A 1928/1, Item 635/38.

38. *SMH*, 'Cilento's Address: Tropical Colonialism', pf.

39. *Ibid*., pf.

40. *Ibid*., pf.

41. *AA*, Series No. A 1928/1, Item 635/38, see *SMH*, dated 19 August, article on same page with title, 'Leprosy, Influence Of Natural Selection'.

42. *Ibid*., pf.

43. *AA*, Series No. A 1928/1, Item 635/38, 'Memo: Cilento to D-G Commonwealth Health, dated 12 October, 1932'; this memo comes both with a typed itinerary and a seven paged report entitled, 'The Leprosy Problem In Australia', p.1.

44. *Ibid*., see attached 'Itinerary', p.2.

45. *Ibid*., see 'Memo: Cilento to Cumpston', dated 12 October 1932, p.1.

46. *Ibid*., pf.

47. *Ibid*., pf.

48. *Ibid*., see final para under initial heading, 'Early Records', p.1.

49. *Ibid*., see under heading 'tracing contacts', p.1.

50. *AA*, Series No. A 1928/1, Item, 690/8/106, see Sir Raphael Cilento, Preliminary Progress Report: Leprosy In North Queensland', pp.1-4.

51. *AA*, Series No. A 1928/1, Item 635/38, 'Memo: Cilento to D-G Commonwealth Health, dated 12 October, 1932'.

52. *Ibid*., pf.

53. *AA*, Series No. A/1928/1, Item, 690/8/106, see 'Sir Raphael Cilento, Preliminary Progress Report: Leprosy In North Queensland', p.2.

54. AA, Series No. A 1928/1, Item no. 635/38, see 'Memo: Cilento to D-G Commonwealth Health, dated 12 October, 1932'; this memo comes both with a typed itinerary and a seven paged report entitled, 'The Leprosy Problem In Australia', see under heading, 'Progress Of The Infection', p.2.

55. *AA*, Series No. A 1928/1, Item no. 635/38, 'Leprosy Problems In Australia', pf.

56. *Ibid*., pf.

57. *Ibid*., pp.3-4.

58. *QSA*, Series No. A/58640, 'Report on Mona Mona – Health & Medical', see copy of 'memo: from R.W. Cilento, Director-General of Health and Home Affairs to Minister For Health and Home Affairs, Queensland, dated 23 March 1937', pp.1-4, with 4 page attachment.

59. *QSA*, A/58640, see copy of 'Report by the Director-General of Health and Home Affairs, to Queensland Minister for Health and Home Affairs, dated 23.3.37', pp.1-4.

60. *Ibid*., see attachment headed, 'Mona Mona', pp.1-4.

61. Cilento, in *AA*, Series No. A 1928/1, Item 690/8/106, see 'memo from Cilento to Chairman of NH&MRC, dated 28 October, 1938' p.1; see also 'memo: Cecil Cook to

Acting Director School of Public Health and Tropical Medicine, Sydney, dated 16th August 1940.

62. *QSA*, A/58640, see Cilento, in 'Copy of Report by the Director-General of Health and Home Affairs, to Queensland Minister for Health and Home Affairs, dated 23.3.37', p.2.

63. *Ibid.*, see 'covering memo to Cilento's Report to Minister, dated 23 March 1937'.

64. *AA*, Series No. A 1928/1, Item No. 690/8/106, see 'Memorandum, Report On Leprosy in Queensland, 19 June 1940, by Cecil Cook, pp.1-8, (including graph showing increase of leprosy throughout Queensland).

65. *Ibid.*, p.2.

66. *Ibid.*, p.2. Cook indicated that Croll's data was suspect.

67. *Ibid.*, p.3.

68. *Ibid.*, p.5.

69. Fedora Gould Fisher, 1994, pp.83-175; see *Health Act Amendment Bill, 1934*, *QPP*, (vol. 175, 1934), p.1580, quoted in Fisher, 1994, p.313.

70. A.T. Yarwood, in MacLeod and 1991 pp.47-63; see also, Fisher, 1994, see pp.67-69, and see also pp.212-214.

71. Benenson, 1990, pp.441-444; see also copy of report entitled, 'Trachoma In Queensland School Children'.

72. Long, 1970, pp.102-136, and see also, pp.139-172; Long does not mention the school health program, which is referred to only to show that the education department serviced Aborigines on reserve and mission schools.

73. 'The Queensland School health program', op.cit., p.1.

74. *Ibid.*, p.2.

75. *Ibid.*, p.1.

76. *Ibid.*, p.2.

77. *Ibid.*, pf.

78. *AA*, Series No. A 1658/1, Item 807/1/5 pt 1, see Memo for Director General of Health dated 26 September 1934, which came through Australia House in London to the PMs Dept, p.1.

79. *Ibid.*, see copy of 'memo: from J.H.L. Cumpston, Director-General of Health to the Official Secretary High Commissioner's Office Australia House London, dated 5 April, 1934'.

80. *Ibid.*, see 'memo: from Cilento to Director of Health Canberra, dated 6 November 1931, on nutrition and trachoma'.

81. Cumpston, in *AA* 1658/1, Item 807/1/5 pt 1, 1, 'Ophthalmia Disease Trachoma', p.1.

82. *Ibid.*, pf.

83. *AA*, Series No. A/431/1, Item 46/2123, 'General Review of existing Medical Services in Northern Australia', p.4.

84. *Ibid.*, pf.

85. *Ibid.*, pf.

86. *Ibid*., p.5.

87. *Ibid*., pf.

88. *Ibid*., pf.

89. *Ibid*., pf.

90. *Ibid*., pf.

91. *Ibid*., pf.

92. Long, 1970, pp.176-188.

93. Maisie McKenzie, 1990, pp.36-65.

94. *AA*, Series No. A/431/1, Item 46/2123, 'General Review of existing Medical Services in Northern Australia', pp.6-7.

95. Maisie McKenzie, 1990, pp.46-77.

96. *AA*, Series No. A/58856, 'Queensland Ambulance Transport Brigade: Hospital', see 'note from Browning to Chief Protector dated 9 January 1931'.

97. *Ibid*., pf.

98. *QSA*/A58856, Item 36/9457 and 37/2324, 'Aboriginals – General', see 'Letter from Home Secretary's Office, Brisbane, to the Queensland Ambulance Transport Brigade, dated 24 July 1933'; see also, Bleakley, 1961, pp.167-178.

99. *Ibid*., pp.198-204.

100. Bleakley, 1961, pp.277-283.

101. AA, Series No. A/431/1, Item 46/2123, 'General Review', pp.11-12.

102. *QSA*, A/44746, 'Transportation of Insane Aboriginals', see press cutting *The Brisbane Courier*, of July 13, 1933, entitled, 'Mental patient transported by train', see also, article in *The Melbourne Truth*, dated Sunday, 22 September, 1935, entitled, 'Pitiful Freight'.

103. *Ibid*., see 'memo: from Cairns Police Station dated 4 January'.

104. *Ibid*., see 'memo: from Senior Sergeant Howard on Transporting of insane or Aborigines', on 4 January 1935'.

105. *Ibid*., see undated (possibly October 1935) 'reply from Murton, Secretary to Commissioner for Railways'.

106. *Ibid*., pf.

107. *Ibid*., see 'letter from Toohill dated 26 November, 1935'.

108. *Ibid*., see memo dated 18 November 1938.

109. *QSA*, A/58831, 'Health Weipa', see memo on 'Suspected Lepers examined at Woorabinda by Dr Blackburn from Duaringa, on 30 August, and 1 September 1933. This file contains names of people committed to Palm Island.

110. Denise K. Conroy, in John Ritchie (gen. ed.), pp.292-293; see also, D.B Waterson, 1972, p.24; see also, (*QSA*, A/58863, Item 36/688 – 'Aboriginals General and Hospital Boards', see, 'letter from Collard to Minister for Agriculture, dated 21 April, 1933'.

111. *Ibid*., pf.

112. *Ibid*., see 'hand written letter from Collard to Home Secretary, dated November 21, 1933'.

113. *Ibid*., see 'telegram dated November 21, 1933'.

114. *Ibid*., see 'letter from Home Secretary's Dept., to Cook Hospital dated 30 November, 1933'.

115. *Ibid*., see 'one page Memo: Under Secretary to Home Secretary, dated 18 July, 1933'.

116. *Ibid*., pf.

117. *Ibid*., pf.

118. *Ibid*., pf.

119. *Ibid*., see 'letter from Collard to Under Secretary Home Dept., dated 17 October, 1934'.

120. *Ibid*., see 'quotation form prepared by F.R. Sydes, dated 3.1.35', (see remarks at bottom of quote).

121. *Ibid*., pf.

122. *Ibid*., see 'letter from Deputy Chief Protector to the Under Secretary, Home Secretary's Department, dated 7 February 1935', p.1.

123. *Ibid*., p.1.

124. *Ibid*., p.2.

125. *Ibid*., see 'Memo from Deputy Chief Protector of Aborigines to the Chief Protector of Aborigines, dated 3 February 1936', pp.1-2.

126. *Ibid*., p.1.

127. *Ibid*., pf.

128. *Ibid*., pf.

129. *Ibid*., p.2.

130. Bleakley, 1961, pp.178-179.

131. *QSA*, A/58863, Item 36/688, – 'Aboriginals General and Hospital Boards', see 'letter from J.W. Bleakley, Chief Protector of Aborigines, to Under Secretary, dated 25 February 1936', pp.1-2.

132. *Ibid*., p.1.

133. *Ibid*., p.2.

134. *QSA*, A/A58856, Items, 36/9457 and 37/2324, 'Aboriginals General', see, letters re: 'Aboriginals and Appointments regarding Illtreatment of Northern Aboriginals, letter dated 7 May, 1934'.

135. *Ibid*., pf.

136. *Ibid*., see 'Chief Protector's Briefing Report to Minister, dated 25.5.1938', (see clause (e)), p.4.

137. *Ibid*., pp.4 and 4 (a).

138. *Ibid*., p.4.

139. *Ibid*., pf.

140. *Ibid*., pf.

141. *QSA*, A/58640, 'Report on Mona Mona – Health & Medical', see on this file, in

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142. *Ibid*., p.1.

143. *Ibid*., pf.

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Conclusion

This book has considered aspects of Indigenous demography, health and identity among the Aborigines of Western Australia and Queensland between 1900 and 1940. Its theme has been the part that disease has played in shaping Aboriginal identity and in influencing the interaction between the Aborigines and the various members of the settler community most concerned with them—government protectors, missionaries, pastoralists and health workers. It concludes that in the history of contact between Aborigines and outsiders—Asians, Pacific Islanders and Europeans—diseases were a major factor in determining how governments and bureaucracies intervened in Aboriginal society.

Before their contact with outsiders, the Aborigines had harboured a range of infectious diseases, the most serious of which was yaws. Aborigines had their own system of belief about sickness and health based on their reverential awe of sorcerers. As far as we know sorcery was probably no match for infections such as yaws, and customary methods of healing were certainly unable to cope when outsiders began ending the Aborigines' isolation of the preceding centuries. After European settlement commenced in 1788, western medicine began impinging upon Aboriginal belief. It eventually combined with official state protection policies and practices to become part of a set of powerful social processes in Aboriginal–settler social relations. In time, by the end of the nineteenth century, the Aborigines became incorporated into colonial society, especially in rural areas.

After Federation in 1901, rising Aboriginal disease rates forced the State governments to introduce measures aimed at controlling the spread of infection by creating strict Aboriginal management regimes in an attempt to limit settler–Aboriginal contact. Despite the restrictions imposed by the Aboriginal protection legislation, contact proceeded and, with it, diseases that caused debilitating illness, crippling bone disorders and premature aging. These visually disturbing effects, coupled with widespread hunger among the Aborigines as the expansion of white settlement forced them to abandon their hunter-gatherer lifestyle, eventually forced governments and Christian missionary societies to develop Statewide systems of protection policies and practices. In turn, this led to the development of a network of institutions which began to change the earlier Aboriginal relief depots into permanent settlements.

In the meantime, however, some diseases became endemic and spread widely and swiftly throughout Aboriginal communities. Protectors, health workers, missionaries and pastoral employers were forced by the protection policies to concentrate Aborigines in particular into semi-permanent centralised settlements, variously called 'reserves' and 'missions', from which they were unable to escape. Such places became fertile pools for infection and re-infection. Sickness and death became an inevitable theme. Introduced diseases, therefore, imposed on the colonial and Australian states the need to provide services that in turn helped to move people from their homelands and their relatives contributing to what we, today, call Cultural Genocide.

The Aborigines did not die out, however, as many colonial observers believed they inevitably would. Instead, protection provided a bulwark behind which the Aboriginal population increased. The growth of the Aboriginal population created problems for the government, missionaries, settlers and Aborigines themselves because it intensified the effect of disease on populations concentrated at the relief depots, mission stations and reserves. People of full-descent doubled in number while the population of peoples of mixed-descent more than trebled. The sex balance began by favouring males, but gradually protection policies corrected this imbalance.

Contrary to contemporary popular thinking, there was no protracted dwindling of the Aboriginal population but a resurgence to levels possibly higher than ever before. These circumstances, in contrast to present-day conventional wisdom, were both created and assisted by the policy and practice of protection. Aboriginal women of both full- and mixed-descent benefited most, but so did the aged men of full-descent. Changes to the official criteria for racially classifying Aborigines created problems of access to medical services. Confusion arose over who was (or was not) an Aborigine and therefore could (or could not) use 'native' hospitals and mission clinics. Those who failed to gain access drifted into semi-permanent camps on the fringes of society. There, they were ministered to by a new type of missionary, one usually of fundamentalist and evangelical persuasion that specialised in proselytising fringe-camp residents. Such missionaries might have been more concerned with saving souls than lives but they did help the Aborigines gain access to health care.

Segregated disease treatment programs, typically in specially created 'disease' camps, lock-up hospitals and 'native' wards attached to rural

hospitals, did offer limited access to medical treatment. Outside the segregated structures, however, the fee-for-service, user-pays medical system on which most white citizens relied always presented barriers to Aborigines who sought access to hospitals and doctors' surgeries.

Aborigines did not, nor could they, realise the threat that disease posed to their society. Settler society was appalled by the unsightly diseases that Aborigines suffered, but most settlers remained ignorant of Aborigines' understanding of illness and the power of sorcerers. Missionaries, too, were ignorant of Aboriginal social dynamics and knew little about the diseases from which the inmates of their missions suffered. Employers had limited knowledge of the threat of poor hygiene in the camps of the Aboriginal workers they employed. This collective ignorance might have stemmed from different sources but it nevertheless resulted in the Aborigines living in circumstances where they polluted their own living sites. When governments began attempting to attend to these new health threats the solutions led to other social, economic and cultural problems

Although no data was collected in Western Australia to reveal the extent of mortality wrought by the pneumonic influenza in 1918–19, the protection system did limit its impact. In Queensland, however, the pandemic highlighted the inadequacy of government and missionary approaches to health care. The reforms that followed gave the Aborigines better primary and public health care access. The reforms nevertheless brought their own administrative problems as a result of the introduction of professionally trained health care experts from outside the protection agencies and missions. The results, especially in Queensland, where the needs of more inmates had to be managed. The lack of access to medical practitioners and to hospitals remained a barrier to good health and hygiene; meanwhile tight control over the residents' movements ensured that infection continued spreading among them.

In Western Australia, blindness, crippling bone disorders, hunger and sickness forced Governments to extend the protectors' role to include the feeding, caring and removal of the sick to within reach of medical treatment. Temporary locations such as telegraph stations and camps on the fringes of mining towns became so overcrowded with people seeking relief that depots, reserves and missions were created to solve this problem. Soon these locations became permanent living places, and later developed into established Aboriginal settlements. In Queensland, diseased Aborigines in distant rural and bush settings had to be escorted hundreds

of miles by police who acted as unwilling surrogate health workers. Police officers confronted by diseased people lacked the proper administrative support from their Department to deal with sick Aborigines. Under these circumstances, they devised *ad hoc* solutions that sometimes conflicted with departmental directives.

The relief depot clinics were unable to deal with the stresses imposed upon them by epidemics of killer diseases such as syphilis, tuberculosis and leprosy. The manifest deficiencies of the institutions for protection pointed to the need for reform. The reforms that followed were intended to shift health care from a model based on compassion to one based on professional care. Meanwhile, government and mission relief depots began attracting permanent populations during the 1920s. Many groups with incurable infections brought their families with them, and this process transformed the depots into permanent settlements. Because of the inability of Aboriginal patients to access mainstream medical and hospital services, this administrative strategy led to the development of clinics and hospitals which exclusively serviced Aborigines.

When protection was instigated around 1900, in both Western Australia and Queensland hopes were high that the ravages of encroaching settler society could be rectified. The enthusiasm with which protection began in the late nineteenth century had faded by 1910. Aboriginal populations did recover under the policies set in place as a result of the protection legislation. What continued, however, were high rates among Aborigines of diseases from which relatively few other Australians suffered. Segregation of the sick on isolated islands and remote government and mission reserves failed to halt diseases generally, and the killer diseases in particular, from spreading among the Aborigines.

Poor hygiene in environments occupied by indigenous people, even in traditional bush camps, meant that almost all suffered from infectious diseases little known in the white community. The bush dwellers and hunters did not escape either the pre-contact endemic infections which they brought with them to their dwelling places or the new types of diseases nurtured in centralised locations. Similarly, as relief depots, government reserves and missions were transformed into modern Aboriginal settlements, even more exotic diseases emerged to threaten their survival. Aborigines eventually became aware of the promise of western medicine, but they could hardly have been expected to appreciate that the promise would not be delivered in the immediate future.

Epilogue

As an historian on the left of the political spectrum, I take an optimistic view of history. 'Progressivists' like me believe in the perfectibility of human society—in progress towards a socially just society, the steady removal of disadvantage and the attainment of the equalitarian ideal. The history of Aboriginal epidemiology challenges such faith, however.

The period examined in this book ended more than six decades ago, soon after World War II had begun. We might therefore have expected that in the meantime gross suffering from introduced communicable diseases by Aborigines would have diminished somewhat. To some extent it has, for nowadays few Aborigines die from syphilis, tuberculosis or leprosy. Sadly, however, other destroyers have replaced them. The list includes heart disease, diabetes, substance addiction, injuries resulting from communal violence, sexual abuse, suicide and other such causes indicatative of severe social dysfunction.

The mortality rates from the newer maladies are higher for Aborigines than for any other community in Australia. Aboriginal life expectancy rates are consequently decades lower than those of the wider society. By any measure the Aborigines remain the most disadvantaged group within Australia. The continuation of Aboriginal deprivation underlying the socio-medical indicators at the beginning of the twenty-first century is a greater scandal than it was at the end of the nineteenth. For Aborigines it is a national scandal, but for Australia it is an international scandal.

As an optimist, I must hope that a century hence, Aboriginal morbidity and mortality rates will be exactly the same as those of the wider society. By then, most 'non-Aboriginal' Australians will probably have some Aboriginal ancestry as well. That, hopefully, will have produced a determination among Aboriginal and non-Aboriginal citizens alike that the indigenous people should enjoy all the rights expected by other Australians, including the right to good health, a healthy lifestyle and timely expert care. If this hope becomes a reality then Aborigines might no longer die from preventable disease.

Gordon Briscoe
Canberra
April 2003

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