

**A MULTIDIMENSIONAL ASSESSMENT OF HEALTH  
AND FUNCTIONAL STATUS IN OLDER  
ABORIGINAL AUSTRALIANS  
FROM KATHERINE AND LAJAMANU, NORTHERN TERRITORY**

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Thesis submitted for the Degree of Doctor of Philosophy of  
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School of Archaeology and Anthropology  
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## Statement of authorship

Except where otherwise stated in the text, this thesis represents my own original work.

This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

All research procedures reported in the thesis were approved by the relevant Ethics Committees.

Signed .....

Date .....

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*“I am not an island, while life is my true privilege that I often tend to forget of”  
(unknown Serbian writer).*

And what a privilege my life becomes knowing all these wonderful people.

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## **ABSTRACT**

Human health is multidimensional: apart from physical, mental, and social aspects, it also incorporates subjective perceptions of health, and functional status (FS). Given that elderly persons have very distinctive health and social needs, multidimensional assessment (MA) of health proves particularly useful in this age group.

Aboriginal populations suffer poor health, and there are relatively few studies addressing the health problems of older Aboriginal Australians, mainly because of their distinctive demographic structure, and the low proportion of their elderly. Also, there is no prior information available on MA of health in this Australian population group.

This thesis offers a MA of health in older Aboriginal persons from two, urban and rural/isolated, locations in the NT, Katherine and Lajamanu (the NT survey).

This thesis specifically addresses the following questions:

- what is the physical health, FS, subjective perception of health, and social functioning amongst the NT survey participants?
- what are the possible similarities and differences in various dimensions of health between the two major survey locations, what age and gender patterns are observed, and what are the reasons for these patterns, similarities and differences?
- how do various dimensions of health relate to each other, and why?
- how do current findings relate to broader Aboriginal and non-Aboriginal populations, and why?
- what can MA add to a better understanding of various aspects of morbidity and health care use?
- what are its possible implications for health planning?

Findings from this work indicate poor physical health amongst participants in almost all investigated aspects, comparable to information available from other Aboriginal populations. These are accompanied by low levels of ability for physical functioning.

Despite this, subjective perception of health is rather optimistic amongst participants, and levels of social functioning high. Use of health services is mainly related to available health infrastructure. Important health differences exist between Katherine and Lajamanu, and they became particularly visible when all dimensions of health are considered together.

The Main conclusions from the current work are that 1) poor physical health is not necessarily accompanied by similar level of deterioration in other dimensions of health: even though participants from the isolated community of Lajamanu experience most chronic diseases, their ability for physical functioning is better, self-perceived health (SPH) more optimistic and levels of social functioning highest 2) institutionalised participants from Katherine suffer by far the worst health of all sample segments in this study; at least some of the poor health outcomes are potentially avoidable, and could be improved by more appropriate residential choices for Aboriginal elderly 3) better health infrastructure does not necessarily bring better health in all its dimensions, suggesting that other factors (primarily socio-economic and cultural) should be addressed in conjunction with this in solving complex health problems of Aboriginal Australians, and 4) it provides strong support that MA can become a useful tool in comprehensive health assessment of older Aboriginals.

## Abbreviations

11CS	Eleven Countries Study
ABS	Australian Bureau of Statistics
ADL	Activities of Daily Living;
AIATSIS	Australian Institute of Aboriginal and Torres Strait Islander Studies
AIHW	Australian Institute of Health and Welfare
ALSA	Australian Longitudinal Study of Ageing
ATSI	Aboriginal and Torres Strait Islander
BMI	Body Mass Index (weight (kg) / height (m) <sup>2</sup> )
CACP	Community Aged Care Package
CAEPR	Centre for Aboriginal Economic Policy Research
CDCS	Chronic Diseases of the Circulatory System
CDEP	Community Development Employment Projects
CHD	Coronary Heart Disease
COPD	Chronic obstructive pulmonary disease
CRF	Chronic Renal Failure
CVD	Cardiovascular Disease
DM	Diabetes Mellitus
ESRD	End-Stage Renal Disease
FAI2	Functional Ability Index 2
FS	Functional Status
FSS	Functional Status Scores
HACC	Home and Community Care
IADL	Instrumental Activities of Daily Living
ICD-IX	International Classification of Diseases, 9 <sup>th</sup> revision
MA	Multidimensional Assessment
MFAI2	Modified Functional Ability Index 2
MFSS	Modified Functional Status Scores
NATSIS	National Aboriginal and Torres Strait Islander Survey
NHMRC	National Health and Medical Research Council
NIDDM	Non-Insulin Dependent Diabetes Mellitus
RFPS	Risk Factor Prevalence Study
SAI	Social Activity Index
SAR	Standardised Admission Rates
SMR	Standardised Mortality Ratio
SPH	Self-perceived health
SRH	Self-rated health
WHO	World Health Organisation
WHR	waist/hip ratio
WW	Wurli Wurlinjang