SOME MYTHS IN THE DEMOGRAPHY OF ABORIGINAL AUSTRALIANS

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Stereotypes of Aboriginality constituted the basis of Aboriginal affairs administration in this country for so long that their pervasive influence is still a force with which to reckon. As social policy has changed to a more enlightened outlook and the restraints on Aboriginal people's participation in Australian society have been reduced, rapid changes in the demographic characteristics of the Aboriginal population have occurred. The pace of analysis of change has barely kept abreast. An unexpected result has been the proliferation of various new myths to replace the old stereotypes.

In many cases, these myths are harmless in themselves. For instance, it was said over and over by Aboriginal representatives during the 1970s that the Aboriginal infant mortality rate was the highest in the world, which it never was, and at that time the infant mortality rate was falling very rapidly. This myth had a political value, was sincerely believed by those who spread it, and probably helped to speed the process of infant mortality decline by applying pressure on health authorities to demonstrate progress.

Other myths are less benign, in that they obscure sound analysis. In this paper, four of these myths will be discussed, in the hope that a basis for constructive analysis of recent and historical demographic change can be laid. The first of the myths is actually outside the scope of current demography, but its rebuttal is an essential component in the process of building a reasonable historical demography of the Aboriginal population.

The Myth of the Continental Chronological Watershed (1788)

This is a new version of the old myth that it is invalid to draw inferences about Aboriginal society in any social setting that has changed or been affected in any way through contact between Aboriginals and non-Aboriginals. The new version is stated by Butlin (1983: 8):

It seems most likely, however - and this is very important - that much anthropological description of aboriginal society relates to populations that were radically destabilised and possibly with their practices and values deeply disturbed. It is by no means clear that the aboriginals that the whites saw behaved in a manner closely akin to groups 'stably related to their environment'.

Butlin's reason for this warning is based on his modelling of the effects of known smallpox epidemics and possibly other diseases that spread rapidly throughout Australia beyond the frontier of European settlement. The first of the recorded smallpox epidemics was in 1789,
Butlin assumes three things about these epidemics: that the first epidemic hit a population previously unexposed to smallpox; that both epidemics affected almost all the tribes in the south-east; and that mortality was on the pattern of age-specific rates in unvaccinated patients in an Indian epidemic in 1974-75.

All of these assumptions are arguable. If a smallpox epidemic (perhaps) began in Port Jackson in 1789 and spread at least as far north as southern Queensland and as far west as South Australia, why would possible epidemics from earlier Macassan landings in north Australia not have spread far and wide and so spread some immunity? Butlin effectively claims that Aboriginal communication systems were restricted to the river systems. He questions Macassan introductions, although earlier writers (for example Cumpston 1912, whom Butlin cites) argued that a north-south movement for the 1830 epidemic was consistent with the evidence available. The only evidence Butlin cites for Macassan introduction is an outbreak in the Kimberleys in the 1870s. There also exist references to an epidemic in west Arnhem Land at an unspecified time between 1849 and 1864, which "came one year shortly after the Malay prahu had started back for Macassar" (Foelsche 1882: 7-9), and two in the Pilbara, in the 1860s and the 1870s (Radcliffe-Brown 1930), and I would guess that many more references could be found. Foelsche's discussion makes clear that the Aborigines were very familiar with periodic epidemics, that they had developed a smallpox remedy and expected periodic reappearance. Note that whether Pilbara epidemics had a northern or southern origin, they could only have reached there by traversing tracts between river systems.

Butlin's second assumption was that almost all tribes in New South Wales and Victoria were hit uniformly. Yet the evidence he presents of American Indian epidemics shows that smallpox had great variation in impact there, and a reasonable initial hypothesis for Australia would be that smallpox had a very substantial impact on some population clusters and did not reach others at all. A much better-documented case exists of the impact of an even more fatal disease on an unexposed population (with highly-developed communication systems), namely the introduction of pneumonic/bubonic plague to Europe in the fourteenth century. Plague had been absent from Europe for about five centuries. While it is not strictly an epidemic disease (it is epizootic, in that it is carried by rats), the evidence is that the disease had very uneven impact, severe in some localities while others escaped (Hollingsworth, 1969: 355-74). Even where it occurred in the cramped streets of medieval cities, in the pneumonic form with nearly total fatality of infected persons, the infection and mortality rate was generally less than 50 per cent. According to Butlin's reconstruction, the 1789 smallpox epidemic may have killed more than half the population in south-eastern Australia in 1789 (op.cit.: 69), an extreme impact by any standard. The more severe of the two strains of smallpox (variola major) is reported to have case-fatality rates of 15 to 40 per cent (Nakano, 1980: 810).

The third assumption, an age-specific mortality pattern for unvaccinated persons who actually contracted the disease in an Indian