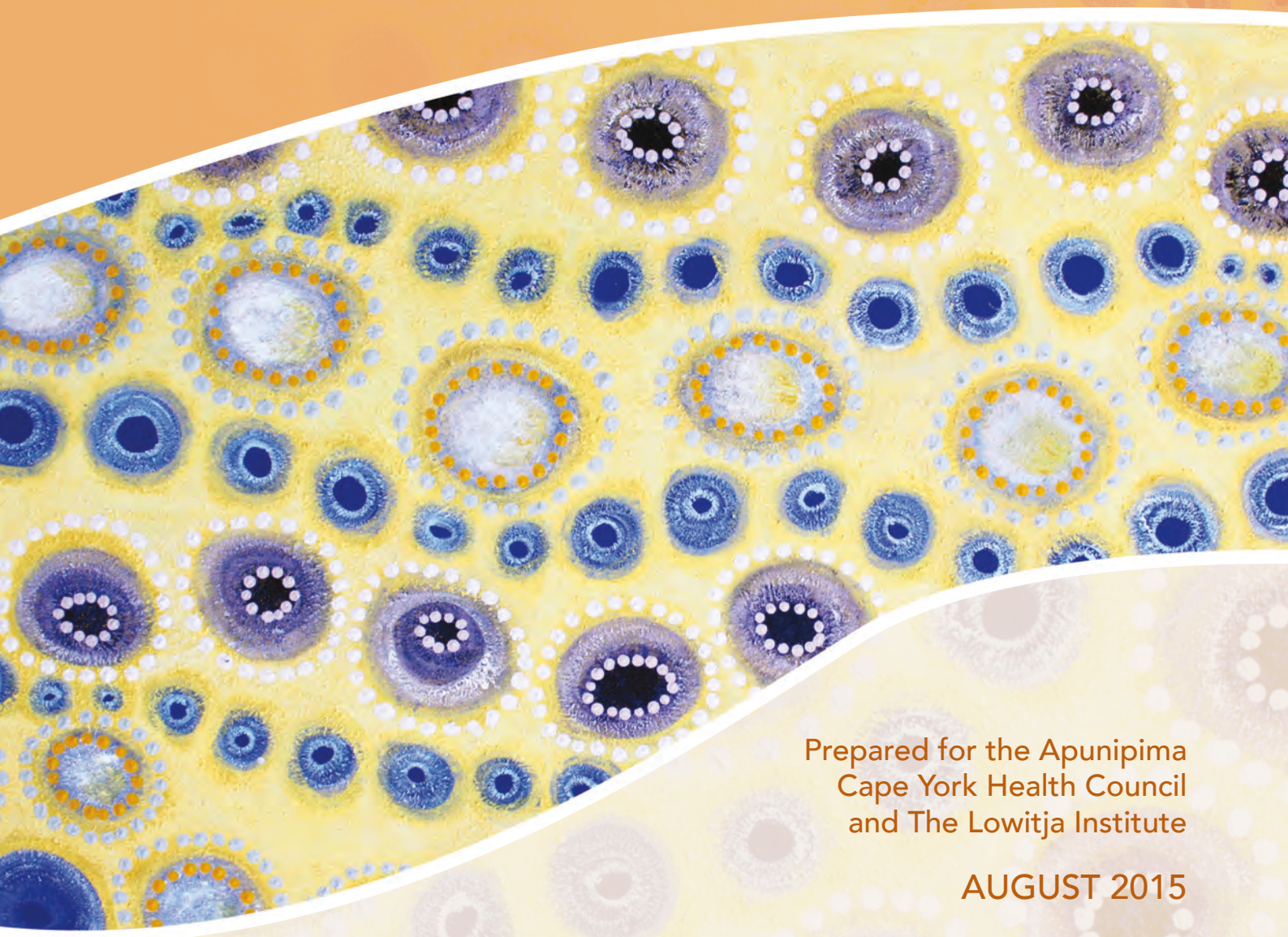
Towards a History of Apunipima Cape York Health Council, 1994–2006

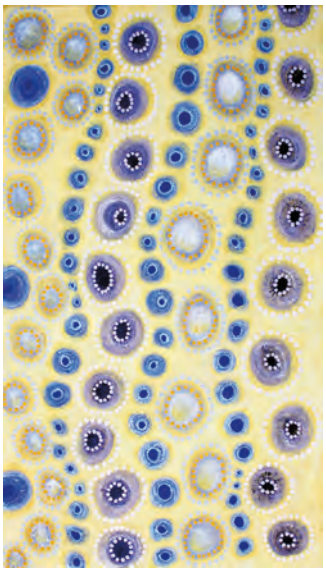


Prepared for the Apunipima Cape York Health Council and The Lowitja Institute

AUGUST 2015

Edward Tilton
Angelita Martini
Cath Brown
Kristy Strout

ARTWORK



About the artist
Karen Kulyuru was born in 1969 and raised in Ernabella (Pukatja) on the Anangu Pitjantjatjara/ Yankunytjatjara Lands. Karen first learned to paint by watching her mother, and comes from a family of batik silk artists. She started painting at Ernabella Arts and Crafts many years ago. Karen lives in Adelaide with her family and children and regularly attends professional development workshops at Better World Arts. Her paintings have been exhibited extensively across Australia.

About the artwork
Tjukula (Rockholes) 2012
Acrylic and sand on canvas
61 x 107 cm
Better World Arts catalogue KKU0073

This painting was produced during the 'Manta' (earth) workshops. Karen describes her painting as Walka. Walka is any meaningful mark or pattern and may be an image on a cave wall, on rock or on sand and has cultural and ritual significance. It is used on the body during inma or ceremony. This painting is reminiscent of the designs that are created on batik. Karen's work is heavily influenced by the beautiful batik designs she painted alongside her mother Angkuna and sister Unurupa from the 1970s onwards in the Ernabella craft room.

Batik designs evolved from a mixture of traditional imagery, Indonesian influences, as well as the early Walka drawings painted at the Ernabella mission school in the 1940s and 50s. Karen's mother Angkuna was prolific in her craft making and produced beautiful lengths of fabric, many of which are in public and private collections. Karen painted batik for many years and this influence is still visible in her highly decorative, detailed paintings today.

Important traditional symbols are still placed within these works, including tjukula (rockholes represented by concentric circles), creek beds and bush foods for harvesting. This painting depicts rockholes (tjukula), and sandhills surrounding them. Karen is influenced by the beautiful colours and shapes of the landscape. She uses both desert tones and brighter hues in her works and often illustrates aspects of nature from the desert country where she grew up, to the flora here in Adelaide, where she has lived for many years.

REPORT TITLE

The title is taken from Antonio Machado's poem 'We make the road by walking' in *Selected Poems of Antonio Machado*, Louisiana State University Press, Baton Rouge, LA, 1978.

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Australia's National Institute for Aboriginal and Torres Strait Islander Health Research

apunipima CAPE YORK HEALTH COUNCIL

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Contents

Tables and figures

About this report

This publication is one of five that report on the work of the **Funding, Accountability and Results (FAR)** project, all published by the Lowitja Institute in 2015.

FAR is a study of reforms in primary health care for Aboriginal and Torres Strait Islander communities in the Northern Territory (between 2009 and 2014) and Cape York, Queensland (between 2006 and 2014). The study background, its aims and methods, case studies, findings and conclusions, and the suggested essential elements of reform are reported in the project report and the summary report.

Two brief histories, of which this is one, and a case study of our research partner organisations have also been prepared in order to contribute to the record of development of the broader Aboriginal community controlled health sector in Australia, to give context to the larger research study, and for our partners' own use.

Project report:

The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples – Report

Judith Dwyer, Angelita Martini, Cath Brown, Edward Tilton, Jeannie Devitt, Paula Myott and Brita Pekarsky

ISBN 978-1-921889-43-1

Project summary report:

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The Northern Territory Aboriginal Health Forum: A historical review

Jeannie Devitt, Judith Dwyer, Angelita Martini and Edward Tilton

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Paula Myott, Angelita Martini and Judith Dwyer

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The Funding, Accountability and Results (FAR) project, of which this history is a part, relied on the generous engagement of our industry partners, Apunipima Cape York Health Council, Miwatj Health Aboriginal Corporation and the Northern Territory Aboriginal Health Forum. We are grateful to the staff and members of the Board of Apunipima Cape York Health Council, who participated in interviews and meetings to inform this historical review, and to all members of the research team, including our international and national advisors.

The team gratefully acknowledges the funding of this study by the Lowitja Institute CRC and the support of Flinders University.

Abbreviations

Apunipima	Apunipima Cape York Health Council
ACYHC	Apunipima Cape York Health Council
ATSIC	Aboriginal and Torres Strait Islander Commission
CYI	Cape York Institute
CYRHF	Cape York Regional Health Forum
FAR	Funding, Accountability and Results
HAT	Health Action Team
NACCHO	National Aboriginal Community Controlled Health Organisation
NAHS	National Aboriginal Health Strategy
NSFATSIH	National Strategic Framework for Aboriginal and Torres Strait Islander Health
OATSIH	Office for Aboriginal and Torres Strait Islander Health
QAIHC	Queensland Aboriginal and Islander Health Council

Terminology

In keeping with usage in the Aboriginal Community Controlled Health sector, the term 'Aboriginal' is sometimes used in contexts that may also apply to Torres Strait Islander people. The term 'mainstream' is used to mean non-Indigenous institutions and organisations.

The names of all government departments and several other organisations have changed during the study. For simplicity, we use the names that were current in December 2014.

Introduction

This review tracks the development of Apunipima Cape York Health Council (Apunipima or ACYHC), an Aboriginal community controlled health service for Cape York, Queensland. It covers the period from 1994—when Apunipima was established by Aboriginal community representatives to advocate for the health of all communities of Cape York—until 2006, when transition to community control of primary health care services was endorsed by all key players in Cape York.

This review of the history of Apunipima has been written to create a summary of what is known about the development of Apunipima for the organisation's own use and as part of the record of development of the broader Aboriginal community controlled health sector in Australia. It has also informed the larger research study of which this is part.

The review is based on available documentation and on interviews with eight people involved in Apunipima's development. It is limited by the relatively small number of people available for interview, and because our knowledge of the perspectives of government representatives is limited to the recollections of the even smaller number of former public servants among those we interviewed.

There are some important gaps in the documentary records to which we had access. Although Apunipima generously gave us the documents it holds, we had no access to records held by other bodies that were not partners in the research project, including Queensland Health, the Aboriginal and Torres Strait Islander Commission (ATSIC) and the former Cape York ATSIC Regional Council.

Quotes from interviews in this document are identified with a three digit code number (e.g. [701]) to preserve the anonymity of the participants.

Significant events in the development of Apunipima and the transition to a community control process are included as a timeline in the Appendix.

Historical and policy context, 1967–94

The 1967 referendum to amend the Australian constitution with regard to Aboriginal and Torres Strait Islander peoples, and the overwhelming support it gained, was an important part of the struggle for Aboriginal and Torres Strait Islander civil rights. By increasing Commonwealth government responsibility for Aboriginal and Torres Strait Islander citizens, it also laid the foundations for the development of a series of national plans aimed at addressing their health needs.

The most significant of these was the 1989 National Aboriginal Health Strategy (NAHSWP 1989), which advanced a holistic definition of health for Aboriginal and Torres Strait Islander peoples and prioritised primary health care under Aboriginal and Torres Strait Islander community control as a key strategy for achieving it. The establishment of the Aboriginal and Torres Strait Islander Commission in 1990, the report of the Royal Commission into Aboriginal Deaths in Custody (Johnston 1991) and the Mabo decision by the High Court of Australia (*Mabo v. Queensland [No. 2] 1992*) 175 CLR 1) provided further impetus for national and local campaigns by Aboriginal and Torres Strait Islander peoples for self-determination and action on their health.[1]

These campaigns were effective and in 1994 the then federal Health Minister Graham Richardson committed to putting increased funding for health at the centre of the Labor government's new social justice package to be negotiated with Aboriginal and Torres Strait Islander peoples.

In Queensland the 1989 election of a Labor government after 32 years of National Party rule, which was marked by hostility to Aboriginal and Torres Strait Islander rights, also provided an opportunity for change.

At the regional level the establishment of the Cape York Land Council in 1990 and the emergence of a new generation of Aboriginal and Torres Strait Islander leaders were also significant. Their comprehensive agenda—centred on land rights, education, economic development, health and welfare reform—also proved important.

These national, state and regional developments were the context in which a new approach to designing, governing and delivering health services to Australia's First Peoples was created.

1 This included support and advocacy by non-Indigenous organisations that had previously taken little direct interest in Aboriginal and Torres Strait Islander health. The appointment, for example, of Barbara Flick as the Australian Medical Association's Indigenous Adviser in the early 1990s was significant in adding that organisation's voice to calls for increased funding and more appropriate services. It was also important for the establishment of Apunipima as Flick became the organisation's first Chief Executive Officer.

The establishment of Apunipima, 1994

Support for Apunipima

The key driver for the establishment of Apunipima was the widespread recognition—among Aboriginal communities, senior Cape York health officials, the federal government and regional Aboriginal and Torres Strait Islander organisations—that the existing health system was not working to improve the health of Aboriginal and Torres Strait Islander peoples on Cape York and that a new approach was needed. There was a strong feeling among Cape York Aboriginal people that the services provided by government-run health clinics were not leading to better health and that it was time for the people who received the services to have a say in how they were delivered.

One observer at the meeting that established Apunipima (see below) recalled how Noel Pearson of the Cape York Land Council made explicit the importance of better health and the link between land and health:

> As Cape York people were becoming more and more successful in getting their country back there was a grave concern that many of the old people were dying very early, so a lot of the knowledge connected to that country was going to be lost… [there was a] need to concentrate on getting people healthy because without health then the return to the land [was] not going to be nearly as significant as it might otherwise have been. [701]

Participants also spoke of their dissatisfaction with how health services were delivered and the way the health system treated Aboriginal Health Workers.

The success of Aboriginal and Torres Strait Islander communities elsewhere in gaining more control of their health services was recognised among Cape York people and provided further motivation. Successes included community controlled health services such as those in northern Queensland (Wuchopperen in Cairns and the Townsville Aboriginal and Islanders Health Service), as well as the example provided by the 'Indigenisation' of Queensland Health[2] services in the Torres Strait under the leadership of a local man, Philip Mills.

During the early to mid-1990s, Queensland Health had recruited senior staff in Cape York who had experience in primary health care and in Aboriginal and Torres Strait Islander health. Those senior staff recognised that the continuing poor health statistics, and the apparently worsening social problems in some communities, required a reorientation of health services from the narrow focus on acute medical care towards a much broader model of primary health care that included prevention and health promotion. Queensland Health also realised that such an approach required active engagement with the Aboriginal and Torres Strait Islander community. As one Queensland Health official of the time recalled, 'with a good primary health care approach you need a partner and it became really obvious that there wasn't any voice for Aboriginal people in Cape York' [202].

This thinking was in line with policy directions in Queensland Health, but putting them into practice was not a state-wide process: 'although Queensland Health had policies around that stuff no-one actively implemented them except the regional directors in the northern peninsula and Torres Strait region' [202].

2 For clarity, throughout this report we use the term 'Queensland Health' to refer to the state government department with responsibility for health services, even though the name of the department changed during this period.

There was also federal government support for action on health in Cape York.[3]

The establishment process

At the regional level, both the ATSIC Peninsula Regional Council (ATSIC Regional Council) and the Cape York Land Council provided decisive support—organisational, as well as financial—for a health meeting to be held at the Pajinka Wilderness Lodge near Injinoo, at the tip of Cape York, and for the establishment of Apunipima. Although there was broad recognition of the need for action on Aboriginal health in Cape York, the events leading to the meeting at Pajinka were marked by conflict.

In the view of a senior officer in Queensland Health in the region:

> Apunipima came about from… a policy directive that was given by… the State Tripartite Forum and Gracelyn Smallwood, she was the chairperson of the Queensland State Tripartite Forum. [The Forum was] set up under the National Aboriginal Health Strategy that was released in 1989. [203]

According to this view, Queensland Health's Cape York Regional Health Authority allocated $50,000 to progress the establishment of an Aboriginal health organisation, and spoke at an ATSIC Regional Council meeting in April 1994 about getting support for this. However, apparently unbeknown to Queensland Health, the Cape York Land Council also spoke at the same meeting about the same issue. ATSIC's decision was that the Cape York Land Council and Queensland Health should work together to organise a region-wide meeting to establish a Cape York Health Council, but with the condition that Queensland Health staff needed to work from the premises of the Cape York Land Council 'because if it's going to be community control we don't want any of this sitting in government' [203].

This arrangement did not eventuate; instead, the Cape York Land Council and Queensland Health Regional Health Authority staff attempted to work alongside each other to make the Pajinka meeting happen. This led to conflict, according to the same Queensland Health official:

> It was like a tug-o-war of who controlled the agenda… because we had the money and we paid for all the people to go to Pajinka my line was that 'it's our staff, it's our agenda… this is how we would progress with things'. [203]

Despite the conflicts, it seems clear that there was considerable practical support from the three key organisations involved: the ATSIC Regional Council, which provided funding to support the Pajinka meeting; the Cape York Land Council, which provided Aboriginal leadership and on-the-ground organisation; and Queensland Health, which, as well as its funding contribution, worked with communities to get support and attendance at the meeting.

The Pajinka meeting

Apunipima was established in September 1994 by Aboriginal community representatives from across Cape York at the four-day meeting at Pajinka. Injinoo Elder Gordon Pablo gave the new organisation its name, which means 'All in one, united' in the Injinoo Ikya language.

The meeting was historic. It was the first time people from all communities across Cape York had come together to discuss health and the participants were aware of its significance:

> Apunipima proposes that a new kind of organisation is required on Cape York Peninsula to improve the standards of health of Aboriginal people to the same standards as other Australians enjoy. (Statement by Wilfred Gordon, Chairperson; ACYHC 1994a)

3 It is significant that the keynote address at Pajinka was given by Dr Tony Adams, the Chief Medical Officer of the Commonwealth government. See ACYHC 1994a.

The founding role of this new organisation was to be as an advocate and voice for the health of all the communities of Cape York.

The Pajinka meeting took place with the explicit aim of creating an Aboriginal health organisation for Cape York (ACYHC 1994a). However, what that health organisation might look like and what its role might be were the subject of some debate at the meeting. In particular, there was much discussion about whether the new organisation would be involved in the direct delivery of primary health care services or whether it would be primarily an advocacy organisation. One observer recalled that

> the view of most of the people attending… [was] that the organisation should be an advocacy body rather than a body to deliver health services… It was argued very strongly that… there was already an organisation there with the resources and the facilities to deliver health to Cape York people, and that was Queensland Health, and the problem was not so much that there was a lack of clinics or a lack of resources but that there was a lack of good policy and a lack of Aboriginal voices to argue how best to deliver [on] the policies. [701]

The wording of a statement from the meeting (ACYHC 1994b:1), while obviously drawing inspiration from other Aboriginal community controlled health services, made it clear that Apunipima was

> a new development in Aboriginal-controlled medical services and health organisations… [proposing] a partnership arrangement with the Peninsula Regional Health Authority of the Queensland State Government and with other relevant Commonwealth and State departments [with the aim of] strengthening and improving the existing services and making them more appropriate to Aboriginal communities.

Under a board to consist of two representatives (a man and a woman) from each of 17 Cape York communities, plus representatives from the Cape York Land Council and the ATSIC Regional Council (ACYHC 2012), the new organisation was to pursue a number of objectives, including:

- ensuring that comprehensive, accessible and appropriate health services are provided for the Aboriginal people of Cape York, and that local health services are properly resourced
- increased local input to and management of each community's health service
- supporting the role of Aboriginal Health Workers, through employment, training and their inclusion in the process of developing policies on all aspects of health
- ensuring control of decision making regarding research proposals in the Cape
- the development of local and regional strategies for alcohol and substance abuse
- advocating for healthy community environments through remedying problems with essential services. (ACYHC 1994b)

The new organisation was to put Aboriginal Health Workers at the centre of a comprehensive approach to health service delivery and policy development. Answering to the community, Aboriginal Health Workers were to be advocates within the health system to ensure appropriate policies were developed and acted upon.

Apunipima's early years, 1995–2000

Advocacy

Soon after its establishment, the new organisation threw itself into its role as an advocate for the health of the Aboriginal communities of Cape York.

Funded during 1995 by the ATSIC Regional Council, Apunipima established itself with a staff that varied from four to eight people at an office in Fearnley Street, Manunda. Its first Operational Manager (1995–96) was a journalist rather than a health professional and this reflected the importance given to advocacy and communications during the early years of the organisation. Apunipima's Communications Unit played a central role. Through its innovative use of digital communications, as well as the more conventional means of radio, press releases, posters and newsletters, Apunipima maintained contact with and informed Aboriginal communities across Cape York, supported health promotion activities, and held governments and service providers to account. According to an Apunipima staff member of the time:

> If people didn't have access to medications in communities we'd blurt it out on the radio and write it up in the newspaper. If people didn't get a thorough examination and died as a result of going into hospital and the family had a complaint, [and] the complaints processes didn't work for them, then they'd bring their complaint to us; we'd sort it out and, again, in a very public way hold people to account. [700]

In using the media to advocate for better health, another staff member recalled that Apunipima developed a national profile:

> There was a great willingness, particularly from urban media, to [write] stories on… the plight and concerns and aspirations of Aboriginal people, so we had a really good success rate. [701]

This media profile was accompanied by the involvement of Apunipima in national policy forums, through which the organisation could add its voice to calls for effective health system action on Aboriginal and Torres Strait Islander health. The first two Chief Executives (Barbara Flick, 1995–98; Kerry Arabena, June 1998–2000) were on numerous national committees and, according to an interviewee who was involved at that time, Apunipima was seen within these forums as 'a mover and shaker [with] an innovative model that was forcing change to happen rather than being responsible for the change to happen'.

Apunipima also put great effort into informing and influencing senior figures by hosting visits to Cape York, including by federal Ministers for Health, state Ministers and senior public servants such as those from the newly created (1996) Office for Aboriginal and Torres Strait Islander Health (OATSIH).[4]

Apunipima also employed more personal and direct methods to advocate for positive changes to the health system in Cape York, as reported by a Queensland Health staff member at the time:

> [The Apunipima Executive Director] visited me… [and] put to me that I had a hospital with a racist attitude and that we, as mainstream health back then, needed to look closely at the cultural awareness and capability of our staff. [703]

4 See, for example, ACYHC 1998.

Service delivery

Through all these methods—local and national media, involvement in national policy forums, influencing key policy figures and local face-to-face negotiation—Apunipima fulfilled its role as an advocate for the health of the communities that created it.

Early in its history Apunipima also became a provider of health services—not the clinic-based medical services that were the responsibility of Queensland Health, but of health promotion and public health projects. As Queensland Health moved towards a broader model of health care delivery beyond the delivery of acute medical care, Apunipima was supported as the place in which to locate new services. As one senior official of the period remembered:

> If new monies came in we were starting to allocate that money to Apunipima on a service contract arrangement… it wasn't holus bolus handing over services that we had [but] certainly we were looking to Apunipima to take on the delivery of those functions. [202]

With the Commonwealth also seeking to expand its support of primary health care in recognition of the continuing gap in health outcomes between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians, Apunipima received numerous special purpose grants from federal and state governments, as well as from non-government organisations and private foundations.[5]

The early focus of Apunipima's services was on sexual health, social and emotional wellbeing (including suicide prevention), alcohol and smoking, women's health and family violence. Activities also drew on its holistic definition of health; for example, the Respect Your Elders project (1996–2001) sought to record the oral histories of prominent Elders from across Cape York to maintain and strengthen local cultures. Most of these projects were founded on community development and/or health promotion principles though the Well-Person's Health Checks focused on clinical prevention. Most of this activity was funded by government grants for two- to three-year periods.

Some of the many funders developed long-term relationships with Apunipima, including ATSIC, the Commonwealth Department of Health,[6] Queensland Health, the Queensland Department of Family, Youth and Community Care, and the Queensland Department of Environment and Heritage/Environmental Protection Agency, all of which funded Apunipima every year (or nearly every year) from 1996 to 2006. Other organisations funded Apunipima for much shorter periods. Overall, from 1996 onwards a dozen or more separate projects ran at Apunipima, with funding from 10 or 12 organisations through more than 20 grants.

Relationships

From its establishment at Pajinka, Apunipima was committed to a partnership approach to improving health services and making them more appropriate for Aboriginal communities. While some tensions were inevitable, its early years were marked by an extraordinary level of successful relationship building.

Given the strong support for the establishment of Apunipima by the Cape York Land Council and the ATSIC Regional Council, it was not surprising that these relationships continued to be important. However, there was also intersectoral collaboration with Balkanu (an economic development corporation set up in 1996), the Tharpuntoo Cape York Legal Service

5 Much of the information for the following section comes from 'The Apunipima Story' (ACYHC 2012) and ACYHC annual reports for the period to 2005.

6 For clarity, throughout this report we use the term 'Department of Health' to refer to the Commonwealth government department with responsibility for health services, even though the name of the department changed during this period.

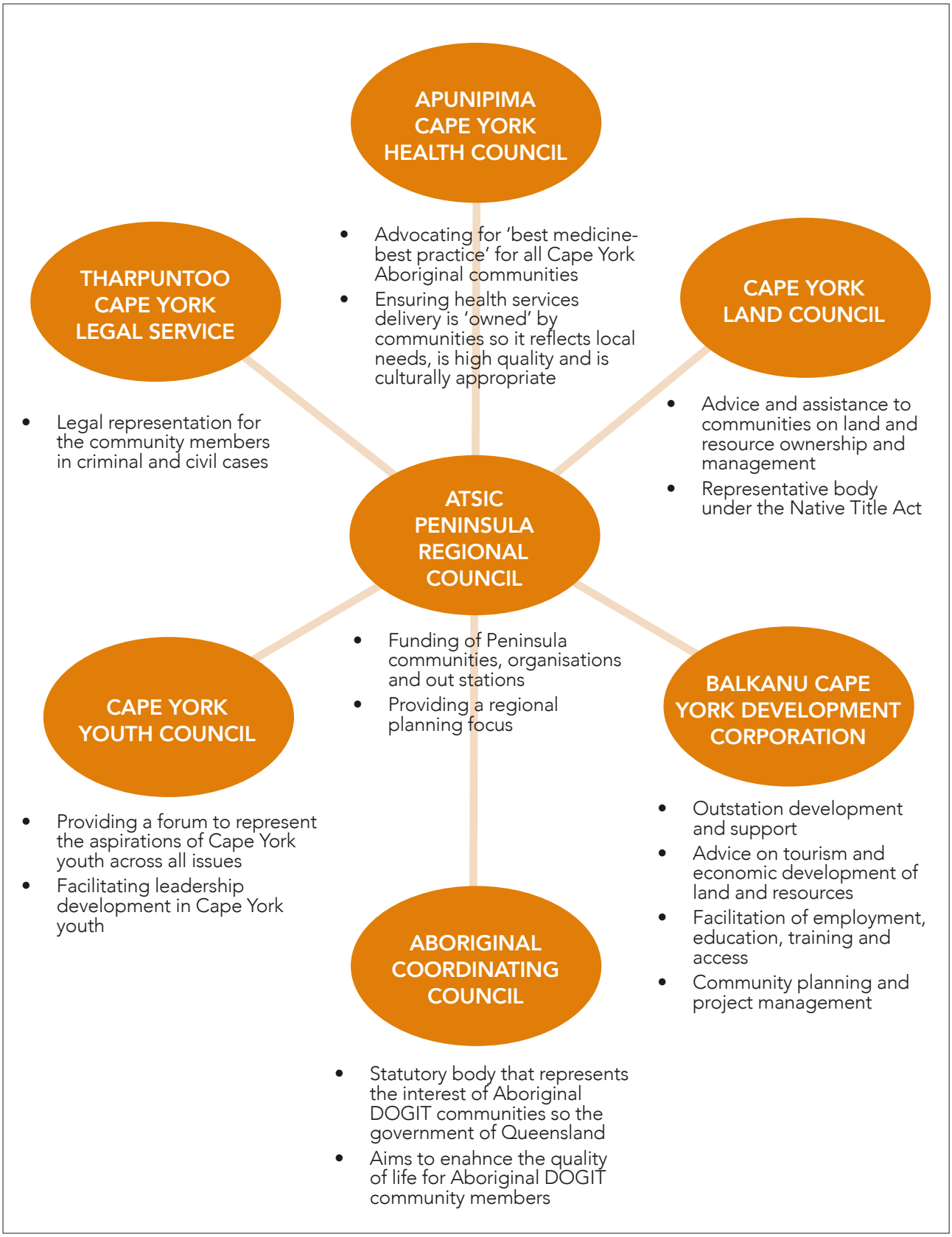

Figure 1: Apunipima's relationship with other regional Aboriginal organisations
(Source: ACYHC 1999:5)

and the Aboriginal Coordinating Council. According to a senior Apunipima staff member:

> We were very much one of the regional organisations back then, very interconnected… There was always a lot of discussion amongst the leadership [and] at one stage we were [even] all going to move in together. [702]

This very strong regional collaboration (Figure 1) strengthened Apunipima's position with regard to its advocacy and service delivery roles.

Outside the region, Apunipima developed links with Aboriginal community controlled health services elsewhere in Australia (in the Northern Territory and Western Australia) in order to learn from other regional models of health service delivery [702:4]. However, the organisation's relationship to the broader community controlled movement did not include membership of the Queensland peak body (now the Queensland Aboriginal and Islander Health Council (QAIHC)) or the national peak body (the National Aboriginal Community Controlled Health Organisation (NACCHO)). The reasons for this include a strong spirit of regional independence. According to a senior Apunipima staff member of the time:

> The Cape York Health Council absolutely was a people's movement and didn't need to, or want to really, subscribe to what NACCHO told it [that] it should be [or] what the Department thought it should be; [it] was absolutely from within the psyche of Cape York people and that was a different kind of verve to it. [700]

Apunipima maintained a strong relationship with the Commonwealth government, particularly the Department of Health and, within it, OATSIH. Commonwealth government support was based on a recognition of the need for action both on Aboriginal and Torres Strait Islander health, and on policies that supported primary health care approaches maximising community involvement—as established by the 1989 National Aboriginal Health Strategy (NAHSWP 1989). The close understanding built with senior health figures (including the federal Health Minister) was also important.

The relationship with Queensland Health, however, proved the most complex. The support of Queensland Health for the Pajinka meeting and in the establishment of Apunipima was important. However, Apunipima now faced the challenge of maintaining that support while also holding Queensland Health to account for its health service delivery to Aboriginal communities. As the Apunipima Chairperson Gerhardt Pearson noted in the organisation's first annual report:

> We want to attend fewer funerals. It is for this reason I say our relationship with [Queensland Health] is close but firm. We cannot let anyone who is at the coal face and charged with health service delivery off the hook. It is their responsibility as much as ours to see that Cape York Bama [Aboriginal people] are no longer treated as second class citizens in their own country. (ACYHC 1997:5)

At the local, health clinic level, attitudes among non-Indigenous staff towards Apunipima were mixed at best: while there was some support, there was also disquiet, suspicion and even antagonism towards the new community controlled organisation—even in this early period when it was primarily an advocate and provider of community development and public health programs.

There were also mixed feelings about Apunipima among senior regional staff of Queensland Health. According to one of these:

> Not everybody was supportive but I think that comes… from not having a full understanding. That comes from having a very mainstream understanding about how health care should be delivered. [703]

Despite this, a cohort of senior regional Queensland Health officers in Cape York strongly supported Apunipima. For many of these staff members, support for Apunipima was based on a recognition that the mainstream system was failing to improve Aboriginal and Torres Strait Islander health, and on a personal commitment to the principles of comprehensive primary health care that demanded the engagement and participation of the Aboriginal and Torres Strait Islander community:

> It became very apparent that you can 'do with', you can 'do to' or you can 'do for' and neither 'doing for' nor 'doing to' is actually sustainable; it's as simple as that. The 'do with' was truly a principle of primary health care… [Apunipima] had a mandate from conception; it just had to be given an opportunity to exercise it. [703]

There were also senior people within Apunipima (including on the board) who had worked, or continued to work, within the mainstream health system and whose influence remained important: 'They certainly knew how to play the politics and keep everyone onside' [702]. This contributed to a web of working relationships between Apunipima and the regional leadership of Queensland Health that was marked by trust and personal respect.

In general, this relationship was managed at the regional level within Queensland Health, but Apunipima also managed to gain support from senior levels of the Queensland Health bureaucracy:

> I think [Queensland Health Directors General]… all had a sense of social justice… they were very, very supportive of Queensland Health… getting in there and doing its bit and not being shy of taking some risk. [703]

Apunipima was thus able to manage a complex relationship with Queensland Health, advocating strongly and often publicly for better health services for the communities it represented while gaining significant levels of support within Queensland Health for its role and its service delivery. Although it seems there was an intricate network of relationships, with no one level of the mainstream health system being marked wholly by one attitude to Apunipima, a senior Apunipima staff member of the time summarised the situation succinctly:

> I think that the more you moved out from the radius of the four triple zero bloody postcode the more parochial everyone got and… the more difficult it was for them to give up control, whatever that meant, even though they knew that they weren't doing it too well. [700]

Moving towards comprehensive primary health care, 2000–06

By 2000 there were many reasons to believe that the organisation established half a dozen years before at Pajinka was a success. However, there was also an increasing realisation of the limits to what Apunipima could achieve in its existing form. According to one senior Apunipima staff member:

> We did really come face to face with the bounds of the model in which we were operating in to a point where, you know, the issues around power and control just played itself out in merciless ways through departments, you know, being able to say no or keep you outside… [700]

The success of the organisation had come at a price. Although it had attracted funds for public health and community development programs, Apunipima continued to be reliant on short-term grant funding. For example, in 2000–01 Apunipima administered 23 projects (including Family Wellbeing, Sports & Recreation, Family Violence Advocacy, Sexual Health, Donovanosis Elimination, Mental Health and Suicide Prevention) with grants from nine funders. The previous year it had 21 projects funded by eight agencies, and in 1998–99, 21 projects were funded by 10 agencies (ACYHC 1999, 2000, 2001). Grants were rarely made for longer than two or three years, and were often restricted to implementation in individual Cape York communities. This situation undermined Apunipima's effectiveness and affected its standing with the communities it served:

> There are many examples of Apunipima Cape York Health Council being funded to implement programs in a limited number of communities and for limited time periods.… [This] leads to a lack of long-term engagement with health promotion strategies and a loss of faith in Apunipima Cape York Health Council because they are not resourced to continue to provide the programs in all communities. (CYRHF 2006a:20)

Increasingly, it became apparent that advocacy alone was not enough to change the way the health system operated. The strong relationships with senior regional health administrators and their personal commitment to positive change did not necessarily translate into a better regional health system for Aboriginal communities for several reasons. The administrators were part of a department with state-wide policies and practices focused mainly on the delivery of urban hospital services to non-Indigenous people (CYRHF 2006a), resources were lacking and locally based non-Indigenous staff, who did not share their leaders' commitment to change, continued to wield considerable autonomy in how they operated 'out bush'.

After all the high expectations of the participants at Pajinka, those in leadership positions at Apunipima began to realise that

> we could only do so much… the real influence came from being in control of the way that services were delivered. The real control came with being able to fly people into hospital and make sure that they got back out to communities well… the real control came around being able to have those resources and make them as obviously community [driven] as possible. [700]

Apunipima's response: Towards primary health care delivery

Apunipima's response to this emerging situation was gradual but profound. The first element was the River of Life health strategy. Drawn from meetings with community members and adopted by the Apunipima Board in 2000,

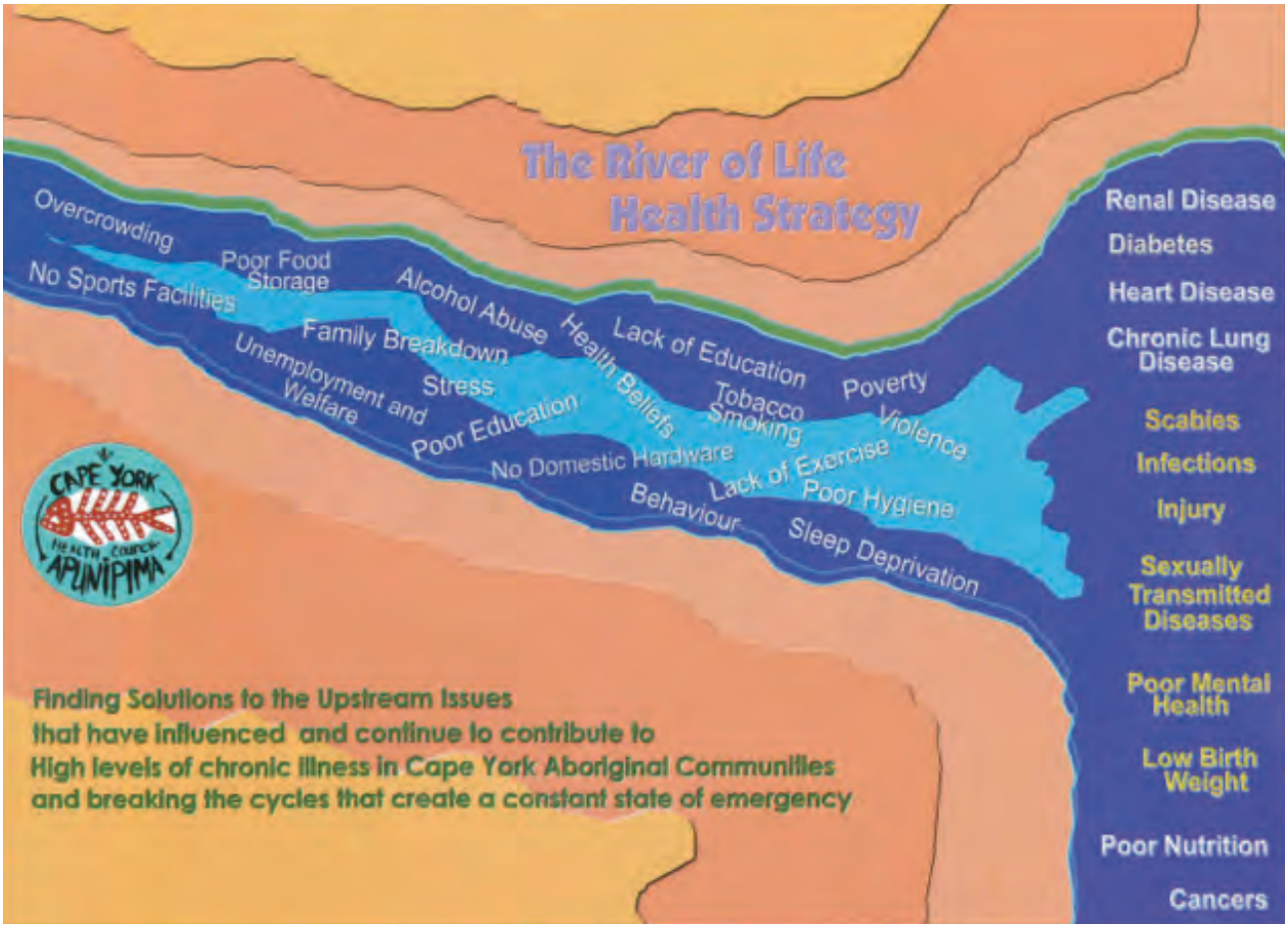

Figure 2: The River of Life health strategy (Source: ACYHC 2000:6)

this strategy was based on a holistic view of health that went beyond the delivery of health services to include the 'upstream' factors—the social determinants of health—that were the underlying causes of illness and injury: factors such as overcrowding, unemployment and welfare, poor education, alcohol abuse and poverty (Figure 2 above). It was clear that any attempt to address such issues needed to be strategic rather than opportunistic and long term rather than based on two- to three-year funding cycles.

The River of Life approach was developed within a broader context in Cape York. Many of those involved realised that despite all the advances of the 1990s (in gaining control of land and setting up Aboriginal and Torres Strait Islander organisations), health and wellbeing improvements still seemed distant. This realisation led Aboriginal leaders such as Noel Pearson to advocate for greater levels of control and responsibility. The resulting Cape York Partnerships Strategy was to be 'the main vehicle for people to become agents of their own change', with Apunipima recognised as the lead health agency (Tsey, Gibson & Pearson 2006:26).

This reorientation of thinking about health at Apunipima led to a commitment to re-engage with the individual communities in Cape York, in particular by supporting them to develop their own health plans based around the River of Life concept (ACYHC 2000). This process led to the reinvigoration of the Health Action Teams (HATs), groups of key people in each community with an interest and/or expertise in health, an approach that had been trialled by Queensland Health in the early 1990s. After 1994 it seems that Apunipima took on responsibility

for organising the HATs, and they were seen as a key method for community engagement and accountability:

> I think for us to be seen or [to] engage with communities we needed a group through which we could… ensure that… we were… being responsive to community need and also… being accountable… it was a good way of being able to keep people engaged and informed [and] if we were going to have a meeting… they were… the ground facilitators for our activities. [700:11]

The use of HATs was episodic in the early days of Apunipima, with each being organised to respond to particular initiatives or programs, and then becoming dormant until needed again—a pattern enforced by the lack of ongoing resources to maintain them. However, once the Apunipima Board had endorsed the River of Life concept, and directed the organisation to develop plans around it for each community, the HATs became the key method for guaranteeing a strong community voice.

The renewed emphasis on the role of the HATs was also driven by a deeper realisation that in a regional organisation such as Apunipima, covering numerous communities and language groups, an elected board alone could not provide the level of local Aboriginal input necessary to give the community a sense of ownership and control. A senior Apunipima staff member recalled this particular challenge:

> You couldn't just have that regional Apunipima board speaking for every community because again it's just one or two reps… who may or may not be across all the issues in the community and often times didn't really have much health expertise or planning expertise. [702]

The community development unit at Apunipima, funded by the Primary Health Care Access Program and made up of people with extensive local knowledge of the region, was critical of the establishment of the HATs. As an Apunipima staff member recalled:

> We knew the Cape fairly well across the team… we also got advice from the governing committee but we looked at [getting] an appropriate mix [of members of each HAT]… we strategically looked at the communities as to what would be a good representation and a fair representation. So we'd have one person from each of the clans, we had the clinic on there… someone from council, someone from the school. [702]

Despite the resources and the local knowledge, some communities were more engaged than others, but the result was that by 2004–05 Cape York Aboriginal communities had developed their own local health plans, based on a holistic view of health and with a strong emphasis on prevention. For some, the HATs were needed not just to develop the plans, but as a permanent and necessary part of Apunipima:

> [We realised] we're going to need to revise those plans from year to year. We're going to need to consult on various programs, get their input into how a program would best run in the community… we weren't talking about a steering committee we were talking about a team or a group that would facilitate all those things on a long-term basis and that we could provide skills and training and opportunities to. [702]

At this time Apunipima also developed an important long-term partnership with James Cook University and the University of Queensland to establish the Family Well Being Empowerment Team, which adapted an Adelaide-based program for family and clan engagement to enhance the capacity of residents of Cape York to take greater control and responsibility for their lives (Tsey, Gibson & Pearson 2006).

The River of Life approach and the Cape York Partnerships Strategy also provided the impetus for reorienting the relationship with

health care providers in Cape York. Apunipima began working with providers, and particularly Queensland Health, to secure agreement on developing a comprehensive health strategy for Cape York that included prevention at its core. The strategy itself took some years to eventuate (see below), but in the meantime the two organisations signed a Memorandum of Understanding. This contained agreements on developing and refining 'upstream strategies affecting Aboriginal health', as well as improved community engagement and definition of each organisation's role in Cape York (ACYHC 2000).

Most importantly, in the early 2000s Apunipima was also developing its position regarding the control of health services. From seeing its core business as coordination, advocacy and a partnership approach to the development of health solutions, by 2003 the organisation was arguing for 'the formation of a regional intergovernmental agreement on primary health care' and a short- to medium-term expansion of its own advocacy and service delivery role, with the long-term goal of the 'devolution' of responsibilities in health and greater community control of services (ACYHC 2003).

The challenges of management and governance

By the early years of the new century Apunipima was, in the words of its Chairperson, Wilfred Gordon, 'an organisation that is evolving as we strive to meet the needs of the communities we represent' (ACYHC 2001:5). Nevertheless, the success of this evolution was challenged by governance and management issues.

Apunipima had five Chief Executives (or General Managers) between 1995 and 2005, and it appears that at least three of these left the organisation after some difficulties with the board.

On the one hand, the demands on senior management were very heavy, particularly when it meant balancing a high-level advocacy role with maintaining contact with regional communities and local issues. There were concerns that some people in senior management lacked the requisite skills to do this while also running what had become a large organisation with numerous and complex funding streams and service delivery responsibilities. In the mid-2000s significant attention was given to staff development and addressing the challenges of high turnover in leadership (McEwan et al. 2010).

On the other hand, the board faced its own challenges. The increasing complexity of the organisation and the environment in which it operated required increasing levels of health knowledge, planning skills, and understanding of governance roles and responsibilities. At the same time, it became clear that the structure of the board—two representatives from each of the 17 communities on Cape York—while reflecting the common commitment to Apunipima, made for a very large governing body.

Changes were made to the Apunipima constitution in 2001, requiring local communities to nominate their representatives prior to the Apunipima Annual General Meeting and increasing board members' terms from one to two years (ACYHC 2001). Further changes were made in 2004 to ensure that all communities had one vote regardless of the number of people attending an annual general meeting and to re-set the numbers required for a quorum. These changes were both a recognition of the challenges at the governance level and an attempt to rectify them.

However, in 2005 the Health Reform Project of the Cape York Institute, an independent policy and leadership organisation, noted a number of commonly expressed concerns about governance at Apunipima. They included queries about the representative capacity of board members, lack of communication between members and the community they represented, lack of commitment by board members to the goals of the organisation, possible conflicts of interest, and limited literacy and financial literacy among board members (CYI 2005).

Moving towards community control

During the early 2000s, while Apunipima was reorienting its role towards a holistic, preventative model of health service delivery under community

control, changes were also occurring in the broader policy and planning landscape.

The transfer of administrative responsibility for Aboriginal and Torres Strait Islander health from ATSIC to the Commonwealth Department of Health in 1995 had led to increased funding for primary health care (AIHW 2001, 2013), but to make best use of these increased funds by targetting areas of need and reducing overlap and duplication, collaborative, joint planning processes were required. However, setting these up, especially in Cape York, took some time.

In Queensland the 1996 Framework Agreement, signed by the Queensland and federal Ministers for Health and the Chairperson of ATSIC, committed to 'joint planning processes which [would] inform the allocation of resources' (ATNS 2007), but attempts to set up a Cape York Regional Health Forum that could undertake this role were not made until 2001 and soon failed.[7] Significantly, this Framework Agreement had not included the community controlled health sector as a signatory.

However, a new Framework Agreement in 2002 (this time including QAIHC, as well as ATSIC and the state and Commonwealth governments) recommitted the partners to joint planning processes, as well as to improved access to health programs, increased resource allocation and transparent reporting (ATNS 2006). The National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH), released the following year with the agreement of all states and territories, provided further impetus, not just to joint planning processes and increased resourcing but also to primary health care and Aboriginal and Torres Strait Islander community control (NATSIHC 2003). In 2003 Apunipima joined QAIHC and thus became formally connected to the broader Aboriginal community controlled health sector.

In this environment, the Cape York Regional Health Forum (CYRHF) was re-established in early 2005, with a membership consisting of:

- Apunipima Cape York Health Council
- Department of Health and Ageing (OATSIH)
- Queensland Health
- Aboriginal and Torres Strait Islander Local Government Association
- Mookai Rosie Bi-Bayan Aboriginal and Torres Strait Islander Corporation
- Far North Queensland Rural Division of General Practice
- Royal Flying Doctor Service. (CYRHF 2006b)

This time there appeared to be a degree of urgency and commitment by all partners and the CYRHF moved quickly to oversee the development of a Cape York Regional Health Strategy.

With funding from the Commonweath Departments of Health and of Employment and Workplace Relations, and Queensland Health, the recently established Cape York Institute was commissioned to develop a health service model for comprehensive primary health care in Cape York for the consideration of the CYRHF. The case for reform was clear:

> Considerable effort, expertise and good intentions have gone into addressing the Indigenous health crisis in Cape York with little change in health determinants or health outcomes. It is therefore timely for an examination of all of the evidence for what is needed for a solution and to look for reform. (CYI 2005:28)

The resulting Health Reform Project & Social Enterprise Proposal (CYI 2005) was an in-depth look at the health status and services in the region. The Cape York Institute's recommended model for reform was founded on the NSFATSIH's commitment to community control, and a thorough analysis of models of regional health service delivery to Aboriginal communities in the Northern Territory, South Australia, Western Australia and the Torres Strait. The recommendations were unambiguous: progress in health status would

7 The reasons for this failure are not fully clear. One view is that it lacked a 'supporting policy framework and coordination structure' (CYRHF 2006a:6).

require the establishment of an Aboriginal community controlled comprehensive primary health care service for Cape York, funded through pooling of existing Queensland Health expenditure plus new Australian Government funds from the Primary Health Care Access Program[8] and other mainstream sources, including Medicare (CYI 2005).

Further, the Cape York Institute report recommended that Apunipima should take on the new community controlled health service role. This was not without reservation—note was made of its perceived and self-acknowledged difficulties with governance, and the difficulty it faced in delivering programs in some communities (CYI 2005:27). Nevertheless, other options (such as setting up an entirely new community controlled organisation for Cape York) were seen to be less likely to succeed. Apunipima was also to reform its governance structures to include:

- an overarching representative council made up of representatives from each community in Cape York
- a governing board made up of a smaller number of members from the representative council, each representing a 'cluster' of communities, plus the Cape York Institute, plus non-voting membership from funders (Queensland Health and OATSIH), with outside expertise to be invited as necessary.

Significantly, this option had been canvassed with, and supported in principle by, the Apunipima Board in April 2005 during the Health Reform Project (CYI 2005).

Cape York Regional Health Strategy and Deed of Commitment

The Cape York Institute's Health Reform Project proved to be the 'breakthrough moment' in the development of regional primary health care under community control in Cape York. The CYRHF took the Cape York Institute report of the Health Reform Project and various other sources, most notably the community health plans developed by Apunipima over the previous years, and in January 2006 endorsed the Cape York Regional Health Strategy. The overall aim was to

> [ensure] that Aboriginal and Torres Strait Islander people in Cape York enjoy a healthy life equal to that of the general population that is enriched by a strong living culture, dignity and justice. (CYRHF 2006a:2)

The key reform to achieve this was 'the establishment of a Cape York Health Board and a community controlled health service for Cape York' (CYRHF 2006a:2). This service was to be a reformed Apunipima, with a new governing structure based on that recommended by the Health Reform Project, funded under a funds-pooling model whereby:

> All funding for primary health care services in Cape York from Queensland Health and the Australian Government is put in the one bucket with the Governing Board deciding how the money is to be spent. (CYRHF 2006a:27)

The strategy had detailed plans for this transition to community control, with ambitious timeframes that included the development of a transition plan by June 2006, completion of funding agreements by December 2006, and a staged implementation process beginning in demonstration sites by June 2007 to be completed in all remaining 'clusters' of communities by December 2008.

In responding to these developments, the Apunipima Board was keen to emphasise that despite the proposed changes, the vision of the organisation remained unchanged—it was still focused on ensuring that Cape York people were empowered to take responsibility for

8 The Primary Health Care Access Program was a federal government initiative announced in the 1999–2000 Budget to improve Aboriginal and Torres Strait Islander access to comprehensive primary health in areas identified through regional planning processes. See McDonald n.d.

improving their own health, as individuals, clans and communities. Nevertheless, Apunipima recognised that

> ... in its current form it will need to undergo significant changes and capacity building if it is to accept the role of developing a community controlled health service for Cape York and to lead the implementation of a Cape York Health Strategy. (ACYHC 2005)

In accepting the role, Apunipima began a major round of consultations among Cape York communities to present the new model of community controlled health care to the Aboriginal and Torres Strait Islander peoples of these communities. As the Chairperson of Apunipima reported, 'In principle, the communities have welcomed the idea of community control with the qualifier that they do not want to see a decrease in service quality' (ACYHC 2005:4).

A transition to community control of primary health care services had thus been endorsed by all the key players in Cape York (through the CYRHF) and a clear map of the process to be undertaken to reach this goal had been agreed. In addition, all members of the CYRHF signed a Deed of Commitment in August 2006 (CYRHF 2006b).

The Deed of Commitment endorsed the Cape York Regional Health Strategy and the development of an Aboriginal community controlled health organisation for Cape York (with Apunipima to undertake reforms to allow it to play this role). It also recommitted to the concept of funds pooling, with funders to maintain their existing levels of resourcing. It did, however, change the timeframe, setting a target for a transition to a purchaser-provider model of service delivery by June 2007, and for full community control of health services in five years by June 2011 (CYRHF 2006b).

It seemed, then, that 12 years after it was established at the Pajinka meeting as an advocate for the health of the peoples of Cape York, Apunipima was now firmly established on a new path to deliver community controlled primary health care across the region.

Apunipima had accepted, indeed argued for, this new role, stemming from the realisation that advocacy alone was unlikely either to change the health system significantly or to address the underlying social and cultural determinants of health, and thus to improve the health and wellbeing of Aboriginal and Torres Strait Islander communities. Independent reports had recommended the new model. The funders and other service providers had agreed to a strategy based on funds pooling and the transition to community control, and had formalised this agreement in signing the Deed of Commitment.

Yet almost immediately there appeared to be doubts about the reasons for, importance of and even legitimacy of the Deed of Commitment. To Apunipima it was clear—the Deed 'formalise[d] the commitment to the required reforms' (ACYHC 2007). For some, at least in government, its role was less clear, as one former public servant explained:

> The Deed of Commitment wasn't something that was, I suppose, marketed, acknowledged by Queensland Health when I was [there]… it wasn't something that was openly talked about… there was no supporting documentation… I think it was again one of those things that was… 'on the spur of the moment'. You've got a commitment to something but what does that commitment need and to what extent? [200]

Questions were also raised about whether the signatories for each of the CYRHF members had the necessary authority to make such commitments. Even the timing of the signing of the Deed of Commitment seemed to conspire against it, with a state election being announced within an hour of its signing on 15 August 2006 and the Queensland Government's consequent caretaker role until the election on 9 September.

Despite such doubts, the Deed of Commitment remained the foundation for the next period of Apunipima's existence, and it focused on a transition to providing community controlled primary health care.

Issues and analysis

The following themes emerge from the story of Apunipima in the years 1994 to 2006, with many continuing to have resonance in the 'transition to community control' period of 2006–14 (see 'Conclusion').

The importance of community action

Apunipima was created by the collective action of the Aboriginal communities of the Cape York region. The representatives at Pajinka, acting on behalf of Aboriginal people across the region, wanted a voice in the health system because they knew that it was failing them. The creation of Apunipima was fundamentally an act of regional self-determination, shared by the diverse Aboriginal clans and communities across Cape York:

> [The establishment of Apunipima] was a really intrinsic part of building self-confidence amongst Cape York people, of providing Cape York people with a strong political voice. I think it really raised the expectations of Cape York people in terms of what they should expect in terms of their own health and the way governments provide health services to them. [701]

While focused on the instrumental aims of better health services, it was also an inspiration to those involved and a source of legitimacy and pride over many years:

> There was a lot of love when things were going really, really well. There was just a hum, sort of almost a vibrational pull where everything was as it should be and you absolutely knew that that was right. Some of those Cape York health summits were brilliant… Seeing Elders get up and dance for each other and then talk stories and then… sit up in the front row of all us young ones, getting up there being strong and being really supportive was incredibly powerful. [700]

The collective act of regional self-determination that began Apunipima, and the inspiration that it provided subsequently, remained key drivers along the road towards the transition to community control in the period up to 2006.

The importance of support from other Aboriginal organisations

The support of other Aboriginal organisations within the region was critical for the establishment of Apunipima and its role as advocate, and later for it moving towards primary health care delivery. Both the Cape York Land Council and the ATSIC Regional Council played an important role in funding and organising the Pajinka meeting, and ATSIC became the organisation's first and most consistent funder in the early years.

In the 1990s the newly formed Apunipima became part of the alliance of Aboriginal Cape York organisations that came into being under the guidance of a strong and articulate network of leaders. Many interviewees noted the importance of this alliance:

> We were very much one of the regional organisations back then, very interconnected, so it was always Land Council, Balkanu, Apunipima, you know, connected together to some extent, and to the legal service, so we all felt very tied together. There was always a lot of discussion amongst the leadership at that level and I think that's what originally drove it. [702]

Later, it was the Cape York Institute—through the Health Reform Project—that provided the details of a new model of regionalised community controlled primary health care, following years of a gradually building realisation of the limitations of a model based solely on advocacy and the delivery of short-term projects.

Apunipima did not develop in isolation from the broader attempts to increase Aboriginal and Torres Strait Islander participation and control of health services, examples of which—in the Torres Strait, Cairns, Townsville and beyond—were part of the inspiration at Pajinka. Apunipima Board members visited other regionalised health services in the 2000s to see how they worked, and the Health Reform Project carefully considered and analysed a number of other regional models in order to design one that would work for Cape York. Later Apunipima became a member of both QAIHC and the Northern Aboriginal and Torres Strait Islander Health Alliance, the peak regional body representing the Aboriginal and Torres Strait Islander community controlled health sector in Far North Queensland.

The importance of relationships of trust with government

Support from individuals working within government departments, both Commonwealth and state, was also critically important in the development of Apunipima as a regional Aboriginal health organisation.

The holding of the Pajinka meeting and the establishment of Apunipima were supported by both levels of government, and particularly by Queensland Health's regional administration. In the years after 1994, Apunipima worked hard to maintain these relationships, emphasising the need for a partnership approach, even while delivering on its mandate to hold the mainstream system to account for the health of the peoples of Cape York.

Thus, for much of the period 1994–2006, Apunipima had substantial though not universal support from Queensland Health at senior levels and particularly at the Cape York regional level. Much of this support came from administrators who recognised that the mainstream health system needed to change, and who had personal and professional commitments to a comprehensive model of primary health care that emphasised the need for Aboriginal and Torres Strait Islander agency.

At the same time, there were senior Aboriginal people who played important roles at Apunipima who had also worked, and continued to work, within the mainstream health system. There was thus a network of relationships marked by trust and goodwill between Apunipima and Queensland Health at the regional level, which, despite the legitimate advocacy role of Apunipima and its sometimes challenging methods, mitigated against the development of a simple 'us versus them' mentality between the organisations.

The importance of individuals and their relationships was also apparent at the local level with individual health clinics. Here, support for Apunipima seems to have been much more mixed—some non-Indigenous staff members clearly regarded the organisation with suspicion, if not hostility:

> I think the suspicion and disquiet… was more related to the actual staff in the clinics themselves and they were pretty well universally nurses. They felt that they were professionals. I guess that they'd spent careers fighting doctors for some sort of professional recognition and here was a bunch of black fellas about to come and take it off them and they were… pretty possessive of what they had there. [701]

The attitude of these non-Indigenous staff members could have an important effect at the local level. For example, in the establishment of the HATs and the development of community health plans in the 2000s, the level of support and engagement from the community in these processes was affected by the support or otherwise of local non-Indigenous staff:

> There were levels of cynicism [in some communities, and] I think that depended on the level of support in the community

> from the clinics. [There were] clinics that had really quite negative and almost hostile Directors of Nursing and… they were very cynical it was ever going to happen. The others that had nice [Directors of Nursing] and staff and things there, they were all like 'yeah, that'd be great. We can all work together'. [702]

The importance of the policy context

The relationships of trust with individuals within the mainstream health system were supported by a state-wide and national policy context that prioritised action on Aboriginal and Torres Strait Islander health through comprehensive primary health care that involved some degree of Aboriginal and Torres Strait Islander community control and/or participation.

The National Aboriginal Health Strategy (NAHSWP 1989) formalised these principles and provided the national policy foundation around which Aboriginal and Torres Strait Islander community organisations—such as Apunipima and the other regional organisations, as well as their supporters within government—could advocate. The 2003 National Strategic Framework for Aboriginal and Torres Strait Islander Health (NATSIHC 2003) was also explicitly used in the argument for the transition to community control in the period 2004–06 in Cape York.

The transfer of responsibility for the administration and funding of Aboriginal and Torres Strait Islander primary health care from ATSIC to the Commonwealth Department of Health in 1995, while controversial at the time, in the longer term led to substantially increased funding and to a formal commitment (through the signing of Framework Agreements) to joint planning processes.

At the state level, the development of Aboriginal and Torres Strait Islander health and primary health care strategies in the early 1990s was also explicitly used by Queensland Health regional administrators to argue for, and to justify the support of, the establishment and funding of Apunipima.

The challenge of governance

With the Aboriginal and Torres Strait Islander community committed to action, with the support of other regional community organisations and a good part of the mainstream health system, and with a generally favourable high-level policy context, it seems that Apunipima faced two key challenges in the formative years 1994–2006. The first of these was internal—the challenge of managing and governing a health organisation across a large and diverse region of communities, clans and language groups.

The Pajinka meeting established what seemed a logical and fair governing structure—two representatives from each of the 17 Cape York communities (plus one each from ATSIC and the Cape York Land Council). However, this led to an unwieldy board of close to 40 people, which, while representative, found itself in difficulties when it came to the practicalities of running what soon became a complex, multi-million dollar organisation, especially as Apunipima began to move towards the direct control of health services. It also became clear that, paradoxically, two people per community was not enough—how could those two people represent all the diverse interests of each of those communities without considerable support? Variable literacy and numeracy, and sometimes limited knowledge about health systems and the roles and responsibilities that went with being a board member, added to what was already a difficult governance challenge. As one senior staff member recalled:

> It was a very, very difficult time, trying to be present and trying to be representative and having a board from those different communities that would kind of engage at a very superficial level around the actual organisation and operation of the organisation. [700]

An additional governance challenge was the influence of Aboriginal leaders who may not have been formally represented on the Board but whose opinions were nevertheless highly influential and had to be taken into account.

Apunipima's solution to the challenges of governance did not emerge until the 2000s. The first response was the development of the HATs to provide a stronger, more diverse link to the concerns and interests of each community. Establishing the HATs was a major exercise, and maintaining them was a continuing challenge that was not always successful. Nevertheless, they provided the critical link between the organisation and the community that could not be provided solely by the board.

The second response was reform of the governing board, which was modified slightly as the problems with the structure emerged. But it was not until the Health Reform Project that a new, two-tiered model was designed and later adopted, involving a Representative Council (essentially the old board) and beneath it a board made up of a much smaller number of members drawn from 'clusters' of communities. In addition, there were to be non-voting members of the board (including senior government staff) with particular skill sets to assist the board in its decisions.

With the challenges of governance described above, it was not surprising that the management of Apunipima was also difficult—there seem to have been significant periods of struggle between board and management during the years 1994–2006. But the demands on management were huge even without the issue of conflict within the governance structure. The advocacy role of the organisation inevitably meant involvement and participation in forums outside the organisation and in some cases outside the region. At the same time, Apunipima management was expected to maintain contact with communities across the large Cape York region. It was a recipe for burn out:

> Everyone wanted to see you out in communities and during that time some of our staff relationships broke up because of the enormous pressure on travelling around the place. I had to leave my kids in other people's houses because I was away for three weeks out of every five. [700]

All in all, Apunipima faced exceptional governance and management challenges. Its region is highly diverse and complex in terms of people, place, health, histories and priorities; and there were high community expectations for improvements in health care. There was a lack of clarity about roles and responsibilities and limited organisational capacity. Most critically of all, there was great need in the communities of the Cape, but chronically insufficient resources. In this situation, it is not surprising that there were issues with governance and management—indeed, it is a testament to the organisation that it managed to survive, reform and grow.

The challenge of government funding

Government funding structures also proved to be a critical challenge for Apunipima during the period 1994–2006. Despite positive support for the organisation, and macro-policy settings that were largely favourable to Apunipima, in practice government funding methods were problematic.

Government funders had recognised in the early 1990s that the provision of acute clinical care only (i.e. without ongoing supportive and preventive PHC) was failing to address the health needs of the Aboriginal communities of Cape York. Almost immediately following its establishment, funders saw Apunipima as an outlet for funds to address the non-acute care needs, but the only funding method readily available was short-term grant funding. Less than two years after its establishment, the organisation was receiving at least nine short-term project grants—by 2002 there were a minimum of 14 short-term funding contracts with 12 funders.

The negative effects of this kind of piecemeal funding have been well-documented (Dwyer et al. 2009; Moran, Porter & Curth-Bibb 2014). As well as the administrative burden of managing this complexity, the short-term funding led to high staff turnover in a challenging environment where building relationships, experience and

knowledge over time was critical to success. The short-term projects became potential sources of conflict at the community level because there were rarely enough resources to run these projects in more than a few communities at a time, and they undermined program effectiveness where long-term strategic effort was needed to improve health.

The commitment to funds pooling that emerged through the CYRHF from 2005 was a recognition of this fundamental challenge to the delivery of regional health services that could drive better health outcomes. Unfortunately, and in contrast to Apunipima's action to address the internal governance and management challenges, this has yet to be realised.

Conclusion

This overview of the history of Apunipima's establishment and development (from 1994 to 2006) documents the commitment and hard work of Aboriginal people and organisations in Cape York, and the active support and engagement of Queensland Health and the Australian Department of Health during some of those years. The continuation of the story of the transition to community control is outlined in *The Road Is Made by Walking: Towards a better primary health care aystem for Australia's First Peoples* (Dwyer et al. 2015), in a detailed case study covering the period from 2006–14.

Apunipima was created by concerted action on the part of community leaders in Cape York who saw the need for community controlled health advocacy and care delivery; an initiative supported by both state and national health departments. While challenges were encountered in the early years, this was also a period of growth and development. The signing of the Deed of Commitment in 2006 put the promise of continuing growth on a more secure footing, and towards the vision of regional community controlled comprehensive PHC.

Despite this promise, and the timelines that were established, Apunipima's campaign for Aboriginal community control of primary health care services in Cape York is still underway, and the transfer of primary health care services for the Cape York region to an Aboriginal community controlled health service remains only partially realised.

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Appendix: Timeline of key events relevant to the history of Apunipima

This timeline outlines the key events—within Apunipima Cape York Health Council, in the Cape York region, and at a wider Queensland or national level—that impacted upon the establishment and development of Apunipima during the period 1994–2006. It is compiled from documentary sources, but we acknowledge that many other events—for example, within local communities—may also be important.

	Apunipima Cape York Health Council	Cape York	Queensland/National
1967			Australians vote overwhelmingly in a referendum to amend the Constitution to include Aboriginal and Torres Strait Islander peoples in the census and allow the Commonwealth to create laws for them.
1971			First Aboriginal community controlled health service established in Redfern, NSW.
1972			Department for Aboriginal Affairs established with responsibility for Aboriginal and Torres Strait Islander health.
1975			National Aboriginal and Islander Health Organisation formed to promote Aboriginal community control and to lobby for the establishment of new services.
1989			National Aboriginal Health Strategy (NAHS) (NAHSWP 1989) released, advancing a holistic definition of health for Aboriginal and Torres Strait Islander people and prioritising primary health care (PHC) under Aboriginal and Torres Strait Islander community control.

	Apunipima Cape York Health Council	Cape York	Queensland/National
1990		Cape York Land Council established.	Aboriginal and Torres Strait Islander Commission established with 35 regional councils across Australia. Cape York falls within the Peninsula Regional Councils.
1991			Royal Commission into Aboriginal Deaths in Custody report (Johnston 1991) released, supporting community control of Aboriginal and Torres Strait Islander health services and implementation of the NAHS. Regionalisation of Queensland Health commences, decentralising health services to regional health authorities.
1992		Strategic Plan 1992–1997 (Northern Regional Health Authority 1992) released by the Northern Peninsula and Torres Strait Islander Regional Health Authority. This is the operational plan for the Queensland Health Primary Health Care Policy (1992). Priority area is Aboriginal and Torres Strait Islander peoples. Strategies include increasing community participation and the provision of culturally appropriate services.	Queensland Health Primary Health Care Policy (Queensland Health 1992) released, outlining a comprehensive approach to improve health, with a key principle of community participation.
1993			National Aboriginal Community Controlled Health Organisation (NACCHO) established as the national umbrella organisation representing Aboriginal community controlled health services.

	Apunipima Cape York Health Council	Cape York	Queensland/National
1994	**September:** Apunipima Cape York Health Council established by Aboriginal community representatives at a four-day health conference held at Pajinka Wilderness Lodge near Injinoo at the tip of Cape York. **October:** Apunipima sets up an office in Lovett Street, Cairns, with 4–8 staff, funded by the ATSIC Regional Council. **November:** Apunipima becomes an incorporated organisation—the first community controlled health organisation covering Cape York. **December:** Inaugural Meeting for Apunipima held in Napranum.	**April:** ATSIC Regional Council meeting in Cape York attended by community, Cape York Land Council and Queensland Health representatives. Support given for a Cape York Health Summit with the aim to establish a Cape York Health Council.	Queensland Health releases the Aboriginal and Torres Strait Islander Health Policy 1994 (internal). Priority areas are community controlled PHC services, local participation in health decisions/services. A comprehensive definition of community control is provided. The document also discusses the facilitation of Health Action Groups, which are the grassroots governance of community control. **December:** *National Aboriginal Health Strategy: An Evaluation* (ATSIC 1994) concludes the NAHS was not effectively implemented.
1995	Apunipima sets up alliance with Torres Strait Health Council (Cape and Torres Strait Alliance), with a purpose to increase advocacy power. **January–June:** Apunipima consults all Cape York communities to develop its first strategic plan, focusing on three main areas: (1) establishing Apunipima's role, (2) areas for urgent action, and (3) key health areas to build long-term health. **October:** Cape York Land and Health Summit held: endorses Apunipima's first strategic plan. **November:** Apunipima sets up an office in Fearnley St, Manunda, with support of ATSIC and Commonwealth Department of Health.	**October:** Substance Misuse Summit held.	**May:** Responsibility for Aboriginal and Torres Strait Islander health transferred from ATSIC to Commonwealth Department of Health.

	Apunipima Cape York Health Council	Cape York	Queensland/National
1996	**June:** Apunipima first annual report, 1995–96.	**June:** Joint Health Planning Meeting held in Wujal Wujal attended by Apunipima, Torres Strait Regional Health Authority, Cape York Land Council and Queensland Health.	**February:** Queensland elections result in victory for National Party led by Premier Rob Borbidge. **March:** Federal elections see a Coalition government come to power headed by Prime Minister John Howard. **July:** First Queensland Framework Agreement signed by the Commonwealth and Queensland governments and ATSIC. **September:** Restructure of Queensland Health services from regions to districts.
1997		**September:** Cape York Forum established with the aim of providing a coordinated approach for all Cape York agencies and the Aboriginal Coordination Centre.	
1998	Federal Health Minister Michael Wooldridge visits Apunipima and undertakes a tour of Cape York communities with senior Commonwealth health officials. Apunipima appointed to the Queensland Aboriginal and Torres Strait Islander Health Advisory Council, as well as two National Health and Medical Research Council committees, the Research Agenda Working Group, and the Cairns and Districts Ethics Committee.	New state minsters visit Cape York, including Anna Bligh (Human and Family Services), Wendy Edmonds (Health) and Judy Spence (Fair Trade).	**June:** Queensland elections result in victory for the Labor Party under Premier Peter Beattie. **November:** Restructure of Queensland Health services from districts to zones.
1999	Apunipima begins developing the River of Life health strategy with a focus on preventative health and chronic disease. Apunipima signs a Memorandum of Understanding with Queensland Health to continue and strengthen their collaboration.		**August:** NACCHO report on the Implementation of Framework Agreements (Evaluation). Positive factors include increased intersectoral collaboration, joint planning and some increase in resourcing. Negatives factors include Aboriginal and Torres Strait Islander peoples not being included in decision making, accountability issues and inadequate resourcing.

	Apunipima Cape York Health Council	Cape York	Queensland/National
2000	Apunipima Board endorses the River of Life health trategy. Apunipima signs Memorandum of Understanding with Queensland Health to improve services in the wake of a Review of Health Services in Cape York.	Elim Land and Health Summit (Hope Vale) held.	
2001	Apunipima commences the Whole of Health planning process with the support of Cape York Partnership and Queensland Health to develop health plans for all 11 Cape York communities.	First Cape York Regional Health Forum established, but soon ceases to meet.	
2002			**April:** Queensland Government releases the Meeting Challenges, Making Choices (Queensland Government 2002) strategy aimed at improving the health of Aboriginal and Torres Strait Islander peoples. **June:** Second Framework Agreement signed Queensland Aboriginal and Torres Strait Islander Health, including the Queensland Aboriginal and Islander Health Council, to represent the community controlled sector. **November:** Aboriginal Primary Health Care Access Program begins to be rolled out across Australia in partnership with state/territory governments, the Aboriginal community controlled health sector and ATSIC. Queensland Health begins implementing the Enhanced Model of Primary Health Care in Cape York, with strong Aboriginal leadership and a goal of comprehensive approaches to PHC.
2003	Apunipima becomes a member of QAIHC (previously Queensland Aboriginal and Islander Health Forum) and NACCHO.		**July:** National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013 (NATSIHC 2003) released.

	Apunipima Cape York Health Council	Cape York	Queensland/National
2004	Apunipima begins analysis of the 11 Whole of Health Plans as the first stage of a regional health planning strategy for Cape York.	**July:** Cape York Institute (CYI) launched as an independent policy and leadership organisation in partnership with the people of Cape York and the Commonwealth and Queensland governments.	**April:** ATSIC abolished by federal government.
2005	Apunipima undertakes community consultations in Cape York to present the Cape York Regional Health Strategy and the concept of community control to the communities. Delegates from Apunipima visit community controlled health services in the Kimberley (WA), the Northern Territory and New South Wales to learn from the experiences of community control elsewhere in Australia.	**April:** Apunipima reconvenes the CYRHF. CYI commissioned to undertake the Cape York Health Reform and Social Enterprise Project, which recommends transition to community control under Apunipima and funds pooling. Cape York Regional Health Strategy is endorsed by the CYRHF, as are the recommendations of the Cape York Health Reform and Social Enterprise Project.	
2006	**January:** Apunipima relocates to McCoombe Street, Cairns, with 21 staff. **January:** Transition Planning Unit established at Apunipima, funded by Commonwealth Department of Health, to plan the transfer of services from Queensland Health and other service providers to community control. **May:** Changes to the Apunipima constitution to restructure the board to include 'cluster' representatives and ex-officio members.	**August:** Apunipima instrumental in developing the Deed of Commitment, which is signed off by all members of the CYRHF committing to health reform in Cape York, including transitioning health services to Apunipima and funds pooling. The Improved Primary Health Care Initiative Funding released—awarded to the Far North Queensland Rural Division of General Practice and the Royal Flying Doctor Service (with proviso that funds be transferred to Apunipima when possible).	

Author biographies

Mr Edward Tilton has more than 20 years of experience in the Aboriginal and Torres Strait Islander health field, with particular expertise in primary health care planning, community development, policy development and consultative processes. He has worked for the Aboriginal community controlled health sector at a local, jurisdictional and national level, as well as for the Northern Territory Government. He currently provides consultancy services to a wide range of Aboriginal community controlled services, government departments, and research agencies across the country, specialising in the complex and culturally diverse environments of northern and central Australia.

Dr Angelita Martini is a Senior Lecturer in the Centre for Health Service Research in the School of Population Health at the University of Western Australia. Her current research is focused on the health needs of vulnerable Western Australians, and models of care in cancer services. She has extensive experience in research coordination, tertiary education and curriculum development roles in medicine, nursing, Aboriginal studies and public health. Angelita has held management positions in the private and public sectors, both nationally and internationally, in health, education and correctional services.

Ms Cath Brown is a Noonuccal woman from Minjerribah [North Stradbroke Island] off Brisbane. In 2007 she took up a Research Officer position at James Cook University, within the School of Indigenous Australian Studies Empowerment Research Program, to become involved in the delivery of the Family Wellbeing Program. Cath facilitated the empowerment program with Aboriginal and Torres Strait Islander individuals, groups and organisations predominantly in North Queensland. She has completed a Graduate Diploma in Indigenous Health Promotion, graduated Master of Public Health [Health Promotion] and has begun a research Masters looking at Aboriginal health advocacy.

Ms Kristy Strout has a Master in Public Health (Health Service Management and Policy) and a Postgraduate Diploma in Health Promotion. She worked in a range of health promotion roles before moving into management, where she has worked in government and non-government agencies spanning different sectors, including health, disability and human services, and the tertiary sectors. Kristy has a genuine passion for improving health and social outcomes for marginalised populations (particularly Aboriginal and Torres Strait Islander populations) through policy and systems approaches, which aligns with her research interests.

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