Learning from Action:

Management of Aboriginal and Torres Strait Islander Health Services

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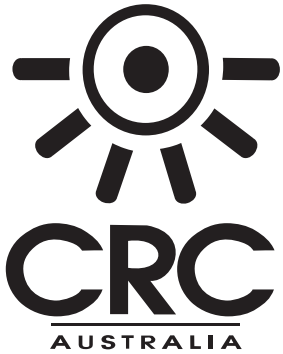

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Foreword

QUEENSLAND ABORIGINAL & ISLANDER HEALTH COUNCIL

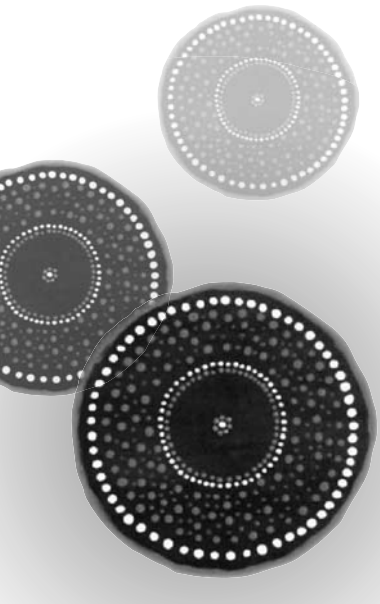
Aboriginal and Torres Strait Islander communities have worked hard to establish and run good primary health care services over more than 30 years. There are now more than 120 community-controlled health organisations around the country, serving rural, remote and urban communities. The organisations were established as part of our struggle for better health, and for self-determination. Commitment to these goals remains as strong as ever as our communities face critical problems and uncertainties.

The health problems we face, and the care we need, are complex, and answering the need requires strong organisations which are in tune with their communities. The Queensland Aboriginal and Islander Health Council aims to progress the individual and collective development of community controlled health services for Aboriginal and Torres Strait Islander people in Queensland. We undertook the project documented in this report as part of our strategy to support professional development for managers of member organisations, and in order to better understand the management challenges our member organisations face. We recognise the need to reflect and learn about both the good practice and the problems.

Following the Board's endorsement of the project report in March 2007, we have already moved to ensure that managers in our sector can undertake both formal study and other professional development activities that are relevant to their settings and their learning needs. We are also addressing several other issues raised and explored in this report. This action is in keeping with our commitment and responsibility to give leadership for improvement and development of the sector. It also demonstrates the value for the sector in working with researchers and teachers to address the issues we know are important.

We hope that this report will be useful for our members, and for other community-controlled health services around the country, as well as for the funding bodies, researchers and teachers with whom we work.

Adrian Carson
CEO, QAIHC



Acknowledgments

The development of Aboriginal and Torres Strait Islander health services has been and continues to be a political issue, and the efforts of the sector to improve its effectiveness occur in an environment that is often sceptical and critical. In this context, the willingness of our industry partners to engage in a research project that, of its nature, must focus on the challenges and problems that managers encounter is courageous, and bears witness to their commitment to the health of their communities and to strengthening the capacity of their services. We wish to acknowledge this courage and commitment, and to thank our partners and all the participants (our co-researchers) for allowing us to 'walk with them'.

We are grateful to Ms Lizzie Adams, Ms Valerie Craigie, Dr Bronwyn Fredericks, Ms Sheryl Lawton, Ms Mary Martin, Mr Mark Moore, Ms Janelle Murphy, Mr Justin Saunders and Ms Bronwyn (Warner) Smith, as well as those who have chosen to remain anonymous, for their generous contribution to this project.

We would also like to acknowledge the help and support of many advisers and colleagues, including the staff and board of the Queensland Aboriginal and Islander Health Council, Professor Ian Anderson, Ms Christine Bright, Mr Mick Gooda, Associate Professor David Legge, and the anonymous members of a mainstream learning set who allowed us to use their experiences as a comparison. We are most grateful to the participants of workshops held in Brisbane and Melbourne in May 2006 for the purposes of assisting us to draw out the policy implications of the research, including Ms Jenny Baker, Ms Stephanie Bell, Dr John Boffa, Ms Wendy Edmondson, Mr Dennis Eggington, Mr Shane Houston, Mr Sam Jeffries, Dr Tamara Mackean, Dr Beverly Sibthorpe, Mr Eamonn Thackaberry, Mr Mark Thomann and Mr Peter Waples-Crowe.

Judith Dwyer, Cindy Shannon and Shirley Godwin

Reading this report

This section gives an explanation of what is in each chapter, and then explains some of the words we use throughout this report. At the beginning of each chapter, and many sections of the chapters, there is a short description *in italic print* which summarises the material that follows. Reading these statements will help you find what you are looking for.

Chapter 1 gives the history and context behind the development of Aboriginal and Torres Strait Islander health services. It also explains what other researchers have found out about management and managers in these services.

Chapter 2 explains this project, how it got started and why, who the participants were, and what we aimed to achieve.

Chapter 3 explains how the project worked—the methods we used and why.

Chapter 4 reports on the learning program, which was an essential element of this project, and the participants' evaluation of it.

Chapter 5 presents the research results. We summarise what the managers told us in workshops about their challenges, how they arose, what strategies they use to address them, and what helps and hinders their efforts. This chapter finishes with a listing of the major issues that emerged from all this material.

Chapter 6 explains what we think is the significance of the results, and what they tell us about what needs to be done to help the managers and the organisations in their continuing efforts to be more effective in addressing the health problems of their communities.

A word on words

We use the term Aboriginal Community Controlled Health Service (ACCHS) in accordance with the definition developed by the National Aboriginal Community Controlled Health Organisation (NACCHO). We also intend its use to be inclusive of Aboriginal and Torres Strait Islander peoples. We use the term 'Indigenous-specific health services' the way that the Office for Aboriginal and Torres Strait Islander Health (OATSIH) uses it—to mean all healthcare services that are primarily focused on the needs of Aboriginal and Torres Strait Islander communities. We are aware that there is some controversy about the use of the word 'Indigenous' (because it is very generic), so we use it sparingly.

We always use capital letters for the words 'Aboriginal', 'Torres Strait Islanders' and 'Indigenous', as a sign of respect, again in accordance with usage by OATSIH and other bodies.

We use the term 'mainstream' to mean the non-Indigenous health sector, and sometimes non-Indigenous people, in accordance with common usage in the Aboriginal and Torres Strait Islander health sector. We use some abbreviations often, and they are spelled out in the glossary that follows.

Please note that we sometimes refer to ourselves throughout the text by our initials: Judith Dwyer (JD), Cindy Shannon (CS) and Shirley Godwin (SG).

Glossary

ACCHS	Aboriginal Community Controlled Health Service
AHW	Aboriginal Health Worker
CEO	Chief Executive Officer
CRCAH	Cooperative Research Centre for Aboriginal Health
HR	human resources
NACCHO	National Aboriginal Community Controlled Health Organisation
OATSIH	Office for Aboriginal and Torres Strait Islander Health
QAIHC	Queensland Aboriginal and Islander Health Council
VACCHO	Victorian Aboriginal Community Controlled Health Organisation

Chapter 1: Context for this Project—Aboriginal and Torres Strait Islander Struggles for Good Health and Healthcare

This chapter explains the recent history and context of efforts to improve health and healthcare for Aboriginal and Torres Strait Islander peoples. It also summarises what is known from other research projects about the management of Aboriginal and Torres Strait Islander health services.

The history of exclusion and neglect of Aboriginal and Torres Strait Islander peoples' health is a powerful background to the experience and approaches of Aboriginal and Torres Strait Islander communities to the healthcare system (NAHS 1989; NATSIHC 2003:5). The development of Aboriginal and Torres Strait Islander community controlled healthcare in modern Australia was founded on principles of self-determination articulated by the Aboriginal and Torres Strait Islander rights movement (NAHS 1989; Griew *et al*. 2004). The first Aboriginal Medical Service was established in the inner-city Sydney suburb of Redfern in the early 1970s, staffed by volunteers (Indigenous and non-Indigenous) and operated without government funding. This initiative was followed quickly by other such community-led developments around the country. Federal government funding followed some years after this beginning. There are now approximately 170 Indigenous-specific health agencies established around the country, some of which provide comprehensive primary healthcare, while others focus on substance abuse or provide a more limited range of health promotion or counselling services.

The activism of Aboriginal and Torres Strait Islander organisations, and increasing awareness of the shocking health differentials between Aboriginal and Torres Strait Islander and non-Indigenous Australians, led to the development of the *National Aboriginal Health Strategy* in 1989, a document heralded for its vision but not implemented (NAHS Evaluation Committee 1994). Part of the reason for this neglect was seen to lie in the diffuse responsibility for Aboriginal and Torres Strait Islander health, split between states and the Commonwealth, and between the Aboriginal Affairs and Health portfolios. The decision in 1995 to 'mainstream' responsibility for Aboriginal and Torres Strait Islander health into the health portfolio was welcomed at the time by both the Aboriginal and Torres Strait Islander and mainstream health systems (Anderson & Sanders 1996). The advantages were seen

to lie in two factors: Aboriginal and Torres Strait Islander health services would gain access to the much larger health portfolio budgets; and mainstream services would no longer be able to maintain that Aboriginal and Torres Strait Islander health was not their responsibility.

Aboriginal Community Controlled Health Services

According to NACCHO, the peak body for Aboriginal and Torres Strait Islander community-controlled health services, these services are 'initiated and managed by local Aboriginal communities to deliver holistic and appropriate care to people within their community and their Board members are elected from the local Aboriginal community' (NACCHO 2003:2).

This model has features in common with community-controlled primary healthcare services that have been important contributors to improved health outcomes among Indigenous peoples in other countries. International comparative analyses provided by Kunitz (1996) and Ring and Firman (1998) demonstrate the success of community-controlled models of healthcare through attention by governments to the development of effective and efficient systems. For example, through the 1976 *Indian Health Care Improvements Act* in the United States of America, legislation mandated that resources were to be used to expand health services, build and renovate medical facilities, step up construction of safe drinking water and sanitary disposal facilities, and establish programs to increase the number of Indian health professionals to meet Indian needs. There is no similar act, aimed at long-term effort to improve Aboriginal health, in Australia.

The principle of community control requires that ownership and management of the health agency is vested in the local Aboriginal and Torres Strait Islander community, generally through the mechanism of a local Aboriginal and Torres Strait Islander board of management. This arrangement is seen to enable the local community to decide on its priorities, policies, management structure, staff and service profile (within funding guidelines) when most of the funding comes from governments. Dwyer, Silburn and Wilson (2004:36), in their review of the effectiveness of primary healthcare for Aboriginal and Torres Strait Islander communities, note that:

the principle of community control has similarities to the traditional and still common governance structures of public hospitals, community health centres and other mainstream health agencies (including the substantial non-government sector), and draws on some of the same democratic, communitarian traditions. The degree of power-sharing with the funding bodies may differ (with greater independence being held in Indigenous agencies in some jurisdictions). Another important difference is in the relative size of agencies and thus the degree to which management functions can be delegated to staff (with Indigenous boards generally being less well resourced).

Through this model of service delivery, decision-making authority over healthcare (within the constraints of funding and regulation) is devolved to the local community level. The model is based on the central role of the community and its delegation of decision-making responsibilities in health to the ACCHS board. Formal partnership and funding arrangements with government (both state and national) influence the way in which the service is managed, as do a range of other linkages with mainstream service providers and non-health sector agencies.

Why comprehensive primary healthcare is important

International experience has shown that a comprehensive approach to primary healthcare can contribute to significant improvements in health in developing countries and among Indigenous populations in developed countries comparable to Australia (Ring & Firman 1998). The comprehensive approach to primary healthcare is based on the definition given in the World Health Organization's Alma-Ata Declaration (WHO 1978):

essential health care based on practical, scientifically sound and socially acceptable methods and technology

made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's overall health system, of which it is the central function and main focus, and the overall social and economic development in the community with the national health system bringing care as close as possible to where people live and work, and constitutes the first elements of a continuing health care process…

For the purposes of Aboriginal and Torres Strait Islander health policy and programs, comprehensive primary healthcare includes:

- *Clinical care*—including emergency care, treatment of acute illness and management of chronic conditions.
- *Population health programs*—examples include antenatal services, immunisation, screening programs for early detection of disease, and specific health promotion programs (for example, physical activity).
- Facilitation of *access to secondary and tertiary care*—including the improvement of linkages across a range of services that would otherwise be inaccessible to many Aboriginal and Torres Strait Islander people, such as specialist medical care.
- Client/community *assistance and advocacy*—including an advocacy role where health risk factors and health determinants fall outside the direct ambit of the health system (OATSIH 2003; NATSIHC 2003; Shannon & Longbottom 2004).

Aboriginal and Torres Strait Islander primary healthcare agencies provide a needed resource both for their patients and for other care providers, and thus play an important role in the health system as a whole. While ACCHSs may be the only local providers in remote areas, their role in urban settings is more often challenged. The role of Aboriginal and Torres Strait Islander health services in urban settings has been defined as having the following five components:

- acting as *informed advocates* for the health needs of the local Aboriginal and Torres Strait Islander community;
- ensuring *access to primary healthcare* for many urban Aboriginal and Torres Strait Islander people who would otherwise not access care;
- specialist *resource to the mainstream* and as a lever for action to improve the responsiveness of the mainstream health system;
- *education and training* for Aboriginal and Torres Strait Islander and non-Indigenous health professionals in the delivery of primary healthcare to Aboriginal and Torres Strait Islander people; and
- *support* for some Indigenous-specific rural and remote services (Dwyer, Silburn & Wilson 2004:7).

A comprehensive primary healthcare approach is also important given the increasing impact of chronic disease in Aboriginal and Torres Strait Islander communities. Primary and secondary prevention are critical, as well as clinical management strategies. Clearly, where access to primary care is compromised, people are more likely to present for care at a later stage when they are significantly sicker. In the mainstream health system, there has been a strong focus on strategies that shift many care needs of people with chronic illness out of the hospital and into the primary healthcare setting. This is in stark contrast to the outcomes for the Aboriginal and Torres Strait Islander community, where age-adjusted hospitalisation rates are between two to eleven times higher for similar conditions (Stamp, Duckett & Fisher 1998).

Finally, a comprehensive approach to primary healthcare requires a mix of services working under such a banner, but the mix will vary at the local level, depending upon several factors including the availability of other providers.

Partnerships, alliances and mainstream involvement

In proposing a dual strategy using both Indigenous-specific and mainstream agencies to deliver healthcare in Aboriginal and Torres Strait Islander communities, Dwyer, Silburn and Wilson (2004:23) identified four key reasons why the Aboriginal and Torres Strait Islander

community-controlled health services will continue to play an essential role in the health system:

1 Aboriginal and Torres Strait Islander health needs are different—for example, the greater prevalence of chronic diseases requires an ongoing complex set of interventions provided by a multi-disciplinary team that is able to sustain relationships with a range of other providers.

2 Mainstream services are generally not structured or organised to address the spectrum of Aboriginal and Torres Strait Islander disadvantage, largely as a result of cultural and historical reasons.

3 The market power of the Aboriginal and Torres Strait Islander population to stimulate mainstream services to be more responsive to its needs is severely limited. This is largely because Aboriginal and Torres Strait Islander peoples make up such a small proportion of the total primary healthcare market in many parts of Australia.

4 Aboriginal and Torres Strait Islander services should not be viewed simply as a *substitute* for mainstream services. They also provide a training base for health professionals, support research and development of new approaches in Aboriginal and Torres Strait Islander health, provide the referral pathways and patient support for specialist and tertiary care, and provide an appropriate base for community development approaches to improving Aboriginal and Torres Strait Islander health.

All Australians need access to a wide range of primary healthcare services, and no one type of service or agency can provide the full range. While the precise mix of agencies and service delivery methods is highly variable across different settings, Dwyer, Silburn and Wilson (2004) identified the following characteristics of the required delivery system for Aboriginal and Torres Strait Islander health.

- **A combination of Indigenous-specific and mainstream services**—a strong argument exists for the complementary nature of these services and the critical need for both types of services to work well for Aboriginal and Torres Strait Islander peoples. As Professor Ian Anderson pointed out in one of the workshops for this project (Brisbane, December 2005), 'community control can't work without the mainstream also taking responsibility'.
- **A combination of *horizontal* and *vertical* systems and programs**—the former consist of primary healthcare agencies and general practitioners, complemented by specialist services, while the latter consist of national and state/territory targeted programs. Work by Beaver and Zhao (2004) indicates that a strategy of funding 'best buys' will not work unless there is a strong network of local and regional service providers. They also note that there is evidence of Aboriginal and Torres Strait Islander community-controlled health services in the Northern Territory taking advantage of the potential leverage that effective intersectoral collaboration can generate.
- **There is a minimum size below which healthcare agencies cannot be effective**—the provision of primary healthcare is a complex role, and agencies that make a significant contribution to it require a certain critical mass. This technical reality contributes to the problem of primary healthcare delivery to small communities, and the development of regional models has been suggested. While the historical development of ACCHSs needs to be respected, there is also recognition of the need for change to ensure effective primary healthcare service delivery and sustainability of programs. Dwyer, Silburn and Wilson (2004:44) identified the following mix of organisational arrangements that could exist:
  - link local ACCHSs at the regional level through consultation and negotiation forums and shared support services;
  - have regional ACCHSs that deliver local-level clinical services and programs;
  - develop regional primary healthcare networks that include ACCHSs and mainstream providers working together; and
  - facilitate arrangements where ACCHSs can purchase services on a contractual basis.

All Australians, and particularly those with chronic diseases, need access to a range of health services, and in recent years there has been increasing attention to the need for effective collaboration and partnerships among providers of healthcare to ensure that such access is

reasonably achievable. This is a strong feature of the Aboriginal and Torres Strait Islander health field, both as part of ACCHSs' efforts to coordinate for their clients and because mainstream providers need to work with ACCHSs in order to improve their services for the Aboriginal and Torres Strait Islander population. The development of effective partnerships and networks is not an easy task and takes time. For ACCHSs the difficulties are increased due to stark differences in size and available resources between them and their mainstream partners, and the frequent problem of lack of awareness and knowledge among mainstream staff about Aboriginal and Torres Strait Islander culture and health concerns (Wakerman *et al*. 2000; Williams, Thorpe & Chapman 2003).

Aboriginal Community Controlled Health Services in Queensland

The first ACCHS in Queensland was established in Brisbane in 1972. Since then there has been substantial growth in the number of such services, and twenty agencies are now affiliated with the Queensland Aboriginal and Islander Health Council (QAIHC), the peak body for community-controlled health services in Queensland. The growth in the number of services has also resulted in variations to the models (scope and focus) of service delivery, but the model of governance has remained unchanged, with the services continuing to be managed by an elected board of management. The relative size and age of the organisations, along with the dominant mode of service delivery, are important influences on management.

Queensland Health, the government health authority that also incorporates the mainstream public health system, provides some Indigenous-specific clinical services, particularly in small communities. In those settings, the ACCHS tends to provide health promotion and other non-clinical services, sometimes in an explicit partnership arrangement with Queensland Health. The situation varies in other states, with some states having less direct provision of Indigenous-specific services by the mainstream.

Previous management research

In this section, we focus on the small number of studies that are directly relevant to our project. Throughout this report, we refer to other research that bears on particular management issues.

While there has been limited work that has specifically examined the management issues in Aboriginal and Torres Strait Islander health services, there are some findings that have informed this project.

A relevant study by Wakerman *et al*. (2000) examined cross-cultural management knowledge and distinct management features in Aboriginal and Torres Strait Islander health organisations through questionnaires and interviews with forty-one middle- and senior-level Aboriginal and Torres Strait Islander health sector managers. The focus of this study was on recruitment, retention and professional development for Aboriginal and Torres Strait Islander healthcare managers, and the interviews covered management practices, career development and the experience of being a manager.

This study used an explicit focus on the ways managers approached the dilemmas of operating at the interface between cultures. It identified five distinctive features at the individual level (strong personal motivation, wide leadership roles, high levels of support for Aboriginal and Torres Strait Islander staff, high stress levels and a 'hands on' approach to resolving complaints or problems). At the organisational level they found a belief that Aboriginal and Torres Strait Islander management was 'different', a sense that the managers were agents of change, careful approaches to recruitment (with care to manage the reality of family relationships and the perception of nepotism), and different approaches to managing time and communication. At community level the managers felt a strong sense of obligation and accountability to the community (as distinct from board or bureaucracy), which was matched by high volumes of community feedback that could be received anywhere, any time; and the managers also felt strong influences from family and community in their career choices.

The authors identified four major types of strategies used by the managers to deal with the contradictions and challenges of managing at the interface between cultures and systems. The first was *oppositional* strategies—that is, using the circumstances set up by authorities for their own purposes. The managers did not mean direct opposition, but rather subversion of policies or programs to enable what they saw as better directions; the authors noted that more senior managers were more frequently comfortable with this strategy. The second strategy type was *separation*, that is, 'a deliberate effort… to make a distinction between the Aboriginal… and non-Indigenous domains in order to minimise conflict or confusion' (Wakerman *et al*. (2000:65). This was sometimes expressed as the role of being the interface, and thereby minimising the need for community members to deal with bureaucracy. It was also expressed in terms of making a clear distinction between community relationships and obligations (such as respect for senior family members) and the need to settle issues in one's work role (for example, by arguing with a senior person, or making a decision that person does not agree with, or failing to employ family members). The third category was *integration*, that is, adapting and transferring management techniques between domains (for example, finding ways to engage communities in formal budget-setting processes). The final strategy type was *compromise*, that is, finding a middle path to partly satisfy two conflicting sets of needs or obligations.

In a related paper (Hill *et al*. 2001), the authors focused on the managers' use of oppositional tactics in support of their pursuit of community interests and ways. In the conclusion to this paper, the authors noted the importance of opportunities to tell stories of strategies and tactics, and the possibility that while oppositional behaviours are largely unable to change the power relationships (and, we would add, their success depends largely on not doing so), oppositional narrative has 'the power to seduce the reader' and thereby change the reader's perspectives (Hill *et al*. 2001:478).

In another related paper, Angus (1999:28) comments on the 'thin white line' of non-Indigenous middle managers/health professionals in many health services. These are staff positioned between Aboriginal and Torres Strait Islander senior managers at the top, and the predominantly Aboriginal and Torres Strait Islander 'bottom stratum of the workforce'. This paper outlines strategies for improving the recruitment and retention of Aboriginal and Torres Strait Islander managers in health organisations.

In a personal reflection based on his experiences, Dr John Wilson (2001) identified three key management issues facing healthcare managers: reconciling client and staff expectations with resources and practice constraints; reconciling community control ideology with requirements for a skilled and expert workforce (and the need for technical knowledge for decision-making); and 'reconciling the complexities of health status determinants… with the need for a clear bounded organisational vision' (Wilson 2001:138). He argued that effective services need focused and strategic application of resources and pragmatic and culturally appropriate management practices.

Taylor *et al*. (2001) highlighted the difficulties of community-controlled health service management operating within a dominant Western framework based on contractualism, privatisation, competition and a health outcomes focus.

In an interesting personal perspective, Armstrong (2003) defined three key areas for building Aboriginal and Torres Strait Islander capacity: governance (the heart), strategy (the brain) and finance (the backbone). Armstrong identified two categories of barriers to effective financial management. Internal barriers are the lack of understanding of the role of the board, the lack of strategies and business planning, and the lack of financial management skills. External barriers are 'conflicts between cultural values and financial accountability' (Armstrong 2003:6), problems of loss of experienced board members due to turnover (and lack of a ready pool of experienced new members), inflexible reporting formats and language barriers.

Williams, Thorpe and Chapman (2003) studied the history, work and occupational health and safety of Aboriginal and Torres Strait Islander workers and managers in South Australia. They used the concept of emotional labour, that is, the 'way certain jobs require employees to use, but also control, their own emotions

to deal with their clients' (Williams, Thorpe & Chapman 2003:49), and also introduced the term 'obligatory community labour' to describe the work involved in responding to the needs of extended family and friends within the Aboriginal and Torres Strait Islander community—a set of obligations that are qualitatively different to those applying to non-Indigenous staff (Williams, Thorpe & Chapman 2003:51–2). They interviewed 133 Aboriginal and Torres Strait Islander workers in South Australia, and assessed their levels of exposure and harm from occupational health and safety risks. They described the 'cultural borderland' (between Western medicine and the Aboriginal and Torres Strait Islander communities) that is occupied by Aboriginal and Torres Strait Islander Health Workers (Williams, Thorpe & Chapman 2003:65). The Aboriginal and Torres Strait Islander managers (in both Indigenous-specific and mainstream organisations) were the group under the most pressure, and most of them had an occupation-related illness or injury. The managers spoke of work overload, of stress and exhaustion, of bullying and abuse, and of racism and shame (arising from being treated with a lack of respect). They noted that Aboriginal and Torres Strait Islander managers had jobs with high demand and often low levels of control (arising from having to respond to the demands of both non-Indigenous superiors and Aboriginal and Torres Strait Islander board members and managers) (Williams, Thorpe & Chapman 2003:108).

There is also a more extensive literature of Aboriginal and Torres Strait Islander governance, but it is focused more on community governance (that is, the arrangements by which a community or region governs its local affairs) than corporate governance (that is, the way in which an organisation is directed and controlled). This literature includes some relevant considerations of the relationships between Aboriginal and Torres Strait Islander community structures and processes and organisational management (in particular, Martin 2003; Smith 2005; Sanders 2006; Sullivan 2006). We do not attempt to review this literature here, but will refer to it in the body of this report.

Most of the studies reviewed above focus on the particular dilemmas for managers of Aboriginal and Torres Strait Islander health organisations arising from the position of these organisations at the interface between mainstream and Aboriginal and Torres Strait Islander structures and processes. The challenge of effective service delivery in environments constrained by inadequate capacity and resources is a related recurring theme. We return to a consideration of this literature in relation to our project in the discussion of our methods (Chapter 3) and the implications of our research results (Chapter 6).

Conclusion: Aboriginal and Torres Strait Islander health and self-determination

The need for better healthcare for Aboriginal and Torres Strait Islander peoples has a long history, but it was not until the struggle for self-determination in the 1960s and 1970s that health services specifically designed to respond to that need were established. The ACCHS sector continues to combine the goals of better health and healthcare with the principle of self-determination, expressed as community control. While there are several different approaches under this principle (Shannon & Longbottom 2004), there is a common commitment. The challenge for health service boards and chief executive officers (CEOs) in this context is to deliver effective healthcare and to assist their communities in making effective use of the mainstream healthcare system. To be able to do this, they need to achieve good governance and management as defined by the funders and regulators of the sector, and also to find ways of giving expression to the priorities and goals of communities as determined by Aboriginal and Torres Strait Islander peoples. This project seeks to contribute to addressing that challenge.

Chapter 2: The Project — Aims, Setting and Participants

This chapter describes the origins of the project, what we set out to achieve, and the establishment of a partnership with Queensland Aboriginal and Islander Health Council and the twelve senior managers who participated as learners and co-researchers in the project.

Aims and scope

The intention of this learning and research project was that it would describe the management challenges faced by senior ACCHS managers and would do so in a way that would enable participants to share and build their knowledge and skills. On the research side, we wanted to collect first-hand information about management practices and problems, rather than make assumptions about areas of strength or areas on which improvement effort should be focused. This approach is intended to provide information relevant for policy-makers within the sector and in government; and to lay the foundation for further research that would aim to develop, trial and evaluate management models, methods and tools tailored to the needs of small to medium agencies in the Indigenous-specific primary healthcare sector, with a particular focus on ACCHSs.

We were also interested in exploring the corporate governance challenges of ACCHSs from the perspective of the management level (by 'corporate governance' we mean the system of control and accountability for the organisation). We expected that the managers' experiences would give insight into governance processes and structures, because it is managers who are responsible for the implementation of governing policies and decisions. They are the interface between the governance level and the delivery of healthcare, and they work at the level of the organisation where the impact of governance structures and processes is played out.

The project was funded by the Cooperative Research Centre for Aboriginal Health (CRCAH), which had decided that primary healthcare would be one of its five main programs of research effort. Within that program, ways of improving the overall effectiveness of primary healthcare services for Aboriginal and Torres Strait Islander communities was to be an important focus. La Trobe University, Flinders University and QAIHC also provided resources for the project.

Beginnings

The project leaders (CS and JD) had worked together preparing papers for OATSIH as part of an Australian Government Interdepartmental Primary Health Care Review in 2003. This work strengthened our interest in exploring the experiences of managers of ACCHSs, as we believed that their collective knowledge would provide a reliable base for work to improve organisational effectiveness. The project was funded by the CRCAH, to commence in 2004, and SG was recruited as the project officer. Initial approaches were made to NACCHO for support and input into the recruitment of managers to the learning sets. At the time, however, NACCHO was unable to provide a commitment in this regard due to timing and other issues, including its own approaches to OATSIH for funding to progress an agenda in relation to the governance of ACCHSs.

QAIHC had for some time been considering new ways of supporting and developing the skills of managers in its member organisations, particularly the concept of a regular forum at which problems and challenges could be shared, and expert support and guidance offered. QAIHC was, therefore, interested in what this project offered, and it already had a strong basis of trust and respect with one member of the research team (CS). We also discussed the possibility of extending the project to include the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), but the project's learning goals were seen to overlap with existing educational and development programs offered by VACCHO. Consequently, VACCHO remained an interested stakeholder in the project, but project activities were conducted only in Queensland.

Partnership with Queensland Aboriginal and Islander Health Council

Following endorsement of the project by the QAIHC Board of Directors, a formal partnership agreement between QAIHC and the research team was developed during 2004, and the project commenced with its first workshop in March 2005. Under the terms of the partnership agreement, QAIHC agreed to take responsibility for inviting participation, coordinating workshop arrangements (travel, venues, dates, accommodation) and directly engaging a workshop facilitator (CS). The team (JD, CS, SG) was responsible for the design and delivery of the workshop content and the conduct of the research aspects of the project.

The participants and conditions of participation

QAIHC invited senior managers of its member organisations and two senior staff members of QAIHC to participate in the program. Those who accepted this invitation were CEOs and deputy CEOs of ACCHSs, and managers within QAIHC. Participants were then offered a series of four workshops (of two or three days each), which would involve a combination of formal learning sessions and interactive 'learning sets' (see below for explanation). They were also offered the option of academic credit for participation (under certain conditions).

Participants were actively engaged as co-researchers in the project in several ways, which are explained in Chapter 3. They were assured of anonymity in the documentation of learning set data, and they engaged actively with the process of giving informed consent to participate. Participants were also asked to enter into a confidentiality contract with each other, to ensure the safety of learning set discussions. They did so willingly and with care, and confidentiality requirements (the 'cone of silence') were often reinforced in discussion during the workshops.

Chapter 3: Methods

This chapter describes how the learning and research program was conducted, and explains the theory on which the approach was based. The setting and participants have been described above.

Principles guiding research with Aboriginal and Torres Strait Islander communities

We aimed to conduct this project in accordance with both formal and informal principles and protocols for working with Aboriginal and Torres Strait Islander organisations and communities. In particular, we sought guidance both from QAIHC and the participants to ensure that the project was conducted with respect for Aboriginal and Torres Strait Islander knowledge and ways, and provided cultural and personal safety for those participating.

More formally, we sought to ensure that the project complied with National Health and Medical Research Council guidelines (NHMRC 2003), including the requirement that research outcomes provide equitable benefits of value to Aboriginal and Torres Strait Islander communities or individuals. Benefits are defined as 'enhancement of capacities, opportunities or outcomes that advance interests', and should be maintained beyond the life of the research through, for example, 'the development of skills and knowledge or through broader social, economic or political strategies' (NHMRC 2003:10–11).

The CRCAH's ethical requirements are consistent with the National Health and Medical Research Council guidelines, and include an obligation to ensure that the results of research are effectively disseminated and made available for use by Aboriginal and Torres Strait Islander communities (CRCAH 2006).

Ethics approval was sought and obtained from the La Trobe University Ethics Committee: QAIHC accepted La Trobe University approval as meeting the ethical requirements of the project in the context of the partnership agreement. The participants engaged in consideration of these issues at the first workshop, and contributed actively to the final wording of the informed consent form for the project.

The learning program

The project was designed as a combined action learning and research endeavour. The learning component was designed to meet the learning needs of the participants in their management roles and had two main parts—formal seminars and learning sets.

Seminars

Participants collectively identified management topics and skills that the formal seminars then addressed; the exception was the first topic (managing money), which the researchers identified. At the first workshop, participants were asked to nominate their individual and collective goals for the project, and to identify the components of their roles and responsibilities about which they were most concerned. Lists were developed on whiteboards, and then checked, grouped and allocated priority in discussion by the whole group. The topics chosen by this process then provided the basis for half-day or longer seminars in subsequent workshops. CS and JD designed and delivered the majority of the content, with additional expert input on two occasions. The seminar topics were:

- Managing money (financial planning and analysis).
- Managing people (recruitment and managing performance).
- Managing strategy (implementing strategic plans; writing feasible plans).
- Managing systems and policy (reading policy and managing partnerships).

Mick Gooda, CEO of the CRCAH, addressed the first workshop on the topic of governance and management in Aboriginal and Torres Strait Islander organisations. Professor Ian Anderson, Director of Onemda VicHealth Koori Health Unit at The University of Melbourne, addressed the final workshop on the topic of 'reading' and working with policy.

Learning sets

Two learning sets (of six members each) were established at the first workshop, and continued to meet for the equivalent of one day at each workshop. In the learning set sessions, which were facilitated by CS and JD, participants presented current challenges or opportunities with which they were engaged, and the group discussed the nature of each problem and potential strategies for addressing it. Care was taken by participants to ensure that presentations did not involve unnecessary disclosure of identifying information (for example, the names of other people). At the end of the discussion, each presenter said what he or she intended to do, and, at the subsequent session, reported back on what had been done and the outcomes.

This method is based on action learning theory (Revans 1982; Schon 1987) and the methods of reflective practice (DeFilippi 2001), and also, in this project, on the Dadirri principles adapted from the writings of Miriam Rose Ungenmerr (n.d.). Action learning methods are based on the principle that managers (or professionals) need to learn their professional practice by confronting and resolving complex challenges that are not amenable to 'text-book solutions'; and from reflecting on, discussing and writing about their thinking, actions and interactions in the context of their work. In learning sets (groups of peers who act as 'comrades in adversity'), managers typically report that they get valuable learning from:

- the discipline of framing and analysing their challenges in order to present them as part of set meetings;
- the insights of trusted peers into the learner's typical habits of thought and action, assumptions, oversights, blind spots or reliance on a tested 'bag of tricks';
- the knowledge and experience of set members applied to the learner's situation (both revealed in discussion and shared through giving access to each other's resources and networks);

- the formulation and testing of an action plan with set members;
- the process of reflecting on set discussions and the realities of their situations ;
- the process of reporting on actions and results some time later, thus closing the loop on the problem story;
- the process of engaging with the challenges and situations of others, and observing common patterns and differences; and
- the support and encouragement they experience from being able to discuss their problems in a 'safe' environment, entirely separate from the workplace and their line managers or boards.

Academic credit

An academic unit of postgraduate study was developed by the research team and accredited by La Trobe University; it was based on the learning program of the workshops and completion of a written assignment (either a project report on work arising from the issues discussed in learning sets, or a critical reflection on the management of one of the learner's own issues). Partial scholarships were offered by the Faculty of Health Sciences at La Trobe University and remaining fees were covered by the project budget. Five participants chose to enrol, and three completed and passed. The academic credit is equivalent to 25 per cent of a graduate certificate in health services management. This aspect of the project was a high priority for QAIHC, which is also pursuing discussions with local universities to build on this beginning towards formal management qualifications for its members.

All participants who attended three or more workshops were presented with a La Trobe University/QAIHC certificate of completion, and those who participated in two workshops received a certificate of participation.

The research method

Our research goal was to identify and explore the management challenges faced by senior managers in ACCHSs. The research component of this project is based on the 'stories' of problems or opportunities that the managers presented and discussed in learning sets. We chose this method because it had strong synergy with the learning goals of the project, and because the information it generated was seen as having high validity. That is, the context encouraged participants to focus on the issues that they wanted help with—the current issues in their organisations that were challenging or difficult for them—rather than focusing simply on their opinions or beliefs about management challenges.

We used grounded theory method (Strauss & Corbin 1990); that is, we developed the categories and themes 'from the data' rather than by filtering or organising the information we gathered in accordance with a pre-determined set of categories. Several of the published studies on Aboriginal and Torres Strait Islander health management reviewed above (Angus 1999; Wakerman *et al*. 2000; Hill et al. 2001; Taylor *et al*. 2001) were focused on some aspect of what makes Aboriginal and Torres Strait Islander management 'different'. We set out simply to investigate the nature of the challenges the managers face, while being alert to their contexts.

Data gathering

During learning set meetings, detailed notes of the stories, the discussion and the presenters' intended actions were entered into laptop computers; entries were made by a member of the team (SG) for one set and by a sessional research assistant for the other set. The note-takers sought to record the key points of each issue, the context, the contributing factors to the problem or opportunity, the possible options for action and the presenters' stated intentions. Immediately after each workshop, the facilitators of the sets read the notes and clarified any points of ambiguity or confusion. The team worked together on the notes to produce structured summaries, so that each story had a title, a problem definition, a body, a list of intended actions and a set of 'themes'—that is, important elements drawn out of the story. We use the term 'themes' in a way that is different from its meaning in much qualitative research in healthcare, in which the words of interviewees are recorded and analysed through the identification of common ideas or themes emerging in that material (see, for example, Liamputtong & Ezzy 2005:257–85). In contrast, we developed 'themes' as structured elements of the stories we had recorded, and then grouped them into categories in various ways, which are explained below.

One of the challenges in defining the themes was to express the content in a way that would prevent identification of the setting, while not losing the specific meanings. We decided to err on the side of specificity, and to audit the presentation of results to ensure absence of potentially identifying features. Each story summary was checked by the relevant participant, who was also invited to correct it. Several did so, and the amendments—which were uniformly of a clarifying or factual nature, with no sense of movement away from the meaning or import of the story as told—were incorporated into the database.

Because of the confidentiality requirements of the research, the team had decided that the stories themselves would never be reproduced, even with the identifying details removed. This was clear to participants from the beginning, and we instituted strict control procedures on copies of the stories.

Data analysis

The researchers conducted preliminary thematic analysis and grouped the themes into categories after each workshop. We then reported cumulatively on the themes emerging at each subsequent workshop. Participants were asked to affirm (or otherwise) their agreement that the themes were an accurate reflection of the meanings of the stories as they knew them, and to engage in discussion on their meaning and import. Notes of these discussions were taken and used to refine the analysis as the project progressed.

Initially the themes were simply a list of the major problems or opportunities and related factors. As the body of material developed, the team developed a more structured format for the themes, and they were then organised (or, for the data from the first workshop, reorganised) into the following categories:

1 Main problem, challenge or opportunity.

2 Causative or related factors.

3 Strategies for resolving the problem or exploiting the opportunity.

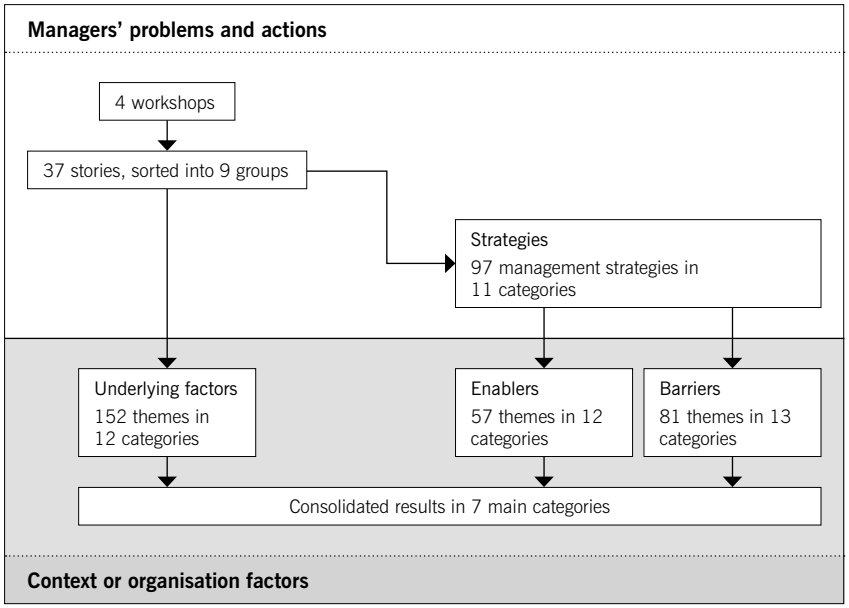
4 Factors that act as enablers or barriers to the strategies.

At subsequent workshops, when the participants gave reports about what they had done and the outcomes, notes were taken and incorporated into the data analysis, but additional themes were not created from this material. The outcomes were simply noted in the data on the strategies, and used to inform our understanding of the use and success of the strategies. Approximately six months after the final workshop an email was sent to each participant who was contactable at that time (eight of the ten who participated in the final workshop). The email requested a brief report on what each participant had done about the challenge he or she had raised in the final workshop and the outcome.

Thematic analysis was conducted on each of the four main groups of themes—that is, the primary problem or opportunity, the underlying or contributing factors, the strategies, and the enablers and barriers. As explained above, the themes were generated through a discussion and consensus approach among the three researchers, and subsequently checked with the participants and amended as requested by them. The grouping and analysis of the themes was conducted initially by JD, and checked by CS and SG. Amendments were made on the basis of discussion and consensus, both initially and as the material accumulated and new themes and groupings emerged.

The goal of this analysis was to generate an understanding of the nature of the challenges, problems and opportunities that managers in Aboriginal and Torres Strait Islander health services face, and the contributing factors that underlie or exacerbate the challenges and help or hinder the ability of the managers to resolve them. The expectation was that the underlying factors, together with the enablers and barriers, would give a realistic representation of those aspects of the organisations and their operating environments that give rise to management challenges or that affect the organisation's ability to achieve its goals. That is, while the 'presenting problems' of the stories (and the strategies the managers intended to use to attempt to resolve them) tell us something about the managers' focuses and practices, the underlying factors and the enablers and barriers tell us about the organisations—their situations, resources, strengths and weaknesses.

FIGURE 1: Data analysis



After completing the analysis of each of the groups of themes, we then compared the underlying factors, the barriers and the enablers, and grouped them to identify the major issues emerging from the data. We report on the relative strength or weight of the various themes, but do not suggest that the relative weights are representative of the field.

The focus on problems or challenges could be seen as unduly negative. However, problems that managers find difficult to resolve provide opportunities both for learning and for insight into areas where improvement efforts should be focused. We balanced this potentially negative focus with attention to the strategies that managers used to address their problems, and the enabling factors that assisted them. We also note that there was no intention to evaluate or assess the effectiveness of the managers—we sought only to understand and document the challenges they face.

Comparison with mainstream learning set themes

During the period of the research, one member of the team (JD) also conducted a learning set for senior managers in the mainstream health system. With the permission of participants, she kept notes of their stories and prepared a summary of the main problems, challenges or opportunities for comparison purposes.

Participant evaluation

Participants were asked to complete evaluation questionnaires for each workshop. The questionnaires asked the participants to respond to statements about the workshop content and process on a Likert scale from 0 to 4 (0 = poor and 4 = excellent). There were some statements that varied across the workshops, reflecting differences in structure and content of each workshop, but a sub-set of standard statements was included in each questionnaire. Ratings of the variable statements were used by the team to review and refine the workshop design. Ratings of the standard statements regarding the seminars, learning sets and the workshops as a whole for the four workshops were collated, and are reported in Chapter 4.

Chapter 4:
Learning Results

This chapter presents a summary of the participation by the managers in program activities, their satisfaction with the learning aspects of the project and the outcomes of formal study.

Participation

A total of thirteen managers (eight women and five men) attended at least one workshop. One person attended the first meeting, but did not return. Four people attended two workshops—two of them left their original roles and organisations, but returned to the program in new roles after a break; one person retired from a management role after the first two workshops; and one person attended the first two workshops and did not return for the final two. Eight people attended at least three of the four workshops. In total, there were thirty-seven presentations at learning set meetings, and twenty-four reports of action and outcomes at subsequent meetings. The number of presentations is one higher than the number of attendances shown in Table 1 because one participant presented two problems in one session.

Eight of the ten participants in the final workshop were emailed their story summaries, along with a request for a brief email response outlining the action and outcomes of the situations presented in their final stories (two were omitted because they were on leave at the time). Four responses were received and included in the analysis, bringing the total number of reports back to twenty-eight.

Participation at each workshop (with notes on absences) is summarised in Table 1.

In all, four participants experienced a job change or moved from an acting to an ongoing appointment during the nine months of data collection. Three were in acting positions during at least part of the period. There were two resignations from CEO or acting CEO roles during the period, and one retirement (an annual exit rate of 23 per cent).

Satisfaction with the learning program

All completing participants were very positive about the experience of the project, including the seminars and the sets. The evaluation questionnaires were completed by the participants after each workshop, and thirty-two of a potential thirty-six were returned (89 per cent). The responses to the standard statements included in each of the four questionnaires are analysed below.

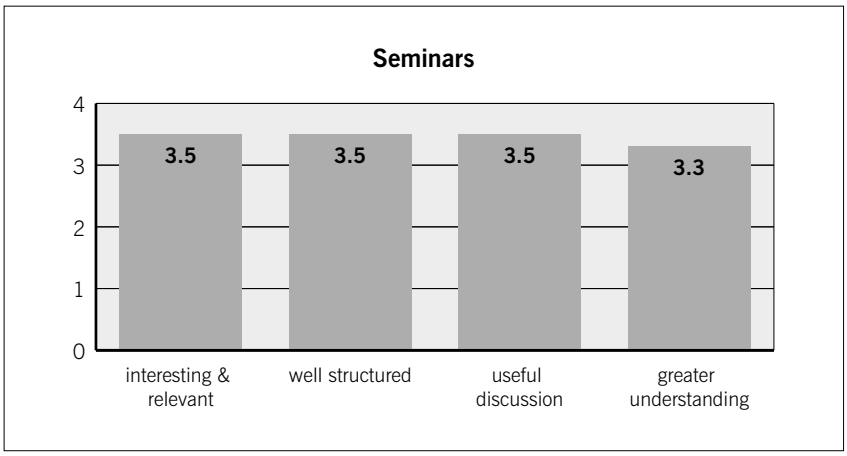
TABLE 1: Participation at workshops

Workshop	No. present	Comments
1	9	4 people unable to attend due to short notice
2	10	1 person dropped out; 2 unable to attend
3	7	change of venue and arrangements affected attendance
4	10	1 person retired; 1 dropped out; 1 unable to attend
TOTAL	**36**	

Seminars

Over the four workshops, the average score in response to statements about whether the seminar sessions were interesting and relevant, well structured and provided useful discussion was 3.5 (or 87.5 per cent of the maximum score available). An average score of 3.3 (or 82.5 per cent) was obtained in response to whether the session led to a greater understanding of the topic covered in the seminar.

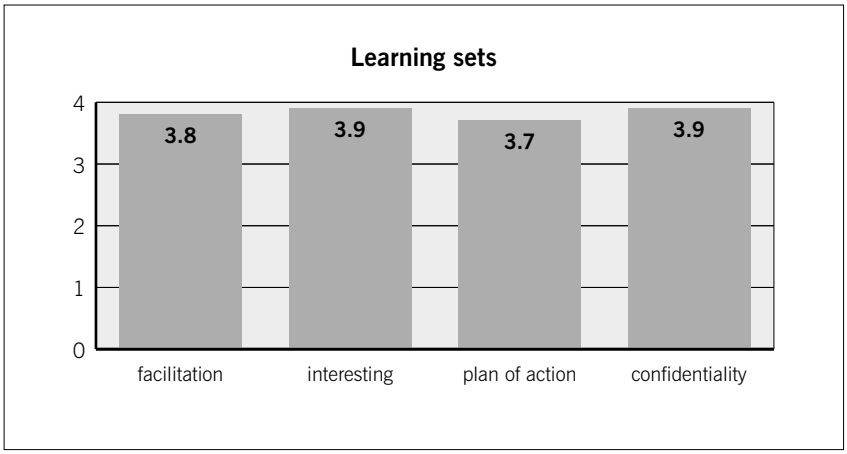
FIGURE 2: Seminar feedback results



Learning sets

The learning sets scored very highly, with an average over the four workshops of 3.8 (95 per cent) for the facilitation of the session, 3.9 (97.5 per cent) for interest in working with other people's problems, and 3.7 (92.5 per cent) for having a plan of action to address the issue raised. An average score of 3.9 (97.5 per cent) was obtained in response to the participants feeling okay about the confidentiality aspect of the learning sets.

FIGURE 3: Learning set feedback results

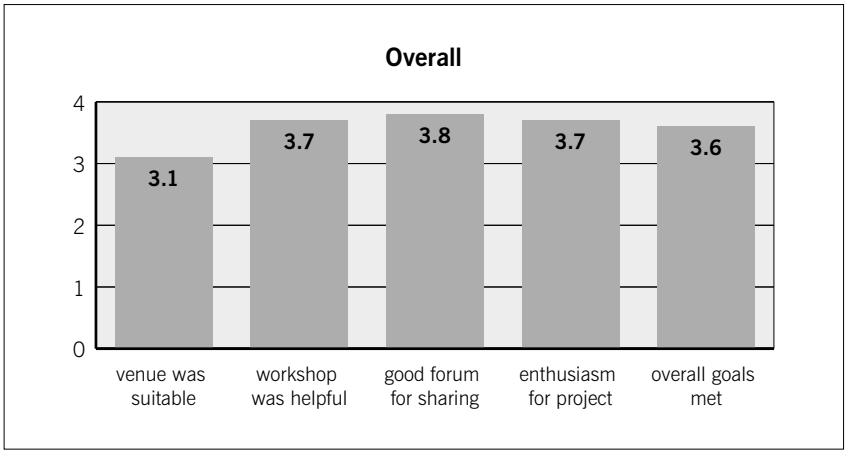


Workshops overall

An average score of 3.1 (77.5 per cent) was obtained regarding venue suitability: this reflected some difficulties with the venue for Workshop 3, which was subsequently changed for Workshop 4. Average scores of 3.7 (92.5 per cent) and 3.8 (95 per cent) were obtained respectively in response to whether the project workshops overall were (1) helpful and (2) provided a good forum for sharing. Enthusiasm for the project remained high throughout, with an average score of 3.7 (92.5 per cent). A score of 3.6 (90 per cent) reflected that the participants' overall goals for the project, as identified at Workshop 1, had been met.

These results indicate a generally high level of satisfaction with the program, but do not of themselves confirm learning outcomes. Longer term follow-up with the participants would give an indication of their more considered assessment.

FIGURE 4: Workshop feedback results



Formal study outcomes

Three participants achieved postgraduate academic credit for their participation and written work, equivalent to 25 per cent of a graduate certificate in health services management. Eight participants received certificates of completion (on the basis of participation in at least three workshops), and three received certificates of participation (two workshops).

Chapter 5:
Research Results

In this chapter we first describe the nature of the primary problems or opportunities that formed the basis of the managers' stories. We examine the underlying factors as a group, in order to develop a picture of the causes of the problems managers face (and the related organisational vulnerabilities). We then describe the nature of the strategies they intended to use, and examine the factors (enabling and impeding) that were seen as likely to influence their success. We report briefly on the implementation and outcomes as noted in subsequent learning set sessions. Finally we bring together the underlying factors, the barriers and the enablers to generate an overview of the major organisational issues and challenges emerging from the managers' stories.

The challenges

The thirty-seven problems or challenges discussed in the workshops fall into nine main groups. The groupings are based on the content of the stories, and the team's understanding of the main issues as framed by the managers and tested by the learning sets.

The groupings and the defining problems are outlined below in order of frequency. The codes in brackets refer to the individual and the workshop at which the story was presented. Thus, '101' refers to the story presented at the first workshop by the participant coded 01.

Managing staff (eight stories)

Not surprisingly, the problems most frequently raised by the managers related to the challenges of managing staff. In two cases [111 and 210] there was a problem of non-compliance by staff with policies and procedures in relation to the management of leave and other workplace entitlements. Other issues involved dealing with staff who challenged the authority of their managers [412], or whose attendance and effectiveness were compromised by chronic illness [201], or who habitually found and stirred up potential trouble [205]. The struggle to find effective ways of delegating work in small teams with high workloads and varying skills [302, 402] was the subject of two stories. One participant discussed the hostile aftermath of a complaint about co-workers in a mainstream organisation [413]. The managers were generally concerned about the impact of these problems on performance, and in two stories in this group there was an explicit focus on the shortage of supply of skilled workforce [201, 402].

Managing the organisation (six stories)

Managing the organisation was among the biggest challenges the managers faced, with three managers reporting a sense of organisational dysfunction; poor or underdeveloped structures, policies and practices; and reduced effectiveness of service and program delivery as a result [213, 406, 407]. Other stories concerned the challenge of managing teams at remote sites [413], and of working with other organisations in a framework of mutual accountability when relative roles and responsibilities are not clear [202, 309].

Managing relationships with the board (six stories)

Six stories focused primarily on the task of managing relationships with the board. This relationship is a critical one for managers, and its importance is reflected in three stories of tension or lack of support for the CEO in exercising his or her role, and intervention in day-to-day management [101, 212, 203]. Difficulties in managing conflict-of-interest situations (where board members have family members on the staff) were the primary problem in one story [401], and one manager spoke about the challenge of ensuring appropriate training for the board in its role [204].

Working with external partners (five stories)

Five stories focused on challenges arising from the need to work with other organisations—in order to deliver primary healthcare in small communities, to ensure that Aboriginal and Torres Strait Islander interests are addressed in mainstream organisations, and to influence decisions of government authorities. These tasks are a significant workload for managers, and smaller organisations seemed to have a disproportionately high burden in this area. Three stories focused on working and negotiating with governments (local, state and federal) to ensure that community priorities were addressed in partnership arrangements [108, 112, 408], while two were about working with other healthcare organisations to achieve common goals or to share facilities [109, 410].

Managing oneself in the job (four stories)

Four stories focused on the challenge of the job itself and the experience of the manager. In these stories the core problems were in the transition between CEOs. The difficulty for boards in managing the exit of longstanding CEOs or in managing extended periods of leave for CEOs facing personal problems is highlighted in these stories [106, 306, 107, 105]. This is an expected difficulty since, by definition, boards cannot depend on their CEOs to drive action on these issues (as they can with almost everything else). The managers who were acting in CEO (or assistant) positions reported the experience of not getting the needed support; of not having anyone appointed to their substantive positions (and, therefore, carrying extra workload or having no second person to 'check' financial transactions); of missing out on proper handover and induction processes; and of having to deal with unpredictable engagement by absent CEOs in difficult matters that the acting CEOs were trying to manage.

Managing finances and funding (three stories)

While difficulties with managing within the budget were commonly occurring factors in the managers' stories, only three were focused primarily on funding issues. Each of these was about difficulties caused by the complexity of managing multiple short-term funding sources/programs. One manager faced a serious challenge with short-term project funding making up most of the budget for the service (and the resulting difficulties in getting and keeping staff in a situation of workforce shortage) [208]. Another was seeking a way to negotiate how to carry over funding that had not been spent within the first year of a three-year program (and recruitment problems were an issue here as well) [304]. The third story concerned several ACCHSs missing out on a component of available funding—some seemed to be unaware of the funding, and others were uncertain about the process for claiming the money [409].

Managing the role of Aboriginal Health Workers (two stories)

Two stories concerned the expanding role of Aboriginal Health Workers (AHWs) and the challenge for these staff to accept, and adapt to, change in their accountabilities and roles. In one case AHWs were seen not to be performing at the required level in the delivery of health promotion programs [212.1]; in the other, AHWs were reluctant to take on emerging roles in chronic disease management [301]. In both cases there was a sense that some of the AHWs were either failing to comply with policies and procedures, or actively resisting change.

Managing non-Indigenous staff (two stories)

There were two stories dealing with particular difficulties for managers in working with non-Indigenous management staff. These stories could logically be grouped with the 'managing people' group but are discussed separately because, in both cases, the problems were partly shaped by the pervasive influence of race and culture (for example, as seen in the relative ease for non-Indigenous ACCHS staff in relating to the non-Indigenous staff of funding bodies).

There was an element of power struggle in both cases, with one person seeking to avoid line management accountability to the CEO by using credibility with funding bodies and an external reference group [312], and the other resisting the change resulting from the arrival of a new CEO who had a more active management approach [310]. The impact of conflicting culturally based approaches to management, and to the resolution of differences, is evident in these stories.

Valuing cultural knowledge (one story)

This story was unique in raising explicitly the problem of the value of 'cultural knowledge', and the role of cross-cultural training, both within ACCHSs and between ACCHSs and the mainstream [209]. There was a sense that there has been a shift in recent times in Aboriginal and Torres Strait Islander organisational practice, with more emphasis on mainstream management skills and approaches, and less focus on 'Aboriginal and Torres Strait Islander ways' of working. It was felt that a focus on culturally based practice has given way to more mainstream approaches and that there is a lack of understanding of the community struggles and political issues that have laid the foundation for the ACCHSs. There was also a concern that the work of providing cross-cultural training to mainstream organisations was seen as being of less strategic importance than it had been in the past.

Comparison with mainstream learning set stories

The mainstream learning set had six members, all of them senior managers in public health organisations in Australia and New Zealand, with only one of them reporting to a board of directors. The set met four times over a twelve-month period with JD as facilitator. The method was the same as applied in the project sets, the only difference being the absence of a note-taker. The facilitator took brief notes of each problem as it was presented, and of the reporting back at subsequent meetings. Of a potential twenty-four attendances, there were twenty-one. The problems or challenges the participants discussed fell into the categories and distribution as shown in Table 2.

The human resources (HR) issues included managing poor performance or conduct by staff (three stories), conflict with peers within the organisation (three stories) or leaders in the broader system (one story), and resistance to role change (two stories). The five challenges in managing the participants' own jobs or careers were largely related to the opportunity or need to make new

TABLE 2: Mainstream learning set stories

Category	No.
HR management	9
Managing the job/career	5
Organisation strategy and structure	4
Workforce	2
External relationship	1
TOTAL	**21**

career choices arising from organisational restructuring in the public system (four stories); one story concerned a strategy for retiring.

The four stories about organisational strategy and structure related to the impact of amalgamations (two stories), the lack of a local management structure within a large health service (one story) and the challenge of overall strategy development for a new CEO (one story).

The workforce problems concerned the availability of medical staff willing to work in the public sector (two stories).

The external relationship issue was a conflict between the public health service and private providers about the 'ownership' of certain community-based services.

There are strong similarities in the range and relative weight of the primary problems or challenges that the members in the project sets and this set discussed, notably the predominance of HR management problems and the challenge of managing one's self in the job or one's career. Apart from the absence of board considerations, other differences include the absence of the need to deal with community relationship issues or with issues of race and culture. The mainstream managers did encounter problems of power and working with partners, but they were more likely to be located within the large health services in which these managers worked, rather than with external organisations.

Moving from the stories to why they happened

Because of the sensitivity of much of the information participants gave us, and the ease with which knowledgeable readers would identify (rightly or wrongly) the settings and the individuals, we have not presented any stories in this report. The brief descriptions above are intended to give the reader a sense of the territory that the stories covered. The analysis that follows is designed to make explicit the forces and factors that lie beneath the stories—that is, to answer the question of 'why did these problems happen'. This is where we want to focus—on understanding the conditions and forces acting on the organisations and the managers that lead to management problems. So in the rest of this chapter, we analyse the 'themes' that we extracted from the stories, in an effort to share and draw out their explanatory power. There is a lot of detailed information. At the end of this chapter, we attempt to summarise its meaning through analysing the common themes in the underlying factors (including the barriers and enablers that helped or hindered the managers when they acted to resolve the problems or take advantage of the opportunities).

Underlying or contributing factors

There were a total of 152 factors arising from the thirty-seven stories. They were grouped into twelve categories, distributed as shown in Table 3. A description of the nature of these categories and themes is presented below.

TABLE 3: Underlying or contributing factors

Category	No.	%*
HR management	35	23
Organisational capacity	20	13
Funding and funding body relations	15	10
Race and culture	14	9
Board: CEO relationship	13	9
Partnerships and power	10	7
Workforce	10	7
Community and family relationships	9	6
Board capacity and workload	8	5
Organisational structure and systems	8	5
AHW role	5	3
Community capacity and tensions	5	3
TOTAL	**152**	**100**

**Note: Percentages are given for descriptive purposes only—no statistical significance is implied in quantitative data in this study.*

Human resource management

There were thirty-five themes in this category, spanning eight of the nine story groups (eighteen stories). They are presented here using sub-headings, with the relevant number of themes shown in brackets.

Employee conduct (nine)

Problems with staff compliance with their obligations as employees, or willingness to accept policies and procedures and management decisions, were the most common themes (five), along with inappropriate use of all-staff meetings (one), small-scale misuse of funds and resources (one), disloyalty to the organisation (one), and the problem of deciding whether to act on a small but niggling conduct issue (one).

Performance management (six)

This was a diverse group, with themes relating to the lack of a performance management system; inappropriate practice in managing the performance of the CEO by the board; inflexibility in objective setting; failure to recognise the impact of illness on performance; the workload for the CEO in managing poor performance; and one case of poor performance by someone who had been promoted beyond his or her capabilities.

Organisational climate (four)

This group is made up of acceptance of poor practice arising from previously ineffective or authoritarian management (two), perceptions of unfair treatment among staff, and discomfort arising from a shift in leadership style.

Problems with role definition (four)

Three themes concerned the lack of clearly defined roles for an assistant manager or team leaders (and the resultant conflict between staff); one concerned a finance officer who needed to take on broader roles because the finance work in a small agency was not sufficient to occupy them.

Staff development needs (three)

This group is made up of a lack of induction processes, lack of ongoing professional development opportunities for health workers, and the need for support and mentoring for a new manager.

HR policies and procedures (three)
These themes concerned lack of procedures, the problem of the effect on all staff of overly 'tight' procedures enacted because of poor compliance by a few, and the need to manage cultural leave for family and community obligations with respect but also with proper accountability.

(Mis)use of longstanding relationships (two)
There were two themes related to the use of longstanding relationships with the (retiring or former) CEO or with board members to undermine or circumvent the manager's authority.

Staff skills (two)
In one case a staff member with a strong practice background lacked the policy skills needed in the current role; the other concerned a group of staff members who required 'upskilling' to take on new and more complex duties.

Workload for managers (two)
Two themes related to workloads that were too high for managers.

Organisational capacity

Twenty themes across all story groups focused on challenges or problems in the capacity of the organisations. Six of these were directly concerned with clinical/health program capacity: the ability to deliver clinical services in small communities and/or small organisations; the effectiveness of small health promotion programs; the lack of a codified body of knowledge in health promotion specific to ACCHSs; the difficulty of finding the right balance between acute clinical care and comprehensive primary healthcare; the challenges of taking on services without experience; and concern about the effectiveness of a split between health promotion (provided by the ACCHS) and clinical services (provided by Queensland Health) for the one community.

The remaining fourteen themes relate to capacity problems common to small community-based organisations. Four concerned the workload for managers arising from a lack of 'backfill' in support roles, growing pressure for services or the backlog that greeted the CEO on appointment. Three concerned having only one or two people with certain skills or roles (for example, in finance or HR). The difficulty of coping with rapid growth affected three stories. Other themes were failure to capture all available sources of funding; over-reliance on external support for basic management functions; and, more generally, the lack of capacity to implement plans and strategies in a timely way. The final theme was the critical need for support in managing the interface with funders, and their expectations and requirements.

Funding and funding body relationships

There were fifteen themes arising from funding, and relationships with the funding body. Six concerned the challenges of managing short-term project funding and reconciling funding cycles with implementation realities and business plans (four), of absorbing the terms of contracts properly, and of the related constant requirements for proving the value of services. These factors were all seen as a drain on management resources. Negative relationships with funding bodies/officers were a feature of five themes: the use of audits as a method of control; the large impact of attitudes of individual staff of the funding body; use of inappropriate communication channels with the organisation; the experience of funding cuts due to funding officer perceptions of incompetence or non-compliance; and failure of funding body staff to pass on community complaints to the organisation concerned in accordance with established protocols. The other four themes were the impact of timing delays in decision making by the funding body; the problem of being highly dependent on government grants; the impact of vertical program funding on accountability lines; and the complexities of having two major funding bodies (national and state levels).

Race and cultural issues

There were fourteen themes (arising from nine stories in seven story groups) that related specifically to issues of race and culture. Eight of these themes addressed difficulties associated with non-Indigenous staff in ACCHSs (including the lack of a career path for them) or in partner organisations (five) or non-Indigenous board members (one); and the general impact of cross-cultural interactions (two). Two themes were about cultural

brokerage—both a declining focus within ACCHSs on cross-cultural training, and high expectations of Aboriginal and Torres Strait Islander organisations to provide such training for the mainstream without adequate respect for the knowledge and skills involved. One theme was the perception of undervaluing of community and traditional knowledge compared with bureaucratic and mainstream knowledge. Another theme concerned problems arising from the different perspectives of those people with community and political backgrounds and those with more bureaucratic and mainstream backgrounds. Two themes concerned the challenges of reconciling professional practice in HR management with community expectations, and of managing senior community people in relatively junior organisational roles.

The board: CEO relationship

There are thirteen themes in this category, drawn from eleven stories across five different story groups—the board, organisation, staff, non-Indigenous staff and 'managing the job' groups. Six themes concerned lack of support or understanding about the role of the CEO by the board, as shown by failure to support the CEO's authority (two), failure to put the CEO on the appropriate pay scale (one), bullying behaviour (one), unreasonable denial of access to leave (one), and lack of support for the CEO due to the legacy of a contested CEO appointment (one). The challenge for boards that face tough decisions about incumbent CEOs and the resultant delays were factors in four stories. The challenge of moving between board and CEO roles was a factor in two stories, and, in one, a board member was directly involved in staff appointments (in ways that breached basic HR principles).

Partnerships and power

Ten themes (arising mostly in the 'external relationships' group of stories) were about the problems of partnerships and power relations. Four themes concerned the imbalance of power between small ACCHSs and their funding bodies or other government authorities. Two concerned the implications for community control of working in partnership for service delivery or with a partner with a conflicting approach to governance. There was one in which the partners' lack of a common understanding of the primary healthcare model was a factor, and one was concerned with lack of clarity about relative responsibilities. The final two were about the complexity of multi-party agreements and the problems arising from differences in views about what services should be delivered in a community.

Workforce

Ten themes across seven story groups concerned the problems of workforce supply. Seven of these were about the difficulty in rural areas of attracting and retaining managers (two), professional staff (four) or both (one). The others were the frequency of serious illness in the workforce (one), the problem of conflicting values in a mainstream organisation (one), and the problem of the capacity of health workers to undertake effective health promotion programs (one).

Community and family responsibilities and relationships

The challenges of combining community and family responsibilities with work responsibilities were seen in nine themes arising from eight stories. The inevitable tensions between two sets of relationships were factors in six stories—the difficulties of managing performance or compliance with policies when family members work together (three), and the situation of members of one family occupying both board and CEO positions (three). Two themes concerned the 'never off duty' experience of being a senior manager in a small community.

Board capacity and workload

There are eight themes in this category, drawn from four stories in the board and organisation groups. They concern the skills and knowledge of board members in relation to the role, differences in the perception of the role, the limited time members have to devote on a voluntary basis, and the difficulties for boards in dealing with conflict of interest issues.

Organisational structure and systems

There were eight themes arising from six stories in which organisational structure or systems were underlying factors. Problems concerned the challenges of responding to new demands or taking up new roles with an old

structure (three), a general lack of structure and systems (two), lack of capacity to delegate to team leaders (one), lack of clarity in the relative roles of the CEO and an advisory committee (one), and the problems arising from lack of a local management structure for a remote team (one).

AHW role

There are five themes in this category, drawn from the two stories concerning AHWs. They addressed the pressure towards increasing professionalisation of the role within multidisciplinary clinical teams, in the context of a historical focus on a narrower range of functions, and of competency-based training programs. The challenges for the current AHW workforce were recognised.

Community capacity and tensions

There were five themes arising from four stories that related to community politics or the lack of resources in small rural communities. The community political issues were ethnic diversity within the local Aboriginal and Torres Strait Islander community and the impact on both staff and services; the impact on relations among staff of conflicts in the community; and a history of struggle over control of the health service. The two resourcing problems arose from the demands on a small number of community members, with varying levels of relevant experience and skill, to support organisations in small communities.

Strategies

After each manager had told the story of the problem that he or she sought assistance with, the learning set offered insights, resources and advice on ways in which the manager might resolve the problem—that is, management strategies. There were ninety-seven strategies identified, and they have been grouped as shown in Table 4.

TABLE 4: Strategies

Strategy group	No.
Developing systems, structures or policies	20
Confronting the issue, bringing into open discussion	18
Working with and through others	12
Pressing on with existing strategies or settings, sticking to the purpose	11
Actively managing staff or performance problems	11
Advocacy or influencing	10
Developing new skills or awareness in others	7
Getting support from QAIHC or others	4
Seeking or using information or guidance	2
Planning	1
Service development	1
TOTAL	**97**

Developing new systems, structures or policies

Strategies that involve organisational development of some kind form the largest group, underlining the need for managers to change the way things are done in order to achieve improvements or resolve problems.

The most common focus of these development strategies (ten) was policy and procedure development for the management of staff, including performance management systems (three of ten). Five of these strategies were directed towards the development of the organisation's structure, including role responsibilities and reporting relationships. The remaining five related to policies and procedures governing relationships with external partners (four) or peers within the organisation (one).

Confronting the issue

Frequently the process of articulating and discussing the problem in the learning set meeting served to strengthen/awaken the manager's determination to act, and a common first step was to bring the issue out into the open. Engaging with the board (seven) or a supervisor (three) was the most common strategy in this group, which is not surprising given that confronting issues with one's superiors is inherently challenging. The remaining strategies in this group required engagement with staff (three), funders or external partners (three) and peers (two).

Working with and through others

Ten of the twelve strategies in this group involved working with external bodies or processes. In six cases the manager needed to work with an external body to establish and/or pursue common goals, while in three cases the manager planned to bring in external assistance or an externally driven audit process to assist in resolving the issue within the organisation. Another strategy involved obtaining funding body agreement to a change in the end-of-year financial acquittal procedures.

The remaining two strategies in this group involved working with internal allies to overcome a difficult working situation (one), and getting top internal leadership support for a preferred outcome (one).

Pressing on, sticking to the goal

Seven of the eleven strategies in this group required the manager to maintain or renew focus on the basic goals in the situation: by sticking to the expressed priorities of the community (two); by focusing on those who are willing to complete training; by vigorous pursuit of needed capital resources; by being willing to go it alone if partners fail; by staying focused on substantive responsibilities when under threat from office politics; and by returning to the proper focus of external reporting requirements (on outputs or outcomes rather than on internal management issues). The remaining four strategies involved persistence: pressing on with an existing strategy (three) or weathering the storm in the establishment period of an organisation.

Actively managing staff or performance problems

Six of this group of eleven strategies required the manager to actively manage individuals, in order to address performance (two) or conduct (two) problems, or, more positively, to develop skills and confidence (two). In addition, for one of the performance-related problems, a contingency plan to cover a likely vacancy in an area of high workload was required. The remaining four strategies were addressed to staff as a group, and were focused on ensuring compliance with policies and procedures, as well as commitment to organisational outcomes.

Advocacy or influencing

Three of the ten strategies in this group involved using evidence of need or effectiveness of services to advocate for support and/or funding. Two others involved external advocacy to influence the board—membership change (one) and availability of training programs (one)—while a third involved internal advocacy to convince the board of the need for action. There were two cases where external advocacy was focused on organisational partners or allies, and two cases that involved engaging the community or politicians and the media.

Developing new skills or awareness in others

Five of these seven strategies were about the delivery of training or development programs to staff (four) or board (one). The remaining two were about raising the awareness of external partners (one) or the board (one) about the implications for them of the situation the manager was seeking to resolve.

Getting external support

These four strategies focused on mobilising QAIHC's member support services, which were held in high regard by the participants.

Remaining strategies

In two cases, managers intended to gather more information or to seek guidance from trusted others. In one case a manager intended to engage in long-term planning to seek to develop a pathway for transferring current government-provided services to community control. The final strategy involved developing a medical clinic (using Medicare funding) in order to address a service need without grant funding.

Enablers

During the discussions about the problems and the strategies that the managers might use, there was quite a lot of information gathered about things that would be likely to help or hinder their efforts. These 'enablers' and 'barriers' are similar to the underlying factors presented above. That is, they indicate something about the conditions and forces that would operate on the organisations and the managers as they worked to resolve the problems. In this section we present the data on the enabling factors, and in the section that follows we present the barriers.

There were fifty-seven supporting or enabling factors, which we grouped into twelve categories, that were expected to assist the managers in the successful implementation of their strategies. The categories and distribution are shown in Table 5.

TABLE 5: Enabling factors

Category	No.	%*
Good leadership	11	20
Role of QAIHC	9	16
Board support	7	12
Funding body requirements	5	9
Staff commitment and participation	5	9
External expertise	4	7
Using influence	4	7
Peer support	3	5
Resources	3	5
Community seniority	2	3.5
Partnering	2	3.5
Procedures	2	3.5
TOTAL	**57**	**100.5***

**Error due to rounding*

Good leadership

There were eleven themes from eleven stories that described the competence and strengths of good managers. They focused on strong active leadership (four), consistency and fairness (three), the value of experience in working with diverse interests and in different capacities (two), the benefits of supporting team leaders in their roles, and the capacity of a newcomer to act as a circuit breaker for board/management interactions that had been complicated by family relationships. It should be noted that these themes did not arise from the presenters' self-descriptions, but rather from their peers' perceptions, which were articulated in learning set discussions of strategies and methods.

QAIHC support

The effectiveness of the support and advocacy services offered by QAIHC was noted in nine stories. Advocacy for member organisations in negotiations with funding bodies or other external partners was most often cited (six). Other themes concerned the role of QAIHC in supporting training for boards (two), and as an agent for quick placement of an acting CEO (one).

Board support

Seven themes affirmed the importance of board support, which includes good relationships and support between board and CEO (five), the positive contribution to activities and services by board members in a small community (one), and the impact of recent changes on the board that had seen 'interfering members' depart (one).

Requirements of funding bodies

While funding body relationships were important underlying factors in the management problems that participants faced, funding body reporting and accountability requirements were seen as positive in three themes. In a further two themes, policies that support the primary healthcare approach and community control were seen as enabling factors.

Staff commitment and participation

There were five themes in this category. They related to the commitment and capacity of motivated and skilled staff (three), and to the value of engaging staff in the development and review of policies governing their work (two).

External expertise

The impact of using external expertise provided the basis for four themes—working with HR consultants, with researchers and with a respected board director from another community, and using resources developed by a peer organisation.

Using influence

Four themes were primarily about the use of influencing methods to achieve success—influence with board members, influence arising from relationships with a mainstream external partner agency, community influence on a partner agency, and influencing board members to participate in governance training.

Peer support

The three themes in this category concerned the support of fellow learning set members, the support of other staff within an agency, and the support of external peers for the work of a manager.

Resources

There were three enablers arising from organisations' current ownership of existing or new resources—additional funding, extra staff and new facilities.

Community seniority

In two stories managers identified the value of their senior community status as an enabler to their managerial roles.

Partnering

In two stories the support of partnering agencies (that is, other organisations with which the ACCHS had formal or informal partnership arrangements for joint service delivery or collocation of services) and the ability to share skilled staff through a secondment arrangement were noted as enabling factors.

Clear procedures

Two themes were based on the contribution of clear policies and protocols as elements of the participants' strategies for improvement.

Barriers

There were eighty-one major barriers to the implementation or chances of success of the strategies the managers intended to pursue. They were grouped by content analysis into thirteen categories, as shown in Table 6. There was significant overlap with the factors that were contributing to the problem or its consequences, but also significant differences. In this section we focus on problems that the managers, and/or their fellow set members, foresaw.

TABLE 6: Barriers to achievement of strategies

Category	No.	%
HR management difficulties	13	16
Problems with authority of CEO/manager	11	14
Dilemmas for CEO in the role	8	10
Barriers in the board's approach	8	10
Funding and funding body barriers	8	10
Partnership complexities	6	7
Problems in delivering member support	6	7
Capacity and resource limitations	6	7
Family/work relationship complexities	4	5
Cross-cultural working barriers	4	4
Workforce problems	3	4
Limits in community capacity	2	4
Barriers in AHW role	2	2
TOTAL	**81**	**100**

Human resource management difficulties

As expected, this is the largest group of barriers, dominated by resistance to change—in structure, strategy and/or policies (five)—and problems in performance management (five). Performance management barriers included the lack of good systems, and the difficulty of addressing the performance of middle managers or of senior community members. The remaining three barriers arose from the complications caused by staff also being clients of the organisation; the difficulty of managing staff who are seconded from a partner agency; and the potential resentments arising from differential entitlements for Aboriginal and Torres Strait Islander and non-Indigenous staff.

Problems with the authority of the CEO/manager

Seven of the eleven themes in this group concerned the barriers to effective leadership by the CEO/acting CEO when the authority of the position was undermined by lack of permanent appointment (four) or by other internal factors including informal relationships between staff and board members (three). Two barriers arose from the need for a new CEO to establish authority (one) or problems with the CEO's community status (one). The final two arose from the actions of people with alternative organisational power bases challenging the managers.

Role dilemmas for CEO

Five themes in this group of eight concerned the stresses inherent in the role, arising from internal conflict, high workload, being 'lonely at the top' or isolated (two), and the ever-present problem of managing staff performance. Two of the remainder concerned uncertainty about continuing in the role, arising from the classic career dilemma about taking on leadership in one case and from health problems in the other case. Another barrier in this group arose from the lack of succession planning for new leadership.

Barriers in the board's approach

Three of the barriers in this group arose from the approach of board members to managing their roles—entrenched attitudes about the right to intervene, direct involvement in staff management, and failure to apply procedures for avoiding the impact of conflicts of interest. A further two related to lack of skills in governance, and an *ad hoc* approach to skill development. Two arose from lack of board support for the CEO, or the power of a board member who was related to the CEO, and the final barrier concerned the inability of other board members to 'take on' the difficult behaviour of one of their number.

Funding and funding body barriers

Four of the barriers in this group arose from 'the rules'—short-term funding *per se* (two), inhibitions on building up reserves across financial years (one), and the administrative load arising from multiple funding sources (one). The other four related to the approach of the funding bodies: methods of responding to community complaints; their distance from the issues they were making decisions about; high levels of scrutiny; and the tendency for non-Indigenous staff of the funding agency to feel more comfortable with or more confident in non-Indigenous staff of the ACCHS.

Partnership complexities

The difficulties of making partnerships work were evident in the barriers the managers foresaw. The complexity of managing relationships was the most common (three); two other barriers related to mainstream responses to Aboriginal and Torres Strait Islander organisations, agendas and roles; and one arose from the status differential between the large mainstream partner and the smaller ACCHS.

Problems in delivering member support services

Four of the six barriers in this category related to the 'meat in the sandwich' position occupied by member support services within QAIHC. The services of this branch of QAIHC were very much appreciated by the participants, but the position of a peak body in supporting its members is always sensitive—this was seen in the difficulties of balancing support with autonomy (three) and operating at the interface of boards with CEOs. The other two barriers were internal to QAIHC: one concerned the perceived mismatch between demand and resources, and the other the need for a good process for involving other branches in the response to members' relevant support needs.

Capacity and resource limitations

The barriers commonly faced by community organisations were evident in this group. They were lack of experience of the organisation and/or CEO (two), lack of information technology resources (one), lack of adequate space (one) or control of capital resources (one), and the problem of managing out-posted staff from a distance (one).

Family/work relationships

These four barriers arose from the need to manage members of one's own family or family relationships among staff (three), or having one's own family members on the board (one).

Cross-cultural barriers

These four themes concerned the loss of priority given to culturally based practices or ways of working (two), lack of understanding of the principles and methods of community control by mainstream organisations, and dependence on personal relationships to maintain this work.

Workforce

There were three specific barriers that related directly to workforce supply, a major issue for ACCHSs. The main focus in the stories was on the scarce supply of skilled workforce personnel in several categories, in particular AHWs and financially trained Aboriginal and Torres Strait Islander staff.

Community capacity

These two barriers were the lack of local leadership capacity (one), and the problem of community divisions (one).

AHW role

These two barriers concerned problems with the overlapping roles of AHWs and nurses in clinics, and one case of a lack of clear goals and targets for AHWs.

Outcomes

It is in the nature of management challenges that there is not a single correct answer, and rarely a 'recipe' for how to resolve problems—that is, it is not possible to produce instructions in the same way as it is for, say, 'how to change a tyre'. We have, therefore, not attempted to evaluate or make linkages between strategies and outcomes (as in 'this strategy worked; this one didn't'). Neither were we attempting to evaluate performance or assess the effectiveness of the participants or of the strategies they pursued between meetings.

However, we report here briefly on the overall pattern emerging from the twenty-eight reports we gathered of the progress or results of managers' actions. In many cases the matters were not yet resolved, and the reports must be regarded as interim. In ten reports the situations had been resolved to the managers' satisfaction; in nine cases the managers had pursued the intended strategies and the situations had improved but were not resolved; in four reports the managers had not been able to take action; in two cases, only limited action had been able to be taken, and there was little improvement; and in three reports the managers had left the organisation in response to lack of progress on the issues, or because crises intervened.

The pattern in the mainstream learning set follow-up reports (fifteen reports in total) is similar. In three, the situation was resolved to the managers' satisfaction; in ten, the managers had pursued the intended strategies and the situations improved but were not resolved; in one, the manager had not been able to take action; and in another, the manager had left the relevant role (but not the organisation).

Summary of results

The wealth of material identified through the analysis of themes has been presented in detail in this chapter. As described in the methods section, there is a need to further integrate this wealth of detail in order to consider its implications. To achieve this, the underlying factors, the barriers and the enablers—which collectively describe those aspects of the organisations and their contexts that give rise to management challenges or affect the organisation's ability to achieve its goals—were grouped and sorted using the same methods as previous steps. The major headings that emerged, and the theme categories they consist of, are presented in Table 7 below.

TABLE 7: Summary of results

Workforce and people manangement		**68**	**Role of communities and boards**		**59**
U*	HR Management	30	U	Board: CEO relations	13
U	Workforce	10	U	Community and family relations	9
U	AHW role	5	U	Board capacity and workload	8
B	HR management	13	U	Community capacity and tensions	5
B	Workforce	3	B	Board approach	8
B	AHW role	2	B	Family/work relationships	4
E	Staff commitment	5	B	Commnunity capacity	3
			E	Board support	7
			E	Community seniority	2

Organisational capacity, systems and structure		**54**	**Strengths and needs of managers**		**37**
U	Capacity	20	B	CEO/managers authority	11
U	Structure and systems	8	B	CEO dilemmas	8
B	Capital resources	6	E	CEO leadership	11
B	Internal support services	6	E	Using influence	4
E	Resources	3	E	Peer support	3
E	Procedures	2			
E	Role of QAIHC	9			

Partnerships and external relationships		**31**	**Funding and working with funding bodies**		**28**
U	Partnerships and power	10	U	Funding and funding relations	15
B	Partnerships	6	B	Funding and funding relations	8
B	Partnering	11	E	Funding body requirements	5
E	External expertise	4			

Working with culture and race		**17**
U	Racism and cultural factors	14
B	Cross-cultural work	3

** U = underlying factor; B = barrier; E = enabler*
These headings are used for the discussion of our results presented in the next chapter.

Chapter 6:
Discussion and Conclusions

In this chapter we sum up the project and discuss the implications of the results. We review the context of the research and the goals of its stakeholders, and we outline the limitations to what we did (and what we did not do). We suggest that the project has successfully demonstrated the potential value of learning sets in the sector, and that it has met the ethical requirements of reciprocity and benefit. We discuss each of the seven main areas of findings, and how progress might be made on them. We conclude with a quote from Miriam Rose Ungenmerr's reflection on learning and listening as a two-way process.

This project was undertaken in partnership with QAIHC and was commissioned by the CRCAH. QAIHC's purpose was to enable its managers to benefit from the learning sets and seminars, and to gain information that would help QAIHC and its member organisations to enhance the effectiveness of the services and managers. The project also supported QAIHC's own strategic vision and plan, especially its goal to enhance its education and professional development arm.

Like all Australian cooperative research centres, the CRCAH aims to bring 'industry' (in this case, the Aboriginal and Torres Islander health sector) and researchers together to shape and conduct research that is relevant to the needs of industry. This is a particularly interesting challenge in the health sector, in which research is so central to the development of new technologies, treatment regimes and professional practice. We tend to think of the industry as being 'research-led'; the CRCAH aims to turn this around so that its research is 'industry-led'. This is consistent with efforts in the mainstream system to increase the amount of health services research conducted in Australia and internationally, and to ensure that research 'provides important new evidence to inform policy and practice' (NHMRC 2006:1). The CRCAH provides an interesting model for this effort. It certainly requires a different relationship, and a different way of commissioning research.

In the case of this project, the CRCAH's purposes are both research oriented (to develop evidence on which to base further, more focused research) and practice oriented (to generate knowledge that can guide the development of the Aboriginal and Torres Strait Islander health sector). Given this context, we now turn to considering the implications of our results for management and development of the sector—and we include in this the providers of care for Aboriginal and Torres Strait Islander communities, the

policy-makers, and the funders and regulators (mainly state/territory and national governments). While we focus on the Indigenous-specific providers of care, there are also implications for the mainstream health sector.

The picture that emerges from the managers' stories shows many elements of the expected pattern of management problems, contributing factors, strategies, barriers and enablers that are so familiar to those working in the health system: the struggle to manage a complex set of needs and expectations with funding sources that are controlled by others, continuous growth in demand for care, and problems in the supply of the skilled workforce on which healthcare depends. There are also problems that are typical of small organisations and organisations in small communities everywhere.

But there are also some distinctive features, reflecting the particular difficulties and strengths of Aboriginal and Torres Strait Islander communities and organisations, and the strategies and coping skills that have been developed in response.

Limitations—what we did not do or study

This learning and research project had several limitations, which need to be kept in mind when considering the meanings and implications of the results.

This is not an evaluation of the managers or their organisations

We did not set out to assess or evaluate the effectiveness of management, or of the strategies that the managers used to address their problems. Rather, we set out to understand what the current challenges and strategies are, in order to be more certain that any efforts to support improvement in the overall effectiveness of management are designed to address real needs, not assumptions.

Our results are not based on the perspectives of boards or funding bodies

We gathered information about the problems confronting managers, not board members or funding agencies. This was a deliberate choice made for several reasons, as explained in Chapter 2. This choice means that our results reflect neither the perspectives of those who serve on the boards of ACCHSs nor the funders. They do, however, shed some light on governance and stewardship for the sector—that is, the role of boards in governing and directing the services, and the roles of government in supporting services through funding, regulation, policy, workforce development and other capacity-development functions.

We were identifying, not counting, the challenges and strategies

This is a qualitative study that aims to *identify* the major management challenges and strategies, not to measure their incidence in the sector. While we have reported on the relative 'weight' of various themes (that is, those occurring commonly or rarely in the managers' stories), this does not imply that the relative weights are representative of the field generally. The method does enable us to claim that the major issues facing this group of managers have been identified—that is, we collected enough stories to be confident that no further major issues would have emerged had we continued collecting more stories. We had reached the point of 'saturation'—that is, 'the point at which additional information no longer generates new understanding' (Liamputtong & Ezzy 2005:86).

This work was done in Queensland only

All of the participants were working in Queensland and in member organisations of QAIHC. The structure of the Aboriginal and Torres Strait Islander health system is partly shaped by state and territory jurisdictions, and no doubt the results would have been somewhat different in other states. Those working in this field in other states are likely to be able to identify where Queensland-specific issues (such as the role of Queensland Health in delivery of clinical services to Aboriginal and Torres Strait Islander communities) are influential. Readers in each jurisdiction will need to assess the applicability of our results in their contexts. Based on our knowledge of the sector nationally, we think it likely that the major issues emerging from this project have at least some relevance in other jurisdictions.

The context of Aboriginal and Torres Strait Islander ill-health and heavy burden of disease was a given

Because the managers work and live (at least much of the time) within Aboriginal and Torres Strait Islander communities, the high burden of disease among patients and staff was an accepted part of their realities, and was not commented on as much as readers may expect. However, the problems of managing staff with poor health, and the difficult balancing of formal leave entitlements with community responsibilities when there is too much sorry business related to chronic illness and death among relatively young people, were identified.

Ethical issues

The management of confidentiality during the project has been successful, due in large part to the care and attention by participants to this important aspect of the project. We have taken all the measures we can to preserve the anonymity of the participants' contributions in the writing of this report.

We believe that the results of the learning component of this project are evidence that the ethical requirement for mutual benefit has been met. The fact that QAIHC has taken on the continuation of the learning set approach for its members is perhaps the most convincing evidence in this regard.

However, the deeper ethical concern for the researchers and QAIHC is that the results of this project must contribute to and support the efforts of those in the field to improve the effectiveness of Aboriginal and Torres Strait Islander healthcare. To achieve this, the research must provide information to guide organisations and policy-makers that is both useful (that is, relevant to their information needs) and valid (that is, an accurate reflection of the reality we studied). The extent to which this obligation has been met will be judged by others in the future.

Learning sets as a method for research and development

This project has been the first time, to our knowledge, that formal learning set methods have been taken up in the Aboriginal and Torres Strait Islander health sector, although we note the consistency of this method with informal practice. The participants' high level of satisfaction with the learning set method indicates that it is an acceptable development and support method for CEOs and managers in this sector, and that the managers perceive it to be effective. QAIHC has indicated its intention to pursue further learning sets for its members.

Our experience with using the stories presented in learning sets—as data about the challenges managers face and the strategies they rely on to meet them—has also been positive. Importantly, it provides a basis for the design of management research that meets the ethical criteria applying to research with Aboriginal and Torres Strait Islander communities—there is a direct tangible benefit to the participants and a realistic way in which they can participate in analysing and interpreting the data.

What the research results mean

In the sections that follow, we discuss the implications of the results of this project using headings derived from an analysis of the results and presented in Table 7.

Workforce and people management

The shortage of Aboriginal and Torres Strait Islander health professionals is a major challenge for the whole health system, particularly for ACCHSs that aim for majority Aboriginal and Torres Strait Islander staffing. Workforce shortages in all categories were identified as problems or limitations in our data. National strategies to improve the supply of health professionals—through more successful recruitment and education of Aboriginal and Torres Strait Islander people into the health professions—have been designed and are being pursued (Standing Committee on Aboriginal and Torres Strait Islander Health 2002). The success of these strategies cannot yet be assessed.

At the same time, it is vital for Aboriginal and Torres Strait Islander health that all health professionals are competent in providing effective care for the Aboriginal and Torres Strait Islander population and are motivated to do so. Again, programs are underway in all the professions and educational institutions to ensure that the health workforce as a whole is better equipped for working with, and providing care for, Aboriginal and Torres Strait Islander peoples (for example, Paul, Carr & Milroy 2006).

AHWs need more support for their roles

Some of the measures that could help with workforce issues are also needed to support effectiveness of care. Our results indicate that Aboriginal and Torres Strait Islander health staff sometimes work in roles for which they are not adequately supported, and that require them to extend beyond the levels of competence and knowledge for which their training and experience equip them. Examples of this in our study include AHWs whose roles require them to design, plan and conduct health promotion/disease prevention programs with low levels of expert input, support and resources—levels that would not be tolerated by equivalent staff or managers in the mainstream health system.

This study also highlights the acknowledged emerging need for change in the roles of AHWs, particularly with the increased focus on chronic disease management and both primary and secondary prevention of chronic disease. (By primary prevention we mean approaches that aim to eradicate or modify underlying causes of ill-health; by secondary prevention we mean approaches that address the needs of people at higher risk of experiencing health problems.) As always, such changes raise difficulties for the existing workforce, which must accept and adapt to new responsibilities and methods. In our study, the roles of AHWs were seen as complex, spanning cultural brokerage (assisting patients in their interactions with healthcare and the mainstream health and other social service systems), specialised clinical practice and delivering health promotion programs. The expectations of workers in these roles are broad in comparison to the level of training they generally receive, and bring with them a heavy responsibility and often a workload of 'emotional labour' that extends through and beyond their working hours.

We note that the role and training of AHWs is an area of ongoing study (Genat 2006), debate and development work, and that a review of the curriculum has recently been completed (Community Services and Health Industry Skills Council 2007). In this project the need for knowledge and skills for health promotion, health education and chronic disease management was highlighted.

Managers need more preparation and support

Managers, too, are often working at and beyond the edges of their competence. While many of them are natural leaders and highly resilient people, their training and health sector experience are not at the levels that would enable them to approach their roles with confidence, nor to minimise the stress they experience (as Williams, Thorpe and Chapman's 2003 study demonstrates). A requirement for heroism (that is, roles that only extraordinary people can fill) is not a sustainable organisational strategy.

Managers would benefit from more access to education and development programs tailored to the needs of the sector. The content and teaching methods of such programs should integrate mainstream knowledge and methods with Aboriginal and Torres Strait Islander knowledge and methods, and equip Aboriginal and Torres Strait Islander managers for careers in both ACCHSs and mainstream health organisations. Programs are needed at undergraduate and postgraduate levels, as well as in-service development programs. The data

presented in this report provide one source of guidance on the competencies that managers need, and important curriculum areas.

The value of the support provided by QAIHC for managers—such as, assistance with managing difficult issues, finding and placing 'locum' CEOs, technical and practical help with planning and policy tasks—was validated in this study (and we note that other state peak organisations provide similar services). This area of work could be expanded to ensure that needed support is reliably available to managers.

HR management is an important area for development

Indigenous-specific health services have important roles to play in the training and development of all health professionals, particularly those Aboriginal and Torres Strait Islander health professionals who wish to specialise in this sector. In a situation of workforce shortage, ACCHSs need to maximise their ability to attract and retain a skilled and motivated workforce through appropriate job design and good people management practices. This emerges from our research as one of the most significant challenges.

As senior managers of relatively small community-based organisations, most of the participants in this project were working with little or no access to in-house professional HR advice and support. They were generally well aware of the principles of HR management, and many had quite detailed policy and procedure manuals. They valued the advice and support available from QAIHC (Member Support Services).

While much HR practice in ACCHSs is based on the same principles, legislation and goals as practice in mainstream health agencies, there is a need for supportive resources and services tailored to the particular styles, challenges and strengths of Aboriginal organisational practice. Many of the managers in this study reported a robust and open approach to managing staff and performance, but also expressed the need for assistance with this difficult area. Resources for HR policy, practice and 'hands on' support could be developed at national and state levels for the sector, while specialised services could operate at state or regional levels. Peak bodies are potentially well placed to take on this role, as evidenced by QAIHC's success.

The need for assistance with managing staff performance was highlighted in this study. A combination of individual and team-based approaches may be more effective in any setting, and may also be more in tune with the organisational culture of ACCHSs. While local managers must be responsible for managing staff performance, better methods and tools that are tailored to the sector could be developed nationally or at state or regional level. The same applies to ongoing learning and development programs for ACCHS staff.

Role of communities and boards

For the community-controlled sector, good corporate governance derives partly from the role of community members and community relationships in the running of the organisation. For many organisations, particularly those in small communities, the network of family, community and organisational relationships is both an important resource and a potential source of difficulty for management. Community members make a major voluntary contribution to the ACCHSs through membership of boards and various support activities. This reality is reflected in our data on the importance of board support as an enabling factor for the managers. The strength that some managers could draw on as result of their senior community status is another example.

Methods of supporting good governance are needed

In some circumstances, the demands placed on community leaders and communities more generally are significant. The data from this study highlight board capacity—in terms of the range of skills and knowledge available among board members and the sheer time and effort required of a small number of people—as sometimes being a limiting factor, as were the difficulties for managers caught up in community tensions (between different families, clans and/or factions, or different cultural sub-groups).

The problems arising from the relative scarcity of community board members who can collectively bring the full range of desirable skills and experience to a board post have been identified by other researchers and commentators (Wilson 2001; Armstrong 2003; Hoy, Kondalsamy-Chennakesavan & Nicol 2005). They include particular knowledge of healthcare methods

and evidence to support good practice, of financial management, and of compliance and accountability requirements applying to incorporated bodies. Attention to training and development for board members has grown over recent years, and programs are available in most states. However, such programs will not quickly overcome some of the experience gaps identified above, particularly where turnover of board members is high.

The results of this study highlight the need for the sector to continue with efforts to strengthen good governance practice in the way that board members are elected/appointed and in the way their roles are structured. ACCHSs are reforming their practice in this area, for example, in the length of terms of appointment (one year is too short; on the other hand, there should be limits on how many consecutive terms a member can serve).

There is a need for continuing attention to limiting the capacity for board members to intervene as individuals in day-to-day management and operational roles. Direct action by board members—for example, in appointing or disciplining staff or countermanding the management decisions of the CEO—is not compatible with good corporate governance. Delegations of authority need to be clear and binding, and board protocols need to reinforce the principle that board members do not have authority (in a formal sense) as individuals, only when they act collectively as a board.

The concept of conflict of interest requires appropriate definition and safeguards, derived from the values and customs of Aboriginal and Torres Strait Islander communities, as well as from the principles of good corporate governance (Smith 2005; Sanders 2006).

Community relationships are both a strength and a source of problems

The managers encountered some problems arising from the fact that they need to conduct working relationships with staff who are also family or community members and have their own networks inside and outside the organisation. It is harder to take on a difficult issue with a member of staff who is related to you and/or senior to you in the community. It is also more difficult to tackle family members who are on your board. These problems are not unique to ACCHS managers, but they may be more frequent given both the small size of communities and the importance of family and traditional relationships.

The principle of community control is still critical

The principle of community control is deeply rooted in the history of the development of ACCHSs, and it is important to preserve the strengths of the model (which has parallels in the traditional board structures that until recently governed most Australian mainstream hospitals and other healthcare providers). The health-related goals in implementing this principle are to ensure that healthcare is focused on community needs and priorities, and is delivered in a way that is culturally safe and supportive (so that services are acceptable to community members, and receiving care does not entail unnecessary stress, shame or harm). These goals are no less critical now than they were in the 1970s.

The problems of small size need to be addressed

It needs to be acknowledged that some communities may simply be too small to be able to support the technical, governance and management requirements of running an effective health service. Regional models of management (with local priority-setting capacity), as well as state- or territory-level infrastructure, may be critical to the provision of community-controlled healthcare for these communities. Our data affirm that community control is not automatically achieved through the existence of a community board.

It may be helpful for organisations to consider reducing the numbers of independent boards that are required (through aggregating governance arrangements for small organisations). Another possible strategy would be to seek the services of skilled advisers (without voting rights) to attend board meetings and to offer advice on technical questions. Careful attention to defining this role, and to building-in ways of ensuring confidentiality and respect, would be needed.

It may also be possible to learn from the corporate structures developed in other Aboriginal and Torres Strait Islander organisations, whereby community boards retain their policy and strategy roles, but delegate operational oversight and technical compliance roles to smaller 'business boards' that report to the community board.

The stewardship role of government is valued and necessary

The stewardship role of government funding bodies in the development of supportive policy and resources, and in requiring accountability from funded organisations, is valued and should be exercised consistently and fairly. OATSIH and, where relevant, state funding bodies need to continue their efforts to be effective stewards of the system when organisations are in trouble. We acknowledge that OATSIH has made significant progress around this difficult issue. However, accountability requirements, like laws, cannot be respected if they are not honoured by the regulators through effective, consistent and fair monitoring or enforcement.

Organisational capacity, systems and structure

The limitations of organisational capacity (including inadequate systems and structures) were a pervasive theme in this project.

Periods of establishment and growth are exciting, but difficult

Many of the organisations were in a period of establishment and/or growth, and were facing the painful transitions that growth involves—notably the shift from a flat structure ('we're all one team'), with everyone reporting to the CEO, to the development of several teams with team leaders. Greater recognition by funding bodies of the challenges of growth would be helpful, along with better processes to negotiate achievable timelines and milestones. The urgency brought on by 'money that rusts' on 30 June each year needs to be avoided as much as possible.

A systematic approach to the development of infrastructure is needed

Problems with support services and other infrastructure are common to community-based organisations and small organisations everywhere. In this sector, where the limitations of funding and community size are significant, the most useful remedies seem to lie at the level of peak bodies and regional support services. There is a need for infrastructure (that is, resources and functions that underlie and support the structures and systems of the care providers), some of which should be at national level (for example, national quality and performance standards), some at state/territory level (for example, HR systems and industrial advice) and some at regional level in a state such as Queensland where distance is an important limitation (for example, financial processing, HR support). The frequent reliance on QAIHC support by participants is evidence of this need and of the effectiveness of peak body services. OATSIH has also identified this need and is working with the sector. Development of infrastructure should be addressed as a shared responsibility for government, peak bodies and ACCHSs.

Boards need support when the CEO is the problem

In this study there were situations where the development of better structures and systems had been delayed by an incumbent or former CEO whose own health or management approach left him or her unable to take on the significant tasks involved. Sometimes, as in all sectors, CEOs had reached or exceeded the limits of their capacities but continued in the roles, because of inertia or the loyalty of their supporters on the board and/or among the staff. Career planning and management for CEOs is needed, so that both advancement and retirement/exit can be managed more effectively, but boards may need the support of peak bodies.

The strengths and needs of managers

Not surprisingly, concerns about the roles and capacities of managers arose frequently in our data. The most common problems were about the level and effectiveness of the authority available to managers because of structural or individual issues: the difficulty of establishing one's authority in situations of uncertainty (for example, unclear tenure in the role) or where formal authority was questioned because of characteristics of the individual (for example, age or gender), or because of the informal authority of others (for example, senior community members). These are common challenges for managers in all settings.

The establishment of clear delegations of authority and consistent support from boards is critical to the ability of senior managers to fulfil their responsibilities.

The value of the learning set method, or other forms of peer support among senior managers in the sector, is

highlighted by the results of this study. It seems that the method resonates with informal practice among managers in this sector as elsewhere, and that the basis in working with the managers' real problems is valued.

The support services offered to the participants by QAIHC are a valued and scarce resource, which should be continued and strengthened. Sister organisations in other states also provide important support and resources (for example, Briggs 2004; AMSANT 2006).

Partnerships and external relationships

For the managers in this study, the challenge of finding effective ways to work in partnership arrangements with other Aboriginal and Torres Strait Islander organisations and with mainstream organisations is increasingly important. This challenge arises partly because the effective delivery of healthcare to any person or family requires the engagement of multiple providers, and thus the roles of ACCHSs are inextricably linked with the mainstream system. In turn, the mainstream system has a responsibility to ensure its effectiveness, both in providing direct care to Aboriginal and Torres Strait Islander peoples and in working well with the Indigenous-specific sector. The current policy environment, particularly the government strategy of mainstreaming, also requires increased attention to networks and partnerships.

Protocols and commitment to good process are needed for 'partnering'

The mainstream system is becoming more active in engaging with Aboriginal and Torres Strait Islander organisations, and is beginning to take on its proper responsibilities for Aboriginal and Torres Strait Islander health. Partnering relationships in our study were sometimes very unequal (for example, a small Aboriginal organisation 'partnering' with Queensland Health, which is also a major provider of funding), and the concept may be losing its meaning through such usage. However, partnering requires particular skills, protocols and processes, and peak bodies have a role to play, both as lead agencies in some partnership arrangements and in the development of protocols and support for member agencies.

Funding and working with funding bodies

The data in this category highlight the importance of the roles of funding bodies and their staff, and the nature of their influence as both enabling and problematic for managers. The positive aspects arose from the value of external accountability requirements as a lever for internal improvement, and from the value of supportive policy in decision making and negotiations. The problems arose from the complexity of funding arrangements (including short-term project funding), the inevitable tension between funders and recipients, and the failure of funding body staff to adhere to established protocols for handling complaints.

Funding is complex and there is too much short-term funding

The problem of short-term funding has been widely recognised. OATSIH has taken major steps to reduce its significance in its funding programs and thus the burdens it entails. However, ACCHSs receive funding from many sources and usually two, and sometimes three, levels of government, which means that the problem remains an important one. There is a sense that short-term funding is partly used because of a lack of confidence by funders in the service providers. If this is true, it may be a self-fulfilling prophecy. Reliance on short-term project funding, and the complex reporting and timing requirements it entails, is a serious impediment to the effectiveness of service delivery, to the ability to attract and retain a skilled workforce, and to management. Better methods of ensuring accountability across complex health goals and programs are urgently needed.

Funding body staff members vary in their support for the sector and their adherence to protocols

Tension between the givers and receivers of funding is normal. However, the managers experienced great variation in the quality of their relationships with funding body staff. Our data also indicate that funding bodies experience difficulty managing complaints from within the Aboriginal and Torres Strait Islander communities, and that protocols for handling such complaints need to be strengthened.

Working with culture and race

Aboriginal and Torres Strait Islander health services operate in a broad environment, which is often dismissive, uncomprehending or hostile to their aspirations and efforts, in spite of recent progress among mainstream health organisations. Mainstream agencies also face difficulties in working effectively with the sector; for example, staff members are often not aware that some of their assumptions about the roles and resources of ACCHSs are wrong. In any case, working across cultures always requires additional effort and attention to building relationships. The pervasive influence of racism, prejudice and stereotyping remains as a barrier to effective health and healthcare for Aboriginal and Torres Strait Islander peoples.

Mainstream organisations have a responsibility to improve their effectiveness

The specific problems the participants discussed fall into three categories. The first is the difficulty of working with mainstream organisations or staff who are not well informed, or who are not motivated to support the role of the sector or who find it difficult to provide effective care for Aboriginal and Torres Strait Islander peoples. The common ground for addressing this problem is the motivation of both mainstream clinical staff and the Aboriginal and Torres Strait Islander sector to ensure that effective clinical care can be provided. This common ground is the logical focus of efforts to improve relationships and the effectiveness of care.

Non-Indigenous staff in ACCHSs

The second specific problem is the challenge to make effective the working relationships between Aboriginal and Torres Strait Islander managers/staff and non-Indigenous staff. In this study the focus was on non-Indigenous management staff roles and relationships, but some of the same problems are likely to apply among health professional staff as well.

Methods of addressing cultural competency and cultural safety

The final category is the question of the place of cultural awareness training in the roles of ACCHSs, and of the need for Aboriginal and Torres Strait Islander cultural knowledge within ACCHSs. The role of cultural awareness training in equipping mainstream organisations and staff to work with Aboriginal and Torres Strait Islander patients, communities and colleagues is being questioned, with alternative approaches to developing cultural competency and cultural safety being explored.

There is a continuing need for mainstream organisations, both alone and working with Aboriginal and Torres Strait Islander organisations, to ensure that their staff members are equipped and supported to care effectively for Aboriginal and Torres Strait Islander peoples, and that they have access to advice and knowledge about Indigenous-specific services and their roles. However, further work is required to determine the best methods of developing the capacity of mainstream staff to achieve this goal.

Reconciling community and mainstream ways within ACCHSs

ACCHS managers and staff occupy 'cultural borderlands' between mainstream and Aboriginal and Torres Strait Islander domains. There was some evidence in our data of tension between the valuing of traditional, community-based and politically activist ways and styles on the one hand, and more mainstream, managerial and technical methods and values on the other. This tension reflects different backgrounds and orientations, and will probably continue.

Conclusion

This project has followed a shared learning and research pathway, seeking to enhance the effectiveness of the managers who participated, and to improve understanding of the challenges they face and the strategies they use to address them. The managers in this study showed significant leadership, skill, resilience and commitment to their communities and their agencies. The challenges they faced are largely similar to the problems of managers in other health sectors, with some differences arising from the needs and ways of their communities and the under-funding of their services relative to need. Many of their challenges could be made easier through supportive infrastructure and policies. We hope that this report will contribute to an understanding of ways to enhance the effectiveness of management in the sector, and that it will lead, ultimately, to action both by the sector and the agencies that fund and regulate it.

*Our people are used to the struggle and the long waiting. We still wait for the white people to understand us better. We ourselves have spent many years learning about the white man's ways; we have learnt to speak the white man's language; we have listened to what he had to say. This learning and listening should go both ways. We would like people to take time and listen to us. We are hoping people will come closer. We keep on longing for the things that we have always hoped for, respect and understanding (**Dadirri—Aboriginal Way**, Ungenmerr n.d.).*

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Appendix:
Workshop and Seminar Program

Workshop 1: March 2005

Workshop program

Time	Day 1	Day 2	Day 3
	Tuesday 15 March	**Wednesday 16 March**	**Thursday 17 March**
9:00–10:30	Welcome and overview of program for the workshop and the year	Learning Set: Session 1 Stories and action plans	Seminar: Managing Money
10:30–11:00	Morning Tea	Morning Tea	Morning Tea
11:00–12:30	Guest Lecture: Challenges for ACCHS managers Mr Mick Gooda, CEO, CRCAH	Learning Set: Session 2 Stories and action plans	Seminar continued
12:30–1:30	Lunch	Lunch	Lunch
1:30–3:00	Presentation: Managers' stories Presentation: Action learning and action research	Learning Set: Session 3 Stories and action plans	Feedback and next steps Reflecting on practice Keeping in touch, dates
3:00–3:30	Afternoon Tea	Afternoon Tea	Close
3:30–5:00	Setting our goals: what do we each want to achieve? Top topics for teaching	Learning Set: Session 4 Stories and action plans	

Seminar session

Managing money (financial planning and analysis)
Issues covered in seminar:

- Managing budgets: salaries, assets, insurance
- Types of funding
- Reporting requirements
- Financial planning and managing change.

A fictitious case study was used to facilitate discussion about current management challenges associated with funding arrangements for Aboriginal and Torres Strait Islander Community Controlled Health Services. The data provided was based on published, unrelated data sources that typified the financial management issues for many such services. Participants worked with the data to identify what factors might impact on financial planning arrangements, how system influences affect funding trends and the short- and long-term implications of such influences for the organisation. The participants then explored financial reporting and accountability by working with periodic financial statements and discussing problems arising from differences in approved and actual budget figures.

Workshop 2: June 2005

Workshop program

Time	Day 1	Day 2
	Wednesday 1 June	**Thursday 2 June**
9:00–10:30	Welcome, getting organised Enrolling at La Trobe University	Learning Set: Session 2 Stories and action plans
10:30–11:00	Morning Tea	Morning Tea
11:00–12:30	Seminar: Managing people	Learning Set: Session 3 Stories and action plans
12:30–1:30	Lunch	Lunch
1:30–3:00	Seminar continued	Learning Set: Session 4 Stories and action plans
3:00–3:30	Afternoon Tea	Afternoon Tea
3:30–5:00	Learning Set: Session 1 Report back on Workshop 1 action and starting on stories	Results of Workshop 1 Between-workshop action Dates and close

Seminar session

Managing people (recruitment and managing performance)
Issues covered in seminar:

- Theory that underpins HR practice—staff motivation, causes of problems
- HR processes—for example, recruitment and selection, retention, staff training and development, appraisal and performance review
- Context issues—HR management in environment of uncertainty, cultural and other practice issues that relate specifically to HR management in Aboriginal and Torres Strait Islander organisations.

Participants continued to work with the fictitious case study from Workshop 1, this time with data that typified many of the HR issues for Aboriginal and Torres Strait Islander Community Controlled Health Services. The budget data were revisited to identify specific influences that impact on staffing arrangements and the likely staffing and HR management consequences of funding changes over both the short and long term. Discussions were then held around a number of scenarios involving accommodation of growth in staff numbers, a need for diversification in terms of skill requirements, changes in board membership and approaches, and impacts on staff job satisfaction.

Workshop 3: September 2005

Workshop program

Time	Day 1	Day 2
	Tuesday 6 September	**Wednesday 7 September**
9:00–10:00	Welcome and agenda Reflecting on practice	Learning Set: Session 2 Stories and action plans
10:00–10:30	Morning Tea	10:30–11:00 Morning Tea
10:30–12:30	Seminar: Managing strategy	11:00–12:30 Learning Set: Session 3 Stories and action plans
12:30–1:30	Lunch	Lunch
1:30–3:00	Seminar continued	1:30–2:00 Learning Set: Session 4 Stories, plans and wrap up
		2:00–3:00 Discussion: Aboriginal/Islander culture and work culture - what is good practice?
3:00–3:30	Afternoon Tea	Afternoon Tea
3:30–5:00	Learning Set: Session 1 Report back on Workshop 2 action and starting on stories	Feedback on Workshop 2 'data' Plan for Workshop 4 Meeting with enrolled students

Seminar session

Managing strategy (implementing strategic plans; writing feasible plans)
Issues covered in seminar:

- Linking the ideas of mission, strategy and implementation
- Making realistic plans
- Making good use of performance indicators
- Using good methods for implementing plans and managing change.

In this session participants explored the theoretical basis of organisational mission statements and developing strategic plans to reflect organisational objectives. Working with mission statements and strategic plans from their own organisations, the participants discussed major challenges in, and realistic approaches to, implementation. Further discussions explored the use of performance indicators and setting targets in an environment of service and system level change.

Workshop 4: December 2005

Workshop program

Time	Day 1	Day 2	Day 3
	Tuesday 6 December	**Wednesday 7 December**	**Thursday 8 December**
9:00–10:00	Welcome and Workshop 4 agenda	Learning Set: Session 1 Report back on Workshop 3 action and starting on stories	Themes of stories What the data tells us
10:00–10:30	Morning Tea	Morning Tea	10:30–11:00 Morning Tea
10:30–12:00	Guest lecture and dicussion: Reading current policy Professor Ian Anderson, Director, Onemda VicHealth Koori Health Unit, The University of Melbourne	Learning Set: Session 2 Stories and action plans	Were your goals met? What happens next... • With the research? • Your involvement? • And the learning sets? Formal close
12:00–1:00	Lunch	Lunch	1:00 Lunch
1:00–2:30	Seminar: Managing systems and policy	Learning Set: Session 3 Stories and action plans	
2:30–3:00	Afternoon Tea	Afternoon Tea	
3:00–4:30	Seminar continued	Learning Set: Session 4 Stories and action plans	

Seminar session

Managing systems and policy (reading policy and managing partnerships)
Issues covered in seminar:

- Working with government and the mainstream
- Partnerships in Aboriginal and Torres Strait Islander health
- Managing partnerships work—governance issues, strategic engagement, community capacity, measuring success
- Funding issues–system level influences, workforce changes.

This session explored the importance and nature of both formal and informal agreements in contributing to better outcomes for Aboriginal and Torres Strait Islander Community Controlled Health Services. Using a partnership analysis tool (developed by VicHealth), participants shared examples of partnership arrangements from their own organisations and identified issues in planning, managing and reviewing these relationships.