



# Revitalizing Health for All: International Indigenous Representative Group

Learning from the Experience of Comprehensive  
Primary Health Care in Aboriginal Australia—A  
Commentary on Three Project Reports

*Discussion Paper*

Prepared by Bronwyn Fredericks and David Legge







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## Abbreviations

ACCHO	Aboriginal Community Controlled Health Organisation
AHDG	Aboriginal Health Development Group
AHMAC	Australian Health Ministers' Advisory Council
AHW	Aboriginal Health Worker
AMS	Aboriginal Medical Service
AMSANT	Aboriginal Medical Service Alliance of the Northern Territory
ATSIC	Aboriginal and Torres Strait Islander Commission
COAG	Council of Australian Governments
CPHC	Comprehensive Primary Health Care
DAA	Department of Aboriginal Affairs
HFA	Health for All
HREOC	Human Rights and Equal Opportunity Commission
HRSCAA	House of Representatives Standing Committee on Aboriginal Affairs
NACCHO	National Aboriginal Community Controlled Health Organisation
NAHS	National Aboriginal Health Strategy
NAIHO	National Aboriginal and Islander Health Organisation
OATSIH	Office of Aboriginal and Torres Strait Islander Health
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VAHS	Victorian Aboriginal Health Service
WHO	World Health Organization



# Executive Summary

This paper presents a regional commentary (hereafter 'the commentary') on the three Australian projects of the Teasdale-Corti Global Health Research Partnership Program. The three Australian projects are: Victorian Aboriginal Health Service Ltd (VAHS), Melbourne, Victoria—*Forty Years of Comprehensive Primary Health Care*; Central Australian Aboriginal Congress Inc. (Congress), Alice Springs, Northern Territory—*Ingkintja, Male Health Program*; and Urapuntja Health Service (UHS), Utopia, Northern Territory—*Outstation Health Care*. It highlights common themes and lessons in respect to the Revitalising Health for All project in the context of Aboriginal and Torres Strait Islander health in Australia.

The commentary was commissioned at the Adelaide, Revitalising Health for All workshop, 28–29 October 2010. It was agreed that the writing of the commentary (and the associated conversation among the participating projects) would be a way to represent the project work carried out in Australia.

## ***Aims and objectives***

The purpose of the commentary is to:

- contextualise the findings of the three case studies in relation to the history of Aboriginal and Torres Strait Islander affairs in Australia, particularly in health, and the history of comprehensive primary health care in Australia
- generalise on the basis of the three case studies, having regard to the wider context, towards more widely applicable (but still tentative) insights into causes, principles and strategies for Aboriginal and Torres Strait Islander health development and for comprehensive primary health care.

## ***Methods***

The Aboriginal organisations participating in the global study have asked deep questions about the nature of the problems which their communities are facing. Moreover, they have sought to identify the strategies deployed by their organisations. The commentary endeavours to document these using the headings 'causation', 'agency' and 'strategy'. We have reflected on each of the project reports against this framework and drawn some tentative conclusions from this reflection. Informing this analysis is the macro micro principle (Legge et al. 2007) which argues for the integration of strategies conceived at the macro level with strategies directed at the personal and immediate level.

## ***Results***

Community involvement, at the board, staff and broader community level, is fundamental to the Aboriginal Community Controlled Health Organisation (ACCHO) model. Each of the three projects illustrate different aspects of this aspect of the ACCHO model from the representation of each outstation on the board of Urapuntja Health Service, to the role of Aboriginal health staff and community consultation in the Ingkintja Male Health Program in Alice Springs, to the sequence of outstanding community leaders who have worked in a voluntary capacity on the board or with program activities at the Victorian Aboriginal Health Service.

## ***Conclusion***

This paper reviews the three Australian projects and assembles our comments in accordance with a framework that includes: causation (history, macro-environments, local environments, families and individuals, ill-health); strategy and agency.





# Introduction

## Revitalizing Health for All

This commentary is prepared as part of the Australian arm of the international research and training project, Revitalizing Health for All: International Indigenous Representative Group— Learning from Comprehensive Primary Health Care Experiences (University of Ottawa n.d.). This is a multi-partner collaboration based in Ottawa, Canada, and Cape Town, South Africa, and funded through the Teasdale-Corti Global Health Research Initiative. This collaborative research funding partnership of the Canadian Institutes of Health Research, the Canadian International Development Agency, Health Canada, the International Development Research Centre and the Public Health Agency of Canada aims to build a sustainable research environment on comprehensive primary health care (CPHC).

### ***Health for all in the Australian context***

The World Health Organization (WHO) published a series of documents in the late 1970s and early 1980s that addressed aspects of comprehensive primary health care and altered the way health, health programs and community development was discussed and implemented. These documents included: the *Declaration of Alma-Ata* (WHO 1978); the *Global Strategy for Health for All by the Year 2000* (WHO 1981); *Targets for Health for All* (WHO 1985); and the *Ottawa Charter* (WHO 1986).

In response to the work being done at the global level, Australia established the Better Health Commission in 1985 to investigate and report on the health status of Australians, including factors that impact on health status and ways for the government to better address health issues. This was subsequently detailed in a three-volume report (Better Health Commission 1986). The Commission's terms of reference included the need to give 'specific attention to sectors other than health, and to at risk population groups' (Nutbeam et al. 1993:7). The Australian Government prepared a Draft Plan in response, which outlined ten goals addressing causes of death, disease and disability in Australia (Nutbeam et al. 1993). A Health Targets and Implementation Committee was established, which was given responsibility for developing national health goals and targets and to plan the implementation of their attainment. The document this committee produced (Health Targets and Implementation Committee 1988), was the first attempt in Australia to develop goals and targets for improving health and inequalities in the status of Australian health. Nutbeam et al. state that

*the Health for All Australians report contained a thorough exploration and synthesis of knowledge on the health status of Australians, of the perceived needs of the community, and of the infrastructure, funding mechanisms, and direction required to improve health status (1993:8).*

The document's overall goal was to emphasise 'the need to influence determinants of health beyond behavioural risk factors and to reduce unjust inequalities in the health status of Australians' (Nutbeam et al. 1993:3). Historically, Australia has had little experience in accomplishing this. From this report, some States developed State plans, based on their interpretations of the national

goals and targets and agreed to commit further funding to the national monies allocated via the National Better Health Program.

Nutbeam et al. (1993) reviewed the health goals and targets of Australia through and structure for setting goals and targets, proposing a new set of goals and targets and finally identifying how some of the basic options for implementation of the goals and targets (1993:2). In addressing health inequalities, the authors make three observations. Firstly, ‘... requires a balance of action by individuals and of action by and for the whole community’. Secondly, ‘... much of the social action will be outside the boundaries of the health care system, and will require close consideration of the health impact of decisions taken in other sectors such as housing, urban development, transportation, and education’ and thirdly, ‘... the health system itself will need to respond positively to the challenges implied by those unjust inequalities – both in the range and direction of services provided’ (Nutbeam et al. 1993:13).

This analysis of reflection on the past policies, attempting to set goals and targets for achieving healthy people and striving for better health, was not restricted to Australia.<sup>1</sup> Numerous countries and nations of people developed statements and policies based on the *Declaration of Alma-Ata* (WHO 1978); the *Global Strategy for Health for All by the Year 2000* (WHO 1981); *Targets for Health for All* (WHO 1985); and the *Ottawa Charter* (WHO 1986). The documents were used within Australia by Aboriginal community controlled health organisations (ACCHOs) as a platform for policy and advocacy and to further develop notions of primary health care (NAIHO 1979). It is well established that

*Aboriginal community controlled Primary Health Care services have led the way in Australia in developing a model of Primary Health Care that is able to address social issues and the underlying determinants of health alongside quality care* (Bartlett & Boffa 2001:74).

Moreover, Bell et al. (2000:75) state the ‘ACCHS [Aboriginal Community Controlled Health Service] model of care pre-dates and exemplifies the application of the Alma-Ata Declaration on primary health care endorsed by the World Health Organization’. Within Australia, Aboriginal and Torres Strait Islander peoples have developed their model, and extended and enhanced it to meet their needs, and demonstrated primary health care to other groups.

### ***Revitalizing Health for All***

At the People’s Health Movement (PHM) Assembly in Cuenca, Ecuador in June 2005, Pat Anderson and Stephanie Bell led the Australian delegation’s discussions with a number of people including Ron Labonte, David Sanders, Fran Baum and David Legge on the status of the *Declaration of Alma-Ata* (WHO 1978); the *Global Strategy for Health for All by the Year 2000* (WHO 1981); *Targets for Health for All* (WHO 1985); and the *Ottawa Charter* (WHO 1986). Bronwyn Fredericks, Lisa Jackson-Pulver and Peter Waples-Crowe and other Aboriginal and Torres Strait Islander delegates participated in the conversations. Discussions centred on the need for a project to document the many facets of comprehensive primary health care. The Australian teams are mindful that

<sup>1</sup> In 1992 the Department of Health in the United Kingdom produced *The Health of the Nation: A Strategy for Health in England*, which includes targets for improved health (UK 1992). In Canada, the Ontario Premier’s Council on Health: Panel on Health Goals for Ontario established health goals within *Health for All Ontario: Report of the Panel on Health Goals for Ontario* (Spasoff 1987). The United States of America (US) published its first document in 1980 entitled *Promoting Health/Preventing Disease: Objectives for the Nation* (US Public Health Service 1980).

one of the seeds for the Revitalizing Health for All: International Indigenous Representative Group—Learning from Comprehensive Primary Health Care Experiences project was laid at the PHM Assembly in Cuenca. We are respectful of the role that Pat Anderson and Stephanie Bell had in those early discussions in Cuenca and in the discussions that followed that led to Australian organisations being offered the opportunity to participate in the global project.

Revitalizing Health for All (HFA) includes participating project sites in Asia, Africa and Latin America. It also includes projects with a specific Indigenous health focus in Canada, New Zealand and Australia. Each of the participating projects has been encouraged to identify a set of research questions regarding its experience of implementing comprehensive primary health care. Each project was based on a triad of trainee researcher, manager and research mentor.

The projects were provided with support for a trainee researcher and research mentor through both the Global Health Research Initiative and, in the case of the Australian Aboriginal and Torres Strait Islander projects, through the Cooperative Research Centre for Aboriginal Health (CRCAH). The CRCAH was refunded in 2010 as the CRC for Aboriginal and Torres Strait Islander Health operating under the aegis of the Lowitja Institute, Australia's National Institute for Aboriginal and Torres Strait Islander Health Research. The Lowitja Institute brings together Aboriginal and Torres Strait Islander organisations, academic institutions and government agencies to facilitate collaborative, evidence-based research into Aboriginal and Torres Strait Islander health.

Australia's First Peoples have had a vibrant tradition of community-controlled comprehensive primary health care since 1971, when the first Aboriginal Community Controlled Health Organisation or ACCHO was established in Redfern, Sydney. There are now more than 140 ACCHOs around Australia. Three of these, from very different settings and facing different health challenges, agreed to participate in the Revitalizing HFA collaboration. The three organisations, and their particular projects, are:

- Urapuntja Health Service, Utopia, Northern Territory—*Outstation Health Care (2009–2011)*, (Moore 2001).
- Central Australian Aboriginal Congress Inc. (Congress), Alice Springs, Northern Territory—*Ingkintja Male Health Program (2009–2011)*, (Rosewarne & Wilson 2011).
- The Victorian Aboriginal Health Service Ltd (VAHS), Fitzroy, Victoria—*Revitalising Comprehensive Primary Health Care at the Victorian Aboriginal Health Service (2009–2011)*, (Fredericks, Luke & Brown 2011).

A poster summarising the three projects can be found overleaf.

The Revitalizing HFA collaboration calls for reports from each project. The Australian project reports along with other project reports from other countries appear on the Revitalizing Health for All: International Indigenous Representative Group—Learning from Comprehensive Primary Health Care Experiences project website (University of Ottawa n.d.). This paper presents a commentary on the three projects, seeking to draw out common themes and lessons regarding the revitalising of HFA in the context of Aboriginal health in Australia. This commentary was commissioned at the Adelaide Revitalizing HFA workshop, 28–29 October 2010, where it was agreed that the writing of the commentary (and the associated conversation among the project participants) would be coordinated by Bronwyn Fredericks and David Legge under the aegis of the Lowitja Institute.



## Aboriginal Community Controlled Health Organisations

Since their establishment in 1971 ACCHOs have played an important role in providing comprehensive primary health care services to their communities. Services are planned, managed and controlled by local Aboriginal and Torres Strait Islander communities and deliver high-quality, holistic health care. The three participating organisations, like other Australian ACCHOs, offer an array of programs and services to diagnose and treat illness, provide referrals to specialists and other providers and allied health services, provide individual and family counselling and support, and undertake broader community advocacy and support roles.


Although they receive grants from government and other sources to run some of their services, they are not government services and their employees are not government workers. Most ACCHOs have a board of directors or a management committee that is elected from a membership base drawn from the Aboriginal and Torres Strait Islander population that resides in the local or regional area. Accountability is through the board, annual general meetings, annual reports and reports to funding bodies. The elected boards are entrusted with the overall direction of ACCHOs and, in formal terms, employ the staff.

### Purpose of this commentary

The organisations participating in this study have asked deep questions about the nature of the problems that their communities are facing and about the strategies that the three ACCHOs are deploying. The purpose of this commentary is to:

- contextualise the findings of the three case studies in relation to the history of Aboriginal and Torres Strait Islander affairs in Australia, particularly health, and the history of comprehensive primary health care in Australia
- generalise on the basis of the three case studies, having regard to the wider context, towards more widely applicable (but still tentative) insights into causes, principles and strategies for Aboriginal and Torres Strait Islander health development and for comprehensive primary health care
- suggest some next steps regarding Aboriginal and Torres Strait Islander health development in Australia, including training, political advocacy and research that will advance the more clearly identified strategies and help to clarify the critical uncertainties.





# Background and Context

## Aboriginal and Torres Strait Islander affairs in Australia since colonisation

A great deal of historical and organisational context is assumed (but not included) in the three project reports, but is, nevertheless, critical to deep learning from these projects. Much of this is broadly familiar to Australian Aboriginal and Torres Strait Islander health activists but readers unfamiliar with these stories will miss much of the richness of the project reports. We do not have space or capacity to include complete or exhaustive details here. Rather, we review a small number of specific histories that are particularly relevant:

- the history of invasion, colonisation and dispossession and the subsequent waves of official policy and the changing relationship of Aboriginal and Torres Strait Islander people to the rest of Australian society
- a history of survival and resistance, which continues to the present
- official policy and program administration since the funding of the Aboriginal Medical Service in Redfern in 1971
- debates around the strategic underpinnings of Aboriginal and Torres Strait Islander health policy since 1971 (when Redfern was established)
- globalisation and neoliberalism
- relations between Aboriginal and Torres Strait Islander Australia and the wider global networks of Indigenous solidarity.

### ***Invasion, colonisation and dispossession***

Aboriginal and Torres Strait Islander peoples are the Indigenous peoples of Australia—Aboriginal peoples are the Indigenous people of mainland Australia, and Torres Strait Islanders are the Indigenous people of the islands between the Australian mainland and New Guinea. While Aboriginal and Torres Strait Islander peoples are generally grouped under the unitary banner of Australia's Indigenous people, it needs to be understood that there are significant differences in social, cultural and linguistic customs between Aboriginal and Torres Strait Islander peoples and groups. For example, at the commencement of European settlement it is estimated that there were between 250 and 300 languages, with 600 dialects spoken by Aboriginal and Torres Strait Islander people (AIATSIS 2004). Archaeological evidence demonstrates that Aboriginal people have been present in Australia for at least 50,000 years. Some historians use the figure of 125,000 years (AIATSIS 2004).

Prior to colonisation, Australia's First Peoples had complex societies and led self-determining lives with control and decision making over all of life's aspects including ceremony, spiritual practices, medicine, birthing, child rearing, relationships, management of land, and organisational systems and law. They were able to monitor and evaluate individual, family and community health and

wellbeing, and treatments were provided by traditional spiritual healers, self-care and through traditional remedies (Fredericks et al. 2011). Aboriginal and Torres Strait Islander people kept on the move with activities such as fishing, hunting, food gathering, land management and ceremonies, and, as such, were physically fit (Flood 2006:122).

Australia was invaded by the British in 1788 under the fictitious claim of *terra nullius*, which means 'land belonging to no one'. Colonisation had a profound impact on Australia's First Peoples. The establishment of the British penal colony at Botany Bay began a parallel destruction of Aboriginal and Torres Strait Islander lifestyles and cultures. It involved killings, massacres, and removal of children from their mothers, families, peoples and lands (Blainey 1994; Evans, Cronin & Saunders 1975; Rintoul 1993). Colonisation also brought with it smallpox and other extremely infectious diseases to which Aboriginal and Torres Strait Islander peoples had no prior exposure and limited resistance. The National Aboriginal and Torres Strait Islander Health Council (NATSIHC 2001:5) states that:

the ill health of Aboriginal and Torres Strait Islander peoples exceeds that of any other sector of Australian society and the causes can be partly attributed to the impact of colonisation on the health of Aboriginal and Torres Strait Islander peoples.

It further states that:

*Acts of dispossession, introduced diseases, loss of traditional foods and lifestyle, forced resettlement, loss of social cohesion, separation of children and the actions of health and welfare services reflect this impact (NATSIHC 2001:5).*

This happened at different stages and periods of time within Australia. For example, Europeans had begun to arrive in Victoria by 1830, and in Central Australia by the 1870s when the overland telegraph was constructed and when gold was discovered (Blainey 1994). In some areas of Australia, Europeans were not seen or present until some 100 years after the colonisation of the east coast.

Despite ongoing resistance, Aboriginal and Torres Strait Islander people were progressively displaced and dispossessed through a combination of disease and warfare. But they were not passive in this process and did fight back with acts of resistance against colonisation. However, guns held by Europeans were powerful weapons.

From the early focus on conquest and dispossession, official policy (from the 1860s) moved to 'protectionism' and segregation. Protection was not simply a euphemism; there was a need to protect Aboriginal and Torres Strait Islander clans from settler violence. People from many different language groups and clans were put together in the same area on mission stations and reserves. Denial or disparagement of Aboriginal and Torres Strait Islander culture was common. There was also forced dependency on the colonial state for food and housing via restrictions both on traditional food gathering and hunting practices, and on movement through keeping people within designated area of land under strict regimes administered by either by government departments or missionaries (Blainey 1994; Evans, Cronin & Saunders 1975; Rintoul 1993).

Oral histories such as those told by Charles Perkins (1975, 1993), Henry Fourmile (1993) and others (Rintoul 1993) provide evidence of maltreatment. Fourmile, for example, was in a church mission and lived in the male dormitory where he was forcibly placed at 10 years of age:

*... we were just treated like animals... Lunch was a piece of bread and a plate of soup, if you were lucky. Sometimes it was rotten really, some of the rancid soup. It was only good for animals ... but we ate it. And tea was another slice of bread and syrup and a cup of tea. And this we had for seven days a week (Fourmile in Rintoul 1993:115).*

There were specific policies relating to health, movement, marriage, schooling and in fact every facet of peoples' lives. Rules were often stricter, and the consequences more severe, on reserves or missions that were specifically established by government and church groups for Aboriginal and Torres Strait Islander peoples (see Evans, Cronin & Saunders 1975; Read 1999; Reynolds 1989, 1993; Rintoul 1993). The term 'inmate' came to be widely used at the time missions were established, its use implying some sense of the way Aboriginal and Torres Strait Islander peoples were treated and regarded.

Cope and Kalantzis (2000) state that the Aboriginal and Torres Strait Islander welfare and reserve system was 'so authoritarian as to amount in many cases almost to incarceration' (2000:25), and one in which

*Aborigines were put into the same category as prisoners and lunatics in a society which was busily setting up 'modern' institutions to remove every manner of social evil and to keep these evils out of sight, and, therefore, out of mind (2000:25).*

The colonisation of Australia is filled with evidence of the distinctions and demonstration of power between jailer and inmate. Examples such as children being housed in fenced dormitories (Huggins & Huggins 1996:28), permission being required from the Protector of Aborigines for Aboriginal and Torres Strait Islander people to leave the missions and reserves and then having to carry papers with them (later referred to as dog tags), and the strict monitoring of Aboriginal and Torres Strait Islander reserves (Reynolds 1989:81–93) 'to which any Aboriginal [person] under the Act could be transferred at the direction of the minister' (Kidd 1997:49). Kidd uses the term 'policing' (1997:49), and Huggins and Huggins (1996) the term 'surveillance' to refer to the way in which Aboriginal and Torres Strait Islander peoples' lives were monitored and documented. The practice of taking Aboriginal and Torres Strait Islander adults and children and putting them into institutions has had lasting effects on people's lives.

Even where Aboriginal and Torres Strait Islander people were not herded onto reserves and missions, it became common practice for the cattle station managers to provide rations for families living on those stations and generally working there for little or nothing. There were Aboriginal and Torres Strait Islander people who lived on the fringes of growing urban settlements and who were used as domestics and labourers for those from the dominant culture and migrants from elsewhere. Jackie Huggins writes that:

*Aboriginal women were sent to work as domestic servants and nursemaids in station homesteads and in some cases as stock workers. This work began at thirteen or fourteen years. Domestic service was a cruel time for my mother, like so many women of her generation. The working relation was of master–slave order. The men were addressed as 'Boss' the women 'Mistress'. Many women endured appalling treatment, including beatings and sexual abuse... Rita is reticent to talk about the regular beatings she received from one white mistress. I stumbled on this fact accidentally when a family friend told me of my grandparent's attempts to get Rita out of the way of that mistress before she killed Rita... (Huggins & Huggins 1996:34)*



Rita Huggins says of her time:

*When children were sent out to work it was never discussed with the parents. They were told... My first job was from dawn until the late hours of the evening, a daily routine of cleaning, washing, ironing, preparing food and caring for children... We were always given the children to look after, bath them, change and wash nappies, but we were not allowed to discipline them in any way... The days were long and tiring and never changed. All my days was spent helping the white people (Huggins & Huggins 1996:36).*

Official policy sanctioned the forced removal of Aboriginal and Torres Strait Islander children from their families into government- and church-run institutions. Sandra recounts her own removal in 1958:

*We were told to get in the car and we did. We trusted the policeman. I thought he was taking us for a ride... I didn't see my mother for another 29 years. I will never forget the fear I experienced in that car on that day, it was absolutely devastating... Every function (at the institution she was taken to for children) was systematically organised. It was like rounding up the cows. Every detail of our daily lives was done to a plan. It was a way of controlling kids. It disempowered us. It took away our thought processes. You didn't think of doing anything different because you would get the stick (Sandra quoted by Beresford & Omaji 1998:19).*

These people are part of what are known in Australia as the 'Stolen Generations' (HREOC 1997). Numerous books have been written based on the stories of people who were separated from their families (Bird 1998; Haebich 2000; Mellor & Haebich 2002). In some colonies lighter skinned children were systematically removed so that when the remaining 'full blood' people finally died out, the lighter skinned children would have been assimilated and there would be no Aboriginal or Torres Strait Islander race left.

### ***Survival and resistance***

By the 1930s and 1940s it was clear that the Aboriginal and Torres Strait Islander races were not dying out; indeed, there was a rising tide of political organisation and advocacy, exemplified by the Cummeragunja walk-off in 1939 (Koori Heritage Trust 2009; Nelson, Smith & Grimshaw 2002; Vickery, Clarke & Adams 2005) and the Pilbara stockmen's strike in 1946. Aboriginal and Torres Strait Islander people began to organise themselves and utilise the systems that the British had brought with them. For example, the Aborigines Advancement League was established and a petition to the British monarch tabled against the persecution of people.

By the 1950s, the mainstream polity was increasingly aware of the cost in human terms of policies of assimilation, and there was a rising movement by Aboriginal and Torres Strait Islander people for 'integration' that would recognise the rights of Australia's First Peoples to participate fully in wider Australian society, although the discrimination and inequality structured into the economy and social institutions continued.

Aboriginal and Torres Strait Islander activism strengthened in the 1960s with the Freedom Ride in New South Wales (Perkins 1975, 1993; Rintoul 1993) and the equal pay case for pastoral workers in the Northern Territory in 1965 (Rintoul 1993; Rosser 1985). Increasingly, the activists were going beyond integration to self-determination and national sovereignty.

The 1960s was a period of social activism around a wide range of human rights issues and the continuing constitutional discrimination against Aboriginal people was increasingly seen as anachronistic. At the time of Federation in 1901, the Constitution explicitly excluded the Commonwealth Government having any powers to make laws regarding Aboriginal and Torres Strait Islander peoples. This was reversed with a national referendum held in 1967 that empowered the Commonwealth to make laws and spend money on Aboriginal and Torres Strait Islander peoples' needs. The referendum also entitled all Aboriginal and Torres Strait Islander adults to citizenship rights, which undercut the State laws that controlled the reserves and missions. Aboriginal and Torres Strait Islander people were not passive in this process and lobbied governments and key stakeholders.

Within a few years of the referendum there was a significant migration from the reserves and missions into the cities and towns. In some areas, if you had a white parent and an Aboriginal or Torres Strait Islander parent and a white grandparent and a non-white grandparent, you were no longer allowed to live on certain missions. The government said that some Aboriginal and Torres Strait Islander people were no longer allowed to live in those areas, and it also wanted people to move into the cities and get jobs to support themselves. There was a large drift of people to Brisbane, Sydney, Melbourne and the regional centres.

From the early 1970s there was a rapid development of community-controlled service agencies, with the Aboriginal Medical Service at Redfern one of the first (from 1971). That is not to say that these services were fully funded: VAHS had been operational for six months before it received any funding, and when it finally did, it was not complete funding. There was some reluctance from governments, particularly from the States, to provide funding.

During this time there was also a rising call for the return of Aboriginal and Torres Strait Islander land expropriated for farming, mining and timber, which culminated in the Gurindji hand back in 1975 (ABC 1975) and the *Aboriginal Land Rights (Northern Territory) Act 1976*. The Commonwealth Government at this time was led by Gough Whitlam, a Labor Prime Minister. In 1992, the Mabo case was resolved with a clear rejection by the High Court of the doctrine of *terra nullius* (Meyers & Mugambwa 1993). This was followed by the Commonwealth *Native Title Act 1993* that, under pressure from the big mining companies, was subsequently watered down by the John Howard-led Coalition government in 2007.

Since 1967 there has been a rapid expansion of community-controlled service agencies and other organisations, including ACCHOs. There has been a flowering of innovation and creativity in the arts and a growing increase in Aboriginal and Torres Strait Islander participation in graduate and postgraduate study. The political structures of Aboriginal and Torres Strait Islander debate, decision and representation are increasingly robust.

Likewise, there has been a significant move towards a stronger sense of solidarity, with the Aboriginal and Torres Strait Islander struggle across mainstream Australian society symbolised by Paul Keating's Redfern Park speech on 10 December 1992 (Keating 1992), the walk across the Sydney Harbour Bridge in 2000 and Kevin Rudd's Apology to the Stolen Generation on 13 February 2008 (Rudd 2008). Paul Keating and Kevin Rudd were both former Australian Labor Prime Ministers.

However, despite these achievements, the state of Aboriginal and Torres Strait Islander health has remained significantly worse than that of other Australians, with some regions facing devastating health and wellbeing problems (ABS & AIHW 2008).

Meanwhile, the mining companies and other stakeholders operating at the interface of dispossession have also rallied and, with the support of media groups and various polemicists, have sought to roll back the self-determination movement.

On 21 June 2007, the Australian Government announced the Northern Territory Emergency Response (the 'Intervention'), ostensibly as an emergency reaction to an alleged epidemic of child sexual abuse. This was a series of broad ranging measures introduced in Aboriginal and Torres Strait Islander communities across the Northern Territory. The Australian Government stated that the 'Intervention' was in response to the national emergency confronting the welfare of Aboriginal and Torres Strait Islander children in the Northern Territory, and went on to justify its action as a response to the first recommendation of the *Little Children Are Sacred: Report into the Protection of Aboriginal Children from Child Abuse in the Northern Territory* (Brough 2007; Commonwealth 2008). The majority of the measures that the Australian Government wanted to implement required them to enact new legislation. The legislation process was concluded with 10 days of the bills being introduced to parliament. This meant that there was limited time to offer any detailed and considered analysis despite the issues and complexities at hand (HREOC 2008).

Opinions were divided about the 'Intervention'. The Human Rights and Equal Opportunity Commission states that the introduction of the 'Intervention' has been controversial because 'the approach created or exacerbated division and mistrust between the Australian Government, the Northern Territory Government, Indigenous communities and numerous community organisations. The responsibility for creating such division lies with those who led the process' (HREOC 2008:233).

The development and implementation of the 'Intervention' was very much policy 'on the run', as its shape changed rapidly in the early months and years. The 'Intervention' comprised a range of initiatives, including mandatory income management provisions, increased policing and new governance structures. Provisions of the *Human Rights and Equal Opportunity Commission Act 1986* were suspended to enable the 'Intervention'. This enabled the government of the day to direct the 'Intervention' only at Aboriginal and Torres Strait Islander people; other people were not subject to the same activities within the same geographic area. Land permits that governed the management of Aboriginal and Torres Strait Islander lands were also affected to allow for access by government and institutional groups. This was not implemented without protest and actions by Aboriginal and Torres Strait Islander people and their allies. Various opinions about the 'Intervention' were published, some of which were from the community controlled health sector. For example, the Aboriginal Medical Service Alliance of the Northern Territory (AMSANT), the peak body in the Northern Territory, provided qualified support for the measures introduced as part of the 'Intervention'. In its Annual Report for 2009–10, Chairperson Stephanie Bell states:

*Although we maintain a critical stance to the 'Intervention' as a whole, AMSANT continues to work with the 'Intervention' in trying to achieve real change for our people's health... the expanded resources made available as a consequence of the 'Intervention' have done much to provide greater equity across the Northern Territory, with resources available to some remote areas where few, if any, were available before* (Bell in AMSANT 2009:4).

Moreover, the advocacy was not limited to activities in Australia, but occurred throughout the world (see the Women for Wik website).

While child sexual assault is a significant problem in the Northern Territory, it is clear that the Liberal government was also seeking to cast doubt on policies of self-determination and civil rights and the communitarian assumptions of the self-determination movement. Under the Howard Liberal government, there were strong indications of a push towards home ownership and a development model based on families and households rather than communities.

### ***Official policy and program administration since 1967***

Appendix A provides a detailed timeline of changes in health policy and in the structures to support planning and administration of Aboriginal and Torres Strait Islander health programs in Australia. This timeline is based on the informative website maintained by the Australian Indigenous HealthInfoNet (2010). This section of our commentary should be read in conjunction with the timelines in Appendix A.

Four particular features of this story are worth noting:

- policy uncertainty regarding the merits of funding health care through the mainstream agency or through an Aboriginal and Torres Strait Islander-specific agency
- parallel development of two incompatible administrative strategies—the Aboriginal and Torres Strait Islander Commission (ATSIC) strategy and the National Aboriginal Health Strategy (NAHS), with quite divisive consequences
- influence of economic analyses of per capita health funding and the distribution of per capita health funding on funding arrangements
- the ‘Intervention’.

Since the establishment of the Department of Aboriginal Affairs (DAA) in 1972, Commonwealth policy makers have been uncertain as to whether national-level policy and funding for Aboriginal and Torres Strait Islander health should be administered through the mainstream agency responsible for health or through a specific agency. The never-released Program Effectiveness Review in 1980 (under Malcolm Fraser) recommended administration through health. However, under Bob Hawke in 1984, all funding and administration was centralised within DAA. Indeed, the Aboriginal health branch in the Commonwealth Department of Health was disbanded. With the establishment of ATSIC the health portfolio was moved to it. This had mixed results. Finally, after lobbying from the services and representative bodies and others, administration of health service funding was transferred back from the Aboriginal and Torres Strait Islander Commission to the Department of Health on the 30 June 1995 with the establishment of the Office of Aboriginal and Torres Strait Islander Health (OATSIH) within the Commonwealth Department of Health and Family Services. In 2004, under the Australian Prime Minister John Howard, ATSIC was disbanded and all funding administration was transferred to different government departments and agencies.

Policy during the DAA/ATSIC days reflected a degree of McKeownism<sup>2</sup> within DAA/ATSIC — a belief that funding health care was a bottomless pit and it would be more strategic to fund housing and infrastructure with a view to addressing the social determinants of health. There is a logic to this argument but it was unfortunate given the desperate health care needs in the community. Clearly, there was a need for both health care and investment in infrastructure. Funding for health care increased sharply after the transfer of Aboriginal and Torres Strait Islander health to the health portfolio.

In some respects, Aboriginal and Torres Strait Islander health policy under the Hawke government was a disaster; in particular, the parallel development of two incompatible administrative strategies — the ATSIC strategy and the National Aboriginal Health Strategy or NAHS (Bartlett & Legge 1995). The ATSIC strategy was based on the mainstream electoral governance model (elections, regional councils, ATSIC commission, etc.) and there was only limited consultation with the Aboriginal and Torres Strait Islander polity in its design. In contrast, the structures recommended by the NAHS and the Aboriginal Health Development Group (tripartite State forums and the national council on Aboriginal and Torres Strait Islander health) reflected intensive discussion across the health field. The emphasis on tripartism in the NAHS and Aboriginal Health Development Group reports reflected an appreciation of the long-standing tensions between the ACCHO sector and the State government Aboriginal and Torres Strait Islander health units. Despite the importance of close cooperation between ACCHOs and the mainstream health system, there had been unproductive competition and tension between the ACCHOs and State units. The constitution of the National Health Strategy Working Party is itself tripartite and its recommendations argued for continued application of this principle.

The channelling of Commonwealth funds for community-based Aboriginal and Torres Strait Islander organisations across all sectors through ATSIC regional councils from 1992 contributed to a significant degree of competition between sectors for the limited funds available to the regional councils. This was very damaging in terms of weakening the conditions for effective inter-sectoral collaboration on a range of cross-portfolio issues. In some parts of Australia relations between organisations have not fully recovered from this period.

One highlight of health policy since the transfer of funding to the health portfolio in 1995 has been the growing body of research and commentary regarding per capita health funding for Aboriginal and Torres Strait Islander health, both in terms of aggregate funds and the distribution of these funds. It should have been no surprise that many Aboriginal and Torres Strait Islander people did not have a Medicare card (providing access to medical benefits and pharmaceutical benefits under the national health insurance system) and did not access private general practice. In the context of a much greater burden of morbidity, and notwithstanding somewhat higher per capita expenditure on hospital services, per capita expenditure on Aboriginal and Torres Strait Islander health was well below agreed benchmarks. It is in part a consequence of the transfer of funding responsibility to the health portfolio that the government was able to facilitate access by ACCHOs to Medicare funds and to expand funding, including through innovative models of funding, under the Primary Health Care Access Program.

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<sup>2</sup> A reference to the writings of Thomas McKeown (in McKeown & Lowe 1974) who showed, in the context of the United Kingdom, the powerful effect on life expectancy of improved living conditions.

The ‘Intervention’ in 2007 turned Aboriginal and Torres Strait Islander policy on its head in the Northern Territory (with the suspension of human rights and a return to protectionism) and problematised policy and funding in the other States. However, the health sector, including OATSIH and the ACCHOs, was able to lever considerable extra funding for primary health care out of the turmoil.

### ***Theoretical underpinnings of Aboriginal and Torres Strait Islander health strategy***

From the early years in the 1970s and 1980s of the ACCHO movement, the leading slogans were self-determination and community control—that is, Aboriginal and Torres Strait Islander people argued and advocated for the right to determine what they wanted for themselves and to be in control of their own affairs. Community control in the context of health services was Aboriginal and Torres Strait Islander people being in control of the health services being provided for them. The slogan used by numerous health services in many areas was ‘by us, for us’. There was also a significant push for ‘sovereignty’ as a policy goal. These slogans were directed to reversing the disempowerment imposed through the colonisation process and through continuing dispossession. Around the same time the land rights movement was also gaining traction, reflecting an appreciation of the need for economic independence and cultural security. Running through both of these discourses was a strong human rights emphasis providing inspiration (‘it is our right’) and rhetorical leverage (access to resources).

The conservative side of politics was never happy with the focus on self-determination, land rights and human rights, presumably because it explicitly challenged the legitimacy of the colonial project, while the conservatives sought to control the continuing dispossession of Aboriginal and Torres Strait Islander peoples. The Australian Prime Minister at the time, John Howard, sought to counter self-determination with ‘self-management’ and in the context of the ‘Intervention’ sought to transform the communitarian assumptions of the self-determination movement with ‘family responsibility’, including home ownership. These approaches reflect a disregard for Aboriginal and Torres Strait Islander knowledge, agency and preferences.

Underpinning the growing focus on community discipline and responsibility was a growing recognition of the role of welfare dependency in the colonial project, from rations provided by the squatters and pastoralists (to stop local Aboriginal and Torres Strait Islander people killing their stock) to Community Development Employment Projects (to sustain settlements after the reserve and mission system collapsed). Welfare dependency is part of a damaging dynamic, which includes lack of opportunities for economic participation, the failure of education systems and barriers of institutionalised racism to economic participation.

These discourses (self-determination, community control, human rights, community discipline and family responsibility) wind their way through the deliberations of all ACCHOs and are expressed in their service delivery and advocacy. The Inteyerrkwe Statement described in the Congress Project Report stands as a symbol for the rising appreciation of the need to find the balance across these strategic directions.

However, the issues are not always clearly articulated. As the discussion develops, the underlying logic of these choices will be more clearly expressed in all areas of practice.



## ***Globalisation and neoliberalism***

Aboriginal and Torres Strait Islander affairs have also been affected by shifts in wider international economic policy debate. The global economic crisis of the late 1970s/early 1980s led to the eclipse of the Keynesian policy paradigm (which had sanctioned public spending, including spending to reduce economic inequality) and saw the rise and rise of neoliberalism. Neoliberalism is characterised by a deep scepticism regarding public sector programs, generally because of the vested interests of politicians and bureaucrats. Moreover, it privileges the 'rational', collective populations (dominant culture in Australia) and 'democratic decision making' and is embedded with unintended adverse consequences. Neoliberalism argues for greater reliance on the market place to elicit preferences and allocate resources, even if it does lead to wider inequalities. Discourses of social Darwinism are not so far from the surface.

The rise of neoliberalism has also contributed to the increasing insecurity of middle Australia (concerned about their children's education and employment and their own home ownership and pensions), which may have led to a weakening of solidarity in relation to Aboriginal and Torres Strait Islander peoples, as well as refugees. Family insecurity also appears to have undermined the public commitment to acting on climate change. Some mainstream politicians, while championing neoliberalism, have played upon these middle-class insecurities and thus created and fostered a more insular sentiment among Australian voters. Neoliberalism has also had major consequences for Aboriginal and Torres Strait Islander peoples and organisations (Larkin 2009). Aboriginal Australian scholars such as Cronin (2007), Larkin (2009) and Walter (2007, 2009) demonstrate how neoliberalism maintains cycles of Aboriginal and Torres Strait Islander disempowerment, poverty and welfare dependency within the Australian context.

Meanwhile, globally and in Australia, there is an increasing appreciation of the possible role that Indigenous knowledge systems could play in suggesting alternatives to materialism, consumerism and individualism and the continued despoliation of the environment. In many other countries, in particular in Latin America, Indigenous peoples are playing a leading role in challenging materialism and returning to an earth-focused spirituality.

## ***Wider global networks of Indigenous solidarity***

The Australian Aboriginal and Torres Strait Islander sovereignty movement has had strong global connections with other Indigenous and marginalised peoples for many years. During the 1960s this grew, with Aboriginal and Torres Strait Islander people visiting other parts of the world. This activity has continued, and Aboriginal and Torres Strait Islander Australians now have a regular seat on the International Indigenous Working Party at the United Nations. Australia recently signed the United Nations Declaration on the Rights of Indigenous Peoples after a long period of delay under the conservative coalition.

Global Indigenous solidarity (including mutual support), learning and multiple and collective challenges to the prevailing regime has been expressed through international gatherings, advocacy and calls for action and publications. Some recent global action in support of Australia's Aboriginal and Torres Strait Islander peoples has been demonstrated in the work done by overseas activists in relation to Australia's belated signing of the international documents relating to Indigenous people's rights and, additionally, in relation to the 'Intervention' in the Northern

Territory (Commonwealth of Australia 2008), Closing the Gap in health and other areas of disparity (NACCHO & Oxfam 2007), and various issues. A major focus has been on Indigenous rights but increasing focus is on Indigenous spirituality as a beacon to lead the mainstream beyond materialism and consumerism.

The Indigenous Studies Research Network is an international collective that operates virtually, publishes a journal and sends out notices. It is made up of both Indigenous and non-Indigenous scholars drawn from across the world. The International Network of Indigenous Health, Knowledge and Development is a connected group of people who come together every three years or so to discuss health, knowledge and development. At times they work across and within the network on advocacy or issues of concern. The Native American and Indigenous Studies Association is the only multi-disciplinary scholarly association of people (mostly Indigenous) in the field of Indigenous studies working across the world.

Indigenous peoples are struggling to preserve Indigenous knowledges and ways of being in a world of mass consumerism, and cultural and cognitive imperialism. Indigenous peoples everywhere are being pressured to share their knowledge about the earth and plants and about their languages, cultures and bodies (genome study) so that the Western world can solve the problems that it has created or so that it can own and control (copyright/patent) the knowledge. Battiste 1995, Cajete 1994, Henderson 2000, Martin 2008, Smith 1999, and other Indigenous scholars write about Indigenous knowledges. Battiste (1995) explains how Indigenous peoples' worldviews are based within a defined geographic region and in fact a map of everything within that region.

Indigenous peoples are also under attack by multinationals that continue to want to assert domination and control over Indigenous peoples' mineral and biological resources to either own them, produce products from them and/or to sell them (Battiste 1995). Indigenous knowledge and cultural heritage is not the property of nation states, regardless of jurisdiction, and Indigenous people all over the world support each other in the fight to protect their knowledges and cultural heritage.

## **Comprehensive primary health care**

The history of primary health care comprises part of the context of these three projects.

### ***International debates around primary health care***

The international debates regarding primary health care are well known to the audience of this paper, so the briefest summary only is called for. We may mention the rising interest during the 1960s and 1970s in the Chinese model of primary health care with a number of English-language reports (e.g. Horn 1971) making considerable impact outside China.

An influential collection of case studies of primary health care was published in 1975 by Kenneth Newell. This collection of case studies had been organised through the World Health Organization (WHO), which in 1978 co-sponsored with UNICEF the Alma-Ata Conference and Declaration (WHO 1978).



Werner and Sanders (1997) have described how the vision of comprehensive primary health care was progressively replaced by selective primary health care from 1981 and stratified health care from 1993. This was followed by vertical disease-focused health care from around 2000.

Meanwhile, WHO has remembered primary health care with its *WHR of 2008: PHC—Now More Than Ever* (WHO 2009).

### ***Aboriginal and Torres Strait Islander primary health care in Australia***

Aboriginal community-controlled health care in Australia comfortably antedates the Alma-Ata Conference and Declaration. In fact, the National Aboriginal and Islander Health Organisation, the national peak body, participated in the Alma-Ata Conference and in the drafting of the Declaration.

The Australian Aboriginal community-controlled health sector has always understood itself as expressing the principles of Alma-Ata but it has also travelled somewhat autonomously since then. The vicissitudes of primary health care globally (Werner & Sanders 1997) have in some degree bypassed Aboriginal and Torres Strait Islander primary health care in Australia. However, under separate pressures it has had to face some similar challenges.

Aboriginal and Torres Strait Islander organisations offer programs and services that diagnose and treat illness, provide referrals to specialists and other providers and allied health services (sometimes visiting programs like optometry and podiatry), provide individual and family counselling and support, and undertake broader community advocacy and support roles (Fredericks et al. 2011). At times they might also undertake research projects and support the development of culturally appropriate materials and training of health professionals (Couzos & Murray 2008).

Around 70 per cent of staff in the Aboriginal community-controlled health sector comprises Aboriginal and Torres Strait Islander people, and Aboriginal Health Workers (AHWs) form a core component of the staff. AHWs are vital within community-controlled health services. Eckerman et al. (2006:162) state that ‘relevance, appropriateness and acceptability of health care within an Aboriginal group can only be achieved through Aboriginal Health Workers’. Moreover, they are not only ‘the most appropriate health professionals to be dealing with their own people, but often they are also the cultural brokers guiding and protecting non-Aboriginal peoples in their own community’ (Eckerman et al. 2006:163). Generally, AHWs are there, year in, year out, within health services, while nurses, doctors and allied health professionals tend to come and go. Although ACCHOs tend to receive government grants and other monies to run some of their services, they are not government services and their employees are not government workers (Fredericks et al. 2011).

There are now also State- and Territory-based representative organisations and a national representative organisation—the National Aboriginal Community Controlled Health Organisation (NACCHO). NACCHO and its State- and Territory-based affiliates, through their elected boards, provide a representative voice for Aboriginal and Torres Strait Islander communities in health-related issues. A number of State and Territory affiliates have added established work areas that specifically focus on public health and research.

The establishment of Aboriginal community-controlled health services has played an important role in providing primary health care services that are planned and managed by local Aboriginal and Torres Strait Islander communities, aiming to deliver high-quality, holistic and culturally appropriate health care (Fredericks et al. 2011).



## Method

In developing this commentary we have embedded ourselves in the three project reports, engaging from two different points of view: first, what can be learned in terms of comprehensive primary health care, and, second, what can be learned in terms of advancing Aboriginal health? The two are not independent.

We have adopted a three-prong framework to structure our analysis of the project reports. The three prongs include causes, strategy and agency. We have reflected on each of the project reports against this framework and drawn some tentative conclusions from this reflection.

Informing this analysis is the macro micro principle (Legge et al. 2007), which argues for the integration of strategies conceived at the macro level with strategies directed at the personal and immediate level. Clinical services must address clinical need but they can be delivered in ways that also contribute to redressing the factors that reproduce such needs. Likewise, policies and programs at the macro level focused on macro-level factors must create opportunities for primary health care organisations and practitioners at the local level to gain leverage at the local level.

## Causes

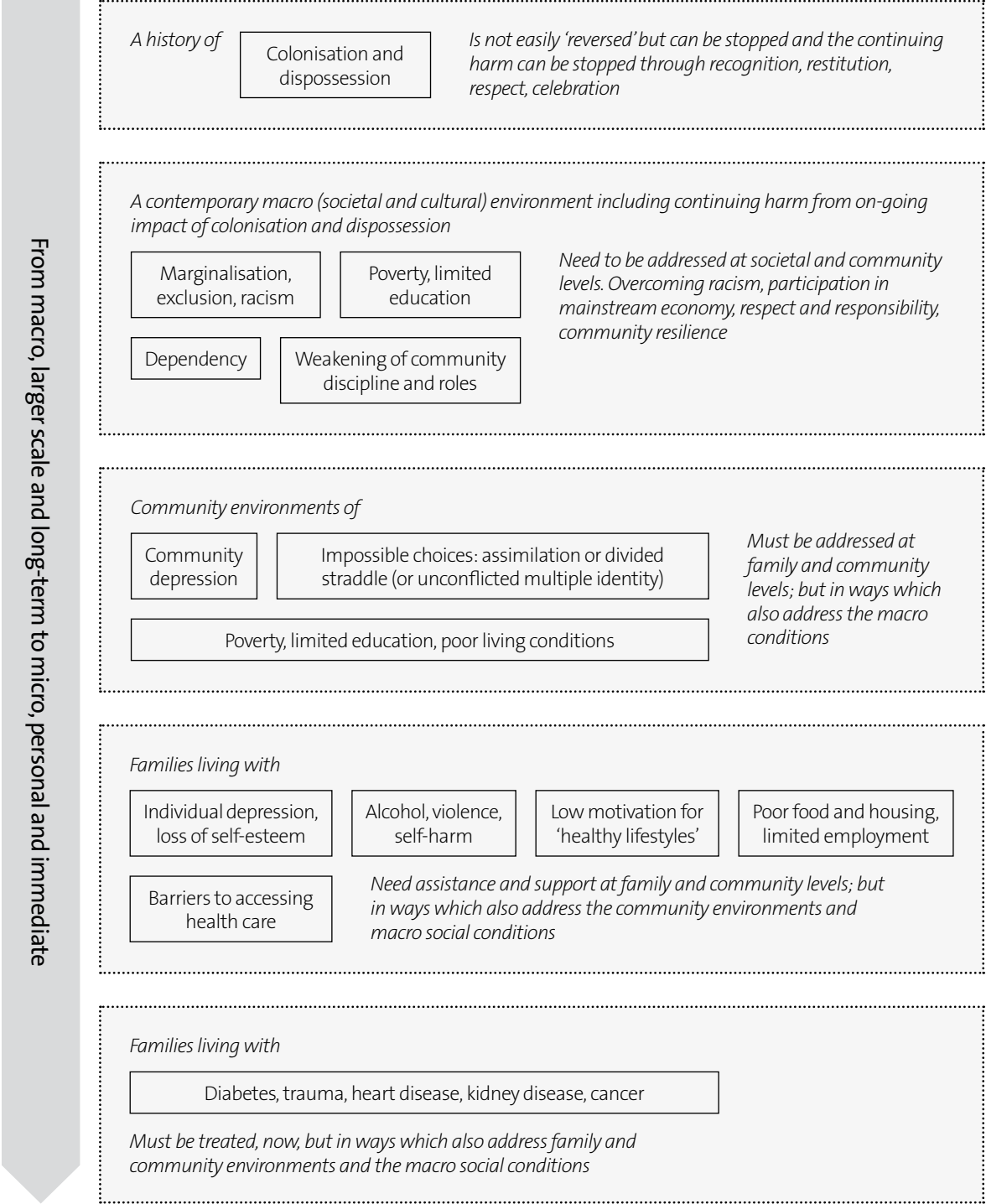
Different understandings of causation and the idea of interrupting causal pathways inform much of the work of clinical services and public health programs. Thus we treat hypertension to avoid stroke and we ban tobacco advertising to reduce the incidence of lung cancer. Of course, causation is less relevant in the recovery from stroke or the treatment of lung cancer.

However, thinking about policy and clinical services in terms of causal factors is complicated because different causal factors can operate at very different levels of scale and term. In Figure 1, we have arranged some of the causal factors underpinning Aboriginal and Torres Strait Islander health disadvantage in different levels to highlight the different levels of organisational scale and timescale across which they operate and, therefore, at which they need to be addressed.

The key principle underlying this figure is the need for coherence across the policies, programs and services that are designed to work at these different levels of scale and term. Thus, policies to address racism (at the national level) must encourage and support action on racism at the community and agency level. Conversely, clinical services addressing the problems of diabetes or kidney disease at the immediate and personal level should be delivered in ways that also contribute to redressing the causative factors at the community and macro societal levels.

Figure 1's penultimate panel mentions 'families living with', but it should be noted that it is not just families—it could also include individuals and families living with these issues. In some cases it may be a linked group of individuals within the community. To address these issues, assistance and support is required at individual, group, family and community levels. Education in the context of Figure 1 refers to participation in mainstream education systems and not within Aboriginal and Torres Strait Islander education systems.

**Figure 1:** Causal pathways underlying Aboriginal and Torres Strait Islander health disadvantage – from macro and long-term to personal and immediate



## **History**

At the top of Figure 1 we have placed the historical experience of colonisation and dispossession, which is fundamental to an understanding of Aboriginal and Torres Strait Islander health. Insofar as colonisation is located in the past, it is not able to be 'interrupted'. In some respects we are still in a process of colonisation. Insofar as there are continuities between the early colonial process and contemporary relations between the Australian state and Aboriginal and Torres Strait Islander peoples, these processes need to be recognised and reversed through restitution (land rights), respect and recognition.

## **Macro societal environment**

The second panel, *the contemporary macro (social and cultural) environment*, refers to the continuing harm from the ongoing impact of colonisation and dispossession. Four aspects of this harm are listed:

- marginalisation, exclusion and racism
- poverty and limited education
- welfare dependency
- the weakening of community discipline and roles.

These need to be addressed at all levels from the macro societal/national policy level, to style of service delivery, to norms of individual understanding and behaviour. The National Health and Medical Research Council states that 'Aboriginality is itself a health hazard' (NHMRC 1996:24). It is sad to read that in one of the most industrialised 'first world' countries, Aboriginality and Aboriginal and Torres Strait Islander culture are a hazard to health. Racism has been part of the processes of colonisation since 1788 and it is racism that maintains inequities in health care. It is not Aboriginality that is a health hazard, but overt and covert racism. Aboriginal and Torres Strait Islander identity is an important underpinning in these three projects.

What is evident is that historically Australia's First Peoples have been asked to fit within the dominant culture's framework of health care, of community and of seeing the world. It is the dominant culture that has been given privilege, status and prominence in Australian contemporary society and overrides other views and systems. This is the nature of Australian Eurocentrism. If Aboriginal and Torres Strait Islander people do not adopt these views and systems or work against 'fitting in', we are put further at risk of remaining sick, poor and being left in the margins. When we access health services because we are in absolute need, not because we agree with the viewpoints, we can serve to affirm the dominant viewpoint and its models of service delivery. At times it is as if we must accept the worldview from which such services operate, and at times almost place our viewpoint to the side in order to receive a service, while services and the staff within those services can ignore the viewpoints of Aboriginal and Torres Strait Islander people. We can be forced to affirm the colonialists' values and sacrifice our own in the name of receiving health care to 'improve our health status'. The health status of Aboriginal and Torres Strait Islander people and any improvements to that status are intrinsically linked to Aboriginality and our sense of health and wellbeing. Our Aboriginality and the recognition and affirmation of Aboriginality through every point of service delivery are vital for improving our health and wellbeing.

The locations and settings in which Aboriginal and Torres Strait Islander Australians live vary, but more than 70 per cent now live in urban or regional urban areas (ABS 2007). The growth of the urban Aboriginal and Torres Strait Islander Australian population has been the subject of a range of reports and studies in the past 30 years (Australia 2002, 1992; Hollingsworth 1992; Ivanitz 1999; Langton 1981). Living in urban environments includes trying to find or make space within the city for Aboriginal and Torres Strait Islander cultures, languages, and individual and collective expression. It has also witnessed the establishment and maintenance of Aboriginal and Torres Strait Islander organisations, programs, services and other structures. One of the issues faced by our people in urban centres is the always present dominant culture—along with this culture’s framework of health care, of community and of seeing the world and Aboriginal and Torres Strait Islander people within that world (Anderson 2003; Fredericks 2004; Hollingsworth 1992; Langton 1981).

### ***Community environments***

The third panel, *community environments*, focuses on how conditions at the community level can contribute to poor health outcomes. This panel should not be interpreted as saying that such conditions characterise all communities simply that they are sufficiently common to be recognised as part of the problem.

Poverty and poor living conditions are recognised as contributing to poor health, and community depression can be palpable in some settings. The idea of forced choices is less straightforward. Underpinning this idea is the recognition that identity or subjectivity in a multi-racial society is complex and often multiple. We are imagining that there should be no conflict between identifying as Aboriginal or Torres Strait Islander and identifying as Australian. We play many roles in the different institutions in which we live and work and play, and each of them provides different subjectivities: nurse, teacher, football supporter, bus driver. However, where those institutions are permeated by racist stereotypes, taking on the role of nurse, teacher, supporter etc. can be difficult because of the flares of disparagement ignited by such racism.

We are suggesting that there are too few pathways through which our young people can find roles and subjectivities in mainstream institutions that do not conflict with their pride in being Aboriginal or Torres Strait Islander. We are suggesting that some young people are forced to suppress their sense of being Aboriginal or Torres Strait Islander as a condition for participation and others are locked out of wider participation because of the pain and discomfort of racist environments.

These kinds of factors (community depression, forced choices and poverty) need to be addressed at the community level, because this is where they are manifest, but action at the community level needs to be supported through initiatives at the more macro societal level. Conversely, initiatives at the community level need to be mounted in ways that also reinforce the pressures for change at the macro level.

## ***Families and individuals***

Our fourth panel, *families living with*, deals with disabilities that are much more visible and evident: individual depression, violence, alcohol use, poor food and housing, limited employment options and barriers to accessing health care. These factors are shaped by the more macro and longer term factors referred to in the earlier panels.

A wide array of policies, programs and services have been implemented to address these family- and individual-level disabilities, including counselling, welfare programs and health promotion. In many cases these programs are delivered through other agencies in the fields of justice, housing, child care, etc. It is an important challenge to implement these programs in ways that also contribute to redressing the more macro and longer term factors.

## ***Ill health***

Finally, the last panel in Figure 1 deals with sickness, injury, disability, and pain and grief. In some cases such problems are just consequences of being human and growing old, but in many others they reflect the workings of the social, cultural and economic dynamics referred to in the previous panels.

Given the heavy burden of individual morbidity, ACCHOs around Australia must necessarily devote much of their attention and a large proportion of their resources to the care and rehabilitation of the sick.

## **Strategy**

The second component of the framework we have used to analyse the three project reports is strategy. In looking at the organisation involved in each case study, we asked the following questions:

- What are you trying to do and how do you think your work will achieve change?
- To what extent are you addressing the causal pressures referred to above?
- How do you achieve a balance between immediate needs and long-term change? How do you maximise the synergies between actions at these different levels?
- All of the projects deliver clinical services. How do you promote cultural safety and access? How do you promote quality and efficiency? What is it about the way you deliver clinical services that also contributes to change at the levels of families and communities and at the macro societal level?
- What is the focus of your community programs? How do these work?
- What is it about the way you deliver community programs that also contributes to change at the macro societal level?
- How do you manage and steer your ACCHO?
- What is your vision for organisational development and how will that enable you to be more effective in delivering clinical services and community programs?

- How does your ACCHO work with community organisations in other sectors to best use your resources to deliver services and programs and to address the macro issues?
- How does your peak body support your work? How do you contribute to the work of the peak body?

## Agency

Understanding causes and strategy is necessary but not sufficient. We also need to recognise and support the *agents* whose actions drive change; the people whose purpose, commitment and leadership are driving those strategies.

In the training and culture of mainstream health professionals, the agency that is assumed is that of the practitioner—the practitioner is the decider, the doer, the teller. The agency of ‘the patient’ is limited to attending the clinic and being compliant. In the culture of the planners and policy makers, the agency that is assumed is the agency of the managers, funders and regulators. The agency of clinicians is limited to ‘carrying out their role’; the agency of patients, consumers, citizens and families is largely invisible.

The perspective from inside the ACCHO is very different. The purpose and commitment of families, and the inspiration and drive of community leaders, have been visible within Aboriginal and Torres Strait Islander communities since white settlement and provide the resistance and the resilience that are the key resources for good health today.

Simple clinical procedures may involve an active clinician and a passive patient but social change (addressing the social determinants of health) involves the interplay of innumerable individuals, organisations and movements. Social change involves collaboration and conflict across various axes of difference and at various levels of scale and duration, and collaboration based on solidarity, conflict involving power, and ideology and access to resources.

Strategy makes assumptions about agency. Clinical strategies may assume the agency of the clinician is paramount. Policy strategies may assume the agency of the manager is paramount. However, such thinking ignores the reality of Aboriginal and Torres Strait Islander health and will do nothing positive for health development.

In the context of the Revitalizing HFA project, the primary agents of change are the ACCHOs and their staff, board members and other community members who contribute to their work. However, it is necessary to go beyond these ‘immediate agents’ to understand the wider array of those who drive change because, in part, the work of the ACCHOs is directed to supporting these other agents of change.

We may start with grandparents as agents whose practice protects and advances the health of their families and communities. The grandparents work to hold their families together, look after the children, and teach culture and roles. Grandparents are also a metaphor for the many ordinary community members whose courage and commitment holds families and communities together in difficult times.

Other agents of health development, not necessarily seen as such by them, include community leaders, workers in other community organisations (culture, sport, housing and education), and the activists who engage on various policy and planning committees.

Other agents, beyond our communities, are the mainstream clinicians who work with the ACCHOs, the politicians and bureaucrats who understand history and seek to work in ways that support Aboriginal and Torres Strait Islander agency, and the solidarity organisations such as Australians for Native Title and Reconciliation (ANTAR) that work to mobilise mainstream Australia against institutionalised racism.

The focus of Revitalizing HFA in Australia is on the ACCHOs, in particular the three participating organisations. Agency in this context points to the drive and commitment of the board members, the managers, clinicians and, critically, the AHWs.

Representing and supporting the ACCHOs are the State ACCHO peak bodies, (AMSANT in the Northern Territory and the Victorian Aboriginal Community Controlled Health Organisation or VACCHO in Victoria) and the training institutions and researchers, as in the Lowitja Institute.





# Structured Analysis of the Three Projects

We have reviewed the three projects against the above framework and assembled our comments in accordance with that framework: causes (history, macro environments, local environments, families and individuals, ill health), strategy and agency.

## Urapuntja Health Service—*Outstation Health Care*

The Urapuntja Health Service is an Aboriginal Community Controlled Health Service located in a remote region of Central Australia. It services a population of about 1000 permanent residents who live in 16 homeland communities. The original Aboriginal nation was spread out over many thousands of kilometres but after colonisation, the massacres and then a ‘buy back’ of their own land the Alyawerr mob decided to cluster in the area of Utopia, with each family group having their own space ‘to keep the peace’ (Moore 2011). This has proven to be very successful and the communities live with much of their culture and traditions intact. Alyawerr language is strong and English is always a second or third language.

Urapuntja has been delivering core primary health care services to the community for more than 30 years. The authority of the health board and community members determine how the service works and to this day health statistics at Utopia are better than most communities in the Northern Territory (McDermott et al. 1998; Moore 2011; Rickards et al n.d.; Togni, Rickards, Brown 2011). Employment of local Aboriginal people has been the mainstay of the service. Exchange of language and ideas has assisted the health service to become what it is today. While the struggle to ‘remain intact’ continues, the Urapuntja Health Service has the aim of delivering a holistic service that assists community members to make informed decisions about their lives and health long into the future (Moore 2011:Abstract). Findings from this project, which focused on the health care delivered through the outstations, can be found in Moore (2011).

### ***Causes***

#### **History**

Culture, spirit, language and way of living have survived colonisation and have resisted dispossession.

The Utopia population is made up of approximately 1000 permanent residents who live across 16 homeland communities located across the Alyawarra and Kayititji and the Angarrapa Aboriginal Land Trusts (Rickards et al. n.d.). It includes the land/Country of the Alyawarra and Anmatjerre peoples.

The pastoral lease for Utopia was established in the 1930s. At this time the clans from the area congregated at Three Bores.<sup>3</sup> It is noted in Rickards et al. (n.d.:5) that with different families and

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<sup>3</sup> Where community members provided a workforce for pastoralists and received rations for payment (Rickards et al. n.d.). Payment for work through food rations was common for Aboriginal and Torres Strait Islander people in Australia during this period (see Rintoul 1993 for experience-based examples).



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

Incorporating the Cooperative Research Centre  
for Aboriginal and Torres Strait Islander Health

**Urapuntja Health Service and Utopia community**  
Alice Springs and Northern Territory

The Urapuntja Health Service is an Aboriginal Community Controlled Health Service located in a remote region of Central Australia. It serves a community of approximately 1,000 people. The Utopia community is a traditional Aboriginal nation that was established in 1971. The Urapuntja Health Service was established in 1997, following the recommendations of the Health Review Commission. The Urapuntja Health Service is a member of the Urapuntja Health Service Group, which includes the Utopia Health Service and the Utopia Health Centre. The Urapuntja Health Service is a member of the Urapuntja Health Service Group, which includes the Utopia Health Service and the Utopia Health Centre. The Urapuntja Health Service is a member of the Urapuntja Health Service Group, which includes the Utopia Health Service and the Utopia Health Centre.

**Revitalising Comprehensive Primary Health Care at the Victorian Aboriginal Health Service**  
Benwynn Fredericks, Joanne Luke and Alan Brown

The Victorian Aboriginal Health Service (VAHS), established in the inner Melbourne suburb of Abing in 1973, has been recognised as a model of Comprehensive Primary Health Care (CPHC) in a community controlled health service sector in Victoria and Australia. This project, based at VAHS, has sought to conduct an historical analysis of CPHC. It explores the ongoing history of VAHS, and its overall role in driving CPHC, via a literature review, VAHS CPHC self-audit, and a focus group. The social determinants of health are also considered as part of this project. The project will be disseminated to other Aboriginal people via a literature review, key reports in the journal and support issues for the future. The project has offered a way to revitalise the past and create enthusiasm for the future. The project has offered a way to revitalise the past and create enthusiasm for the future. The project has offered a way to revitalise the past and create enthusiasm for the future.

**Ingkitjinta - Learning from Comprehensive Primary Health Care Experiences**  
Clare Robertson, Cal Wilson, John Liddell, Steve Luke and Kerry Summers

The Ingkitjinta Learning from Comprehensive Primary Health Care Experiences project examines how the Central Australian Aboriginal Community Controlled Health Organisation (CAACCHO) has made health care more health, as an example of Aboriginal health care in the Alice Springs region. Aboriginal nations identify the need for individuals to take responsibility for their actions, with appropriate support, so this will lead to beneficial changes for their families and their communities, and build individual and collective capacity to address broader social issues that contribute to community health. These Aboriginal nations locate their health within a local and regional health framework. The identified strengths of Ingkitjinta must be an integral part of cultural safety and being able to work with the original approach, multi-disciplinary staffing, advocacy on the social determinants of health, and responsiveness in approach and service delivery. This approach has seen a significant increase in access rates by Aboriginal people. The project has offered a way to revitalise the past and create enthusiasm for the future. The project has offered a way to revitalise the past and create enthusiasm for the future.

Poster depicting the 3 Australian sites: Urapuntja (NT), Alice Springs and Melbourne

clans living in the same area there was ‘Conflict and risk of diabetes and other chronic conditions “Just like a Welfare town”’. Once freehold title was obtained for the land in the 1970s, the leaders of the community decided that they would not live in a centralised way and that they would disperse to their traditional homeland areas (Moore 2011; Rickards et al. n.d.). Once back in their homelands they would then establish small outstations. The leaders wanted to avoid ‘the social health problems associated with living in large towns with other tribal, clan and family groups from numerous areas’ and to ‘enable family groups to live on their traditional Country’ (Rickards et al. n.d.:1). Therefore, there is no centralised township as found in other remote or regional areas. This was a decision made by the leaders of the community for the community.

Authority is vested in the homelands. It is not centralised on one place and on other people’s land. Decisions are made at the point of the family and clan and community. Rickards et al. (n.d.:5) explain that this ‘enables decisions to be made and enforced for the benefit of the community’. People are dispersed across the region, and thus also have access to their sacred sites and places of cultural significance (Moore 2011).

Overall, the decentralised way that Utopia works protects and preserves good health and culture. It maintains a strength that other communities struggle to achieve. One of the major barriers experienced by Utopia is the lack of support from mainstream government. Rickards et al. (n.d.:6) explain that ‘Health bureaucrats and funding bodies appear to have difficulty comprehending and accepting the fundamental role of local Culture in all aspects of health planning and delivery’.

Long-term sustainability depends on continued government funding and the current model carries uncertainties in the longer term. The focus of this project is on outstation health care.

### **Macro social and cultural environment**

Culture and language are strong and proud. Community discipline is strong; traditional roles are respected. The Urapuntja Health Service provides care across a group of 16 remote homeland communities in the area known to many Australians as Central Australia. In this region Aboriginal people are in the majority. The people speak English as a second or third language. There is no centralised township.

Urapuntja Health Service is an ACCHO, in the same way as the Victorian Aboriginal Health Service and the Central Australian Aboriginal Congress are, and has a Board of Directors of Aboriginal people. It differs to VAHS and Congress is that the Urapuntja Board is a representative board based on clan structures rather than through the election of people from the membership. The health service operates through an outreach model that visits the outstations. This enables people to live on their homelands and access good health care within those homelands. In a thematic analysis of interviews from the Kanyini Qualitative Study carried out by Togni, Rickards and Brown (2011:4), one participant suggested that:

*Aboriginal people involved in the health service had been successful in convincing the government funding body to recognize the intrinsic link between culture and health through presenting the results of a study in Utopia that showed the protective factors of the homeland lifestyle with regard to the rates of cardiovascular disease in the population.*

They were making reference to earlier research undertaken by McDermott et al. (1998).

The benefits of living within culture on one's homelands cannot be underestimated and have been described in numerous papers (see McDermott et al. 1998; Moore 2011; Rickards et al. 2011; Togni, Rickards & Brown 2011). One person as quoted in Togni, Rickards and Brown (2011:4) states, 'I mean living on your homeland is the best thing you could probably do...' People have access to bush foods, exercise through seeking out food sources (including hunting) and access to bush medicine. The health service is positive about hunting and gathering and supports people to do this (Moore 2011).

There is no sense of 'dependency' because the traditional Aboriginal economy is strong. Living on Country and being in the majority means that there is no sense of being 'marginalised' or 'excluded' or exposed to the day-to-day types of racism as experienced in and from the dominant culture.

The community has insisted on outstation living despite the pressures from government for a 'hub and spokes' model with aggregation of services.

### **Community environments**

Communities and clans are not depressed; they are living their own culture.

Education is rich but largely traditional; achievement in mainstream education is limited but this is not such a disability because the economy is traditional. People grow up on their homelands and within culture and their land. This is only altered if people need to move to Alice Springs or further away to visit people or to access medical treatment not available through the Urapuntja Health Service.

The community fought for the outreach model of health delivery because it aligned with their personal and cultural philosophical worldviews, and with their model of living through the clan structures on their homelands. The council is made up of representatives from all clans and practises a highly consensual decision-making. The Urapuntja Health Service is controlled by senior people from the clans and works subject to their policies. The service employs numerous Aboriginal people.

Although there are not many pathways to 'unconflicted multiple identities', the community is presently choosing not to engage closely with the mainstream culture so, for many people, the issue does not arise.

### **Families' experience**

While depression, violence and alcohol are not common, it is noted that alcohol and cigarettes are problems causing sickness for some community members (Rickards et al. n.d.), as are sugar and fat from store foods. Rickards et al. (n.d.:6) state that 'Violence and conflict arising from alcohol use is strongly identified as a form of ill-health'.

People have access to traditional foods, and hunting and gathering constitutes a healthy lifestyle. More conventional structures may be less relevant than elsewhere. There is a community store and people access some foods from the store.

The homelands offer a protective factor in that people have less outside influences, less access to store food and less exposure to infectious diseases. People are able to undertake their own cultural practices with regards to health, and partake in ceremonial activities.

The homelands, however, present other challenges. There is limited employment in the sense of mainstream economy, but people are employed in the business of the community.

People utilise the health service on its scheduled visits, and also access bush medicines and Ngangkari (also called traditional healers).

Some participants in the Togni, Rickards and Brown (2011:6) analysis noted that the Urapuntja model 'creates dependency within the community on the health practitioners', while others said that it creates:

*independence in that it supports the way people want to live and encourages them to have confidence to deal with complex health issues in their homelands rather than moving to live close to a health centre.*

### **Illness, injury, disability**

There are better health outcomes found in this area than elsewhere in the Northern Territory. This is despite a poor profile in relation to the conventional social determinants of health (Rowley et al. 2008). The Urapuntja Health Service specialises in delivering health care in a way that is appropriate for this community. Health care involves cooperation between Aboriginal Health Workers and doctors and nurses under the supervision of council.

In the past decade there has been an increase in people with chronic and complex illnesses (Togni, Rickards & Brown 2011; Rickards et al. n.d), which has meant increased pressure and workloads on the visiting services to the homelands (Togni, Rickards & Brown 2011:4). Togni, Rickards and Brown (2011:6) state that 'there has not been a similar increase in the staffing levels within the health service': there was a recent increase in funding and staff but this was connected to the Northern Territory 'Intervention'.

### **Strategy**

The delivery of primary health care services as controlled by Aboriginal people representing the homelands is a key strategy. Aboriginal Health Workers live and work within the homelands. If they need to, they can ring the main clinic to send extra people, medications or supplies when they are coming out to that particular homeland outstation for a scheduled visit (Rickards n.d.:6). Cultural protocols are embedded within health care delivery. There is an awareness of different health systems.

Aboriginal Health Workers in this context form a vital link between the homeland outstations and the main clinic, which employs other community members too. AHWs and community members are active in care and support advocacy.

There is strong leadership and leadership expressed by senior community members. The revitalising comprehensive primary health care project at Utopia found that 'the value of land ownership and autonomy to mental health, harmony and cultural continuity has... often been understated. These are the social and political determinants of health' (Moore 2011:7). One participant in the project

stated: 'living on one's homeland means that you are embedded within your culture; are a distance from fatty store foods; and have access to bush tucker and bush medicine' (Moore 2011).

Culture is a strategy utilised by the people of Utopia and the Urapuntja Health Service. Culture is embedded in its practices and in health care delivery.

### **Agency**

The benefits of living within culture on one's homelands cannot be underestimated in the context of Utopia. The decision made by the leadership of the Utopia community in the 1970s to disperse to their homelands has witnessed them experience better health outcomes than many other Aboriginal and Torres Strait Islander people in other regions of the Northern Territory and, indeed, Australia. Utopia still has strong leadership and strong senior people. The structure of governance and the exercising of authority through the governance is a strength.

Decentralisation prevents people congregating as in other regional areas, stops the mixing of clans and families in ways that are not healthy, and limits access to store foods. It means people need to be more self-reliant on themselves and each other within their homelands.

With regards to primary health care, Aboriginal Health Workers make the system work for people within the homelands. They are the people based in the homelands and provide the link to the clinic.

Culture itself acts as agency. Culture is a driver and an agent to good health and wellbeing.

## **Central Australian Aboriginal Congress Inc. — *Ingkintja Male Health Program***

The Ingkintja *Learning from Comprehensive Primary Health Care Experiences* project examined how the Central Australian Aboriginal Congress Male<sup>4</sup> Health Program reflects the social determinants affecting male health, as articulated by Aboriginal males in the Alice Springs region. Aboriginal males identified the need for individuals to take responsibility for their actions, with appropriate support. It was believed that this would lead to beneficial changes for their families and then their communities, building individual and collective capacity to address broader social issues that contribute to community health (Rosewarne & Wilson 2011). As is evident in the project report, Aboriginal males involved with the project and the Ingkintja locate their health within a social and emotional health framework (Rosewarne & Wilson 2011).

The project identified numerous strengths of the Ingkintja Male Health Program. These include a high degree of cultural safety (including being male only), the mix of preventative, health promotion, treatment and rehabilitation services, taking a broad holistic view of health, the drop-in centre approach, multi-discipline staffing, and advocacy on social determinants of health, along with flexibility and responsiveness in approach and service delivery. A consequence of this approach has been a significant increase in access rates by Aboriginal males (see Rosewarne & Wilson 2011).

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<sup>4</sup> The term 'male' is used in this report for this project, as the terms 'men' and 'man' have particular cultural meaning in Central Australian Aboriginal communities to denote a male who has certain status related to cultural practices and knowledge.



# Ingkintja: Learning From Comprehensive Primary Health Care Experiences

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## Introduction

The Ingkintja Learning From Comprehensive Primary Health Care Experiences project examines how the Central Australian Aboriginal Congress Male Health Program reflects the social determinants of health affecting Aboriginal male health, as articulated by Aboriginal males, in the Alice Springs region, Australia.

## Context

Aboriginal males in central Australia have higher levels of social disadvantage than Aboriginal males in other regions, Aboriginal women in general and the broader non-Aboriginal community and they suffer from high levels of mental health conditions.

Ingkintja is a branch of the Aboriginal Community Controlled Primary Health Care Service, Central Australian Aboriginal Congress.

Programs at Ingkintja at the time of study—GP clinic (adult health checks), counselling, sexual health screening, hygiene facilities, drop-in centre, health education, tool box program, advocacy.



Ingkintja, is a central Australian Aboriginal word, meaning a meeting place for males.

Our logo shows men (in black) sitting down with younger males and non-Aboriginal males to talk, listen and learn about health. Ceremonially, we wear a layer of white cockatoo feathers that allow our true personalities to come out. Two spears are available to be used as tools for destroying danger, a shield for protection and boomerangs as symbols of extending friendship.

## Methods

A narrative case study approach, incorporating lay knowledge perspectives was employed.

Qualitative methods: literature review, document analysis, key informant interviews and community and service user consultations.

Quantitative data: de-identified service use data from the patient recall system Communicare, service data from program records, program evaluation, funding reports and ABS population data.



## Findings

The program in its early years was poorly resourced, inappropriately located and suffered from the social stigma related to being funded as an STI Program. This worked against desire to address poor male access rates to clinics and delivery of a broad holistic health program. Community consultation (2004) is a watershed change for the program.

## Aboriginal male health causes, status and

Aboriginal males identify the need for individuals to take responsibility for their actions, with appropriate support, this will lead to beneficial changes for their families and then their communities, building individual and collective capacity to address broader social issues that contribute to community health. This represents a sophisticated understanding of the pathways to address the individual structural divide.

Motivation to action include responsibility to, and support from, family, their own sense of self esteem (including cultural) obligations.

Aboriginal males locate their health in an emotional wellbeing framework, recognising the impacts of colonisation, changing male roles in contemporary society and social alienation and exclusion from access to employment opportunities as key contributing factors.

## Ingkintja: theoretical frameworks, principles

Ingkintja recognises and works towards empowering Aboriginal males, boosting self-esteem and creating personal and community capacity to address and take action on social issues.

The gender specific nature of the program and its cultural safety aspects are key elements in creating an environment for Aboriginal males to access health care and support.

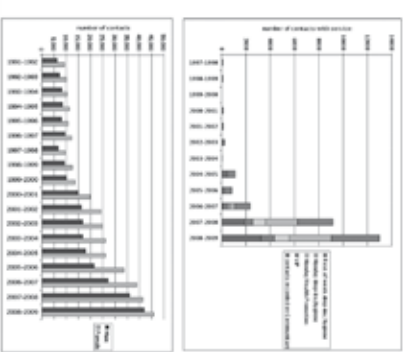
The identified strengths of Ingkintja include:

- high degree of cultural safety,
- the mix of preventative, health promotion, treatment and rehabilitation services,
- taking a broad holistic view of health,
- the drop-in centre approach,
- multi-discipline staffing,
- advocacy on social determinants of health and flexibility and responsiveness in approach and service delivery.

Ingkintja engages in advocacy both under the broader banner of Congress and in its own right, such as the Central Australian Aboriginal Male Health Summit (2008). When Ingkintja has taken direct action on issues coupled with advocacy and capacity building, such as with the Summit, its impact on policy is most recognised.

## Access

There has been a significant increase in access rates by Aboriginal males.



## Barriers

There exists an interrelated set of issues that act as program barriers including:

- ongoing issues around access to services by Aboriginal males,
- limited and inflexible funding and
- government policies that vilify and undermine Aboriginal male dignity and roles within their communities.

This includes a health policy discourse that blames Aboriginal males for their and their community's poor health and social problems and male health policy that focuses on sexual health.

## Conclusion

Congress Ingkintja provides a very successful health service program with high community support and utilisation rates to Aboriginal males in the central Australian region.

Utilising community development and comprehensive primary health care principles, Ingkintja staff work sympathetically and effectively with Aboriginal males to empower them to take action to address the social determinants of health.

The program balances its focus on developing individual capacity to deal with these issues, with broader advocacy work at the structural and policy level.

## Capacity development & training

Capacity development occurred via a formal training strategy, informal transfer processes between researchers and program staff and mentoring.

## Acknowledgements

We would like to thank Central Australian Aboriginal Congress (CAAC) Chair for supporting this research project. Their former A&M Deputy Secretary, the Year of the Researcher and the highly inspirational primary health care training available, are also acknowledged for their considerable financial contribution to CAAC.

This work was funded and supported from the Central Australian Aboriginal Congress (CAAC), a not-for-profit organisation, and the Public Health Agency of Canada. The Australian Commonwealth Development Agency, Health Canada, the International Development Research Centre, and the Public Health Agency of Canada.



Ingkintja provides a very successful health service program with high community support and utilisation rates to Aboriginal males in the Central Australian region. Utilising community development and comprehensive primary health care principles, Ingkintja staff work sympathetically and effectively with Aboriginal males to empower them to take action to address the social determinants of health. The program balances its focus on developing individual capacity to deal with these issues, with broader advocacy work at the structural and policy level (see Rosewarne & Wilson 2011). Findings of this project can be found in Rosewarne and Wilson (2011).

## **Causes**

### **History**

Alice Springs has been the base camp for the colonisation of Central Australia. It has been the urban centre to which 'urban immigrants' from more remote communities have come; slowly in the early years, then in the post-1967 inflow, and subsequently responding to other pressures including the Northern Territory 'Intervention'. Some people plan to only stay a while, and others have been there for long periods of time.

It is important to understand how many of the 'remote communities' were actually aggregations of different clans and language groups that had already been dispossessed but were herded together as part of the protection and segregation era. This aggregation of languages and clans contributed to weakening community discipline, roles and coherence. Utopia is one of the exceptions to this pattern.

While European settlement in Central Australia is generally dated from 1870–80, for many communities in the area the processes of dispossession has been much more recent—some Western Desert people having first contact in the 1950s. In many respects, the struggle for land rights and access to mining royalties (where mining has been approved) has constituted the main resistance to post-colonial dispossession. However, even communities that have access to mining royalties can suffer from the pressures of racism and exclusion.

### **Macro social and cultural environment**

The Aboriginal and Torres Strait Islander community of Alice Springs is quite heterogeneous, including professionals and businesspeople, long-established town camp people and more recent immigrants. The Ingkintja project is mainly working with men who have been through very difficult social circumstances.

Racist attitudes and stereotypes are common in the Alice Springs environment, although they may have less structural effects for people who have careers, jobs and comfortable homes than for people, like many of the more recent 'remote to urban' migrants, for whom these attitudes may increase their sense of marginalisation and exclusion.

Many of the remote to urban migrants come from settlements that are experiencing a weakening of community discipline and prescribed roles and in which dependence on welfare has been a salient feature. Educational achievement is often quite limited. Current Commonwealth and Northern Territory government administrative policies and practices are adding to this migratory pressure.



## **Community environments**

Alcohol misuse is a measure of community depression among these people. However, as well as anaesthetising the pain, it too often serves the purpose of releasing anger and violence, both as self-harm and as violence against others.

The Ingkintja project report (Rosewarne & Wilson 2011) provides some insight into the frustration and grief that is too often expressed in such anger. It is a 'no-man's land' between a fragile community and exclusion from the mainstream. Poverty, limited education and poor living conditions are part of the mix but a lack of hope and lack of clear pathways are more killing.

## **Families' experience**

Depression, lack of pathways and lack of hope, loss of self-esteem and a barrage of demeaning messages, and the epidemic of alcohol, violence, self-harm, sexual assault and teen pregnancy are major factors negatively shaping Aboriginal male health in the region. Aboriginal males identify the need for individuals to take responsibility for their actions, with appropriate support; this leads to beneficial changes for their families and then their communities, building individual and collective capacity to address broader social issues that contribute to community health (Rosewarne & Wilson 2011). These Aboriginal males locate their health within a social and emotional health framework. In this case there is individual agency along with collectivism at work.

Standard health promotion messages—about not smoking, drinking in moderation and avoiding junk food—are near to meaningless in this situation. Even without the emotional burdens, poverty and difficult living conditions mean food choices are limited.

For young people growing up in this environment there are few pathways to unconflicted multiple identity: pride as an Aboriginal is hard to maintain in the face of racism and exclusion and weakening community discipline, and pathways to alternative ways of seeing oneself are blocked by poverty, lack of education and institutional racism (Rosewarne & Wilson 2011).

For individuals and families who are in trouble and ready to seek help, a wide range of health and welfare services is available through Ingkintja. These services are provided in an environment that speaks of Aboriginal pride, community discipline, and pathways to health and wellbeing. The Ingkintja Male Health Program reflects Congress working with Aboriginal males, many of whom have been as low as it is possible to go (Rosewarne & Wilson 2011).

## **Illness, injury, disability**

The clients of the Congress medical service carry a heavy burden of disease. The Aboriginal males who are engaging with the Ingkintja project carry a range of illnesses, injuries and disabilities and are lacking social supports and social resources. Many have been aware that they need help, but until the Ingkintja project the barriers to seeking such support were too high.

## **Strategy**

The overwhelming need for primary sick care in Central Australia has required Congress to develop a well-organised and efficient sickness care service to meet the huge demand. By providing care in culturally safe environments, including through gender-specific programs, Congress has ensured access to primary care for Aboriginal and Torres Strait Islander people in Alice Springs.

The commitment to culturally safe programs of care is illustrated in the establishment in 1987 of the Congress Alukura Women's Health Centre, providing birthing and women's health services according to the grandmothers' law. Congress has been instrumental in establishing ACCHOs for many of the Aboriginal communities of Central Australia, extending access to primary health care services.

Congress has also been at the forefront of campaigns for policy reform—most recently in relation to alcohol, including advocating for restrictions on hours of availability and for taxing drinks according to the alcohol content.

However, the immediate pressures of sick care need have made it hard to mobilise resources for a comprehensive and strategic response to the social determinants of health, including many of the cultural, political and economic issues referred to in Figure 1. Furthermore, the ways in which community-controlled agencies have developed, and, in particular, the competitive dynamics promoted by government funding policies, have created significant barriers to effective inter-sectoral collaboration. There is scope for greater investment in collaborative research, analysis, planning, program development and delivery.

Against this background, the Ingkintja Male Health Program represents a significant move upstream from a sick care focus in working with males who are at risk from alcohol, violence and self-harm, poverty, malnutrition and poor living conditions.

The strengths of the Ingkintja approach include a high degree of cultural safety (including being male only and the involvement of senior Aboriginal men on the staff of the program); the mix of preventative, health promotion, treatment and rehabilitation services; taking a broad holistic view of health; the drop-in centre approach; multi-discipline staffing; advocacy on social determinants of health; and flexibility and responsiveness in approach and service delivery (Rosewarne & Wilson 2011). As a consequence of this approach, there has been a significant increase in access rates by Aboriginal males.

The needs of these Aboriginal males are not seen as separate from the wide issues of responsibility and hope. Ingkintja staff organised the historic Central Australian Aboriginal Male Health Summit at Ross River from which came the Inteyerrkwe Statement (Liddle 2008)), which affirmed clearly the importance of responsibility as well as rights.

## **Agency**

In the Ingkintja project the primary agents of change are the health workers who have shaped the project and whose skills and commitment have ensured its success.

However, in many ways the design of the project is structured around the agency of the Aboriginal males for whom it is designed. They are not passive recipients of clinical services; they are invited into a communal space where there is scope to 'look after yourself', including having a shower and doing some laundry.

On a more macro scale, the project is designed to reach out to Aboriginal males more widely in ways that recognise their agency, their concerns and their responsibility, as with the Ross River Summit.

## **Victorian Aboriginal Health Service—*Forty Years of Comprehensive Primary Health Care***

The Victorian Aboriginal Health Service or VAHS was established in the inner Melbourne suburb of Fitzroy in 1973, so has been offering a comprehensive primary health care service to Australian Aboriginal and Torres Strait Islander people for nearly 40 years. It has played a vital role in the Aboriginal community-controlled health service sector in Victoria and Australia.

VAHS is the site of the project 'Revitalising Comprehensive Primary Health Care at the Victorian Aboriginal Health Service', which has sought to conduct an historical analysis of comprehensive primary health care (CPHC). The project explores the ongoing history of VAHS, and its overall role in driving CPHC, via a literature review, interviews and a focus group. The social determinants of health are also considered as part of VAHS's CPHC approach.

What was demonstrated in the project is how Aboriginal and Torres Strait Islander people have driven the comprehensive primary health care agenda and addressed the issues that have surfaced in the past 40 years. Furthermore, it highlighted key aspects in the journey and suggested issues for the future. The project has offered a way to revitalise the past and renew enthusiasm for the future. Findings of this project can be found in Fredericks, Luke and Brown (2011).

### ***Causes***

#### **History**

Some Aboriginal and Torres Strait Islander nations in Australia have been able to maintain their distinct cultures, languages and worldviews throughout the processes of colonisation and others have had much greater difficulty. Victoria was colonised from the 1830s, in many cases with great brutality although not without resistance. There are numerous stories of conflict and trauma as a result of colonisation. All Aboriginal families in Victoria have been impacted upon in some way through the processes of colonisation.

In the period between the 1830s and 1973 (when VAHS was established) there were many initiatives of resistance and advocacy. By 1973 a great deal of damage had been done to the traditional community and clan structures through colonisation, dispossession, killings, removal of children and the introduction of missions. This history impacted on the ability to use Aboriginal languages and on daily and ceremonial cultural practices. Colonisation in Victoria resulted in highly destructive pressures on traditional Aboriginal cultural norms and forms.

In 2009 Australia's Aboriginal and Torres Strait Islander population was approximately 550,000 people, which was about 2.5 per cent of the total Australian population. While most self-identify as Aboriginal peoples, 6 per cent identified themselves as being Torres Strait Islander and 4 per cent identified as both Aboriginal and Torres Strait Islander (ABS 2007). Of the total Aboriginal and Torres Strait Islander population, 76 per cent lives in major cities and non-remote regional areas (ABS 2007). This is in contrast to perceptions held by many Australians and the images shown by the Australian media both within Australia and overseas. There are large urban populations in some areas: for example, the large groupings of Aboriginal people in suburban areas of Melbourne such as Thornbury, and in regional areas like Shepparton. Some Aboriginal people are now second-



# Victorian Aboriginal Health Service

## Revitalizing Health for All Project

Bronwyn Fredericks, Joanne Luke, and Alan Brown



### The Project

This project is a case study that looks at Comprehensive Primary Health Care (CPHC) at the Victorian Aboriginal Health Service (VAHS). It will serve as an evidence base for community-controlled CPHC, which is the preferred model of health care delivery for Aboriginal people.

**The project was designed to address these questions:**

- What are the key characteristics / elements of the VAHS CPHC approach?
- What are the significant factors that influenced the establishment, development and ongoing continuity of CPHC at VAHS?
- What have been the benefits of establishing and delivering a CPHC in Melbourne?
- How has and does VAHS work individually and collaboratively to address the other broader issues that impact on Indigenous people's health in Melbourne and Victoria?



### Acknowledgements

All of the participants in the project: Victorian Aboriginal Health Service (VAHS); Victorian Aboriginal Community Controlled Health Organisation (VACCHO); Cooperative Research Centre for Aboriginal Health (CRAH); The Lowitja Institute; Queensland University of Technology; Monash University; and The University of Melbourne

### History

VAHS is located in Melbourne, Victoria Australia. Melbourne is a large urban city of 4 million people. Only around 0.4% of the population are Aboriginal or Torres Strait Islander people.



VAHS was set up in 1973 by Aunty Alma Thorpe, Uncle Bruce McGuinness and other concerned community members.



It was a place where Aboriginal people could access medical and social care in a time when racism and other barriers prevented Aboriginal people accessing care. Now, after nearly 40 years VAHS has evolved to become an organisation with over 100 staff, who care for thousands of Aboriginal people across all of Victoria and Australia.



VAHS today delivers a comprehensive range of services across the key areas of: Medical; Women's and Children's; Men's Program; Community Programs; Family Counselling and Dental.

### CPHC at VAHS

In describing CPHC at VAHS, one participant said that VAHS is a place where 'everyone can come and get something, or receive something or participate in something, in a holistic way'.

Another participant stated that: 'Aboriginal health services are quite unique, there are things that we do different that don't happen anywhere else in primary health care services like the community health centre up the road. A couple of things that make us unique is our structure, Aboriginal community control. That is quite unique probably in the world. And the second one is the introduction of Aboriginal health workers into that sector... we looked at the Western model and said yeah we will take the best bits of that like the doctor, maybe a nurse, but we also want to add our cultural aspects around what we do'.

Another person expressed about CPHC, '... is a one stop shop where a person can go and get the whole thing checked out, and I walk in to see the dentist, but I am not just worried about the tooth I have to worry about my diabetes my blood pressure my heart problems, everything. So I know if I go and see [a dentist], he would go and ask me to go and check my blood pressure and blood sugar before he looks at me. So comprehensive primary health care is where you can get holistic approach to health'.



Another person said: 'We have also made it what we wanted it to be, like I said, put those Aboriginal cultural constructs into how we deal with things, you know Aboriginal health workers, the way that people even the way that our health service is called a home away from home.'

### Empowering Self & Others



VAHS has worked hard:

- Offering health and wellbeing services
- Supporting the local community
- Supporting other Aboriginal groups to set up their own health services

One former VAHS worker remembered this: '... we went in, we provided people with the tools to get it up, at no stage would the health service take control of it, the local communities ran their own health services. But we would be there all the time supporting them, supporting them, supporting them, but we wouldn't in those days tell them what to do, they had to do it themselves'.

- Helping others to set up the State and National NGO representative organisations
- Campaigning for better housing, employment, land, social justice and against racism
- Advocating and lobbying against health inequities and other forms of activism



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third- or multi-generation urban dwellers, while others may travel to and from cities and big urban centres and their home communities.

The large numbers of Aboriginal people living within the regional centres, towns and cities demonstrate that living in urban areas is as much part of reality for Aboriginal and Torres Strait Islander people as living in a discrete Aboriginal rural, regional or isolated community or on one of the islands in the Torres Strait (Fredericks 2004). This urban reality includes using a range of accommodation options (houses, flats, caravans, renting, buying, living on the streets or in parks), buying goods and services, maybe finding a job, participating in sporting groups, clubs and organisations, and sharing and interacting with people from a diverse range of backgrounds with their own languages and cultures (Fredericks 2004).

Living in urban environments also includes finding or making space within the city or regional centre for Aboriginal and Torres Strait Islander cultures, languages, and individual and collective expression, and the establishment and maintenance of their own organisations, programs, services and other structures. The experiences of Aboriginal and Torres Strait Islander people living in urban areas include a diversity of needs and prospects shaped by gender, education, religion, age and level of human security (Fredericks 2004). There is no single urban Aboriginal or Torres Strait Islander experience or identity, nor is there one single urban Aboriginal or Torres Strait Islander community in cities and regional areas. The multi-faceted nature of urban Aboriginal and Torres Strait Islander people and communities presents researchers, planners and government officers with a range of issues (Scrimgeour & Scrimgeour 2008).

Regardless of locality and population diversity, there are some statistics and issues that are common for all Aboriginal and Torres Strait Islander people. Overall, they have the poorest health status of any group in Australia. The Aboriginal and Torres Strait Islander population is also much younger than the Australian population. In 2006 the median age was 20 years for Aboriginal and Torres Strait Islander people and 37 years for the other Australians (ABS 2008). This additionally means that there are many young Aboriginal and Torres Strait Islander people who are trying to find paths for themselves, like other Australian youth, but who experience—along with racism—greater difficulties in finding appropriate education or training opportunities, jobs or housing while trying to build confident adult identities.

Changing patterns of family formation and people partnering with those outside of Aboriginal and Torres Strait Islander communities (with people from other cultures and ethnicities) has led to more lighter skinned people (who value this part of their identity) and to new and hurtful discourses of who is a ‘real’ and ‘not real’ Aboriginal or Torres Strait Islander person (Fredericks 2004).

There have also been complex identity challenges for a range of reasons. The right of Aboriginal and Torres Strait Islander people to be Indigenous peoples has been the subject of a continuous flow of commentary and classification regarding Aboriginality: what does it mean to be Aboriginal or Torres Strait Islander, who is an and who is not an Aboriginal or Torres Strait Islander person? There has been, as Beckett (1994:7) describes:

*a medley of voices black and white, official and unofficial, national and local, scientific and journalistic, religious and secular, interested and disinterested, all offering or contesting particular constructions of Aboriginality.*



In most recent times this has been added to and played out within the newspapers in Victoria and at the national level.

While Aboriginal and Torres Strait Islander people have low schooling participation rates and high unemployment rates, increasing numbers in Victoria are engaging in the mainstream economy: that is, they have gained a range of positions in mainstream employment. Some have set up businesses, either as individuals or collectively, and have undertaken, or are undertaking, leadership roles in our community. Similarly, Aboriginal and Torres Strait Islander people have been finding new ways to express their culture and sense of self.

VAHS was one of the earliest ACCHOs to be established. Note the significance of the year, 1973, six years after the referendum and the collapse of the previous system of reserves and missions for non-citizens. Aboriginal people in Victoria, as elsewhere in Australia, became free to move away or were forced from the reserves and missions in rural and regional areas. Many Aboriginal people from across Victoria, and indeed Australia, came to Melbourne. Some settled in the Fitzroy area. Over time there was an increasing need for health care to be provided to Aboriginal people living in Fitzroy and the surrounding areas. Some of the earliest work undertaken by VAHS was the delivery of health care to people living in the parks and to poor families. Some of the care at this time involved food provision. Aboriginal people were experiencing racism in trying to access mainstream health services.

Today a majority of Aboriginal and Torres Strait Islander people in Melbourne do not live on traditional lands, yet many still have strong links to their traditional communities and identify strongly with their traditional groups. Aboriginal people may identify with their traditional groups, as well as with a mission or reserve community and an urban group based on their family's history. All of these associations give people a sense of belonging and are all-important in that person's or family's history. As a minority, Aboriginal and Torres Strait Islander people have also to a greater degree been exposed to the values and systems of the dominant mainstream society.

### **Macro social and cultural environment**

The cultures of the Aboriginal and Torres Strait Islander communities of Melbourne and Victoria have developed and evolved since the colonisation of Victoria. There have been aspects of traditional culture that have been lost, some have been revived and other aspects have been added.

Aboriginal and Torres Strait Islander people in Melbourne are heterogeneous:

- some may be perceived as having 'assimilated'; that is, they have found a place in mainstream society/economy and are 'choosing' not to locate centrally within the wider Aboriginal and Torres Strait Islander community—racism can make such participation quite unrewarding, but this does not mean they are not Aboriginal or Torres Strait Islander
- some have found pathways to co-existing multiple identities
- some might remain torn between thinking they need to choose between 'Aboriginality' or 'assimilation' within the dominant culture
- some affirm Aboriginality as their sole identity and reject other possible identities with mainstream culture.

For all of these groups the continuing bites of racist stereotypes are a major feature of the environment that drives such choices. Many Aboriginal and Torres Strait Islander people in Melbourne/Victoria have participated in mainstream education and are participating in the mainstream economy through renting or buying somewhere to live, working, undertaking studies, moving around, buying food, playing or watching sport, going to the art gallery or being part of an Aboriginal or Torres Strait Islander organisation and more. None of these activities make someone less or more Aboriginal or Islander. Some Aboriginal and Torres Strait Islander people live in poverty; others are just managing; some are managing okay financially.

Brady (1999:28) discussed some of the complexities of Aboriginality and how this manifests when she wrote:

*what dominant culture often refuses to consider are the elements of Aboriginality. Aboriginal Australians reflect the history of invasion and colonisation. We carry it in and on our bodies. We range in colour, form, attitude across a complexity and multiplicity of layers. These layers have come from our generational knowledge and from the imposed notions of who we are as a people. These contradict and are more complex than the often simplistic descriptions used to represent us as Aboriginal people. In contemporary culture we carry those elements which have been imposed but which we have also appropriated from others and retained for our own cultural maintenance.*

### **Community environments**

The Aboriginal and Torres Strait Islander community of Melbourne and the communities around Victoria have particular issues to deal with within their own contextual environments. They are variously coping with financial difficulties, with careers, with services and with education, and are continually facing issues of racism within populations that are dominated by other Australians. Aboriginal and Torres Strait Islander people in Victoria are a minority and as such struggle to be heard by governments. This is the environment in which the VAHS is located and in which the Revitalising Comprehensive Primary Health Care at VAHS project was located.

The stresses of cultural expression and identity choices, expectations of assimilation and conflicts associated with this multiplicity are everywhere. While there are a large number of services for Aboriginal and Torres Strait Islander people within Melbourne and communities across Victoria, there are still gaps.

### **Families' experience**

Some families are living with complex social, emotional and behavioural issues, including depression, low self-esteem, alcohol and violence. Most families are managing the ordinary challenges, which may appear familiar to mainstream families. Except, on top of these 'ordinary challenges', there are the recurring motifs of racial prejudice; images, evocations and riffs that negate the value of Aboriginality and the right to be Aboriginal and express Aboriginality. VAHS offers a range of programs that cater for individuals and families.



## **Illness, injury, disability**

Many Victorians who identify as Aboriginal or Torres Strait Islander find the mainstream health system quite alienating. This is a significant barrier to accessing health care. VAHS provides a safe place for quality health care.

The health status of Aboriginal and Torres Strait Islander people in Victoria is poorer than the health of other Victorians. VAHS has made and continues to make a significant contribution to addressing the health and wellbeing disparities between Aboriginal and Torres Strait Islander people and other Victorians.

## **Agency**

Tremendous levels of agency have been demonstrated at and through VAHS since its establishment in 1973. In the context of this project the primary agents of change are VAHS and its staff, board members and many other community members who contribute to the work and activities of VAHS.

In the early years of VAHS, Aboriginal people were motivated to make a difference to the lives of those living in the parks and dying in the parks. Other Aboriginal people in Fitzroy and the surrounding areas had extremely poor health status and wellbeing. Aboriginal people associated with VAHS or working in VAHS wanted to be able to help the families of those who had passed away, so they started a funeral service. Aboriginal people also witnessed others suffering from acute pain and health complications due to poor dental health, so they started up a dental service in an old caravan that was fitted out by staff and volunteers, including one of the dentists at VAHS. From its beginnings, VAHS was not satisfied with the status quo and its early agenda focused on improving health through service provision and by addressing social conditions such as homelessness, income and racism. In the Revitalising Comprehensive Primary Health Care project, VAHS undertook an historical analysis of comprehensive primary health care at the health service (see Fredericks, Luke & Brown 2011).

There have always been key Aboriginal and non-Aboriginal activists associated with VAHS. Its history is associated with political conflicts and the heroic struggle for better health for Aboriginal and Torres Strait Islander people. The stories are told and remembered.

Members, board members and staff of VAHS supported the establishment of numerous other ACCHOs across Victoria. They were instrumental in the establishment of VACCHO, the peak representative body for the sector, and always contributed to activities at the national level and, at times, the international level.

People connected to VAHS have always sought out knowledge and information, and advocated for the rights of Aboriginal and Torres Strait Islander people. Sometimes this has taken them to the next suburb and other times overseas. For example, during the 1970s a delegation went to China to explore health care delivery. They specifically focused on the training and employment of barefoot doctors—local people trained in health care practices—and what has been useful at VAHS. VAHS later used this visit and the materials to help develop the health worker training program. It was able to incorporate Western notions of medicine and Aboriginal and Torres Strait Islander bush and traditional medicine within the program.

VAHS plays an important role within Victoria and, indeed, Australia. It is a site of inspiration to others, and an example of Aboriginal and Torres Strait Islander solidarity. It is still current and relevant and its staff, board and members keep up to date and are kept up to date. It participates and initiates research and projects.

## ***Strategy***

Since colonisation there has been an urgent need for Aboriginal and Torres Strait Islander people to be able to access primary sickness care in a safe place. Every step in the establishment and protection and development of VAHS has been a focus of struggle and mobilisation of community strength; the number of senior figures in the Victorian Aboriginal community who are seen as heroes in the struggle for VAHS reflects the embeddedness of this struggle in the life of the community.

VAHS provides health care in a way that also affirms the community, coherence, pride and solidarity of Aboriginal and Torres Strait Islander people in Victoria. It is a 'Home Away from Home' (Nathan 1980), a place for people to come to from all over Melbourne and Victoria. At VAHS people don't just see the doctor or dentist or a counsellor and nurse, they sometimes also connect up with one another, hear news about other people (sometimes family) and about community events.

VAHS has the ability to follow up on numerous issues with an individual in ways that impact upon their health and wellbeing. For example, one client came in to have her teeth attended to and while there asked if her partner could come in and see the dentist too. Her partner had numerous oral health issues and felt that his overall health was being affected. He then came in to see the dentist and over a period of time had his teeth repaired. As his teeth were attended to, his overall health improved as did his self-esteem. VAHS was later told by the client that he had gained employment after a long period of being out of work. The dental service 'had made them happy'. VAHS recognises the whole person and provides a holistic approach to health.

The people involved with VAHS in the beginning had visions of what was possible. The vision is still there. VAHS is still delivering a health service for Aboriginal and Torres Strait Islander people and still advocating for their better health and wellbeing. There have been hundreds of people involved in VAHS's history. They have all played a role in being there to help in the vision, acting as a board member, finding premises, setting up programs, advocating, representing the organisation, considering the organisation, writing letters and submissions, cleaning the premises (when VAHS had no cleaning gear and no cleaners), doing the work without pay when there was no money, attending a rally, and helping each other by being physically, emotionally, mentally, socially and intellectually present and available for the organisation and each other. The Revitalising Comprehensive Primary Health Care at VAHS project attempted to capture this data, and this level of commitment by people to ensuring a comprehensive primary health service in their community.



# Learning from the Three Projects

## Quality clinical services matter

All three agencies are fully committed to delivering high-quality clinical services, including investing in clinical information systems, the development, implementation and monitoring of clinical guidelines, and ongoing professional development programs. In each case the delivery of clinical services is undertaken in an environment that affirms Aboriginality and evokes pride. While this is an expression of the pride of those who work there, it is also a symbolic rejection of the whispers of racism in the mainstream world.

In a situation where many mainstream health care settings exhibit hints of racism, or perhaps have historical associations with racist policies past, the emergence of ACCHOs has been instrumental in ensuring access to basic primary care. Underpinning ACCHOs is a cultural approach that makes services applicable to Aboriginal and Torres Strait Islander people. ACCHOs have been developed and controlled by the Aboriginal and Torres Strait Islander people who understand their own complex needs and those of their community.

ACCHOs offer a place where Aboriginal and Torres Strait Islander worldviews are affirmed, and where people do not have to sacrifice their identities in order to receive a service or health care. They offer a point of contact to affirm one's heart, soul and mind while receiving care. They offer places to go that do not mean (and/or can't be interpreted to mean) that we have given in to the dominant culture or are happy with the service just because we/ Aboriginal and Torres Strait Islander people go there.

The clinical program also provides a basis for a deep understanding of the causes and contexts of Aboriginal and Torres Strait Islander morbidity and mortality and a strong relationship with the community upon which action on the more macro issues can build.

## Community involvement is key

Community involvement has been critical to everything that the ACCHOs are and do. The strength of community involvement confirms for clients that they are safe places where the experience of Aboriginality is understood and where special needs are recognised and looked after.

Board members provide one critical link with the community, ensuring that the organisation responds to the needs and hopes of the community. The strength of the board structure in ACCHOs is reflected in each of the case studies. The recruitment, training and election of board members are not simple, particularly in communities where the totality of needs can overburden available leaders.

At Urapuntja Health Service senior people from each of the outstations constitute the board of management. This provides a very direct representation of community spirit and leadership. At Congress and at VAHS there is an electoral process that runs beside a more organic process of emergence and recognition. Aboriginal and Torres Strait Islander people living in Melbourne and

Alice Springs have the opportunity to become members of the health service and be nominated for election and voted onto the board by other members/ Aboriginal and Torres Strait Islander people. In Alice Springs and Melbourne there are a number of other community-controlled organisations that draw their leadership from the same community but sometimes from different networks and clans. There are loose structures for integrating the work of these different agencies. These boards are a way of maintaining traditional practices and community structures, where collective decision-making and input by Elders are important.

The tasks of governing and steering large primary health care organisations are complex and include managing the interface with government, as well as with community. The orientation and training of board members is critical but it is not always easy for managers to play a forward role in this process.

Aboriginal and Torres Strait Islander people employed as either AHWs or as key project workers are the second critical link between the organisation and the community. Training programs and qualification structures differ in the different States and AHWs play somewhat different roles in different agencies, ranging from drivers, interpreters and clinicians to community development workers. The Ingkintja Male Health Program illustrates a model of active Aboriginal involvement at the staff level. Two senior Aboriginal men are employed in community development roles (Peer Educator and Aboriginal Liaison Officer) and provide strong cultural input to the program, support other works and are an integral component in the cultural safety aspect of the program. Other Aboriginal male staff have leadership and management roles. In addition, Ingkintja has developed and maintained a strong community consultation process that has transparently driven the program's development.

## **Reforming the mainstream health system**

Some Aboriginal and Torres Strait Islander patients need specialist care; consultations can be provided in the ACCHO but acute hospital care may mean admission to mainstream hospitals. Some communities have a collective memory of the times when maternity hospitals were involved in the forceful removal of Aboriginal and Torres Strait Islander children. Big hospitals are part of mainstream society and, not surprisingly, reflect many of the prevailing norms. Insofar as racist stereotypes exist in the mainstream society, they also exist in big hospitals. However, they may be visible only to those who are hurt by them. Some Aboriginal and Torres Strait Islander clients choose, for whatever reasons, to attend private general practices for some or all of their medical care needs.

ACCHOs have also worked in ways that have enabled health professionals to utilise their premises to offer clinics; for example, through visiting services to ACCHOs where Aboriginal and Torres Strait Islander clients see a podiatrist, dietician or other visiting health professional within the culturally safe and known environment of the ACCHO rather than needing to go to the premises of the health professional. In this way, the referral relationship is within the ACCHO itself.

For VAHS clients the referral pathways may mean minimal travel, since the referral agencies or health providers are more likely to be in Melbourne. Clients from the Central Australian Aboriginal Congress or the Urapuntja Health Service may need to travel away from their communities to much

larger towns or to large urban centres such as Adelaide depending on the specialist service required. This presents an array of issues.

ACCHOs have a role in working with mainstream services dealing with Aboriginal and Torres Strait Islander clients, including hospitals and private health professionals, to assist them to recognise the ways that institutionalised racism can make the inpatient experience so much more alienating. Sometimes the terms ‘cultural competence’, ‘cultural competency’, ‘culturally appropriate’ and ‘cultural safety’ may be used to refer to or describe training and approaches to health service delivery for Aboriginal and Torres Strait Islander people. Over the past 20 years we have seen substantial growth and emphasis on programs designed to increase cultural awareness of employees so that they might be able to provide care, support and treatment to Aboriginal and Torres Strait Islander people. There are mixed views about such training, and equally mixed experiences, and such an approach might risk reducing history and racism to professional skills. However, mainstream practitioners do not have the experience of living black in a white society and it is critical to provide them with some basic feeling for this experience.

## **Overcoming barriers to inter-sectoral collaboration**

The causal web/hierarchy illustrated in Figure 1 is well understood in the ACCHOs generally and in the three project organisations specifically. The Congress story about the Ingkintja Male Health Program illustrates nicely the ways in which action at the individual level (the Ingkintja centre) and action at a regional and political level (the Inteyerrkwe Statement) can complement and support each other.

However, ACCHOs do not have sole responsibility for action on alcohol or poverty or education, nor for action on racism, exclusion and welfare dependency. The principle of inter-sectoral collaboration highlights the importance of working with agencies, practitioners and community networks that don’t identify as part of the ‘health sector’, including other community-controlled organisations.

This is not such a problem in Utopia, where the senior leaders from each of the outstations are involved in managing Urapuntja Health Service and other community-controlled agencies. However, in Alice Springs and Melbourne collaboration can be more difficult due to numerous stakeholders and relationships and competition between various organisations for funding.

VAHS has undertaken a range of collaborative projects and programs within the greater Melbourne area and Victoria. Its latest venture is with Mission Australia and has resulted in a training program in hospitality and a restaurant that offers food with Aboriginal and modern Australian flavours. The venture is called Charcoal Lane and is based in Gertrude Street, Fitzroy, in the same building that once housed the health service. This new venture offers training and employment and focuses on Aboriginal Australian foods.

## **Solidarity and identity**

We argued earlier that ideas about identity can be helpful in thinking through the ongoing harm of colonisation and racism and in working towards social policies that might open pathways towards ‘unconflicted multiple identities’ or ‘multiple expressions of identity’. These are sensitive issues.

It would be easy to mistake references to multiple identities as diminishing the importance of Aboriginality. This would be a misreading.

The crisis in which many families are living in and around Alice Springs can also be thought about in terms of identity—people whose own communities are not providing them with meaning and security but who are excluded from participating in the wider community. One of the functions of alcohol is to dissolve the pain but when the pain leads to anger, alcohol can release anger in terrible ways. Again the story of the Ingkintja program offers rich insights.

The contrasts between Utopia, Alice Springs and Melbourne also throw further light on the problematic idea of a singular Aboriginal and Torres Strait Islander identity. Prior to white settlement one's subjectivity would be based on language group and clan and family membership. Singular Aboriginality was a construct first of all of the colonial power and later of the resistance movement (although it is customary to introduce oneself in terms of Country and people of origin).

However, it is a sensitive matter. Recent attacks on 'light skinned Aborigines' by right-wing journalist Andrew Bolt reflect a racist discourse, which is not uncommon, of 'real' and 'not real' Aborigines. This language is extraordinarily painful to many. It is fundamentally assimilationist in that it argues that people of lighter skins have the chance to become real Australians and are choosing not to for obscure reasons of personal gain. Conversely, it denies the value of celebrating community and culture. It denies the reality of what has happened to Aboriginal and Torres Strait Islander people throughout the colonisation of Australia and the ongoing impacts of policy and government interventions, and that Aboriginality cannot be reduced to genes and skin colour.

There has also been a shift over the years within the mainstream population. While there are those who do not support Aboriginal and Torres Strait Islander Australians, there is a growing solidarity between Aboriginal and Torres Strait Islander people and other Australians. There is an increased understanding of Aboriginal and Torres Strait Islander heritage, expressed in the lives of Australia's First Peoples, as a core part of what it is to be Australian; as a source of pride. This is already happening in many ways (e.g. Australians for Native Title and Reconciliation). This may have difficulty in filtering through into policy and government levels but some changes are evident.

## Leadership

While ACCHOs tend to receive government grants and other monies to run some of their services, they are not government services and their employees are not government workers. Most ACCHOs have a board of directors or a management committee, which is elected from a membership base drawn from the Aboriginal and Torres Strait Islander population that resides in the local or regional area. Others may operate through a representative structure of families and/or clans. Accountability is through the board, directors, annual general meetings, annual reports and reports to funding bodies (NATSIHC 2003). It is the board that sets the overall direction of the ACCHO and that at the end of the day employs the staff.

VAHS, Utopia and Congress all offer different models of governance that work for them as individual organisations within their cultural and geographical contexts. Their forms of governance and leadership are what has evolved through the communities they serve and by Aboriginal and Torres Strait Islander people being involved and engaged at all levels. Aboriginal and Torres Strait Islander people have been self-determining what they want to happen for their communities and

for themselves. This is not to say that it has been easy. There have been instances in some ACCHOs where people have not improved their skills while their organisations have grown but provision for the training of volunteer board members remains uncertain.

Over the years organisations have grown from small, not-for-profit organisations to large multi-million dollar corporations. When they were small, sometimes there was a need for board members and volunteers to help with day-to-day operational matters. As organisations grew, the needs and skills required of board members changed. One issue for the health services has been how board members keep up with the cycles of growth of the organisation, and the skills and knowledge base required; for example, the increase in skills required in financial management, strategic planning and supervision of a chief executive officer who manages a large staffing base with multiple programs, grants, and clinics and data.

There have been requirements placed on board members, staff members and volunteers to deal with change from a range of angles, including:

- the dynamics of historical change (change of governments, government policy, interventions, strategies by institutions that impact on Aboriginal and Torres Strait Islander people and ACCHOs)
- the strategies of deliberate action for social change (Aboriginal and Torres Strait Islander people lobbying and taking a stand)
- strategies and forms of action (again, lobbying and taking a stand).

## **Relation with the state**

Difficulties in working with Commonwealth and State bureaucracies are a common experience among ACCHOs, including the three participating projects. We have mentioned some of the adverse consequences of policy lurches at the Commonwealth level, including, in particular, the discounting of any need for health expertise during the DAA and ATSIC periods and the stoking of competition between community organisations for funds during the time funds were channelled through regional councils.

We have mentioned also the ideological and political agendas associated with the Northern Territory 'Intervention', including undermining the principles of self-determination and land rights. On the other hand, there has been considerably increased funding to health care and infrastructure as a consequence of the 'Intervention'.

The continuing pressure on the Urapuntja Health Service and other organisations at Utopia to 'rationalise' the distribution of facilities and services and the disparagement of the outstations movement has been a continuing struggle for the people at Utopia.

The most common complaint from all ACCHOs is the burden created by multiple separate funding contracts, each with separate sets of performance indicators and with restrictions on any kind of transfers across funding streams. Excessive and inappropriate performance indicators have been a burden on ACCHOs for many years, drawing away from their core business of caring for the community.





## Conclusions

Where do these reflections lead? We have immersed ourselves in the project reports; reflected on causes, agents and strategies; and drawn together some conclusions. The provision of high-quality clinical services is a critical part of the work of ACCHOs. All three participating projects commit strongly to quality and efficiency in service delivery but it is not easy, nor is it cheap.

Community involvement, at the board, staff and broader community level is fundamental to the ACCHO model. Each of the three projects illustrates different aspects of the ACCHO model— from the representation of each outstation on the board of Urapuntja Health Service to the role of Aboriginal health staff and community consultation in the Ingingintja Male Health Program in Alice Springs, to the sequence of outstanding community leaders who have worked in a voluntary capacity on the board or with program activities at VAHS.

Referral relationships are critical, not just to more specialised medical units but to various kinds of specialised expertise. This can be challenging when those units or experts are embedded in mainstream institutions. Continued pressure for the reform of mainstream institutions is essential.

Inter-sectoral collaboration, including among community-controlled agencies, is critical to addressing the social determinants of health and the more macro and longer term factors shaping Aboriginal and Torres Strait Islander health. There are barriers to more effective inter-sectoral collaboration, some of which have been imposed as a consequence of State/Territory and federal policies. That is, the reason why inter-sectoral collaboration could not be developed, implemented or continued was, in fact, government policy.

Aboriginal and Torres Strait Islander health disadvantage is not just about poverty or ‘low socio-economic status’. Colonisation and race are part of what maintains the ‘gap’. We think that ideas about identity provide a language for speaking about these issues, for tracing how racism harms health and for developing strategies. We have highlighted the ways in which institutional racism creates barriers to people enjoying multiple and unconflicted identities. We have also remarked on the ways in which apologists for the colonial project use identity language to weaken and divide the Aboriginal and Torres Strait Islander movement.

We have highlighted the value of leadership in Aboriginal and Torres Strait Islander affairs, whether it is projected in Utopia, the Inteyerrkwe Statement or at VAHS in Fitzroy: leadership in understanding the issues that communities are facing, including the causes of the causes; leadership in the development of strategies that work at the personal and immediate level but also at the macro and longer term level; and leadership in breaking new ground and carrying the rest of us along.

Finally, we have argued that progress in Aboriginal and Torres Strait Islander health has been retarded in some significant aspects by unwise, inappropriate and occasionally malignant policy making in Canberra and other capital cities. This presents particular challenges for the Aboriginal and Torres Strait Islander health movement.

Our conclusions have implications for policy capacity, organisational development, political development, program development, training and research. Much has been achieved but more remains to be done.

## Appendix A: Australian Indigenous HealthInfoNet Policy Timeline

The Australian Indigenous HealthInfoNet (2010) provides a useful timeline of Aboriginal and Torres Strait Islander health policy. The following account draws heavily on this timeline.

- 1901 The founding Constitution for the Commonwealth of Australia provides for State governments to have sole authority over Aboriginal affairs.
- 1967 Referendum sponsored by the Holt government empowers the Commonwealth Government to make laws and spend money on Aboriginal services and programs.
- 1968 Commonwealth Office of Aboriginal Affairs established.
- 1969 Commonwealth Office of Aboriginal Affairs administers specific-purpose grants to the States for the development of special Aboriginal health programs. State government health authorities establish Aboriginal health units to address the health needs of the Aboriginal and Torres Strait Islander population and to administer the Commonwealth funds.
- 1971 Redfern Aboriginal Medical Service (AMS) established on a voluntary basis.
- 1972 The Whitlam Labor government elected and replaces the Office of Aboriginal Affairs with the Department of Aboriginal Affairs (DAA). DAA continues with the States' grants programs initiated by the Office but also begins to make direct grants to the newly emerging AMSs.
- 1973 The Commonwealth Government makes a formal offer to the State Ministers to assume from them full responsibility for Aboriginal and Torres Strait Islander affairs policy and planning. With the exception of Queensland, all the States accept the offer and negotiations commence for the transfer of responsibility for Aboriginal and Torres Strait Islander policy, planning and coordination from the States to the Commonwealth. DAA is given central authority for policy administration. An Aboriginal Health Branch is established in the Commonwealth Department of Health to provide professional advice to the government. One of its first actions is to propose a Ten Year Plan for Aboriginal Health.
- 1974 The national Aboriginal Medical Service (AMS) umbrella organisation, the National Aboriginal and Islander Health Organisation (NAIHO), is formed.
- 1975 The Liberal–National Country Coalition government, led by Liberal Prime Minister Malcolm Fraser, is elected.
- 1976 The Report on the Delivery of Services by the Department of Aboriginal Affairs is published. It assesses the capability of the DAA to fulfil its responsibilities for Aboriginal and Torres Strait Islander policy development and administration.
- 1977 The House of Representatives Standing Committee on Aboriginal Affairs (HRSCAA) commences a review of Aboriginal health (published in 1979).
- 1980 An internal Commonwealth Government report, the Program Effectiveness Review (never officially released to the public) considers, among other things, the issue of Aboriginal and Torres Strait Islander involvement in health policy development and the introduction of specific Aboriginal and Torres Strait Islander health initiatives.

- The report also recommends that Aboriginal and Torres Strait Islander health funds be administered through the Department of Health.
- 1981 The Commonwealth Government initiates a \$50 million five-year Aboriginal Public Health Improvement Program in response to recommendations outlined in the 1979 HRSCAA report. The program, administered by DAA, focuses on unsatisfactory environmental conditions associated with inadequate water, sewerage and power systems.
- 1983 Labor Prime Minister Bob Hawke elected.
- 1984 Responsibility for all Commonwealth Aboriginal and Torres Strait Islander health programs, including the Department of Health's role in the funding of some AMSs, is consolidated within DAA.
- 1985 The Canberra-based Australian Institute of Health established within the Commonwealth Department of Health. It has Commonwealth responsibility for the development of Aboriginal and Torres Strait Islander health statistics.
- 1987 National Aboriginal Health Strategy Working Party appointed by the Joint (Commonwealth State) Ministerial Forum on Indigenous Health to develop a strategy on Aboriginal and Torres Strait Islander health.
- 1988 Commonwealth funding of NAIHO withdrawn.  
The Royal Commission into Aboriginal Deaths in Custody initiated.
- 1989 The National Aboriginal Health Strategy Working Party final report, a National Aboriginal Health Strategy, is presented to the Joint Ministerial Forum.  
Joint Ministerial Forum establishes the Aboriginal Health Development Group (AHDG), comprised primarily of Commonwealth, State and Territory government representatives, to assess the NAHS report and advise on its implementation.
- 1990 ATSIC established, replacing DAA and the Aboriginal Development Commission, and assumes national responsibility for Aboriginal and Torres Strait Islander health.  
The AHDG's Report to Commonwealth, State and Territory Ministers for Aboriginal Affairs and Health recommendations (including the need for a Council for Aboriginal Health; State/Territory tripartite forums; a specialised health branch, the Office of Aboriginal Health, within ATSIC; and a national Aboriginal community-controlled health organisation) accepted by the Joint Ministerial Forum.  
The Commonwealth Government allocates \$232.2 million (over five years) for implementation of aspects of the Strategy. Of the \$232.2 million only \$47 is for health services. The total allocation is far less than the \$3 billion estimated as necessary for full implementation of the NAHS.
- 1991 The final report of the Royal Commission into Aboriginal Deaths in Custody published. The report recommends support for the implementation of the NAHS.  
Labor returned to power under Paul Keating.
- 1992 The High Court judgment in the Mabo case, Australia's second native title case, overturns the colonial concept of *terra nullius*.  
Negotiations with State and Territory governments regarding matching financial commitments ceases and Commonwealth funds are distributed through ATSIC regional councils to community-controlled organisations.  
The Council for Aboriginal Health established to advise governments on Aboriginal and Torres Strait Islander health policy and monitor the performance of the NAHS.

1993

NACCHO established as the new national AMS umbrella organisation, replacing NAIHO.

The Commonwealth Ministers for Health and Aboriginal Affairs initiate a review of the Council for Aboriginal Health.

Public calls made for responsibility for the administration of Aboriginal and Torres Strait Islander health funding to be moved from ATSIC to the Commonwealth health department.

The Native Title Act becomes law. The Act is intended to recognise and protect native title, and give Aboriginal and Torres Strait Islander land rights, as stated in the Mabo case, statutory authority.

1994

The Commonwealth Government announces a \$500 million five-year health package, the majority of which involves a continuation of existing NAHS activities.

ATSIC establishes the Health Infrastructure Priority Projects scheme. The scheme addresses environmental health issues through large-scale construction of housing and infrastructure.

A high-level Evaluation Committee appointed by the Commonwealth Ministers for Health and Aboriginal Affairs notes that the NAHS has never been effectively implemented and that all governments have grossly under-funded initiatives in remote and rural areas.

A Joint Health Planning Committee, comprising the Commonwealth health department, ATSIC and NACCHO representatives, established to approve funding allocations for Aboriginal and Torres Strait Islander health projects.

1995

Responsibility for Aboriginal and Torres Strait Islander health transferred from ATSIC to the Commonwealth health department and the Office for Aboriginal and Torres Strait Islander Health Services established.

Following the 1992 National Commitment to Improved Outcomes for Aboriginal and Torres Strait Islander People, Health Ministers agree to a process for the development of multilateral framework agreements with States and Territories. The Framework Agreements provide for the establishment of consultative national and State/Territory forums to provide policy and planning advice on Aboriginal and Torres Strait Islander health issues.

Department of Human Services and Health and ATSIC institute a Memorandum of Understanding defining their roles and responsibilities.

1996

The Federal Court decides against the Wik peoples' 1993 land claim on the basis that their native title rights have been extinguished by existing pastoral leases.

Following 13 years of Labor rule, a Liberal–National Coalition Government, led by Liberal Prime Minister John Howard, is elected. The Department of Human Services and Health is renamed the Department of Health and Family Services.

The Commonwealth Minister for Health announces the establishment of the Aboriginal and Torres Strait Islander Health Council as foreshadowed in the Framework Agreements.

Commonwealth approval extended for all existing AMSs to bulk-bill Medicare.

By the end of the year, six of the eight States and Territories have signed the Framework Agreements, agreed to by all Health Ministers in 1995.

1997

The House of Representatives Standing Committee on Family and Community Affairs initiates an Inquiry into Indigenous Health in response to a joint request from the Commonwealth Ministers responsible for health and Aboriginal and Torres Strait Islander affairs.

The Human Rights and Equal Opportunity Commission releases *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families*.

1999

The Office for Aboriginal and Torres Strait Islander Health Services renamed the Office for Aboriginal and Torres Strait Islander Health (OATSIH) but continues to operate within the Commonwealth department responsible for health.

The Primary Health Care Access Program announced in the 1999–2000 Commonwealth Budget. The program aims to improve access to primary health care by facilitating increased community control, reforming existing health system structures, and increasing the available resources within selected sites.

The Commonwealth Minister for Health and Aged Care restructures the National Aboriginal and Torres Strait Islander Health Council.

2000

The House of Representatives Standing Committee on Family and Community Affairs tables its final report *Health is Life*. The report documents the committee's recommendations following the inquiry into the health status of Aboriginal and Torres Strait Islander Australians.

2001

In February the Australian Health Ministers' Advisory Council (AHMAC) agrees to the development of an Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework. The Framework objectives are endorsed by AHMAC in October. AHMAC also agrees to a consultation process for key stakeholders and the development of an implementation plan.

Redfern AMS celebrates 30 years of health care provision to Aboriginal and Torres Strait Islander people.

The National Aboriginal and Torres Strait Islander Health Council releases for discussion the draft National Aboriginal and Torres Strait Islander Health Strategy.

The Commonwealth Department of Health and Aged Care releases *The Aboriginal and Torres Strait Islander Coordinated Care Trials National Evaluation Report: Volume 1—Main Report*. It outlines the background, descriptions, experiences and outcomes of the four coordinated care trials conducted in Aboriginal communities between 1997 and 1999. The trials took place in Katherine (NT), the Tiwi Islands (NT), Wilcannia (NSW) and Perth/Bunbury (WA).

The report *Better Health Care: Studies in the Successful Delivery of Primary Health Care Services for Aboriginal and Torres Strait Islander Australians* published by the Commonwealth Department of Health and Aged Care. The publication examines the concept of comprehensive primary health care, provides national and international evidence of the effectiveness of this approach in improving health outcomes of Aboriginal and Torres Strait Islander people, and illustrates the success of this approach through a series of case studies on successful health service interventions.

AHMAC agrees to establish the Standing Committee on Aboriginal and Torres Strait Islander Health, which supersedes the Heads of Aboriginal Health Units forum.

2003

The Australian and State/Territory governments endorse the National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for Action by Governments. All Health Ministers sign the framework in July. The National Strategic Framework is a complementary document that builds on the 1989 National Aboriginal Health Strategy and addresses approaches to primary health care within contemporary policy environments.

ATSIC releases the Family Violence Action Plan. The Action Plan outlines policy addressing family violence in communities and has a direct focus on improving the health and social environment of individuals and communities.

2004

In early 2004 the Australian Government announces the introduction of significant changes to the way policies, programs and services are developed and delivered to Aboriginal and Torres Strait Islander people and communities. Responsibility for the delivery of all Aboriginal and Torres Strait Islander-specific programs is transferred to mainstream agencies and a 'whole-of-government' approach adopted. This new approach is based on a process of negotiating agreements with Aboriginal and Torres Strait Islander families and communities at the local level in accordance with the concepts of mutual obligation and reciprocity for service delivery.

ATSIC and its service delivery arm, the Aboriginal and Torres Strait Islander Services, abolished. To coordinate the approach at the national level, an Office of Indigenous Policy Coordination is established within the Department of Immigration, Multicultural and Indigenous Affairs.

In May the Australian Government introduces a new health check for Aboriginal and Torres Strait Islander Australians covered by Medicare. The two-yearly checks aim to ensure early diagnosis and intervention for treatable conditions for Aboriginal and Torres Strait Islander Australians aged 15–59.

In June the Council of Australian Governments (COAG) agrees to the national framework of principles for government service delivery to Aboriginal and Torres Strait Islander Australians, which provides a common framework between governments promoting flexibility and tailored responses to form partnerships with Aboriginal and Torres Strait Islander communities. At the same meeting in June, COAG also agrees to the national framework on family violence and child protection, which aims to improve engagement and cooperation between governmental jurisdictions and Aboriginal and Torres Strait Islander communities to help tackle these issues.

2005

ATSIC Regional Councils are officially disbanded in late June as part of the government's restructuring announced in 2004.

In December the Australian Government announces funding for 27 Aboriginal and Torres Strait Islander primary health care services. These services receive up to \$400,000 per year for four years as part of the Healthy for Life program. Funding targets staff increases in child and maternal health, and chronic disease services, as well as health promotion, and education and care plans.

2006

The *Social Justice Report 2005* released by Human Rights and Equal Opportunity Commission (HREOC) in February examines the implementation of the new whole-of-government approach to Aboriginal and Torres Strait Islander administration, noting that some developments have emerged but there are some under-addressed gaps in policy, coordination and representation.

The National Indigenous Violence and Child Abuse Intelligence Task Force, led by the Australian Crime Commission, established in July to address child abuse and violence in Aboriginal and Torres Strait Islander communities in line with the whole-of-government approach.

2007

In the same month, the Australian Government's Department of Health and Ageing releases the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013: Australian Government Implementation Plan 2003–2008, its response to the recommendations made in the National Strategic Framework regarding how the government plans to improve Aboriginal and Torres Strait Islander health.

In July the Australian Government increases funding to a further 26 sites as part of the Healthy for Life program, announced in the 2005–06 Budget. These sites will emphasise primary health care services targeting circulatory disease, eye problems, asthma and diabetes in remote Aboriginal and Torres Strait Islander communities.

COAG meets in mid-July and discusses many Aboriginal and Torres Strait Islander issues, agreeing to establish a working group to develop a detailed plan for practical reform reflecting the diversity of circumstances in Aboriginal and Torres Strait Islander communities across Australia. At the same meeting COAG pledges \$130 million over four years to support national and bilateral actions addressing violence and child abuse in Aboriginal and Torres Strait Islander communities. COAG also agrees to provide more funding for drug and alcohol treatment and rehabilitation, and agrees to early intervention and health checks aimed at improving the health and wellbeing of Aboriginal and Torres Strait Islander children in remote communities.

In August the Northern Territory Government establishes a Board of Inquiry to research and report on allegations of sexual abuse among Aboriginal and Torres Strait Islander children and to make recommendations for the protection of these children from sexual abuse.

In April an Oxfam report, *Close the Gap: Solutions to the Indigenous Health Crisis Facing Australia*, outlines the disparities in life expectancies between Aboriginal and Torres Strait Islander and other Australians, and compares the health of Indigenous peoples in Australia, New Zealand, Canada and the United States of America.

The Close the Gap campaign, sponsored by 40 of Australia's leading Aboriginal and Torres Strait Islander and other health organisations, launched on 4 April. The campaign aims for the federal, State and Territory governments to commit to closing the gap in life expectancy between Aboriginal and Torres Strait Islander and other Australians within a generation.

The Northern Territory's Board of Inquiry, tasked with examining allegations of sexual abuse among Aboriginal and Torres Strait Islander children, publishes its report, *Ampe Akelyernemane Meke Mekarle: Little Children Are Sacred*, in April. The report details 97 recommendations on a variety of topics, including education and schooling, reducing alcohol consumption, improving family and support services, enhancing cooperation between services and communities, and empowering communities.

In June the government announces the Northern Territory Emergency Response (the 'Intervention'): 'health checks' for children, additional police, alcohol restrictions, pornography filters, compulsory acquisition of townships, additional funds for community services, quarantining of welfare benefits and income management, abolition of Community Development Employment Projects.

Parliament tables HREOC's annual *Social Justice Report 2006* in June. The report identifies two major problems with how the government deals with Aboriginal and Torres Strait Islander reform: first, the new whole-of-government approach does not adequately include Aboriginal and Torres Strait Islander people in decision making; second, the government has no framework or benchmarks to gauge improved access to services.



2008

The United Nations General Assembly adopts the Declaration on the Rights of Indigenous Peoples in September, reaffirming the entitlements of international human rights for Indigenous people without discrimination. The Declaration is opposed by Australia and three other nations.

The new Labor government, headed by Kevin Rudd, is sworn in on 3 December.

At COAG's December meeting, the members commit to closing the difference in life expectancy within a generation, and reducing the mortality gap of children under five, as well as the gap in reading, writing and numeracy, by half within a decade. Specifically, the Commonwealth Government agrees to double the funding of \$49.3 million previously pledged by COAG for services dealing with substance and drug rehabilitation and treatment

On 13 February Prime Minister Kevin Rudd formally apologises to members of the Stolen Generations on behalf of the government.

A Statement of Intent is signed in March between the government and Aboriginal and Torres Strait Islander health leaders, signalling the intent to work together to achieve equality in life expectancy and health status between Aboriginal and Torres Strait Islander and other Australians by 2030.

The *Social Justice Report 2007* is released in late March by HREOC, outlining a 10-point plan to modify the Northern Territory 'Intervention' legislation to better protect Aboriginal and Torres Strait Islander children and families.

In July Nicola Roxon, Minister for Health and Ageing, announces the composition of the Indigenous Health Equality Council to advise on the development and monitoring of health-related goals to support the government's commitment to closing the gaps in health between Aboriginal and Torres Strait Islander people and other Australians.

The Close the Gap coalition presents the federal government and opposition with a set of National Indigenous Health Equality Targets in July. The targets aim to address the 17-year gap in life expectancy between Aboriginal and Torres Strait Islander and other Australians.

The Northern Territory Emergency Response Review Board's report, released in October, provides an independent assessment of the progress of the Emergency Response.

COAG announces in November a commitment of \$4.6 billion for Aboriginal and Torres Strait Islander issues. The funds will focus on projects across the areas of early childhood development, health, housing, economic development and remote service delivery.

2009

*Closing the Gap on Indigenous Disadvantage: The Challenge for Australia*, which summarises the Australian Government's progress in 'closing the gap' and addressing Aboriginal and Torres Strait Islander disadvantage, is released in January.

Jenny Macklin, Minister for Indigenous Affairs, announces Australia's official support of the United Nations Declaration on the Rights of Indigenous Peoples, which was adopted by the United Nations General Assembly in 2007.

Aboriginal and Torres Strait Islander Social Justice Commissioner Tom Calma provides a report in August outlining a proposed new structure for a National Indigenous Representative Body to replace ATSIC. The report recommends that the body should be independent of government and have equal gender representation.

The Australian Government announces in November the establishment of the National Congress of Australia's First Peoples, the new national representative body for Aboriginal and Torres Strait Islander peoples.

## Appendix B: Personal Reflection— Bronwyn Fredericks



Bronwyn Fredericks

*The final meeting of participants in the Revitalizing Health for All: International Indigenous Representative Group—Learning from Comprehensive Primary Health Care Experiences took place in Ottawa, Canada from 13–17 June 2011, with all the separate global projects presenting their findings. Co-author Bronwyn Fredericks, Lowitja Institute Chair Pat Anderson, Board member Stephanie Bell and Program Manager Vanessa Harris attended the meeting, along with representatives from the Australian project teams. Commentary report co-author Bronwyn Fredericks also attended and here she reflects on the experience.*

The gathering was inspirational from the point of view of being among people who have been instrumental in developing Comprehensive Primary Health Care (CPHC) projects within their communities and regions. As participants we had the opportunity to hear about the range of projects, tease out specific elements and question and challenge each other on process and praxis. What I found interesting was the similarities in the day-to-day issues our communities are struggling with, such as poverty, food security, education, housing, conflict, representation and local and governmental politics. There were also differences, such as the experiences of colonisation, civil war, resource and land exploitation and the impacts of globalisation on primary producers in third world countries.

The Australian delegation comprised a broad range of knowledge and experiences, which meant that we were able to engage confidently in formal sessions and casual discussion. There was a mutual sharing between the participants of the lessons learned, the models used and the outcomes for the communities in which we worked.

Other participants were extremely interested in the three Australian projects and in the Aboriginal community controlled health organisation (ACCHO) model. I think some of the other participants were surprised by the level of control and say that Aboriginal people have within ACCHOs. There were a number of CPHC models discussed that were still directed or governed by governments and where people had some say but no control or authority over their own services and organisations. Some of the other groups aspired to aspects of the ACCHO model.

I was particularly impressed with the work being undertaken in El Salvador. We heard how a group of community activists had established a CPHC organisation within a small region—initially to address the trauma and injuries of war and the extremely poor health status—and how that CPHC organisation had now become a model of health service delivery for the country. Eduardo Espinoza, one of those activists and project workers, was now the Vice-Minister for Health for El Salvador. Just

imagine if the Aboriginal community controlled health organisation model was adopted by the Australian government as a whole-of-community model.

I was at the People's Health Movement Assembly in Ecuador in 2005 when this global Comprehensive Primary Health Care project was conceived. I have been able to witness and participate in the conception, development, implementation and now delivery. Each group will be publishing from their projects and I do believe that other organisations will be able to use the outcomes.

To be invited to be part of the Victorian Aboriginal Health Service (VAHS) and Victorian Aboriginal Community Controlled Health Organisation (VACCHO) project, and then part of the Australian delegation that was supported by the Lowitja Institute, was a real privilege. I have valued being part of the project team at VAHS and VACCHO and engaging with the Lowitja Institute team.

While I was invited onto the project as a researcher and mentor, I have also learned so much that I can go on and share in other research settings.



**Australian delegates at Ottawa (from left):**

Gai Wilson, Alan Brown, Vanessa Harris, Clive Rosewarne, Pat Anderson

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