COMMUNITY CONTROL THEORY AND PRACTICE: A CASE STUDY OF THE BRISBANE ABORIGINAL AND ISLANDER COMMUNITY HEALTH SERVICE

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Health to Aboriginal people is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity (National Aboriginal Health Strategy, Working Party 1989, p.ix).
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Thesis Introduction

It is accepted protocol among Indigenous communities to identify one’s link to land. I was born and raised in Brisbane. My birth grandmother is a Goreng Goreng woman, my birth grandfather is a Punthamara man. However, I was adopted by a Koombumberri man and an anglo-celtic mother after being removed at birth under the Queensland government policy of the day. The action of my removal and placement has had profound effects upon my growing and my place within my community today.

For the last 15 years I have worked in the health sector. My current position is as a Lecturer within the Department of Nursing, Faculty of Science, University of Southern Queensland, Toowoomba. My areas of expertise are Indigenous Health and Primary Health Care. I have been employed in this capacity since January 2000. Prior to my full time employment as a nursing academic I have primarily been located within three areas of health which have directly impacted upon my current research. I was first positioned within health by undertaking my General Nurse Certificate through hospital-based training commenced in the late 1980s. For me this training meant being immersed within whiteness and specifically the white medical model. This meant learning a set of skills in a large institutionalised health care service with the provision of doctors, nurses, and allied medical staff through a hospital. Within this training there was no Indigenous health curriculum. The lectures provided on “differing cultures” and health were on Muslim and Hindu beliefs about death.
At that point I was painfully aware of the glaring omission of any representation of
Indigenous health and of acknowledgment of the current outstanding health differentials
between Indigenous and non-Indigenous Australians. I knew that the colonisation process
inflicted upon Indigenous Australians was one of devastation. The decline in our health
status at the time of colonisation had been felt immediately. Since this time our health has
been in decline. While in the 1980s it was now no longer acceptable to shoot us, poison
our waterholes, and incarcerate us on missions, we were still experiencing the influence
of the colonisation process, which had strong repercussions for our current health status.
Our communities were and remain rife with substance abuse, violence, unemployment,
and much more. For Indigenous Australians these factors cannot be separated from our
initial experience of the colonisation process but are seen as the continuation of it.
However, there was no representation of this and I received my first health qualification.

My second position was within Queensland Health, Central Office shortly after I
completed my nursing training. Once here I was initially employed as a research/policy
Officer within the Women’s Health Policy Unit, and then in the Aboriginal and Torres
Strait Islander Health Policy Unit. It was here that my desire to work in Indigenous health
became directive. I have since remained in Indigenous health in varying positions and
capacities. Also during this time I attained a Bachelor of Health Science with a double
major in Aboriginal Health and Community Development through the University of
Sydney. This qualification, unlike my first, was immersed within and taught from an
Indigenous perspective. I was taught by Indigenous health professionals in many course
areas. It was while I was attaining this degree I became familiar with the realm of
academia. This impacted on my desire to do further research such as this thesis.

The third position I held which impacted upon my desire for and approach to this research was when I started working at the Brisbane Aboriginal and Islander Community Health Service (AICHS) in 1994 as a locum registered nurse. In September of 1995 I gained a position as a permanent Level 2 Registered Nurse attached to the Youth Section of the AICHS. The section was called Indigenous Youth Health Service and was a “mini” health service. The Indigenous Youth Health Service was on re-current federal funding that was a direct result of the Burdekin Report into Homeless Youth. The Aboriginal and Torres Strait Islander Commission (ATSIC) had purchased an old dance hall directly next door to the Brisbane AICHS for the Indigenous Youth Health Service. The service had an Aboriginal female coordinator, a non-Indigenous part-time doctor, an Aboriginal female youth worker, and a non-Indigenous registered nurse. In the five years that I worked within the service we were successful in gaining both federal and state funding. The service grew to include a male Aboriginal drug and alcohol worker, female and male Indigenous sexual health workers, and a registered nurse position to co-ordinate the Cervical Cancer program, which was the position I held.

It was here that I learnt what a community controlled Indigenous health service was and became familiar with the philosophy of community control. I also learnt and became further immersed in the Indigenous health perspective. For me this represented completeness in my training as an Indigenous health worker. At times it was very difficult to unlearn a white, predominantly all male, interpretation of our health. It was also here that I saw as an Indigenous practitioner the continuing appalling health status of
Indigenous people.

Being immersed in an Indigenous community controlled service was to become the directive for undertaking this research. As an Indigenous nurse practitioner and working in Indigenous health, I wanted to learn more about this unique framework. I had heard Indigenous community members question whether community control was being implemented and operated as best it could. As a practitioner I questioned the same. This led me to the fundamental question of this research, that being to identify “what is community control”? This meant identifying community control theory and practice. The Brisbane AICHS was naturally ideal for use as a case study in this research to explore whether the theory and practice of community control align themselves within the service.

I knew that prior to the establishment of Aboriginal Medical Services, Aboriginal health was administered under western management theories (the provision of hospitals and doctors), which originated in English-speaking countries such as the United States and Britain. The decline of our health is indicative of the inappropriateness of this model. For Aboriginal (or Indigenous) people Indigenous contexts and understandings of health—which encompass language and cultural norms—were and, by and large, remain at opposite ends of the spectrum to western management theories of health.

Within the last three decades there has been a concerted effort to reduce the outstanding health differentials between Indigenous and non-Indigenous Australians. It is important to note that this has occurred as a direct result of agitation and action from within the
black community. This is perhaps most readily identified through the establishment of Aboriginal Community Health Services (in most States referred to as Aboriginal Medical Services) emerging in the 1970s. The establishment of the first Aboriginal Medical Service in Redfern, Sydney marked the beginning of a new era for Indigenous Australians in their fight to reduce the outstanding health differentials between Indigenous and non-Indigenous Australians. What makes the emergence of these services unique is their underlying philosophy of being “community controlled” health services. On a national level there are now approximately 110 Aboriginal (and/or Torres Strait Islander) Medical Services.

However, our health crisis remains: after 215 years of colonisation the reality is that we have the poorest health status of any identifiable group within Australia. Why haven’t things changed? Why isn’t our health profile improving? We continue to live today consumed by a dominant culture which has highly developed technologies and sophisticated social support systems and networks, but Indigenous Australians have a uniformly appalling health profile. By undertaking this research I aim to address this by identifying whether a better day-to-day practice of community control can or may result in improved Indigenous health. This is essential as I suspect it will be explicitly demonstrated throughout this thesis, that from the Indigenous community perspective community control is still the most appropriate way to administer Indigenous health services.

**Methodologies**
To date there has been little health research undertaken by Indigenous people on
Indigenous health compared with the amount of research into Indigenous health that has
been conducted by non-Indigenous researchers. For Indigenous people our health status
is not merely the breakdown or presentation of facts, figures, and statistics of which there
is an overwhelming amount of disputable value. This statistical approach is a western
medical model, which is far removed from the Indigenous perspective on our appalling
health statistics. Our health to date has been largely presented within this western-
determined biological context.

From the Indigenous perspective this is not a true representation of our health status
because within the Indigenous context of health the biological, which is the springboard
of the western medical model, cannot be separated from the psychological, spiritual, and
community aspects of health. This research will look at Indigenous health in a more
inclusive Indigenous way, which encompasses not only the biological (Western context),
but also the psychological, spiritual, and community aspects (Indigenous context) of
health. The facts and figures of Western measurements of health are useful and necessary
within this research for comparison between Indigenous and non-Indigenous peoples and
also for the satisfaction of academic criteria. Not only does this establish these
differentials on a national scale but also on an international scale between Indigenous
Australians and Indigenous populations globally who have experienced the colonisation
process. It is essential to present both the Indigenous and non-Indigenous perspectives on
health as the statistical approach allows us to measure the problem while the Indigenous
perspective allows up to explain the problem.

In presenting the Indigenous perspective it is imperative to remember that when documenting any Indigenous issue there must be representation of oral culture. In traditional Aboriginal society the passing on of information orally was an integral part of the passing on of knowledge and traditions. If we had a history of putting things in writing our history would be documented. While oral culture played an integral role in traditional Indigenous societies it continues to be an integral part of neo-colonial Indigenous communities. Storytelling, according to Baum (2000: 482), is an intrinsic element of Aboriginal culture and a valued method of circulating information. This method is most appropriate due to the existing culture of a well-established oral history.

Therefore, to give the true evolution of community control it is essential to document oral histories. This allows for the working experience of Indigenous people to be articulated. Usually such a transcript of responses would be confined to an appendix. However, I present these materials in the main body of the text for three reasons: initially, it submerges the reader in the raw data which allows the reader to truly grasp an Indigenous perspective of what community control is. Second, this also forms part of a process of empowering the community by enabling community consultation. This method mirrors a fundamental principle of community control as outlined by the National Aboriginal Community Controlled Health Organisation (NACCHO) and the Queensland Aboriginal and Islander Health Forum (QAIHF), which are the federal and state Aboriginal and Torres Strait Islander peak health bodies. Within Chapter 5 and 6 I present to the reader the findings of interviews conducted by 48 Aboriginal and Torres Strait Islanders living
within Brisbane, who have accessed the Brisbane Aboriginal and Islander Community Health Service for health service provision. In presenting the community voices I italicise them within the text. This clearly outlines to the reader when community voices are being articulated.

**Literature review**

Within the literature surrounding my central research question there is a plethora of epidemiological information on the marked health differentials between Indigenous and non-Indigenous Australians. (Bartlett, B 1995, Hunter, E 1993, Moodie, PM 1973, Reid, J and Trompf, P 1991). However, what is lacking in the literature is an Indigenous pool of writings on community control. In particular, the word theory is not often articulated with community control. It is instead noted as an operational framework, however, for the purposes of this research I will contextualize community control by identifying it as theory as well as an operational practice and move towards clearly defining community control. I have made a clear methodological decision in focusing this literature review that Indigenous voices and conceptualisations of community control will be presented as most relevant. This is essential in this research for several reasons. Firstly, the uniqueness of the community control framework in Australia – international comparisons are based on a comparison of health issues not on the implementation or significance of community control. Community control is not present in other first nations when health services are administered to Indigenous peoples. Thus it is essential to concentrate on Indigenous accounts of community control, in documenting the founders, who are Indigenous, and in
setting the foundations of this research. Secondly, very little has been written on community control theory or practice and an even smaller number of these writings have been undertaken by Indigenous peoples themselves. Historically, most research about Aboriginal health has been performed by non-Indigenous researchers with a focus on health rather than organisational framework and operational philosophy. This also sets this research apart as it is both conducted by an Aboriginal researcher on both community control and Aboriginal health issues and it focuses on the link between Indigenous health outcomes and community input and ownership of Indigenous health services.

Thirdly, it is essential to include oral interviews as primary source materials because not only is oral history a significant tradition within Indigenous culture but in addition written records do not exist on the early practices of community control. Watson highlights the lack of records in a letter to the President of the Board of the Brisbane AICHS stating: ‘I also found that company records do not go back to that early period. I conducted searches at the Australian Securities Commission, but I found that all records of the Brisbane AICHS before 1985, have been destroyed’ (Watson, unpub.). These services were established by Indigenous people for Indigenous people and emerged out of the direct needs of the Indigenous community thus an oral history needs to be taken to capture the theory which underpins community control.

Those writings which do focus on community control can be separated into three categories. Firstly, there is a small number of publications outlining histories of several
Aboriginal Medical Services from around the country. The Brisbane Aboriginal and Islander Community Health Service have documented their history which has enabled this research to document the history of the service since its inception. This is outlined extensively in Chapter 3.

Secondly, there is some literature from Indigenous health organisations outlining the theory of community control. This literature is presented within Chapter 4 in detail as the theory of community control. These materials inform the theory of community control presented within this thesis.

Thirdly there is a one article that I could source that presents a comparative discussion and analysis on community control theory and practice (Tsey, 1997). It is interesting to note that this comparison study is delivered by a non-Indigenous person. This perspective questions the function of community control and its impact on Indigenous health outcomes. This was the only literature that I could source that directly engaged in a comparison of community control theory and practice. There is a significant gap in existing research on community control theory. This thesis makes an indigenous addition to knowledge within this area of research interconnecting community control practices of service delivery and community control theory of indigenous empowerment.

The above three areas of writings on community control theory and practice provide the structure for this literature review and it is under these three headings that the literature review will be presented. Overall the literature that is presented below is focused on providing a working definition of community control for this research.
First, forming part of an Indigenous literature, I will draw on oral history obtained from two Indigenous activists who helped establish two of the first Aboriginal community controlled health services in the 1970’s. This individual definition that I obtained in defining community control is articulated from Les Collins and Susan Morgan. Both of them were instrumental in the establishment of the Brisbane Aboriginal and Islander Community Health Service. Also both were present at the first articulation of community control by Bruce McGuiness in 1973 at a meeting in Redfern Sydney of the 6 established Aboriginal Medical Services at that time.

Susan Morgan states:

*Community control is the community having a say again in how a service is established, how its programs and services are delivered through there. If they have any problems with the way it is being administered the community are able to access the right people and articulate dissatisfaction. This process comes from the community not from workers not from Board members but from people that make these organisations work and the people that count and that’s the community.*

Les Collins stated:

*Unlike virtually all other health centres in the world, Aboriginal Medical Services are not run by doctors or other medically qualified people. Also, rather than doctors being considered the most important people in our services, they are the least important. The most important people to us in our services are the patients, the Aboriginal people who, in turn, are the people who run the Service through annually elected Aboriginal Board of Directors.*

These quotes highlight a clear theoretical link between health outcomes and community
management and input.

Second, I will draw on written texts from the Aboriginal community controlled health services themselves. These writings have historically been presented within several contexts, such as Indigenous health conferences both nationally and internationally and it is believed to evolve from the first Aboriginal Medical Service in the country, that being Sydney Aboriginal Medical Service. It is essential to include this text on community control. This brings together theory and practice in my working definition of community control as initiated and practiced by the first Aboriginal Medical Service in Australia.

In defining community control the first Aboriginal Medical Service identifies that:

Aboriginal community control is also about responsibility and accountability to the community having regard for local cultural perceptions and imperatives. The essence of Aboriginal community control, in this context, distinguishes it from all other methods of control by the coming together of minds and experiences, harnessing talent and diverse abilities from within the local Aboriginal community towards regaining and maintaining its well-being. The process of Aboriginal community control in the area of health means that an Aboriginal health service is independent and autonomous and is controlled by the local Aboriginal community it serves in order to provide culturally appropriate health care to meet its health needs as defined by that community

(Foley 1999, pers. comm., 20 April)

Third, I will draw on the theory of community control as presented by the Queensland Aboriginal and Islander Health Forum (QAIHF) and the National Aboriginal Community
Controlled Health Organisation (NACCHO), both being the state and federal peak Indigenous health bodies. Again this draws a theoretical and practical connection between health outcomes and community empowerment. The QAIHF membership is made up of the individual Aboriginal Medical Services throughout the state of Queensland. The individual Aboriginal and Islander community health services are made up from relevant community members. In outlining community control theory QAIHF states:

Health does not just mean the physical wellbeing of the individual but refers to the social, emotional, cultural and spiritual wellbeing of the community. For Aboriginal peoples this is a whole of life view, which incorporates the cyclical concept of life-death-life. Central to this definition is our right to self-determination, which is our cultural and human right. We use the term community control, which basically is a self-determination process. Further, this has been demonstrated as the key process for our communities to maximise health outcomes (Queensland Aboriginal and Islander Health Forum 2003).

The national body (NACCHO) membership is drawn from the various state and territory bodies and is the federal peak body for community controlled Aboriginal and Islander Health Services.

An Aboriginal Community Controlled Health Service must be:

- Incorporated Aboriginal organisations
- Initiated by a local Aboriginal community
• Based in a local Aboriginal community
• Governed by a body that is elected by the local Aboriginal community
• Delivering a holistic and culturally appropriate health services to the community, which controls it. (National Aboriginal Community Controlled Health Organisation 2003).

This draws together both the practical framework and the link between community input and improved health outcomes.

NACCHO has this further to say about community control:

…that each independent and autonomous health service is controlled by the community it serves, in order to provide that community with health care delivery to meet its health needs, as defined by that community. The solution to each community’s health needs is in the hands of that community. Therefore it cannot be said that there is strict uniformity in all Aboriginal Medical Services as different regions and communities face different health problems, or the same health problems but to varying degrees. However, what is uniform in all of the Aboriginal Medical Services is that they all operate under the philosophy of community control (National Aboriginal Community Controlled Health Organisation 2003).

Using these four pools of Indigenous knowledge together allows me to identify community control theory as well as demonstrate to the reader the intricate link that feeds through all four Indigenous perspectives. Therefore, community control theory, as I have articulated from within these four perspectives, is cohesive. First, because of the framework of direct community input which flows from the individual through to national level. This allows for true community representation. Consequently, I would argue that this structure results in a uniformity of community control theory from these four perspectives. For the author this is the theory of a link between community input and best health outcomes that this research utilises for this thesis. This Indigenous
literature both written and oral history is the working foundation of this thesis.

The second source that I will be drawing upon is written by predominantly non-Indigenous people. This presentation on community control is vital to the construction of community control theory from an Indigenous perspective. I also further present the non-Indigenous perspective of community control by outlining primary health care as defined by the WHO. This is necessary as it clearly indicates the intricate similarities between primary health care and community control. This adds to the debate that non-Indigenous primary health care sees community control as an offshoot of it and that the Indigenous construct is that community control lies central to being able to then deliver primary health care to the community.

In 1978 the WHO convened a conference in Alma Ata, Russia. The resolutions of this conference were the formation of the Declaration of Alma Ata of Primary Health Care. The WHO assisted in the adoption of the principles of primary health care by governments around the world after the WHO Conference in Alma Ata in 1978 (World Health Organisation 1978). The programs to implement the principles outlined at Alma Ata have been known as ‘Health For All by the Year 2000’.

According to Alma Ata, primary health care is:

...essential health care based on practical, scientific and socially acceptable methods and technology made universally accessible to individuals and community through their full participation and at a cost that can be maintained at every stage of development in the spirit of self-reliance and self-determination. It is the first level of contact of individuals, family and community with the health system. Primary health care is based on:

the economic and social realities of a community, and the country;

the existing knowledge of the community, its health problems, and the most
appropriate health services which address the main health problems in the community, providing **promotive, preventative, curative and rehabilitative** services (World Health Organisation 1978).

Interestingly, what is lacking in the literature is a substantial comparison of community control theory and practice. After an extensive literature review one article was sourced. However, in identifying the smallness in numbers of publications of a comparative nature available, I also identify what it is that this sets this research apart from existing knowledge of community control. A critical comparison of community control operation and theory is obtained throughout this research and is an integral part of its findings and contribution to knowledge. Thus as part of this research I conducted interviews amongst 48 Indigenous participants who have accessed the Brisbane Aboriginal and Islander Community Health Service since its inception. In doing this I address the third component of this research by undertaking the case study of the Brisbane Aboriginal and Islander community health service which is outlined extensively in Chapters 5 and 6. This is a significant contribution to current understandings of community control. It both draws together existing Indigenous studies and provides primary research to fill knowledge gaps and interconnect the theory and practice of community control so as to understand how it is implicated in better health outcomes. It also provides an oral record of current understandings of community control from within the Brisbane indigenous community.

Tsey, 1997 in presenting at the Aboriginal Health: Social and Cultural Transistions
Conference in Darwin stated that:

At the top of the pyramid is a small group of senior Aboriginal managers usually numbering no more than three or four people. In association with a board of management, these senior managers are responsible for policy development and day-to-day running of the organisation. Directly below senior management and occupying the middle stratum of the organisation is a predominantly non-Aboriginal, professional staff, including lawyers, doctors, nurses, linguists, teachers, anthropologists and a range of other highly educated personnel. The bottom stratum of the work force is predominantly Aboriginal; people are employed in a range of semi-professional (health workers, field officers, language workers), clerical and manual capacities. The implications of this type of ethnically based employment structure and income based employment structure and income distribution in Aboriginal organisations are serious. (Australian and New Zealand Journal of Public Health 1997 vol. 21 no 1).

Obviously the above literature does little in defining community control theory, however, what it does present to the reader is the comparison of community control theory and practice. Tsey goes on further to state that:

On the other hand, income distribution clearly favours non-Aboriginal people because of their higher educational attainments and levels of skills. If we accept that higher income equals better health, in this case Aboriginal organisations themselves may be inadvertently perpetuating health inequalities between

Clearly Tsey is questioning the positions of power that are obvious within the practice of community control.

This study offers a comprehensive critique of this characterisation of the links between community control and indigenous health outcomes. My own research would suggest that the significance of community control is constructed differently from an Indigenous perspective as opposed to a non-Indigenous perspective. Thus there is a gap in the existing literature which masks the current debate between white representations of community control as problematically institutionalising power imbalances on the one hand; and indigenous articulations of community control as implementing Within the non-Indigenous viewpoint community control is seen as an inessential element of primary health care. This therefore means that primary health care services are delivered in a particular community (not necessarily Indigenous) but that the service is not defined by that community and these services are not necessarily answerable to the community. Within this context community control is, I argue, placed as an off shoot of primary health care and viewed as irrelevant or even hindering health service delivery.

The Indigenous context is that community control is the essential element of all service provision to the community including health. Community control is seen as central to the service provision. Within this account, primary health care is delivered to the community by the community and the works to redresses institutional racism structured into most
health service delivery.

The main aim of the literature review then becomes to identify and articulate this fuller theory of community control which links poor indigenous health profiles directly to racism and interconnects indigenous service delivery to both indigenous empowerment and improved health outcomes. This then allows for a comparative analysis of community control theory and practice to be undertaken and presented. This literature review is the framework that the researcher uses herself when working towards defining community control.

Cleary, in some senses, this literature is limited and incomplete, it is rare for a study of indigenous health services to discount the comparative health studies outlined above. However, it needs to be clearly identified that Indigenous voices were given priority and utilised for outlining community control theory. This focus also demonstrates that there is a lack of literature on the Australian phenomena of community control particularly written by indigenous researchers from the perspective of Indigenous peoples and therefore the need for further research like the study reported here is demonstrated.

**Chapter Overviews**

In Chapter 1 I have provided an overall introduction to this research. I documented my history and involvement in Indigenous health and the path that led me to undertake this research. I also clearly established the necessity of the Indigenous perspective so as to undertake culturally safe research such as this. This includes relying heavily on Indigenous voices to tell their stories of community control theory and practice.
This methodology allows a detailed consideration of this study’s central research question, that being “what is community control”?

In Chapter 2 I utilise both Indigenous and non-Indigenous perspectives to compare the health status of Indigenous Australians and their non-Indigenous counterparts. The latter is presented through a statistical approach, which allows the reader to measure and understand this complex problem. This allows a comparison between the striking life differentials of Indigenous and non-Indigenous Australians, as well as between Indigenous Australians and the Indigenous peoples of New Zealand, Canada, and the United States.

An Indigenous perspective is also used to explain these marked life differentials. The Indigenous position argues that these differentials are the result of dispossession and the colonisation process. It is necessary to present both Indigenous and non-Indigenous perspectives on health as the statistical approach, drawn from a white health research model, allows us to measure the problem while the Indigenous holistic perspective allows us to explain the problem from an Indigenous context. Chapter 2 further considers the pre-invasion health status of Aboriginal people and the demise of Aboriginal health, which led to the rise of the community control movement for Indigenous health services within Australia. This chapter is essential in establishing an Indigenous context for the proceeding discussions in this thesis. Chapter 2 also establishes that community control delivers better health outcomes for Indigenous people than services in the white community.
Chapter 3 outlines the documented history of the Brisbane AICHS. The purpose of presenting this history is three fold. First, it documents the transition from a voluntarily run health service with a staff of seven to a multi-purpose built facility with a staff of 53, which is now government funded but remains an Indigenous community controlled organisation. Second, while presenting this history I establish that community control was practiced before it was articulated as a cohesive theory. This is achieved by drawing upon interviews conducted with three prominent Brisbane Indigenous members, Les Collins, Sam Watson, and Susan Morgan. All three activists were instrumental in the establishment of the Brisbane AICHS. Third, I outline the historical practice of community control so as to establish the basis for a wider theory of community control which has emerged from experience from Indigenous community members who were instrumental in the establishment of these services.

In Chapter 4 I address the second underlying question of this research as to the theory of community control. In presenting the Indigenous theory of community control, I contextualise how it was achieved using four Indigenous perspectives. First, I draw on the oral histories I obtained from three members of the Brisbane Aboriginal community, all of whom were present at the articulation of community control as an operational philosophy and were instrumental in establishing the Brisbane AICHS. Usually in reporting the findings of interview research a transcript of responses is confined to an appendix. However, I present these materials in the main body of the text to submerge the reader in the raw data so as to allow a reader to better grasp the Indigenous perspective on the theory of community control. This approach also forms part of an empowering
process for the community as this method sought to directly enable a community consultation process. I argue that this method mirrors one of the fundamental principles of community control as outlined by the Queensland Aboriginal and Islander Health Forum (QAIHF) and the National Aboriginal Community Controlled Health Organisation (NACCHO).

Second, I draw on written texts from the Alukra Congress in Alice Springs and the Sydney Aboriginal Medical Service. It is essential to include these texts on community control as experienced by two distinct community controlled Aboriginal Medical Services. This demonstrates both the variability of practice and the uniform commitment to community control theory among differing communities. It also highlights the differences in practice as identified by the individual communities in implementing community control in an appropriate way. Third, I draw on the theory of community control as presented by the QAIHF, the state peak Indigenous health body. Fourth, to complete this I draw on the NACCHO as the federal peak body for community controlled Aboriginal and Islander Health Services. Using these four pools of Indigenous knowledge allows me to identify a wider and more complete theory of community control. It also demonstrates the intricate link between community control theory that feeds through and informs all four Indigenous perspectives.

Within Chapter 5 I use the Brisbane AICHS as a case study to analyse wider community understandings of community control. I use this to compare the theory and practice of community control, which is a core issue that emerges out of previous chapters. To best answer the research question relating to how widely community control theory is
understood by the Aboriginal and Torres Strait Islander community members, a questionnaire was distributed among Brisbane Indigenous community members who have accessed the Brisbane AICHS for varying lengths of time. This chapter presents the findings of these consumer questionnaires, which were completed by forty-eight such Aboriginal and Islander community members.

The questionnaires are the voices of the community and it is these forty-eight community members who are able to identify if the theory of community control, as endorsed by NACCHO and QAIHF and outlined within Chapter 4, is being achieved by the Brisbane AICHS as best practice. This Chapter presents the results of these questionnaires within a statistical framework. The relatively small number of participants means that caution needs to be applied when using statistical analysis. Nonetheless, it is a useful tool for displaying and analysing the findings of this survey as representative of the wider community.

The questionnaire also allows me to begin to identify if the theory and practice of community control aligns itself within the Brisbane AICHS. Overall, this quantitative analysis pointed to tensions between the theory and practice of community control within the health service. The two identified points of tension are, first, the uneven knowledge of what exactly community control theory means within the wider Indigenous community; and second, the tension between the ideal operation of community control and the reality of its day-to-day operation within Brisbane AICHS. However, at the same time these findings also identify high and partial knowledge of community control working definitions. Also, it identifies that some community members accessing the
service cannot articulate a definition of community control at all.

In Chapter 6 these points of tension are further analysed using in-depth interview responses. My method again requires the voices of the participants to be presented and heard as well as analysed. The responses to the in-depth questions is where community members identify disparities between the theory and practice of community control within the Brisbane AICHS. This qualitative analysis of expanded responses and explanations given by the participants increases my ability to interpret the statistical data of the preceding chapter.

Consequently, Chapter 6 retests and analyses the points of tension identified in Chapter 5. Of particular significance are those participants with a high knowledge of community control theory who express a definite ambivalence about the practice of community control. This chapter presents and discusses these tensions, which is essential to both addressing gaps in community understanding of community control and also between the theory and everyday application of community control in the Brisbane AICHS.

Overall, underlying the findings of Chapters 3, 4, 5, and 6 is substantial evidence that there is an incredible logic to community control. Community input leads to better targeted health services and leads to better health outcomes. These three aspects are undeniably causally related. One of the overarching findings of this thesis is the high levels of commitment and attachment to community control. Without exception the participants clearly indicate that they do not want to abolish community control. Rather, they want to see a better practice of it.
In Chapter 7 I present an overall discussion on the findings of this research and provide recommendations, which, I argue, could lead to a better practice of community control within the Brisbane AICHS. In doing this, I first briefly overview the chapters of this study, which serves as a framework for the proceeding discussion and recommendations offered in Chapter 7. Consistent with the research method of this thesis I again draw on the voices of my in-depth interviews. This is imperative for three reasons. First, the interviewees and participants repeatedly articulate a tangible and important attachment to community control, which is essential place in administering appropriate Aboriginal health service provision. Second, I draw on these interviews to find clear notions as to how to achieve a more efficient community control practice. Third, this method forms part of an empowering process that consults the Indigenous community and seeks to use this community’s ability and knowledge to better the community control practice of the Brisbane AICHS.

After re-presenting the in-depth interviews I then provide a general discussion of the findings of this thesis as a whole. This enables me to discuss some key findings and establishes the necessity of the recommendations I offer. These recommendations are aimed at addressing the points of tension that are identified within this research and that emerge within Chapter 5 and are validated within Chapter 6. The recommendations also include strategies about how to achieve them, as well as an overall rationale as to why they need to be implemented. Finally, I provide an overarching conclusion that draws together the different sections of this research into community control.
Chapter 2

A certain kind of industrial deafness has developed. The meaning of these figures is not heard or felt. The statistics of infant and perinatal mortality are our babies and children who die in our arms… The statistics of shortened life expectancy are our mothers and fathers, uncles, aunts and elders who live diminished lives and die before their gifts of knowledge and experiences are passed on. We die silently under these statistics (ATSIC 1995, p. 99).
Introduction

In Chapter 2 I utilise both Indigenous and non-Indigenous perspectives to compare the health status of Indigenous Australians compared to their non-Indigenous counterparts. The latter is presented through a statistical approach, which allows the reader to measure the problem but also allows comparison between the outstanding life differentials of Indigenous and non-Indigenous Australians, as well as between Indigenous Australians and the Indigenous peoples of New Zealand, Canada, and the United States. An Indigenous perspective is also used to explain these outstanding life differentials; this position suggests that these differentials are the result of dispossession and the colonisation process. It is necessary to present both Indigenous and non-Indigenous perspectives as the statistical approach allows us to measure the problem while the Indigenous holistic perspective allows us to explain the problem.

To date there has been little research on Indigenous health undertaken by Indigenous people compared with the amount conducted by non-Indigenous researchers. For Indigenous people our health status is not merely the breakdown or presentation of facts, figures, and statistics (of which there is an overwhelming amount which arguably is of disputable value). However, this is largely how our health status is presented in the public health domain. This statistical approach is based on a western medical model, far removed from the Indigenous perspective on our appalling health statistics. Moreover, our health has been largely presented within a western-determined biological context. From the Indigenous perspective this is not a comprehensive representation of our health
status, as within the Indigenous context of health the biological cannot be separated from the psychological, spiritual, and community aspects of health.

In response, this chapter will look at Indigenous health in a more inclusive Indigenous way, which encompasses not only the biological (Western context), but also the psychological, spiritual, and community aspects (Indigenous context) of health. Western measurements of health are facts and figures that are both useful and needed within this research for comparison between Indigenous and non-Indigenous peoples and also for the satisfaction of academic criteria. These will not only establish such differentials on a national scale but also on an international scale between Indigenous Australians and Indigenous populations globally who have experienced the colonisation process.

The facts and figures

A recent publication stated:

In general terms, Indigenous Australians are more likely to be unemployed or on lower incomes, less educated, imprisoned or in some form of care, homeless or living in overcrowded or substandard conditions, as well as being unwell or dying earlier compared to the non-Indigenous population (House of Representatives 2000, p. 4).

Indeed, the deplorable state of Aboriginal ill health is well documented (Bartlett 1995; Eckermann, Dowd, Martin, Nixon, Gray, Chong 1992; Sagers and Gray 1991; Hunter 1993; Franklin 1976). There is now a plethora of epidemiological information on our
health status and the outstanding differentials that remain between Indigenous and non-Indigenous Australians. Bartlett summarises the situation starkly, ‘Aboriginal adult mortality rates are the highest in the world apart from regions gripped in war’ (cited in Robinson 1997, p.207).

The latest Australian Bureau of Statistics (2001) report on the issue further outlines:

Over the period 1997-99, the life expectancy at birth for an Indigenous male was 56 years, and for an Indigenous female 63 years. Males in the total population in 1901-10, and females in 1920-22 experienced comparable life expectancies. Today males in the total Australian population have a life expectancy of 76 years and females 82 years (p.4).

The comparative difference in life expectancy is 20 years between Indigenous males and their non-Indigenous counterparts and 19 years for females. These statistics emphasise that there is a difference that requires explanation. More recently, in the written media, it was reported:

This stagnation and slippage [in life expectancy tables] is all the more disturbing when we consider since 1981, overall life expectancies have shown a marked improvement. This means that the relative mortality gap between black and white Australians has widened during a period when governments were supposedly acting on the principle of Aboriginal self-determination (Neill 2002, p. 11).
Australia remains in a unique position in the global community when ‘dealing’ with all things Indigenous. The Australian Indigenous community’s right to self-determination has, throughout the last several decades, received international attention on a range of issues. One of the more recent examples was in July 2000 when Booth, partner of the British Prime Minister, presented to an international United Nations Court findings on Mandatory Sentencing and its detrimental effects on Australian Aboriginals. In fact, Australia compares dismally with other countries that had an Indigenous population at the time of invasion. For instance, the Australian Medical Association and Public Health Association of Australia (cited in House of Representatives 2000, p. 6) states:

The all-causes mortality for the Aboriginal and Torres Strait Islander population is twice as high as the Maori rate, 2.3 times the United States Indigenous rate and 3.1 times the total Australian rate. The Maori death rate declined by 44% in the period between 1974 and 1994 and the United States rate by 30% in the same period.

It further states:

Life expectancy for Registered Indians in Canada continues to approach parity with the general population. In 1995, the life expectancy for Indian males and females was 69.1 years and 76.2 years respectively and the difference between the general populations is expected to be less than six years when 1996 data is released (Australian Medical Association and Public Health Association of Australia, cited in House of Representatives 2000, p. 6).
The above health statistics clearly identify the outstanding differentials in health status between Indigenous populations in New Zealand, Canada, and the United States. While many commonalties exist between the experiences of Indigenous peoples of differing nations, improving health is one that Australian Indigenous populations sadly do not share and is, of course, the most detrimental statistic of all.

The uniformity of these statistics occurs on all levels. Nationally, Indigenous peoples have poorer-than-average health compared to their non-Indigenous counterparts. Internationally, our health status lags behind that of other Indigenous peoples. The difference in health status is also evident at the Queensland state level. When comparing the health status of Indigenous Queenslanders to their non-Indigenous counterparts the health statistics stay relatively the same with other national state comparisons between Indigenous and non-Indigenous peoples and, where they do not, the Queensland figure is worse.

As further outlined by Queensland Health (1996, p. 4):

- In Queensland, the health of Aboriginal and Torres Strait Islander people remains substantially worse than any other section of the non-Indigenous Queensland population.

- The estimated mortality rates for Queensland Aboriginal and Torres Strait Islander people in middle age (40-64 years) are among the highest recorded in the world.
However, to Indigenous Australians the outstanding health differentials are not just facts and figures; they are our living reality and perhaps best summarised by the Aboriginal and Torres Strait Islander Commissioner (1995):

A certain kind of industrial deafness has developed. The meaning of these figures is not heard or felt. The statistics of infant and perinatal mortality are our babies and children who die in our arms… The statistics of shortened life expectancy are our mothers and fathers, uncles, aunts and elders who live diminished lives and die before their gifts of knowledge and experiences are passed on. We die silently under these statistics (ATSIC 1995, p. 99).

It is widely perceived (and perpetuated within written media), that inappropriately large sums of money are expended on Aboriginal communities and Aboriginal health care. However, ‘the fact is that, if expenditure on hospital care is excluded, less is spent per capita on Indigenous health than on the health of other Australians. However, Aboriginal people are admitted to hospital sicker, often with more than one illness, and stay longer’ (ATSIC 1998, p. 34).

This claim can be further dispelled. Recent research has confirmed that Indigenous Australians also have less access to health schemes:

Perhaps as much as 14% of the Aboriginal and Torres Strait Islander population is not even registered to receive Medicare benefits, a situation, which the health Insurance Commission is working to redress. On a per capita basis, Aboriginals
who are registered with the MBS under-use the scheme. Per capita, non-
Indigenous Australians used $327 of Medicare subsidies in the 1995-1996
financial year, but Indigenous Australians only $88. There are even greater
discrepancies in relation to the use of Commonwealth - subsidies prescriptions.
The average expenditure for each non-Indigenous Australian in 1995-1996 was
$450, but the equivalent figure for Indigenous Australians was $113 (ATSIC

Further,

…a 1997 health review put Commonwealth health care expenditure for
Aboriginal people at some 25% less per head than for the general population. For
every dollar spent per head out of the National Pharmaceutical Benefits Scheme
on the general population, only 20 cents is spent per head on Aboriginal people.
The figure is 27 cents for Medicare, the national health insurance scheme. These
figures evidence the major access barriers to mainstream health-funding programs
for Indigenous people (Keys Young 1997, unpub).

Nevertheless, it is imperative to understand that these figures represent only an overview
for the reader. Elliot Johnston, QC, identifies the seriousness of the problem best:

…until I examined the files of the people who died and other material which has
come before the Commission and listened to Aboriginal people speaking, I had no
conception of the degree of pinpricking domination, abuse of personal power,
utter paternalism, open contempt and total indifference with which so many Aboriginal people were visited on a day-to-day basis. (cited in ATSIC 1998, p. 11).

**Pre-invasion health status**

It is now well recognised by many health authorities that these health statistics are the result of the colonisation process. As Bartlett (1995, p. 20) stated, ‘these problems are related to the process of colonisation that Aboriginal people have been subjected to, resulting in dysfunctional families and communities’. It is also now undisputable that Indigenous Australians were, at the time of colonisation, a fit and healthy race of people. The Indigenous oral tradition of passing on history tells us uniformly that we were a functional community, one that was full of physical exercise that took many forms—hunting and gathering, preparation of food, and also ceremonial activities—not only within individual clans but also at larger gatherings of several thousand Indigenous people. The colonisers also noted this level of physical fitness. Bartlett (1995, p. 10) suggests:

The health status of Aboriginal people before colonisation is difficult to assess in ways comparable to current data. However, there is strong evidence that a number of infectious diseases (such as measles, flu, and smallpox) were not present before the invasion. It also appears that ‘life style’ diseases (such as diabetes, high blood pressure, ischaemic heart disease) were unknown. Early descriptions of Aborigines painted a picture of a lean, athletic, robust and dignified people…
Whilst Aboriginal health was not perfect, the style of living was more in tune with the environment in which people lived. Diets were good. Bush tucker was plentiful. Illnesses like heart disease and diabetes were probably non-existent. People lived on their country and accepted the responsibility of caring for their country – protecting water holes and sacred sites. People lived in harmony with their environment, accessing the lands resources in a way, which protected that resource. Waste disposal was not a major issue, partly because of the nomadic lifestyle, and partly because of the lack of consumerism with its non-biodegradable products.

Therefore, we can conclude that the health differentials between Indigenous and non-Indigenous Australia are a direct result of the colonisation process. Prior to invasion, Aboriginal people had control over every aspect of their life. In today’s terminology this has been called a holistic approach to health, but in Aboriginal society prior to 1788 this was perceived as the norm. Every aspect of the person was equally regarded, this being the biological, psychological, sociological, spiritual, and communal.

Aboriginal communities had their own traditional medicinal practices that had been effectively administered and valued for generations. As part of the colonisation process, these treatments and practices were often quashed by traditional, western, medical practices. However, when traditional Indigenous practices were tested within western means, they were often deemed effective. Hunter (1993, p. 55) notes that:

Lawson Holman found confirmation of the effectiveness of a particular traditional
treatment. Patients with lacerations and compound fractures occasionally arrived at the hospital with ‘antbed’ plasters on their wounds, made from material obtained from specific types of anthills. These were usually promptly replaced with a conventional dressing. Having noticed that there seemed to be more problems with infection following removal, Holman opted in certain cases to leave the antbed plaster on, with good results. Subsequent testing demonstrated antimicrobial properties.

However, after 215 years of colonisation, the reality is that Aboriginal health status has been radically and irreparably altered; Indigenous Australians are no longer a fit and healthy race.

**The onslaught and effects of colonisation**

To Indigenous Australians it is not merely a question of having the poorest health status of any identifiable group within Australia, but also about struggling with the ongoing effects of the colonisation process. This alteration of culture is further enforced by the day-to-day experiences of Indigenous Australia. Sadly, many Aboriginal people in urbanised Australia experience racist action on a daily basis. This racism ranges from the psychological (such as the covert hostility at the corner shop or the denial of Aboriginality of fair-skinned or urban blacks), through to the physical brutality of the criminal justice system. Needless to say, these repeated experiences have devastating effects and impact directly on our health status as a community.

Since colonisation, the health of non-Indigenous Australia has flourished while the health
of Indigenous Australia has diminished. The founding penal settlement quickly embraced colonisation mode as the value of resources became recognised.

For Aboriginals, the effects of colonisation were felt almost immediately. Diseases against which Aboriginals had no immunity had devastating effects. As the frontier between the colonists and the Aboriginals expanded over decades the pattern of degeneration in health continued.

Also at this time was the founding of arguably Australia’s greatest self-sustaining myth of ‘terra nullius’, a land without people. The appropriation of lands that had sustained Indigenous Australia’s theology, lives, and economy outcomes has had ongoing traumatic effects. With the colonisation process came not only a loss of land but also a fracturing or severance of attachment for many Indigenous peoples. This needs to be contextualised for the non-Indigenous reader. The Indigenous perspective is that it is the initial loss of land that has changed Indigenous Australia forever. It is essential to understand the importance of Indigenous peoples’ link to the land. The National Aboriginal Health Strategy Working Party (1989 p. ix) identified that ‘Aboriginal people were totally dependent on the land and on all it could provide. To cope with this, they developed a social organisation that would enable them to use their natural environment successfully’.

It is also evident that, throughout the era of conquest and occupation, Indigenous
Australians were inflicted with many new diseases. As Bartlett (1995, p. 11) notes:

The conquest began in different areas of the continent at different times, from 1788 when the First Fleet landed near Sydney, to the 1950s when the Desert people were ‘brought in’ by government officials. During these times, Church missions were set up and many people took refuge in these to escape the murderous gangs, or for food. Once on the missions, however, they were subjected to a process of cultural genocide.

The havoc wrought on Aboriginal society through the destruction of traditional medical practices also proved profoundly damaging to Indigenous health. Aboriginals themselves saw the introduction of disease and the decline of their health as ‘white’ man’s poisons or diseases, and were ill equipped to combat them. The establishment of missions and the incarceration of entire communities saw to a large extent the demise of traditional medical practices. These practices were forbidden on the missions, being seen as ‘witchcraft’. These obscenely racist and inhumane health service provision practices went largely unnoticed and unmentioned until the late 1950s and 1960s.

At this time two of the most detrimental occurrences were happening: while Black Deaths in Custody and the Stolen Generations had not yet been named as such both were entrenched practices within Indigenous communities. These Indigenous experiences were virtually unknown within the non-Indigenous Australian conscious. Both of these experiences have had devastating effects on the Indigenous communities as part of the
The present plight, in terms of health, employment, education, living conditions and self-esteem, of so many Aborigines must be acknowledged as largely flowing from what happened in the past. The dispossession, the destruction of hunting fields and the devastation of lives were all related. The new diseases, the alcohol and the new pressures of living were all introduced. True acknowledgement cannot stop short of recognition of the extent to which present disadvantage flows from past injustice and oppression (Deane, cited in Couzos & Murray 1999, p. 1).

As an Indigenous practitioner I have observed this on an almost daily basis; the effects of removal were palpable when providing health service provision. I talked with many young Indigenous people accessing the Indigenous Youth Health Service who stated the grief and loss they felt over many issues. However, one issue that remained constant was the effects removal had had on not only themselves but also their immediate family members. Not surprisingly, as the Human Rights and Equal Opportunity Commission (1997, p. 3) states:

Grief and loss are the predominant themes of this report…. The histories we trace are complex and pervasive. Most significantly the actions of the past resonate in the present and will continue to do so in the future. The laws, policies and practices that separate Indigenous children from their families have contributed directly to the alienation of Indigenous societies today. For individuals, their removal as children and the abuse they experienced at the hands of the authorities
or their delegates have permanently scarred their lives. The harm continues in later generations, affecting their children and grandchildren.

The grief and loss that many young ones felt took on many forms. Many stated that the best way to deal with this was to just try and forget about it. When questioned further on how they ‘forgot’ about it, the most common response was to drink and or to use drugs. Alarmingly, many were also practising self-harm. This was an all-too-common response in dealing with grief. This grief takes on many forms within the Indigenous community. One of the most detrimental effects is mental illness.

According to The Australian Bureau of Statistics (1999, p. 5) report:

Although there are difficulties in determining the exact extent of the problems, Indigenous people are more likely to be hospitalised for and/or die from conditions that are indicators of mental illness, such as self-harm, substance misuse, and suicidal behaviour. They are more likely to be at risk of reduced mental and emotional wellbeing due to such factors as violence, removal from family, poverty and racism.

**The hopes of a Referendum**

Until the early 1970s there was little western treatment available to Indigenous Australians. The missions provided little, if any, health service to Indigenous peoples and, if it was available, it was often substandard in its delivery. Health services were often enough to sustain only the workforces of the missions. At this time, the trade in
black workers maintained the developing Pastoralists’ Industry. As a result our health declined further:

As the colonisers took control of the country, a new phase developed. These times were marked by a belief amongst the invaders that Aboriginal people would die out. Aboriginal people, they said, would have to be ‘assimilated’ into white society and culture. The view of the invaders was that the ‘solution’ to the ‘Aboriginal problem’ was for Aboriginal culture to be destroyed (hence our health), and that Aboriginal people would then embrace ‘civilisation’ and would become a part of the way the now dominant society worked (Bartlett 1995, p.11).

According to Biskup (cited in Saggers and Gray, 1991), so-called ‘lock’ hospitals were established for Aboriginals in the early 1900s. These were for Aboriginal people with contagious diseases even though effective treatment was not available until the 1930s. Hundreds of Aboriginal people died and were buried far away from their homelands.

This situation lasted until after World War II. ‘In the late 1950s and early 1960s, however, interest in Aboriginal Affairs grew rapidly and that which was described as “such a small problem” became the enormous social and political issue which it still is today’ (Hasluck 1998, p. 10). Moreover, Gardiner-Garden (1996-97, p. 7) noted: ‘In this period more and more voices drew attention to the meagre achievements of the assimilation policy, the denial of civil rights, which it entailed, and the poor international image it gave Australia. These voices were both Aboriginal and non-Aboriginal’.

Continuing into the 1960s and 1970s virtually all organisations working for the ‘welfare’
of Aboriginals were run and administered by white people. No government assistance was received by any organisation that provided services for Indigenous Australians. The 1960s saw the emergence of a demand for self-determination. This was evident in the 1963 Freedom Rides, which drew media and public attention to discriminatory practices in rural New South Wales, and the 1966 walk-off by the Gurindji people, led by Vincent Lingiari of Wave Hill Station, over a land claim in the Northern Territory. During this time there was an ongoing campaign for a Referendum on Aboriginal issues:

This task was largely initiated and facilitated through the Federal Council for the Advancement of Aborigines and Torres Strait Islanders. Their task was to obtain 100,000 signatures on petitions to present to Parliament therefore demonstrating public support for a referendum (1967 Referendum, Citizens at Last 1997).

On the 27th May 1967, an event unprecedented in Australian political history occurred: with a referendum to transfer power from the States to the Commonwealth - with reference to Aboriginal people (Attwood et al. 1997, p. ix).

For the community-based organisation, the Federal Council for the Advancement of Aborigines and Torres Strait Islanders, and other organisations, a decade-long public campaign ended in success. It was a long and arduous task that Aboriginal people faced in the push for the 1967 referendum. However, it is also important to note that agitation and action germinated within Indigenous communities.

The Indigenous community believed that the Referendum would result in Indigenous health being addressed on a national level. However, it resulted in bitter disappointment.
The support of the Australian public to ‘win’ the referendum did not translate into practical support. The working reality was that there was no further improvement in Indigenous health. Governments did not take responsibility for addressing the widening differentials in the health status of Indigenous and non-Indigenous Australians. Aboriginal people were still turned away at hospital casualty departments and general practitioners still refused to see or treat Aboriginal people. Indigenous Australians were still dying in droves. Gardiner-Garden (1996-97, p. 8) notes:

Many popular notions associated with the 1967 Referendum belong in the category of myths. The referendum was not whole-heartedly supported by both sides of politics, did not end legal discrimination, did not confer the vote, equal wages and citizenship for Indigenous Australians and did not permit for the first time Commonwealth government involvement in Aboriginal Affairs. The repeal of the State legislation, which discriminated against Aboriginal people, was a process which was independent of the 1967 referendum and which had begun before the referendum. The Commonwealth government some years before the referendum had clarified aboriginal voting rights and employment rights. The referendum result moreover, did not automatically make the Commonwealth more involved and indeed little changed for five years.

Throughout the decade-long push for the referendum and through intensive lobbying by Indigenous persons and their sympathetic white counterparts, the decline of Aboriginal health was tabled repeatedly as a national disgrace and an embarrassment to Australia. It
was believed that action in reducing these differentials could no longer be ignored.

**So who’s responsible? The State vs. Federal debate**

For many Indigenous peoples the referendum was hailed as a breakthrough for the rights and self-determination of Indigenous Australians. However, as the months passed, it became increasingly evident that the referendum would not lead to parity between Indigenous and non-Indigenous Australians in social, economic, or health status. Indigenous people expected the Commonwealth Government to seize power in determining better service provision for Aboriginals. This was not to be and was made apparent then Prime Minister, Harold Holt, who in 1967 stated that:

> …while the Commonwealth is now in a position to make laws and to prevail should a conflict arise with a State, the Commonwealth does not seek to intrude unnecessarily in this field or into areas of activity currently being dealt with by the States. There is a big variation in the circumstances and needs of Aborigines in the States. For this reason, administration has to be on a regional or State basis if it is to be effective (Holt, cited in Franklin 1976, p. 189).

This was a blow to the Indigenous community. While it was anticipated that the referendum would move responsibility from state to federal level, this was not to be. For Queensland this was an exceptionally hard blow: at the time of the 1967 Referendum, Queensland was arguably entering its darkest Indigenous political administration, headed by Premier Joh Bjelke-Petersen. Bjelke-Petersen was known among the Aboriginal community as exceptionally racist, havingwelcomed the speech by Holt. Responsibility
for Indigenous Australians was, in theory, the responsibility of the Commonwealth government. However, Holt had explicitly stated his reticence to step into state matters. For Queensland Indigenous people this meant that our health would continue to decline, as Bjelke-Peterson had no interest in the affairs of his State’s Indigenous people. This racist behaviour continued throughout the Bjelke-Petersen administration, which lasted until 1988. Sam Watson remembers this time:

You have to remember we were about five years behind all other states. Of course at this time Queensland was under a Bjelke-Petersen regime. I still remember when, in 1978, Mr. Bjelke Peterson kicked Fred Hollows and his trachoma team out of Queensland for fighting against the inequalities in our health. It was seen as threatening and undermining the National Party line on Aboriginal health and was therefore dealt with effectively (Watson 1998, pers. comm., 12 March).

This lack of clarity over the responsibilities of different levels of government for Aboriginal affairs and health care is increasingly blamed among the Indigenous community for poor Aboriginal health outcomes. The debate therefore continues over who is responsible for the funding of Indigenous community-controlled health services. As identified by NAHS ‘Approximately two thirds of total Aboriginal primary health care expenditure is directed through state and territory services, compared with about a third through the same for the rest of the population’ (cited in Couzos & Murray 1999, p. 5).

This might indicate a number of issues such as that the Commonwealth is reluctant to
administer ‘control’ through financial commitment over Aboriginal health or to administer substantial funding into community controlled Indigenous health services. If the government commitment is sincere, ‘the cost of bringing health hardware infrastructure (housing, water, sewerage) to acceptable minimum standards in Aboriginal communities has been put at $4 billion’ (ATSIC, cited in Couzos & Murray 1999, p.6).

It is no wonder that there has been, to date, no government in power prepared to shoulder the above costing and responsibilities, despite a plethora of government reports and Royal Commissions into the outstanding differentials. All espouse the same recommendations that never seem to be fully implemented or endorsed and yet are time and again stated by communities as the best way to reduce the differentials. Community frustration at this tedious process is best summarised by the late Puggy Hunter, Chairperson of the National Aboriginal Community Controlled Health Organisation:

You white people keep telling us Aboriginals that we have ear problems. You keep showing us the graphs and the research. You know, I think you mob are the ones with the ear problems … we keep saying the same things and you don’t seem to hear (cited in Couzos & Murray 1999, p. 1).

Sam Watson recalls the continued discriminatory practices of the late 1960s and early 1970s, when there was confusion as to who held power and who made the decisions. Watson (1998, pers. comm., 12 March) remembers:
For us this was good as there were no state infrastructure on the ground at this time on a state level and all applications and submissions were processed through a central office in Canberra. Also important to remember at this time was Queensland was the last to hand over control of Aboriginal Affairs to Canberra. We were about five years behind all the other states. Of course at this time Queensland was under a Bjelke-Petersen rule. It was an incredibly confusing time, as our national government opposed our state government when dealing with Aboriginal Affairs.

The result is 20 years of what has been described as ‘a period of duck-shoving between the Commonwealth and states in terms of responsibility for Aboriginal health’ and a ‘trail of accountability that has consistently stopped at state borders’ (Watson 1998, pers. comm., 12 March). The necessity of a more co-ordinated effort between state and federal governments has been consistently argued within political arenas. As recently outlined by the Australian Bureau of Statistics (2001) states:

The Commonwealth must take a more active role in the planning, delivery and monitoring of health and related services for Indigenous Australians, if progress is to be made in improving Indigenous health. This role will need to be formalised in agreements with the States, Territories and communities.

**Indigenous perspective**

Many myths abound around Aboriginal Australia and the many facets of Indigenous
culture. These myths are made up of overtly racist statements such as ‘they need to get off their arses and get jobs instead of waiting for everything to be handed to them’. The media perpetuates these myths and Indigenous people are constantly fighting the stereotype of the ‘drunken, black dole bludger’. This is presented in news media, which perpetuates these untruths. What is not presented, however, is that over 30,000 Indigenous people across Australia work for their dole through Community Development and Employment Programs. This is not considered newsworthy because it does not make for sensational media. What is seen as newsworthy most recently is the action taken by the Queensland Premier, Peter Beattie, in tackling and ‘drying out’ our Cape Communities through yet another ten-point plan complete with sensationalised, front-page pictures of yet another pack of ‘drunken blacks’.

One of the most damaging myths is that all the misappropriation and atrocities inflicted upon Indigenous Australians is a thing of the past and ‘that they just need to move on and get over it’. Why is this so damaging? Because it reflects a lack of understanding that the most detrimental effect to Indigenous Australians is the continuance of the colonisation process that continues to manifest itself in health differentials, low levels of employment, and inadequate housing. This is evidenced by the lack of improvement of our Indigenous health status compared to other Indigenous cultures, which have gone through similar colonisation processes. It needs to be remembered that the era of assimilation did not cease until the 1960s. While this overtly racist policy has ceased, it has been replaced by popular myths that surround Aboriginal culture. These myths, as stated before, are rife within the health context.
As an Indigenous practitioner who co-ordinated the Cervical Cancer Screening Program for Young Indigenous Women for five years, it was essential for me to be able to fend off the expectation of knowing all things Aboriginal (this expectation in itself a myth).

Perhaps the most common criticism I heard was that Aboriginals ‘had wasted millions thrown at them’. Of course, these myths are largely facilitated and pushed along by the media and consumed by an eager and largely ignorant community who do not question its validity.

Chapter Summary

Chapter 2 has established the current health status of Indigenous Australians. This was achieved by presentation of facts and figures, as well as through an historical account of how the decline of Indigenous health has occurred and why it has remained largely unchanged for decades. This outline has established that the Indigenous community is in a health crisis. This crisis is an on-going issue. It is one that is often met with disregard from Indigenous and non-Indigenous sectors of the Australian community. From the non-Indigenous sector it is often met with feelings or responses of bewilderment and of not knowing what to do to ‘fix’ the problem. From the Indigenous sector it is met with feelings of almost disregard since it is our daily community reality.

Within Indigenous communities, however, this crisis led to a unique community response: the development of community-controlled Indigenous health services within Australia. The framework of these services was the cornerstone in the fight to gain
equal status in a range of services for Indigenous Australians. The first occurred within legal services; however, this very quickly led to the establishment of health services. The first Indigenous Health Service was established in Redfern, Sydney.

In Chapter 3 I will outline these developments, including giving a brief history of the establishment of the first Aboriginal community controlled health service in Redfern. The establishment of this service had a flow-on effect in other states of Australia. I will then present a detailed history of the establishment of the Brisbane Aboriginal and Islander Community Health Service. This will show the operational development and practice of a community-controlled Indigenous health service and draws heavily on interviews conducted with members of the Brisbane Aboriginal community who were instrumental in the establishment of the Brisbane Aboriginal and Islander Community Health Service.
Chapter 3

We started on the streets with a lot of protesting activities where Aboriginal people in Brisbane and from throughout the state and interstate would come together.

What we were trying to do was to redress some of the more obvious discriminatory practices, for example, the blatant denial of access to existing health care systems for Brisbane blacks. (Les Collins 1998)
**Introduction**

Within Chapter 3 presents a documented history of the Brisbane Aboriginal and Islander Community Health Service (AICHS). The purpose of presenting this history is threefold. First, I document the transition of a voluntarily run service with a staff of seven, to a multi-purpose built government funded but Indigenous community-controlled facility with a staff of 53. The establishment of this service, as outlined in Chapter 3 was a direct response to the health crisis of Indigenous people in Brisbane at the time of the service’s inception. Second, while presenting this history I establish that community control was practised before it was articulated. This, in part, is achieved by drawing upon interviews conducted with two prominent Brisbane Indigenous leaders, Les Collins and Sam Watson. It is essential to include this oral representation because oral history is an innate part of Indigenous culture and written records do not exist. Watson highlights the lack of records in a letter to the President of the Board of the Brisbane AICHS stating: ‘I also found that company records do not go back to that early period. I conducted searches at the Australian Securities Commission, but I found that all records of the Brisbane AICHS before 1985, have been destroyed’ (Watson, unpub.).

Both Watson and Collins were instrumental in the establishment of the Brisbane AICHS and were at the meeting where ‘community control’ was first articulated as an operational philosophy of Aboriginal and Islander Community Health Services. By presenting this history I am answering the first fundamental component of this research, that being to document the practice of community control. By documenting the history of the Brisbane AICHS I immerse the reader in the actual lived experience of the
founding and forming of an Indigenous community controlled service.

Third, I present a global perspective that clearly demonstrates the uniqueness of Aboriginal community controlled health services in their operational philosophy. This also supports and identifies the blatant lack of recognition of this operational philosophy from successive Australian governments.

**In the beginning...**

In 1967 a study conducted by leading health experts from the World Health Organisation, who had worked in third world communities all over the world and their subsequent report roundly condemned the appalling health conditions of the Aboriginal families that they visited within Redhill, Brisbane (Watson, unpub.)

The political activity and agitation occurring in the Brisbane Indigenous community in the late 1960s formed the breeding ground for the establishment, not only of the health service, but also of many Indigenous community controlled services in Brisbane. In the Brisbane community a number of black activists became involved in the Federal Council for the Advancement of Aborigines and Torres Strait Islanders (FCAATSI):

FCAATSI was formed in 1958 in Adelaide at a meeting of Aboriginal leaders, politicians, church and trade union representatives. FCAATSI became the first truly national lobby group that led the battle for equality and better living conditions for Aboriginals. The Council became an effective pressure group (Watson, unpub.).

The Queensland members of FCAATSI included Oodgeroo Noonuccal (then Kath
Walker), Denis Walker (Kath Walker’s son), Pastor Don Brady, and Don Davidson, all of who were active members of the Brisbane community. FCAATSI was the driving force behind the 1967 Referendum and was involved in national Indigenous politics. Once FCAATSI members passed on national information to its Queensland members, agitation began stirring in the Indigenous community of Brisbane.

One of the young members of the Brisbane Indigenous community at this time was Sam Watson. Watson was very active in the establishment of Indigenous services in Brisbane and was also involved in the establishment of the Queensland Chapter of the Black Panthers. I interviewed Watson in-depth about his involvement in the establishment of Indigenous services, in particular the Brisbane AICHS. According to Watson:

…the radicalisation of Indigenous people in Brisbane led to a small group of Aboriginal and Torres Strait Islander leaders holding a meeting in the upstairs room at a bank building in Stanley Street, Mater Hill in 1968. The purpose of that meeting was to talk about the situation of the black community in Brisbane and to formulate strategies to address the seemingly insurmountable problems faced by every Indigenous family and individual in the greater Brisbane area (Watson, unpub.)

Within the Brisbane Indigenous community this ignited the urge to take to the streets and protest. One of the first public street marches for the Brisbane Indigenous community was led by Pastor Don Brady from the Normanby Fiveways to his church in Spring Hill, on Invasion Day 1970. (Invasion Day is a commonly used term amongst many
Indigenous communities and peoples across Australia instead of ‘Australia Day’. Some non-Indigenous people may find this terminology offensive, but this term is how many Indigenous Australians articulate the continuing process of colonisation inflicted upon them). In that same year, 1970, the Aboriginal and Torres Strait Islander Council was established:

In 1970, Don Brady, Dennis Walker and their group set up the Aboriginal and Torres Strait Islander Council. They decided to have a governing committee of twenty people, all of whom had to be Aboriginal or Torres Strait Islander adults. The governing committee drew up the main areas of need and appointed a Tribal Councilor to be responsible for each portfolio. Jane Arnold was in charge of health (Watson, unpub.).

The establishment of the Tribal Council added momentum to the drive in establishing the health service. Much debate and discussion was focused on what could be done about the obvious lack in health service provision for the Brisbane Indigenous population. Further discussion centered on how services could be delivered to this community. The response to this being that:

The late Jane Arnold and her small band of helpers enlisted sympathetic white doctors from the public hospital system and visited Aboriginal and Torres Strait Islander homes in the inner city suburbs and administered free medications and advice to the families they visited. This was the very first actual health program that was conceived, established and run by Aboriginal and Torres Strait Islander
people to serve their own community (Watson, unpub.).

At this time protesting and rallying of support was of paramount importance in the Brisbane Indigenous community. Collins--another young, Indigenous member of the Brisbane community--was also very active in the establishment of Indigenous services within Brisbane. Collins has worked within Indigenous health for many years, across both government and community sectors, and was also interviewed in-depth for this research.

Collins recalls of this time:

We started on the streets with a lot of protesting activities where Aboriginal people in Brisbane and throughout Queensland and Interstate would come together. What we were trying to do was redress some of the more obvious discriminatory practices for example the blatant denial of access to existing health care systems. This included talking to the Indigenous community, lobbying politicians and gaining political support from non-Aboriginal sympathisers, especially students and academics, and essentially we took it to the streets (1998, pers. comm., 14 March).

As a result, the first major civil rights march occurred on the streets of Brisbane in September 1971. In what became known as the George Street Clash, Indigenous men and women from the Tribal Council attempted to storm the Native Affairs building in George Street. Several of the Tribal Council were arrested. While in the Indigenous community
this action was seen as essential in our struggle for the right to Indigenous services, government bodies of the day saw it as too political and militant in its execution and subsequently the small amount of federal funding secured by the Tribal Council was withdrawn.

Although funding had been withdrawn from the Brisbane Tribal Council, their push for the establishment of Indigenous services remained. The Council was still meeting on a regular basis to continue discussing the establishment of Indigenous services in Brisbane. The Tribal Council at this time deemed that:

The Indigenous population base of the greater Brisbane area and the scope of the various areas of need, really required specialist organisations to deal with areas of need in specific ways. Therefore it was decided to set up separate purpose built, organisations to deal with the big three problems – law, health and housing.

The following year saw the development of the Aboriginal and Islander Legal Service. In August of 1972, a public meeting was held at the University of Queensland – Law Faculty, to talk about setting up a legal aid service. That meeting elected a steering committee made up of Aboriginal leaders, lawyers and supporters. In a matter of months, the federal government had granted a small operational budget and the governing committee had leased an office space and hired staff (Watson 1998, pers. comm., 12 March).
In Queensland this was the birth of community controlled Indigenous services. It is important to remember that the term ‘community control’ had not been articulated at this time. However, a common Indigenous catchcry throughout Australia of this time was ‘black affairs in black hands’; this concept is an essential element of community control. It was the above framework that was integral in the development of Indigenous community controlled services within Brisbane. For the first time the local Brisbane Indigenous community had mobilised not only the Indigenous community, but also established a governing committee that was made up of western profession--such as lawyers, doctors, and nurses--as well as the Indigenous leaders within Brisbane. Never before in neo-colonial history within Queensland had a service of any kind been established for Indigenous people where Indigenous peoples were responsible for its establishment and held key roles in its structure. This service was established by Indigenous people for Indigenous people.

It was also the first time that Indigenous peoples were being utilised for their expertise in knowing and being able to truly identify the needs within their community as well as identifying some solutions to these needs. Part of the solution was that community controlled services should be about services for the people and by the people.

It was during this time that the community again came together to discuss and elect a steering committee to establish an Aboriginal and Torres Strait Islander Medical Service in Brisbane. At a national level Queensland differs in its naming of health services, because Queensland has two different groups of Indigenous peoples: Aboriginals and Torres Strait Islanders. Many of Queensland’s Indigenous community controlled health
services therefore represent both groups of Indigenous people within their title and mission. The inclusion of Torres Strait Islanders is unique to Queensland: the other national Indigenous community controlled health services are called Aboriginal Medical Services.

As Watson remembers:

There was only a very small group of us and we managed to get the legal service and we started to initiate funds through fundraising such as barbecues and the like. Basically we were able to with these funds hire an ex bookshop building up on Musgrave Road, Red Hill, Brisbane. We then had a few weekends transforming the shop into suitable space for the health service. Pastor Don Brady was a qualified cottages carpenter so he knew how to handle a saw and hammer. Then we constructed a list of voluntary doctors who could give 2 to 3 hours a week and in that way we were able to launch the clinic on 13th February back in ’73 as a voluntary run health service for the community (1998, pers. comm., 12 March).

For the first three months of operation (February – May 1973), volunteers staffed the Red Hill Clinic on a part-time basis. During this period, 119 different patients were seen, and there were 145 appointments (Department of Aboriginal Affairs 1973). Watson notes:

In those first three months of 1973, whilst the Board waited for the funds to come through, they were able to set up a roster of voluntary doctors who came in for two to three hour sessions and provided general clinics. The word had to be
passed around the community (by word of mouth) that doctors were available on
certain days to see patients. People flocked to see the doctors and were content to
wait for hours. The service was also provided with boxes of free drug samples, so
they were able to operate a limited pharmacy (1998, pers. comm., 12 March).

It was during this time at Red Hill that the Brisbane AICHS was able to deliver a broad
range of services to the community:

General medical and dental

Social work and field work support and advice

Mobile clinics and a transport service

Outreach work to homeless people in South Brisbane and Fortitude Valley

( Aboriginal and Islander Community Health Service Brisbane Ltd 2000-2001, p. 2).

Interesting to note was the range of service provision for the community. It was unheard
of to have a health service provider offering such things as transport and mobile clinics.
This, however, was a need that the community articulated, which would increase their
access to health service provision. It was seen as vital for both the Indigenous community
to be able to access the service through the provided transport and the health provision to
access people through mobile clinics. Of course, both of these services were hugely
successful on implementation.

At the same time other Queensland communities were also looking towards Brisbane for
support and leadership in delivering health care services to their communities. One such
community was the council of the Palm Island Aboriginal Reserve. This small
The community is located on an island off the coast of Townsville in North Queensland. The community was fraught with health issues and then Chairman Fred Clay asked for urgent intervention. The Brisbane Aboriginal and Islander Community Service had to seek federal funding to undertake this trip to Palm Island, which was not forthright under the Bjelke Petersen regime. Watson states:

The Board secured funds from Canberra, which in itself created a situation fraught with political dangers. The state government of Joh Bjelke-Petersen was violently opposed to the Whitlam administration and they resisted every attempt by Canberra to move into a state area. It was at this time that Gough Whitlam called Bjelke-Petersen a “Bible bashing bastard”, during question time in the House of Representatives. This was in reference to Bjelke-Petersen’s habit of returning to his electoral heartland on weekends to deliver sermons from the pulpit, that invariably attacked the socialist menace from Canberra (1998, pers. comm., 12 March).

However, it was this ‘socialist menace from Canberra’ that was providing direct funding to a state, Indigenous, community-controlled health service, which in turn provided funds for health service provision to the Brisbane Indigenous community and Indigenous communities further afield who were in desperate need of direction from Brisbane.

**And then there was funding**

The Brisbane AICHS arose as an initial response to a crisis. Subsequently, the health service applied for funds for ongoing service provision. Some would argue the national
political climate was favourable for Indigenous Australians. Prime Minister Gough Whitlam had appointed Gordon Bryant as the Minister for Aboriginal Affairs. In Australian Indigenous communities Bryant was known for his ceaseless work in the lead-up to the 1967 Referendum, and many in the Indigenous community considered him a friend. Watson recalls:

> We were very fortunate at this time the Whitlam government was well and truly established in Canberra. Gordon Bryant was our first minister who was an old, trusted comrade of the black community struggle and he helped us immeasurably. He had our application administered very quickly. For us this was good, as there was no state infrastructure on the ground at this time on a state level and all applications and submissions were processed through a central office in Canberra. (1998, pers. comm., 12 March).

The AICHS was successful in its application for ongoing funds and was established in Brisbane as a government funded but community controlled service on 14 May 1973. In the second three months (May – August 1973), the Clinic was staffed by fulltime, employed staff. During this period 500 patients were seen in 1,122 appointments. The overwhelming response to the AICHS was clearly demonstrating the need for its continuation (Department of Aboriginal Affairs 1973).

A structure was being established that would be one of the hallmarks of Indigenous services across the nation: the government was funding a community controlled Indigenous organisation that was administered by an Indigenous Board. This Board was
made up of Indigenous people who were representative of the Brisbane Indigenous community. The Board of Directors was voted in at the Brisbane AICHS’s Annual General Meetings (AGM). When the AGM was called, nominations were accepted from the community to fill the open positions of the Board. At the AGM all existing Board members would stand down from their positions. The nominations that had been received were announced and then community members voted. The votes were tallied and the new Board was then presented to the community at the meeting. This process represents one of the major elements of community control. This being that the Board of Indigenous community controlled services are made up of community members who are nominated and voted in by their community. This allows community members to be active in the direction and monitoring of the service.

It was the Board that was responsible for employing the medical and allied health staff required to offer health services to the community. As a government funded but community controlled service the structure was as follows:

1 doctor

1 registered nurse

1 nursing aide

2 field officers

1 receptionist
The Board of the Brisbane AICHS had numbered eight. Four of the Board members made up the Executive Directors. Their positions were President, Vice President, Secretary, and Treasurer. The remaining four were Directors.

When the Brisbane AICHS was founded and established the term ‘community control’ had not been coined. This was to occur at a national meeting in the closing months of 1973 in Sydney. As Collins remembers:

As a sort of national collective all the existing Aboriginal medical services around the country at this stage arranged to meet in Sydney. Those involved were Victorian Aboriginal Health Service, Brisbane AICHS, Congress, (Alice Springs) Aboriginal Medical Service, Perth Aboriginal Medical Service, Redfern Aboriginal Medical Service and a Townsville representative attended as they were about to commence a service. It was Bruce McGuiness from Victorian Aboriginal Health Service in Melbourne, who is known as the father of community control. At this meeting he coined the phrase ‘local community control’. This was spoken in response to the collective discussing and debating the initial philosophy of community control and its place within Indigenous health services. We discussed what it might mean, how it may be practised, where is it derived from, what were the implications and how this impacts on the community (1998, pers. comm., 14 March).
The national collective meeting at Redfern Aboriginal Medical Service in 1973 saw the formation of the National Aboriginal and Islander Health Organisation (NAIHO). The role of the National Aboriginal and Islander Health Organisation and its role in defining the theory of community control will be discussed within Chapter Three. This was the first national forum of Indigenous health services from across Australia and it enabled Indigenous peoples working directly in Indigenous health to discuss and debate community control as a philosophy for the administration of Indigenous health services. Collins explains the evolution of this approach:

We looked at the way that what they called mainstream services were being provided and sussed out why they weren’t as effective as we thought they could be, given the data that says and proved that they obviously weren’t being as effective as what we expected them to be. We all felt that it was not really in the interest of mainstream health or neo-colonial government’s health services to really look after Aboriginal health because in a way it was a continuation of smooth the dying pillow approach. The data told them surely they could do better than this. The data would suggest that they didn’t. That’s where the term community control came from…Obviously Victorian Aboriginal Health Service and its membership and the community it serves which is largely the inner Melbourne suburbs had been talking about this stuff. They said before migloos [commonly used word by Indigenous people for non-Indigenous people] came in we controlled all this type of stuff and what they were saying was that there was a direct link between the term community control and tribal nationhood and
sovereignty and within that is the right of self determination. Self-determination in our view is a cultural construct. It’s a construct of our culture because of who we are and because we are unique by territory our language and by our culture. The other thing about self-determination is it’s recognised in international law as one of the most dynamic sort of notions. So that then began to start to build the theory of community control (Collins 1998, pers. comm., 14 March).

At this time the Brisbane AICHS was first registered under the old Clubs and Societies legislation, but was evolving and changing rapidly. From a staff of seven in 1973, the health service in June of 1976 had grown to twenty-four full-time workers. The services offered were expanding to include general medical, full dental, ante-natal, nutrition, social and preventative medicine, alcohol and drug programs, child care and emergency placement, and maternal and child welfare. The rapid growth in services meant that the service soon had to find new premises:

The Red Hill clinic was invaluable in that it was the starting point for the service and it was based in the centre of a substantial Aboriginal and Torres Strait Islander population. It also seemed appropriate that we started there because the study by the World Health Organisation was on the Red Hill Indigenous population. However as time drew on and the Aboriginal and Islander Community Health Service were able to secure an expanded funding commitment from Canberra, it was quickly apparent that the service needed a much larger building. In June 1976, Brisbane AICHS moved to Gray Street, South Brisbane
Clinics that were offered at Gray Street were:

General Medical and Dental


Nutrition and Social and Preventative Medicine

Alcohol and Drug Program

Child Care and Emergency Placement

Specialty Clinics – Obstetrics, Paediatrics, Psychology, ENT

(Aboriginal and Islander Community Health Service Brisbane Ltd 2000-2001, p. 3).

The 1980s

By 1981 the health service had outgrown its South Brisbane premises. The Board secured federal funding and bought its first premises, an old Queenslander house in Hubert Street, Woolloongabba. The bottom of the house was enclosed and served as the clinic space. Upstairs housed sections such as administration and welfare. The service stayed there for over a decade.

At this time the health service was truly established and had thoroughly entered the Federal Government funding rounds to enable continuation of the service. The conservative Bjelke-Petersen government was in power, so the service did not receive
much state government support. Nonetheless, the health service grew in size and expanded the programs delivered to the community such as HIV/AIDS programs. The development of such programs was essential to the delivery of health promotion programs within the community. The community was clearly articulating their needs for appropriate health information in language that could be understood and easily disseminated on pertinent health issues such as HIV/AIDS. What this demonstrates is the process of community control; community members, through Board representation, could dictate programs that they deemed appropriate for the Brisbane Indigenous community. Once this was articulated at the appropriate board meetings it then became the responsibility of the Brisbane AICHS to find suitable funding and establish the desired program.

The service had grown undeniably over the years since its inception. During the 1980s a service provision statement for the Brisbane AICHS was developed. The following statement was devised to encapsulate the service delivery that the Brisbane AICHS undertook and provided to the Indigenous community. This became known as the mission statement and is as follows.

- To raise the health status of Aboriginal and Torres Strait Islander peoples to that of the wider community by providing holistic health care to the community, which includes physical, emotional, spiritual and mental health, provision for family and community.
• To provide primary health care services that is both culturally appropriate and accessible to Aboriginal and Torres Strait Islander communities.

(Aboriginal and Islander Community Health Service Brisbane Ltd 2000-2001, p. 4)

The 1990s and beyond

Throughout the 1990s the Brisbane Aboriginal and Islander Community arguably went under its biggest period of physical change to date. The service was literally bursting out the walls and work conditions were at times physically difficult due to lack of space. Debate and discussion at the health service, Board, and community level was focused on attaining new premises. The Board and community were aware that until now the service had always fitted into existing space; the service felt at this level that a purpose built facility was required. Community consultation occurred among the Board, staff, and community members. When funds were secured from the Aboriginal and Torres Strait Islander Commission, the building of the new premises commenced. While the construction was occurring, the AICHS moved to the other side of Hubert Street to a disused space above a real estate agent. The AICHS continued to expand and include new programs during this time. As part of its development, and in response to community demand, the Brisbane AICHS commenced a Healing Centre. In a western context this service provision was aimed at providing a community-based mental health service for Indigenous peoples. From the Indigenous perspective it was providing a service for Indigenous peoples who had been affected by a wide range of issues that impact upon mental health. The onus was taken off it being a service for mental health to it being a
place that provides culturally appropriate and safe spaces for Indigenous peoples needing healing for a variety of issues that impact upon mental health. Funding for this program was again received from Federal funding.

Watson remembers this time:

The service had not only made an ongoing commitment to the health and well being of its own local community, but indeed, by virtue of the drive and the vision that inspired the leadership, the Brisbane AICHS occupied a premier place in the national delivery of community based health programs to Indigenous communities across the nation (1998, pers. comm., 14 March).

By 2000 the Brisbane AICHS had continued to grow and include new programs. The following diagram outlines the diversity of programs and structure of the Brisbane AICHS.
ABORIGINAL AND ISLANDER COMMUNITY HEALTH SERVICE BRISBANE LIMITED.
MANAGEMENT STRUCTURE.

COUNCIL OF MANAGEMENT

Indigenous Family and Child Support Service Woolloongabba Manager

Chief Executive Officer

Executive Assistant

JIMBELUNGA Nursing Centre Eagleby Centre Manager

MANAGER - HRM BRANCH
• Human Resources Management
• Cleaning
• Receptionist

MANAGER - COMMUNITY & DENTAL BRANCH
• Welfare
• Dental
• Mental Health
• Stolen Generation Coordinator

MANAGER - MEDICAL BRANCH
• Medical Section - Base
• Hospital Liaison Officer
• Outreach Clinics
  - Woodridge
  - Acacia Ridge
  - Inala
  - Sandgate
  - Musgrave Park Corporation
• Nutritionist
• Eye Health Coordinator

MANAGER - CHILD, YOUTH AND FAMILY HEALTH BRANCH
• Indigenous Youth Health Service
• Cervical Cancer Prevention for Young Women
• Alcohol & Drugs
• Youth Suicide Prevention
• Sexual Health Workers
• Family & Child Health

(Aboriginal and Islander Community Health Service Brisbane Ltd 2000-2001, p. 8)
Tables 1 and 2 (below) further demonstrate the diversity and depth of services offered at the Brisbane AICHS. Table 1 (Aboriginal and Islander Community Health Service Brisbane Ltd 2000-2001, p. 13) outlines the range of locations where clinics are held within Brisbane and the number of clients accessing these clinics. Woolloongabba is the location of the Brisbane AICHS. The outlying clinics are space (usually two or three rooms), which are provided by Community Health Buildings as part of Queensland Health. The clinics here are for 3 to 4 hours once a week in each suburb. Table 2 (Aboriginal and Islander Community Health Service Brisbane Ltd 2000-2001, p. 13) outlines the diversity in the types of clinics offered within the Woolloongabba base and the number of clients accessing these specialist clinics.

**Table 1**

<table>
<thead>
<tr>
<th>CLINICS</th>
<th>ATTENDANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acacia Ridge</td>
<td>178</td>
</tr>
<tr>
<td>Woolloongabba</td>
<td>6702</td>
</tr>
<tr>
<td>Inala</td>
<td>573</td>
</tr>
<tr>
<td>Musgrave Park</td>
<td>284</td>
</tr>
<tr>
<td>Sandgate</td>
<td>602</td>
</tr>
<tr>
<td>Woodridge</td>
<td>1005</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>9334</strong></td>
</tr>
<tr>
<td>CLINICS</td>
<td>ATTENDANCE</td>
</tr>
<tr>
<td>------------------</td>
<td>------------</td>
</tr>
<tr>
<td>ENT clinic</td>
<td>64</td>
</tr>
<tr>
<td>Hearing</td>
<td>92</td>
</tr>
<tr>
<td>Podiatry</td>
<td>271</td>
</tr>
<tr>
<td>Optometry</td>
<td>338</td>
</tr>
<tr>
<td>Hospital liaison</td>
<td>636</td>
</tr>
<tr>
<td>Diabetic clinic</td>
<td>214</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>200</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1815</td>
</tr>
<tr>
<td><strong>TABLE 1 &amp; 2</strong></td>
<td><strong>11 159</strong></td>
</tr>
<tr>
<td><strong>COMBINED</strong></td>
<td><strong>11 159</strong></td>
</tr>
</tbody>
</table>

Below are the numbers of staff that deliver services to the Brisbane Indigenous community. Interestingly, the percentage of Indigenous staff is greater than non-Indigenous staff.
Number of full-time staff  
53

Number of part-time staff  
6

Number of Indigenous staff  
39 (66%)

Number of non-Indigenous staff  
20 (34%)

(Aboriginal and Islander Community Health Service Brisbane Ltd 2000-2001, p. 32).

I have presented above a documented history of the Brisbane AICHS from its inception in 1973 to its present structure and service delivery. At the time of its inception there was only a handful of Aboriginal Medical Services operating nationally. Community controlled services were not being operated to provide any health services to any other sector of the mainstream community of Australia at this time. Health Service provision was, by and large, still delivered through hospital-based care and General Practitioners. Community Health Centres at this time were unheard of. However, to truly understand the unique place that Aboriginal and Islander Community Health Centers held (and still hold) within their operational philosophy it is essential to look at a global perspective. In essence, the global push during the late 1970s was towards the development of Primary Health Care, which was being addressed as the ‘new health care delivery’. However, this ‘new health care delivery’ mirrored the community control philosophy of the Aboriginal and Islander Health Care Centres.

This demonstrates the blatant lack of recognition of community controlled Aboriginal Health Services, but also the acceptance and endorsement of the ‘new health care
delivery’ espoused by the World Health Organisation.

Global perspective

By the end of the 1970s Australia had a number of community controlled Indigenous health services operating across the nation. Within Indigenous communities this was vital for our efforts of self-determination and were seen as vital organisations in the struggle for better health. There was still much debate occurring within political and government circles around the structure and concepts of community control. This was demonstrated by a 1979 letter from Bjelke-Petersen to the Prime Minister commenting on the findings of the House of Representatives Standing Committee on Aboriginal Affairs. He was quoted as saying that ‘The concept of a community basis for the design and delivery of health services is viewed with considerable concern. It is not considered that this concept makes provision for the professional expertise, which is essential in decision-making in such areas’ (House of Representatives 1979, p. 79).

This letter also stated that the ‘principles termed self-management, self-sufficiency and Aboriginality are not so easily adjusted to the process that ensures good health’ and that ‘It does not necessarily follow that programs popularly chosen by a community are necessarily what is required or in the best interest of that community’ (House of Representatives 1979, p. 79).

Many within the Indigenous communities expected such resistance. To better understand this defiance towards Indigenous community-controlled health services funding, it is essential to look at the global push for better health. In doing this I demonstrate the
uniqueness of the community control philosophy of the Aboriginal and Islander Health Care Centres, but also the inherent resistance from Australian governments in acknowledging such an operational philosophy that was endorsed, through the World Health Organisation (WHO) as policy in Australia in 1979. The establishment of AICHS’s were world firsts, although they have not received due recognition. In 1978 the WHO convened a conference in Alma Ata, Russia. The resolutions of this conference were the formation of the Declaration of Alma Ata of Primary Health Care. The WHO assisted in the adoption of the principles of primary health care by governments around the world after the WHO Conference in Alma Ata in 1978 (World Health Organisation 1978). The programs to implement the principles outlined at Alma Ata have been known as ‘Health For All by the Year 2000’.

According to Alma Ata, primary health care is:

...essential health care based on practical, scientific and socially acceptable methods and technology made universally accessible to individuals and community through their full participation and at a cost that can be maintained at every stage of development in the spirit of self-reliance and self-determination. It is the first level of contact of individuals, family and community with the health system. Primary health care is based on:

- the economic and social realities of a community, and the country;
- the existing knowledge of the community, its health problems, and the most appropriate health services which address the main health problems
in the community, providing **promotive, preventative, curative and rehabilitative** services (World Health Organisation 1978).

In addition to the health sector, primary health care involves all related sectors--in particular agriculture, food, industry, housing, education, public works, communications, and others--and demands the coordinated efforts of those sectors. It requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation, and control of primary health care, making fullest use of local and other available resources; and, to this end, develops through appropriate education the ability of communities to participate (Bartlett 1995).

Australia endorsed ‘Health For All’ as federal policy in 1979, although it was slow to follow up its commitment. It has been in the area of Aboriginal health that primary health care principles have been most energetically acted upon (National Centre for Epidemiology and Population Health, 1992).

The establishment of the Redfern Aboriginal Medical Service in 1971, by community initiative, was the first time in neo-colonial Australia that there was a health service provider that was community controlled. This community initiative recognised the need for attention to other issues relating to health--including housing, social services, and cultural support--and was exceptionally successful. In essence, Redfern Aboriginal Medical Service put into action all the principles of primary health care outlined by WHO but preceded them by seven years. No formal recognition was given to this unique framework that on a global scale was being pushed as the new means of delivery of
health care services. Indeed, within the Australian government the issue of putting control into the hands of Indigenous communities who knew the health issues faced within the communities was fraught with difficulties. In Queensland and Western Australia in particular, this was seen as asking for trouble as there was a major shift towards decentralising health provision away from hospital-based care. Existing services had historically been detrimental to the health status of Indigenous Australians who simply did not or could not access culturally inappropriate, western, medical model service provision.

Within the community controlled health services, the approach was more inclusive of the issues that we knew impacted upon our health status such as housing, employment, and the impact of the colonisation process on Indigenous communities. This was evident in the service provision, which was not solely provided by doctors and nurses.

The practice of community control was well established within Indigenous community controlled health services across the nation. The services were in receipt of small amounts of federal funding, although there was considerable argument over the service’s effectiveness and sustainability. This demonstrates the then government’s defiance in funding Indigenous community controlled health services which had a practising philosophy that mirrored the WHO’s Primary Health Care principals. What makes it more blatant is the hypocrisy of the government having endorsed ‘Health For All by the Year 2000’, which was, in fact, the basis of the Indigenous health services. However, Indigenous communities nationally saw how essential these services were among
differing communities and pushed ahead in their development and service provision.

**Chapter Summary**

In Chapter Two I have presented the institutional history of the Brisbane AICHS. By doing this I have documented the history of the service from a voluntary run service to the second oldest and largest Aboriginal and Islander Health Service within Australia. I have shown that the practice of community control occurred before the articulation of it.

As part of presenting this history it was essential to present a global perspective, which demonstrates the uniqueness the operational philosophy of Aboriginal, community-controlled health services. By outlining this I have been able to demonstrate not only the Australian government’s refusal to acknowledge this operational philosophy, but also its lack of understanding of the meaning of the WHO’s Primary Health Care even after endorsing it as a Federal policy in 1979.

By documenting this history, I have been able to demonstrate the practice of community control within the Brisbane AICHS and have achieved the first component of this research. After establishing the practice of community control it is now part of this research to define the theory of community control. As part of establishing the theory of community control it was necessary to interview Aboriginal members of the Brisbane community who have been active within the Brisbane AICHS since its inception. These interviews provide Indigenous self-representation in identifying community control theory and will answer the second component of this research. These interviews are
presented within Chapter 4.
Community control means that each independent and autonomous health service is controlled by the community it serves, in order to provide that community with health care delivery to meet its [sic] health needs, as defined by that community (NACCHO 2003)
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Introduction

Chapter 2 gave the reader an overall historical perspective of the administration of Aboriginal health service provision, particularly within Queensland. This included presenting the pre-invasion health status of Aboriginal people, the demise of Aboriginal health compared to their non-Indigenous counterparts, as well as the rise of community controlled Aboriginal and/or Islander Health Services within Australia since their inception. Chapter 3 addressed the first underlying question of this research by exploring the practice of community control. This was achieved by documenting the operational history of the Brisbane AICHS. This demonstrated the practice of community control before the articulation of it as an operational philosophy.

In Chapter 4 I address the second underlying question of this research by discussing the theory of community control. In presenting the Indigenous theory of community control, I contextualise how it was achieved via four Indigenous perspectives. First, I draw on oral history obtained from three members of the Brisbane Aboriginal community, who were present at the articulation of community control as an operational philosophy and were instrumental in establishing the Brisbane AICHS. Usually such a transcript of responses would be confined to an appendix. However, I present these materials in the main body of the text to submerge the reader in the raw data so as to allow them to better grasp an Indigenous perspective of the theory of community control. This also forms part of an empowering process for the community through enabling community consultation processes. I argue that this mirrors one of the fundamental principles of community
control as outlined by the Queensland Aboriginal and Islander Health Forum (QAIHF) and the National Aboriginal Community Controlled Health Organisation (NACCHO).

Second, I draw on written texts from the Alukra Congress in Alice Springs and the Sydney Aboriginal Medical Service. It is essential to include these texts on community control as experienced by these two distinct community controlled Aboriginal Medical Services. This demonstrates the uniformity of community control theory among differing communities as well as the difference in practice as identified by the individual community.

Third, I draw on the theory of community control as presented by the Queensland Aboriginal and Islander Health Forum (QAIHF), the state peak Indigenous health body. Fourth, I draw on the National Aboriginal Community Control Health Organisation (NACCHO), as the federal peak body for community controlled Aboriginal and Islander Health Services. Using these four pools of Indigenous knowledge allows me to identify community control theory as well as demonstrate to the reader the intricate link that feeds through all four Indigenous perspectives.

The national body (NACCHO) membership is drawn from the various state and territory bodies. The QAIHF membership is made up of the individual Aboriginal Medical Services throughout the state of Queensland. The individual Aboriginal and Islander community health services are made up from relevant community members. Therefore, community control theory, as articulated from these four perspectives, is cohesive because of the above framework of a direct community flow from the individual through
to national level. This allows for a true community representation. Consequently, it is
unquestionable that this structure results in the uniformity of community control theory
from these four perspectives. Below is a diagrammatic representation of this structure,
which delineates Indigenous theory of community control.
Diagrammatic representation of Indigenous community control theory

Indigenous Community Control Theory

Individual
Organisation
State
National
Individual theory of community control

I interviewed three members of the Brisbane Aboriginal and Islander community in early November 1998. I chose two of the participants, Susan Morgan and Les Collins, because of my work history with them. I have known Sam Watson in a broader community context for several years. I spoke with all three, stating that I was enrolled within a Masters program at Griffith University. I explained that my chosen research was to identify community control theory and practice and to undertake a case study of the Brisbane AICHS, to identify if theory and practice are aligned. All three agreed to be interviewed. Two questions were asked at the interview:

1. What does the philosophy of community control theory mean?

2. What makes Indigenous health services unique?

The first question was designed to elicit an in-depth response to identify community control from the individual perspective. The second question was designed to elicit a response on what makes Aboriginal/Islander Health Services unique again from an individualistic, Indigenous perspective.

What does community control mean?

Sam Watson (1998, pers. comm., 12 March)

We ran basic programs back in the 1970s such as the pig patrol through the Black Panther Party. Myself and Dennis Walker and others launched a program that was
true community control. We did not receive one cent of government money. We didn’t employ anybody. It was straight voluntary work where we used to mobilise teams of people to go out on the streets on a Friday and Saturday night. We would observe police behaviour in our community’s drinking spots such as the Grand Hotel, the Alliance, and the Wickham Hotel. Basically, police would come along in their vans and sweep the street just to maintain their quotas for the shift. Our mob would take license plate numbers, officer’s names, time of the incident, where it happened etc. Anyway, this I believe was true community control.

Les Collins (1998, pers. comm., 14 March)

Collins answered by placing it within the historical context of when the term ‘community control’ was first being articulated by the Indigenous community. This, Collins states, was at the time of the national collective meeting at the Redfern Aboriginal Medical Service in 1973, which saw the forming of the National Aboriginal and Islander Health Organisation (NAIHO). NAIHO was the preceding body to NACCHO. This was the first national forum of the six existing Indigenous health services across Australia that enabled Indigenous peoples to discuss and debate community control as a philosophy for the administration of Indigenous health services. Collins (1998) states:

One of the first things that came to mind is that our community has been doing this for 250,000 years or more before migloos [Indigenous word for non-Indigenous people] came here. We did a bloody good job of it; so therefore, we do have the capacity to do be able to do this even though we don’t have all the high fangled
technology. We have the capacity to do this and we have the capability to do this and most importantly we have the determination to do this. So what happened after all that discussion, Brian McGuiness, who was the chair of Victorian Aboriginal Health Service came up with this phrase “local community control” and we talked about it which is quite different from I guess on the process of how we set these things up. I mean in those setting up stages you want to get something done and I suppose the emphasis was on getting something in place rather than the philosophy of which upon it would be based.

From this context Collins further explained:

The Victorian Aboriginal Health Service also discussed at the time of this meeting the example of traditional exclusion as in women’s and men’s business. The mainstream health services at this time fundamentally rejected this (our) system because of its exclusion of women’s and men’s business. Victorian Aboriginal Health Service believed it was time for a whole of community response. The process that had taken place traditionally of gender-based health provision in Aboriginal communities Australia wide was one of community control. This then extended to all the adult people in the community wanting to be able to have a say in where their health was going and what were the things that constituted their well-being. This process is unique to each individual community. In every other community, their understanding and practice of community control is more than likely different. There are places in Australia where traditional Aboriginal law is still practiced so it may be a system of elders or people who are put into positions
of decision making. Their understanding and practice of community control will be vastly different from that practiced within Fitzroy, Melbourne. That is the essence and uniqueness of community control and therefore the theory/practice of it. Each Indigenous health service may differ because you’ve got each community seeing things in a different way even though there may be commonalities of issues there may be different ways of treating those issues and that is determined by the community through the process of community control.

Susan Morgan (1998, pers. comm., 16 March) states:

Community control is the community having a say again in how a service is established, how its programs and services are delivered through there. If they have any problems with the way it is being administered the community are able to access the right people and articulate dissatisfaction. I mean community control it wasn’t so much coined in those days that came a bit later. If you look at the whole concept of why we wanted Indigenous health services it was basically looking at self-determination of Aboriginal and Torres Strait Islander people to say this is how we want our health handled and we want a say in how. The whole process works whether in the delivery of services or the setting up of a health service or whatever the Indigenous people want and if they have a problem with the way it is being delivered they can say to people we dislike the way this is being delivered and we want it delivered in another way. This process comes from the community not from workers not from Board members but from people that make these organisations
work and the people that count and that’s the community.

**What makes Indigenous health services unique?**

Sam Watson (1998, pers. comm., 12 March) states:

There are a number of reasons why this health service is unique. From the top the reason why our great driving urgency to launch the health service was because of the appalling health status of the Murri and Islander community. We knew that if we didn’t start a health service to launch preventative programs and put preventative programs into place we knew our people would continue to die. You see we believed that the process of genocide never stopped and that inaction by state and federal governments was just as deadly as the martini henry rifle. We believed if we didn’t do it then no one else was going to do it. That was our number one driving motivation. Number two we wanted to expose Aboriginal and Torres Strait Islander people to the fact that they could change their lives through direct action. That was also very important.

The theme of the 1970s was very much community control in community affairs. I mean back in the 1960s say 1960-65, was equal wages and we fought that battle in a number of places across the nation. 1965-67 was the lead up to the referendum; 1967 and onwards it was black control of black affairs and their was a very heavy campaign against the state government. We wanted Aboriginal and Torres Strait Islanders to seize control of their own lives and make their own decisions in
improving their own living standards. Of course, it is these beginnings that makes the Brisbane AICHS so unique.

Les Collins (1998, pers. comm., 14 March) notes:

Well, how you come onto this uniqueness business was in 1973 we started talking to the other health services that were established around the country side like Redfern, Fitzroy, Congress (Alice Springs), Perth, and Townsville (which was about to come on board), and we got together as a national collective even though there was only a small number of us and we looked at the way that mainstream services were being provided. We sussed out why they weren’t as effective as we thought they could be, given the data that says and proved that they obviously weren’t being as effective as what we expected them to be. One of the main things was that Murri’s were excluded from mainstream services and that involved, being service providers, planners, designers and policy makers. The other thing that we all felt was that it’s not really in the interest of mainstream health or neo-colonial governments health services to really look after Aboriginal health because in a way it was a continuation of ‘smooth the dying pillow’ approach. The data told them surely they could do better than this. The data would suggest that they didn’t. It’s like that institutionalised exclusion. You could assume on that evidence that that might be the case. That was part of coming to the realisation that we had to do something. So what we had to do was to create a scenario were we maximised Murris involvement. So that then became the unique nature of Aboriginal and Islander Community Health Services. As far as possible it is the community
identifying their health needs and designing responses. This is what makes it unique.

Susan Morgan (1998, pers. comm., 16 March) said:

I think in those days if you’re talking about when we established the Aboriginal and Islander Community Health Services the thing that made them unique was the Aboriginal people having a say in their own health care having a say in service delivery having a say in whether their own personal health was being administered for the way they wanted it to be. I think the uniqueness was that it was Aboriginal and Torres Strait Islander people doing it for Aboriginal and Torres Strait Islander people and, in particular, establishing a service for the people. The service was set up for those people who had no health care and who got third-rate service if they went to hospitals and it was those people for whom I recall that we established the service and the rest of the community came in on top of that.

The above dialogue presents the insight of individual Aboriginal community members who were involved in the establishment of community-controlled services within Brisbane. All three state that the theory of community control was articulated after the establishment of the services. To complement this, I now present an organisational theory of community control. As previously suggested, organisational theory is drawn from individual perspectives, which allows for a true definition of community control theory.

**Organisational theory of community control**
**Alukra Aboriginal Medical Service**

The second source that I draw from in identifying what is the community control model, is taken from The Sydney Aboriginal Medical Service and Congress Aboriginal Medical Service, Alice Springs. Donna Ah Chee the Branch member of the Congress Alukra adds to the theory of community control definition through presenting as the Keynote Address to the Council for Remote Area Nurses, Alice Springs, and Conference of 2000. Ah Chee (2000, p. 3) articulates that the model of community control is:

> ...where communities determine their own health priorities, and manage the planning, delivery and evaluation of their health service programs. This means that the local community decides:

* what types of health services the community needs
* how these services should be run
* the different types of health programs the community needs
* the priorities – what issues are most important now and what can wait a bit longer
* who can talk on behalf of the community

(Ah Chee 2000, pp. 1-8).

To continue to demonstrate the uniformity in the theory of community control I further explore the Indigenous perspective from the first Aboriginal community controlled health service in Redfern, Sydney.
Sydney Aboriginal Medical Service

Aboriginal community control is also about responsibility and accountability to the community having regard for local cultural perceptions and imperatives. The essence of Aboriginal community control, in this context, distinguishes it from all other methods of control by the coming together of minds and experiences, harnessing talent and diverse abilities from within the local Aboriginal community towards regaining and maintaining its well-being. The process of Aboriginal community control in the area of health means that an Aboriginal health service is independent and autonomous and is controlled by the local Aboriginal community it serves in order to provide culturally appropriate health care to meet its health needs as defined by that community (QAIHF 2003).

The above quote further discusses the theory of community control. In doing this it highlights uniformity from the individual through to the organisational perspective. I now present the Queensland Indigenous perspective of community control theory, which again demonstrates true community representation in the presenting of community control theory (as the QAIHF is representative of the individual community health services).

State theory of community control

The third source of Indigenous theory of community control is from the Queensland Aboriginal and Islander Health Forum. QAIHF is a collective of Aboriginal and Islander
Community Controlled Health Services (AICHS) located in the state of Queensland, and is a member of NACCHO. QAIHF’s membership consists of two adult representatives nominated by each Aboriginal Community Controlled Health Service in Queensland.

QAIHF was established in 1990 with a mandate to:

- Provide a forum in which we (AICHS) could share information to assist in progressing our individual and collective development.
- Promote our philosophy and approach to Aboriginal well-being including our Aboriginal community controlled model for the provision of our health services.
- In connection with our national collective (NACCHO), formerly the National Aboriginal and Islander Health Organisation, increase the prevalence of Aboriginal Community Controlled Health Services.
- Progress and monitor the implementation of the National Aboriginal Health Strategy 1989 (NAHS), particularly in the state of Queensland, in keeping with the jurisdictional obligations emanating from the endorsement of the NAHS by all levels of government in June 1990.

(Queensland Aboriginal and Islander Health Forum 2003)

In outlining community control theory QAIHF states:

Health does not just mean the physical wellbeing of the individual but refers to the social, emotional, cultural and spiritual wellbeing of the community. For
Aboriginal peoples this is a whole of life view, which incorporates the cyclical concept of life-death-life. Central to this definition is our right to self-determination, which is our cultural and human right. We use the term community control, which basically is a self-determination process. Further, this has been demonstrated as the key process for our communities to maximise health outcomes (Queensland Aboriginal and Islander Health Forum 2003).

This again extends on Indigenous definitions of community control theory.

**National theory of community control**

The fourth and final source on Indigenous community control theory is drawn from NACCHO; it has a membership of around 100 Aboriginal community controlled health services throughout Australia, which operate in urban, rural, and remote areas (National Aboriginal Community Controlled Health Organisation 2003, viewed 12 May 2003). An Executive Committee whose members are elected through NACCHO’s State/Territory affiliates governs NACCHO. NACCHO was established in 1997 and was historically preceded by the National Aboriginal and Islander Health Organisation (NAIHO) which had commenced in 1973 at the first meeting of existing Aboriginal health services in Redfern, Sydney.

As endorsed by the NACCHO community control means:

…that each independent and autonomous health service is controlled by the community it serves, in order to provide that community with health care delivery
to meet its health needs, as defined by that community. The solution to each community’s health needs is in the hands of that community. Therefore it cannot be said that there is strict uniformity in all Aboriginal Medical Services as different regions and communities face different health problems, or the same health problems but to varying degrees. However, what is uniform in all of the Aboriginal Medical Services is that they all operate under the philosophy of community control (National Aboriginal Community Controlled Health Organisation 2003).

The definition of an Aboriginal Community Controlled Health Service excludes organisations controlled by the government and excludes those that ‘adopt a vertical approach to health inconsistent with the Aboriginal holistic definition of health as defined by the National Aboriginal Health Strategy’ (NAHS 1989).

An Aboriginal Community Controlled Health Service must be:

- Incorporated Aboriginal organisations
- Initiated by a local Aboriginal community
- Based in a local Aboriginal community
- Governed by a body that is elected by the local Aboriginal community
- Delivering a holistic and culturally appropriate health services to the community, which controls it (National Aboriginal Community Controlled Health Organisation 2003).

**Chapter Summary**

Chapter 4 presented the theory of community control from the Indigenous perspective, by
focusing on four Indigenous perspectives. First, I discussed the voices of three Brisbane Indigenous community members who helped establish the Brisbane AICHS. Second, in establishing community control theory, I presented the same operational philosophy of community control as articulated by two separate Aboriginal Medical Services. This demonstrated the uniqueness of community control theory being practiced among differing communities but with the same underlying theory. Third, I considered the written theory of community control as endorsed by the Queensland Aboriginal and Islander Health Forum. And fourth, I discussed the NACCHO theory of community control.

Overall, I have drawn together the theory of community control as articulated by four differing Indigenous perspectives. What is apparent is that all four perspectives articulate the same theory. This also demonstrated that, while the underlying theory of community control is the same, all four perspectives articulated the potential to utilise community control theory differently depending on the community in which the service was being operated. Thus, the theory is the same but the practice is unique to each service.

In presenting the above, Chapter 4 has addressed the second fundamental component of this research: that being to identify the theory of community control. What is now required is to address the third component of this research, of undertaking a case study of the Brisbane AICHS. By undertaking this case study I identify if the theory and practice of community control are aligned within the Brisbane AICHS. This case study is presented within Chapter 5 quantitatively and Chapter 6 qualitatively.
Chapter 5

Aboriginal community control is also about responsibility and accountability to the community having regard for local cultural perceptions and imperatives. The essence of Aboriginal community control, in this context, distinguishes it from all other methods of control by the coming together of minds and experiences, harnessing talent and diverse abilities from within the local Aboriginal community towards regaining and maintaining its well-being (John Daniels 2002).
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Introduction

This chapter uses the Brisbane AICHS as a case study to analyse wider community understandings of community control, which continues my comparison of the theory and practice of community control in previous chapters.

To best answer the research question, “how widely is community control theory understood by the Aboriginal and Torres Strait Islander community members?” a questionnaire was distributed among Brisbane Indigenous community members who have accessed the Brisbane AICHS since its inception. This Chapter presents the findings of these consumer questionnaires, which were completed by forty-eight such Aboriginal and Islander community members. These consumers have had contact with the health service for varying lengths of time.

Using the Brisbane AICHS as a case study, I present the voices of the 48 participants so as to identify whether the theory of community control is currently evident within the operational practice of the service. The questionnaires are the voices of the community and it is these community members who are able to identify if the theory of community control, as endorsed by NACCHO and QAIF and outlined within Chapter 4, is being achieved by the Brisbane AICHS.

This Chapter presents the results of these questionnaires within a statistical framework. The relatively small number of participants means that caution needs to be applied when using statistical analysis. Nonetheless, it is a useful tool for displaying and analysing the findings of this survey. In addition, Chapter 6 presents a
qualitative analysis of the findings, which extends on the findings in this chapter and provides a fuller analysis of the responses.

Cultural Safety and Ethical Clearance

Cultural safety mechanisms were built into all stages of the research process and were informed by the National Health and Medical Research Council’s guidelines on ethical research. The conduct of this research with Australia’s Indigenous people requires ongoing consultation with Indigenous peoples and organisations. It was, therefore, imperative to utilise Indigenous frameworks in comparing the theory and practice of community control within the Brisbane AICHS.

To do this, the NACCHO and QAIHF definitions of community control were used as a comparative benchmark. The definitions of community control theory by both bodies have come directly from Indigenous communities across Australia, because these bodies are made up of representative community members from various community-controlled Indigenous health services.

By both using Indigenous theory as the comparative benchmark and by being endorsed by the Brisbane AICHS this study ensures cultural safety for the health service, the respondents, and also the author. It also presents an entirely Indigenous perspective throughout this research, because an Indigenous researcher is comparing Indigenous theory and Indigenous practice. To this end, I have collaborated with the Brisbane AICHS, my reference group, and the broader Brisbane Indigenous community throughout the research process. Moreover, ethical clearance has also
been obtained by Griffith University through appropriate University protocol and processes.

There has historically been a range of inappropriate research undertaken by non-Indigenous researchers among different Indigenous communities within Australia, without any benefit gained by the participating communities. Because of this there is often a reticence among Indigenous communities to be involved in research. As an Indigenous researcher who has worked as a nurse within the Brisbane AICHS, undertaking this research was immeasurably easier for me than for a non-Indigenous researcher. Indeed, being immersed within the Indigenous community of Brisbane meant that many components of data collection were more readily available to myself.

**Questionnaire Design**

Between myself, the Board of the Brisbane AICHS, and the reference group, a questionnaire was chosen as the most appropriate means to gather the information required to compare community control theory (as identified by the peak bodies) and the practice within the Brisbane AICHS (as identified by the 48 participants).

In order to answer the research question, I designed a questionnaire that would elicit responses from the participants about both community control theory and practice. It was deemed appropriate to ask the participants three questions: what is community control? if they identified the Brisbane AICHS as a community control health service, and if they thought the Brisbane AICHS operated as a community control health service.
service. These three questions address the three Knowledge Areas to demonstrate the links between theory and practical operations of community control.

The questionnaire was devised in September 1999. It was submitted to the Board of Management of the Brisbane AICHS. A copy of the questionnaire was also submitted to the Indigenous reference group for comment. Both the Board and the reference group gave their approval to use the questionnaire. The questionnaire was then piloted among 5 Aboriginal members of the Brisbane community. These 5 participants were asked to comment on the questionnaire design and format, particularly as to whether the questions were easily understood, and asked for any other comments. Each participant noted that the questionnaire was easily understood and no changes were made to the original questionnaire design.

**Data Collection**

As an Indigenous researcher, data collection was a much easier process for me than it would have been for a non-Indigenous researcher given the legacy of mistrust that exists between non-Indigenous researchers and Indigenous communities. Indeed, it arguably would not have been possible for non-Indigenous researchers to conduct this research.

The process of data collection was not one of random selection, which is a highly valued methodology among non-Indigenous researchers. This method of data collection encourages distance and objectivity between researcher and participant. As an Indigenous researcher an integral part of this research was to establish a link
between the participants and myself. This allowed me to be immersed within the community. I readily accessed appropriate organisations and individual Indigenous households. Woodridge was selected because of the high Indigenous population not easily surveyed by other means. These community links are appropriate for Indigenous research and add depth to the responses and knowledge, which are arguably unavailable to non-Indigenous researchers who work at a greater distance to the community they are studying.

After the approval was granted to carry out the study, it was necessary to identify venues for the consumer questionnaires to be undertaken. Both the Brisbane AICHS and Ti-Tree Aboriginal Housing Co-operative were deemed suitable venues to access Aboriginal and Torres Strait Islander people who had received health service provision from the Brisbane AICHS. Permission was received from the Board of the Brisbane AICHS and the Ti-Tree Aboriginal Housing Co-operative to undertake the questionnaire on site. Permission to access the Aboriginal families within Woodridge was established by making phone contact with 4 Indigenous families, all previously known to me. All 4 households agreed to participate in the questionnaire process. Below is a list of when and where questionnaires were completed.

**Brisbane Aboriginal and Islander Community Health Service**

10 Hubert Street, Woolloongabba, Brisbane

December 5 and 6, 1999
Ti-Tree Aboriginal and Islander Housing Co-operative Sandgate

2/10 Second Avenue, Sandgate, Brisbane

December 13 and 20, 1999

Aboriginal community homes (within the Southern Brisbane suburb of Woodridge)

December 16 and 23, 1999

While undertaking the questionnaires it was also necessary for me to assist 5 Indigenous community members to fill out the questionnaire due to illiteracy. This ensures wider representation of views within a community with high rates of illiteracy.

A copy of the questionnaire is attached as Appendix 1.

Presentation of Findings

The quantitative findings of the consumer questionnaires includes demographic data on the participants such as age, gender, postcode, and the number of staff and non-staff members of the Brisbane AICHS who completed the study. From this an overall profile of the 48 Indigenous participants of the study is drawn. Following this demographic analysis the findings on community control are presented as three Knowledge Areas that demonstrate the link between theory and practical knowledge and operation of community control.
The three identified Knowledge Areas are as follows:

**Knowledge Area 1**

Do participants have a comprehensive knowledge and definition of community control as outlined by the National Aboriginal Community Controlled Health Organisation (NACCHO) and the Queensland Aboriginal and Islander Health Forum (QAIHF)?

**Knowledge Area 2**

Do participants have a broad understanding that the Brisbane Aboriginal and Islander Community Health Service is a community controlled health service?

**Knowledge Area 3**

Do participants have a detailed understanding of how the Brisbane Aboriginal and Islander Community Health Service is operated as a community controlled health service?

These three Knowledge Areas provide the framework in which to answer this study’s research question as to whether the practice of community control within the Brisbane AICHS reflects the theory of community control. In presenting this data I provide an overall Table of Responses. This summarises the three Knowledge Areas, associated knowledge groups, and the number of participants in each category.
Subsequent Groups

Within each Knowledge Area participants are grouped together according to their level of understanding of community control. These groups form the basis of further statistical analysis. Each Knowledge Area has a different number of groups and each group of responses is presented according to the following table:
### TABLE OF RESPONSES

<table>
<thead>
<tr>
<th>Knowledge Area 1</th>
<th>Knowledge Area 2</th>
<th>Knowledge Area 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of community control definition as outlined by NACCHO/QAIHF</td>
<td>General knowledge that the Brisbane AICHS is a community controlled health service</td>
<td>Detailed understanding that the Brisbane AICHS is operated as a community controlled health service</td>
</tr>
</tbody>
</table>

**Group 1**

- Fully reflects the NACCHO/QAIHF definition
- 22 participants
- Yes
- 44 participants

**Group 2**

- Partly reflects the NACCHO/QAIHF definition
- 17 participants
- No
- 4 participants

**Group 3**

- Not reflective at all of the NACCHO/QAIHF definition
- 9 participants
- Mixed response
- 18 participants
General Profile of 48 participants

Table 1

<table>
<thead>
<tr>
<th>gender distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>males</td>
</tr>
<tr>
<td>females</td>
</tr>
</tbody>
</table>

Table 1 clearly demonstrates a higher proportion of participants being female. This imbalance may be due to a number of factors. First, among health service providers it is recognised that women are more likely to access health services more quickly and more often than males. Second, Indigenous women are pregnant and giving birth at a younger age than their non-Indigenous counterparts and, therefore, require access to the health service at an early age and for specific pre-natal and post-natal care as well as for the on-going care of their children. Third, the Brisbane AICHS employs a higher number of female staff than male, and staff represents a significant number of the questionnaire respondents. Nevertheless, overall this distribution reflects the population accessing the health service.
Table 2

Table 2 demonstrates a fairly even balance between staff and non-staff respondents. It is probable that staff have a more in-depth working knowledge of community control than non-staff participants who are perhaps less aware of the everyday operations of their health service provider.

Table 3

Table 3 identifies several interesting issues among the participants. This may be due to the small number of respondents. However, this finding also accurately reflects the population of the
health service. First, no teenage males were interviewed. Indigenous men have unique health issues. Statistically Indigenous men have high rates of suicide, addiction issues, self-harm, and mental health needs. This could reflect the rates of teenage pregnancy among Indigenous women in their teens and their need for health service provision that is not required by young Indigenous men. Unlike pregnancy this does not drive them to access the service. Service provision to Indigenous men may be better addressed through the provision of outreach services.

Second, it is noteworthy that it is Indigenous men in their 20s who are the highest represented and that this number decreases across the lifespan for the male participants. Third, the marked drop-off in participants after the age of 60 is striking. This finding is consistent with the life expectancy of Indigenous men and women in their 50s. This trend would not be seen among non-Indigenous Australian health services because the life expectancy of non-Indigenous clients is approximately 20 years longer.

**Knowledge Areas and Group Findings**

**Knowledge Area 1**

Do participants have a comprehensive knowledge and definition of community control as outlined by the NACCHO and QAIHF?

<table>
<thead>
<tr>
<th>Group</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1</td>
<td>Fully reflects the definition</td>
</tr>
<tr>
<td>Group 2</td>
<td>Partially reflects the definition</td>
</tr>
<tr>
<td>Group 3</td>
<td>Not reflective at all of definition</td>
</tr>
</tbody>
</table>
Knowledge Area 1 overall analysis

Table 4

As indicated in the earlier gender analysis the high number of women within group 1 probably reflects the higher ratio of female staff.

Table 5

As expected group 1 has the highest staff responses. Also there are no staff responses within group 3. The non-staff respondents are fairly evenly distributed, across all three groups.
Knowledge Area 1 Group 1 Findings

Fully reflects the definition of community control as outlined by NACCHO and QAIHF

Table 6

![Knowledge Area 1, Group 1: gender * age distribution graph]

This graph indicates that women within their 30s were the highest group of participants who could articulate a full community control definition. First, this could be due to a higher level of staff awareness among the higher ratio of female workers within the service. Second, it could suggest the higher numbers of Indigenous women participating in the study. Third, this could be due to Indigenous women within child-bearing years accessing the Brisbane AICHS for specific child health service provision and thereby understanding the service better.
Knowledge Area 1 Group 2 Findings

Partly reflects the definition of community control as outlined by NACCHO and QAIHF.

Table 7

Table 7 indicates that there is a fairly even distribution of partial knowledge of community control definition across the age spectrum. It is younger men and older women that are best represented within these groups. Interestingly, it is younger men in their 20s and 30s and women participants in their 50s who were most highly represented as having partial knowledge of a community control definition. This suggests that accessing health services provides at least partial knowledge of community control theory for many clients.

Knowledge Area 1 Group 3 Findings

Not reflective at all of the definition of community control as outlined by NACCHO and QAIHF.
First, what is striking in this finding is the lack of knowledge within the 20-30s age bracket. While the numbers are small and must be analysed with caution, this could indicate that because this generation of younger Indigenous people have had continual access to the Brisbane AICHS—and that, therefore, this age group are too young to have taken part in the establishment of community controlled services—their knowledge of community control is limited. Second, against this trend, older Indigenous women in their 50s were the highest represented. This finding is not consistent for this age group who directly agitated for community control. However, a possible explanation could be that within this age group some women may not have been as active within the establishment of community controlled services. Arguably some of this generation of women would have been within child-bearing age at the time of the establishment of the service and they may be polarised as a group. While these women may have accessed the service after its establishment, for health service provision for themselves and/or their children, it does not mean that they were aware of the operational philosophy that inspired the service.
**Summary Knowledge Area 1**

First, the above analysis demonstrates that staff of the Brisbane AICHS have a good knowledge of community control definition. This is evident in their response and validated by the higher representation of staff than non-staff participants within group 1. Second, all the remaining staff had partial knowledge of the definition of community control theory and were in group 2. Third, it is striking that the higher representation of non-staff participants in group 2 have a partial knowledge of community control theory. Fourth, within Knowledge Area 1 there is a portion of the Indigenous community in group 3 who could not articulate community control theory at all. This clearly indicates that there is a lack of knowledge of community control theory among non-staff participants. This suggests that there is a significant minority who need to be given more information about community control theory and the practical application of this theory at the health service. Knowledge Area 1 demonstrates that working within a health service or accessing it can improve understanding of the wider definition of community control.

**Knowledge Area 2 Findings**

Do participants have an understanding that the Brisbane Aboriginal and Islander Community Health Service is a community controlled health service?

<table>
<thead>
<tr>
<th>Group 1</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 2</td>
<td>No</td>
</tr>
</tbody>
</table>
Knowledge Area 2 overall analysis

Table 9

Knowledge Area 2: gender * group distribution

First, Table 9 clearly indicates that the overwhelming response was positive in identifying Brisbane AICHS as a community controlled health service. The gender of the participants was not a big factor in this response. Even those who fell in group 2 with partial knowledge and group 3 with no working definition of community control could nonetheless identify that the health service was community controlled.

Table 10

Knowledge Area 2: staff * group distribution
Predictably, all staff identified the Brisbane AICHS as a community controlled organisation. This will become more interesting when contrasted with Knowledge Area 3 where staff highlight some tension between the ideal of community control and the everyday practical operation of the health service.

**Knowledge Area 2 Group 1**

**Table 11 ‘yes’ response**

Table 11 again overwhelmingly indicates the recognition of the Brisbane AICHS as being a community controlled health service. However, what is striking is that even those participants without a working definition or with only partial knowledge of what community control in Knowledge Area 1 is answered “yes” in Knowledge Area 2. This would indicate that the members of the community accessing the service distinguish it as community controlled even where they are unable to articulate what community control is. This is further validated by the 25 respondents in Knowledge
Area 1 who have only partial or no definition of community control, but who overwhelmingly still identified the service as community controlled in Knowledge Area 2. It also shows some consistency with previous findings in that 2 respondents could not identify the health service as a community controlled health organisation. This would indicate that there is an extreme knowledge deficit among some participants who are not able to articulate either a community control definition or identify the service as community controlled.

Knowledge Area 2 Group 2

Table 12 ‘no’ response

![Bar chart showing gender and age distribution for Knowledge Area 2 Group 2](chart)

While the numbers are small Table 12 suggests that there might be an emerging lack of knowledge among participants in their 20s, both females and males, who could not identify that the Brisbane AICHS is a community-controlled organisation. This may raise a point of tension within this research. The lack of understanding emerging among this age group as previously stated could be due to this age group of Indigenous participants always having access to community-controlled organisations unlike older Indigenous community members. They have no shared history of fighting
for community-controlled organisations and services. What this could also indicate is that the knowledge of community control theory and practice is not being passed on or taught to this age group of Indigenous community members. A more intensive survey of this age group would be needed to confirm these results. A community education program may be needed to guarantee that community control in both theory and practice is understood.

Summary Knowledge Area 2

The most significant finding within Knowledge Area 2 is that even those participants with partial or no working definition of community control from Knowledge Area 1 still identified that the service is community controlled. This would indicate that community control is valued without a full understanding of its definition. Also important to note is the clear lack of knowledge in defining community control among some Indigenous participants. This suggests that knowledge about community control theory and practice is not being passed on adequately. Thus, there is an obvious lack of a working definition of community control for some participants, which represents the first point of tension within this research.

Knowledge Area 3

Knowledge that the Brisbane AICHS is operated as a community controlled health service.
Group 1: Yes response

Group 2: No response

Group 3: Mixed response

Knowledge Area 3 overall analysis

Table 13

Only a small number of participants did not think that the Brisbane AICHS was operated as a community controlled organisation.
Table 14 indicates that Group 2 is made up entirely of staff who stated that the Brisbane AICHS is not operated as a community controlled service. This suggests a second point of tension. Knowledge Area 1 demonstrated that staff understand the theory of community control. Knowledge Area 2 showed that staff recognised the health service as, ideally, a community controlled service. However, Knowledge Area 3 demonstrates that staff are ambivalent about the operation of community control within the everyday operation of the health service. I discuss this further below.
Knowledge Area 3 Group 1 Findings

Table 15 ‘yes’ response

Table 15 indicates that there is a fairly even distribution across all ages. Interestingly, while women participants in their 50s indicated that Brisbane AICHS operated as a community controlled service, this age group were the highest represented of those who could not articulate a definition of community control. This further suggests women in their 50s are attached to the idea of community control, but are divided into those with and those without an understanding and working definition of community control.
Knowledge Area 3 Group 2 Findings

Table 16 ‘no’ response

Table 16 is consistent with earlier findings. Younger respondents and women in their 50s have limited working knowledge of community control both as theory and practice. Staff members of Brisbane AICHS within Knowledge Area 1 gave a full or partial definition of community control theory and identified it is a community controlled health service. However, when asked if Brisbane AICHS operated as a community controlled service a number of staff clearly articulated that it was not. This represents a significant tension identified by this research. Staff identified differentials between the ideal of community control and its practical implementation within the everyday operation of the health service.
Knowledge Area 3 Group 3 Findings

Table 17 ‘mixed’ response

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teens</td>
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<td>20's</td>
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<tr>
<td>80's</td>
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</tbody>
</table>

Table 17 further indicates that group 3 have a high knowledge of community control definition but have a mixed response as to whether the Brisbane AICHS is operating as a community controlled health service. This group, alongside staff in the group 2, together offer a critical analysis of community control theory in practice. Thus, this chapter has identified and confirmed a second point of tension. Table 17 highlights this second critical point of tension, raised throughout this Chapter, between the theory and practical application of community control. The respondents within this group articulated that while they agreed that, in theory, the Brisbane AICHS is a community-controlled organisation, the practical application was not satisfactory. This finding was evident across all ages in group 3. While a few respondents in the mixed group might have been confused because they lacked a working definition of community control, the high number demonstrates that most respondents did, in fact,
have a working definition of community control and simply have a mixed response to its operation and practice.

**Summary of Knowledge Area 3**

The key finding within Knowledge Area 3 is the point of tension discovered between the theory and practice of community control within the Brisbane AICHS, as identified by the respondents. Group 2, made up of staff that answered “no” and group 3, clearly those with a high knowledge of community control theory, had a high ambivalence in identifying the practice of community control within the health service.

As part of my own work history at the Brisbane AICHS I would place myself within group 3. I would articulate an in-depth knowledge of community control. I would also consider the Brisbane AICHS as, in theory, a community controlled organisation. However, I would also argue that the practice of community control in the health service is not fully reflective of the theory. Community control as a practice at the health service does not operate as fully as it could.

**Chapter Summary**

Initially, Chapter 5 has been important in identifying the level of community understanding and knowledge of community control. Chapter 5 has also been important in beginning to answer the third component of this research, that being to identify if community control theory and practice are aligned within the Brisbane
AICHS. By undertaking this quantitative analysis three points have been identified. First, high numbers in the community have either good or partial knowledge of community control and very high levels of attachment to the ideal of community control. It is seen as highly valuable within the Indigenous community. Second, it is also evident from the findings that there is a substantial knowledge deficit among participants in the 20-30s age group. This deficit may be explained by this age group having had access to community controlled services since their inception, unlike older Indigenous people. This is the first point of tension identified in this chapter. Third, in Knowledge Area 3 there are a number of participants in groups 2 and 3 who suggested that while they recognised that the Brisbane AICHS is, in theory, a community controlled health service, the practice does not equate to the ideal. This is a major finding and represents the second major tension identified in this chapter, as articulated by members of the Indigenous community who access the service.

Both of these points of tension will be further examined in Chapter 5, which extends on the findings in this chapter by providing a qualitative analysis of them. In doing this, I use in-depth interview responses to further examine the two identified points of tension discussed in this Chapter.
Chapter 6

These days the way in which community control expresses itself is that at an Annual General Meeting it has been the practice of a number of Aboriginal Medical Services to stack the Board by bussing their relations in on the night who have little else or nothing to do with the health service until the next Annual General Meeting where their voting power will be required again. This process has been happening in some of our communities now for more than a decade. Through this process we have effectively created the black middle class. (Gary Foley 1999)
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Introduction

In the previous chapter I used the Brisbane AICHS as a case study to present a quantitative analysis of wider Aboriginal community understandings and perceptions of community control. Chapter 5 also presented the findings of the consumer questionnaires completed by forty-eight Aboriginal and Islander community members who accessed the Brisbane AICHS. This analysis pointed to tensions between the theory and practice of community control within the Brisbane AICHS and identified two points of tension: first, inconsistent understandings of community control theory within the wider Indigenous community; and second, the inconsistency between the ideal operation of community control and the reality of its day-to-day operation. In this Chapter these points of tension are further analysed using in-depth interview responses. In doing this, I address one of the fundamental questions of this research, namely “are community control theory and practice aligned in the Brisbane AICHS”?

My methodology required the participants’ voices to be heard and analysed qualitatively. Kumar defines a qualitative study as one where “the purpose of the study is primarily to describe a situation, phenomenon, problem or event; the information is gathered through the use of variables” (1996 p.10). The questionnaire allowed this study to obtain 48 participants’ “description of an observed situation, the historical enumeration of events, an account of the differing opinions people have about an issue, and a description of the living conditions of a community” (Kumar, 1996 p.10).
This qualitative approach was crucial for three reasons. First, a qualitative approach allows me to expand on my discussion of the statistical data of the previous chapter. For instance, it was in participants’ responses to in-depth questions that they identified the disparities between the theory and practice of community control within the Brisbane AICHS. Second, this approach lends itself to storytelling, so is particularly appropriate to Indigenous research. According to Baum (2000 p.482), storytelling is an intrinsic element of Aboriginal culture and a valued method of circulating information. Thus, this method is appropriate due to the well-established oral history in Aboriginal culture. Third, as acknowledged in Chapter 5, the statistical analysis was limited by the small number of participants. Therefore, the statistical research findings of the previous Chapter are enhanced by the in-depth qualitative analysis that follows.

Overall, by using a qualitative research framework, I am better able to identify if the practice of the Brisbane AICHS is aligned with the Indigenous theory of community control as defined by both state and national peak Indigenous health bodies. I am also better able to reflect the full range of community opinions surrounding this question.

**Community Control Definition**

I begin by providing a brief summary of the definition of community control that emerged in Chapter 4. This serves as a point of comparison with participants’ responses as to the everyday operations of community control in the Brisbane AICHS.

In the definition endorsed by NACCHO “community control” refers to independent and autonomous health services that are controlled by the community they serve, so as to
provide that community with health care delivery to meet the health needs identified by that community.

An Aboriginal Community Controlled Health Service must be:

- An incorporated Aboriginal organisation
- Initiated by a local Aboriginal community
- Based in a local Aboriginal community
- Governed by a body that is elected by the local Aboriginal community
- Delivering holistic and culturally appropriate health services to the community that controls it. (NACCHO 2003).

Thus, the solution and response to each community’s health needs is in the hands of that community. It cannot, then, be said that there is strict uniformity in all Aboriginal Medical Services as different regions and communities face different health problems, or the same health problems but to varying degrees. However, what is uniform in all of the Aboriginal Medical Services is that they all operate under the philosophy of community control. The definition of an Aboriginal Community Controlled Health Service excludes organisations controlled by government and those that “adopt a vertical approach to health inconsistent with the Aboriginal holistic definition of health as defined by the National Aboriginal Health Strategy” (NACCHO 2003).
**Presentation of Findings**

The following table of themed responses re-uses the three Knowledge Areas and subgroups outlined in Chapter 5. However, in this Chapter the table works to thematically organise and reflect the variety of further responses given by participants. The themes identified in this table are those which emerged repeatedly in further responses and explanations offered by participants. The prevalence of these themes are demonstrated later in this Chapter when the extended answers are quoted in full as part of a methodological commitment to the inclusion of Indigenous voices and perspectives within this report of findings.
## Table of Themed Responses

<table>
<thead>
<tr>
<th>KNOWLEDGE AREA 1</th>
<th>KNOWLEDGE AREA 2</th>
<th>KNOWLEDGE AREA 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Knowledge of community control definition as outlined by NNACCHO/QAIHF</strong></td>
<td><strong>Knowledge that the Brisbane AICHS is a community-controlled health service</strong></td>
<td><strong>Understanding and analysis that the Brisbane AICHS is operated as a community controlled health service</strong></td>
</tr>
</tbody>
</table>

**Group 1**
Fully reflects definition

**Themed responses**
1. Community
2. Election processes
3. Racism
4. Appropriate service provision

**Group 2**
Partly reflects definition

**Themed responses**
1. Community
2. Control
3. Appropriate service provision
4. Board

**Group 3**
Not reflective at all of definition

**Group 1**
Yes response
No themed responses

**Group 2**
No response
No themed responses

**Group 2**
Mixed responses

**Themed responses**
1. Community consultation
2. Funding
3. Board
4. Process
5. Mainstreaming
In order to present the findings qualitatively as well as efficiently I have analysed and identified themes within the responses for each Knowledge Area. Under each Knowledge Area (and subsequent groups), a table compares the number of participants from Chapter 5 who responded. Obviously, questions that required a simple yes/no response did not allow themes to be identified across the group. To identify and group responses sharing a key theme, an analysis of each response was done and the predominant concerns were listed and grouped with like responses. Where responses contained elements of more than one theme, they were included under their main theme for analysis. The identified themes are reflective of all those the participants raised.

Interestingly, the themes which emerged from the community both reflect the theory of community control and resonate with the themes and issues raised by the interviews with health professionals and activists in Chapters 3 and 4. For example, in the community responses Board election processes were articulated by a number of the participants as a point of tension. Board election processes were also identified as one of the fundamental markers of community control according to NACCHO’s and QAIHF’s discussion of community control theory. This and similar tensions and contradictions between community control theory and practice are evident in the themed responses presented in this Chapter, which extend on those identified in Chapter 5.

After presenting the three Knowledge Areas and their associated groups, I then qualitatively analyse the responses. This is where the qualitative experiences of the participants are truly heard and discussed and the statistics of Chapter 5 are rendered most meaningful. I also begin to draw the various elements of this thesis together by
returning to my in-depth interviews with Sam Watson, Les Collins, and Susan Morgan, in articulating community control theory. I draw on my interview with author and activist Gary Foley to enable a deeper analysis of all responses and findings. This is essential to answering the question of whether the theory and practice of community control are currently being achieved by the Brisbane AICHS. Chapter 7 follows this up by discussing these findings and making recommendations about how to strengthen community control practice.

Overall, I have three main intentions in this Chapter. First, I demonstrate the existence of two different tensions surrounding community control, between the theory of community control and the uneven understandings of what this means among the wider Indigenous community. There is also further tension between the ideals and imperfect day-to-day reality of community control within the Brisbane AICHS. Second, I analyse the causes of these tensions using the respondents’ voices to consider how members of the community understand, explain, and negotiate the contradictions between community control theory and practice. Third, I use these findings to present my own analysis of the extent to which the Brisbane AICHS aligns itself with the Indigenous theory of community control. My analysis is part of the broader recommendations I make in the conclusion to this chapter about ways to strengthen this alignment for the delivery of empowering health services with best health outcomes.

The findings of this thesis are not just my intellectual property but indeed are owned by the Brisbane AICHS and the participants. They emerge from Indigenous storytelling and sharing of wider community knowledge, experience, and understanding. Therefore, I
provide a transcript of all responses to the questionnaire. Usually such a transcript of responses would be confined to an appendix. However, I present these materials in the main body of the text for two reasons: first, it initially submerges the reader in the raw data and allows them to truly grasp an Indigenous perspective; second, it empowers the community by enabling community consultation processes. This method mirrors a fundamental principle of community control as outlined by NACCHO.

Knowledge Area 1 Group 1

Do participants have a comprehensive knowledge of the community-control definition as outlined by NACCHO and QAIHF?

Table 18

Group 1 age/gender (22 participants)

<table>
<thead>
<tr>
<th>group</th>
<th>age</th>
<th>teens</th>
<th>20s</th>
<th>30s</th>
<th>40s</th>
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<th>60s</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>males</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>females</td>
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<td>6</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Participant responses

The four themes identified among respondents who have a comprehensive knowledge of community control were:

1. community

2. election processes

3. appropriate service provision

4. racism

Qualitative analysis and report of findings

The below 22 participants were able to clearly articulate a definition of community-control as defined by NACCHO/QAIHF. Of these 22 participants 14 were staff members of the health service. This leaves a group of 7 non-staff community members who were able to articulate a definition of community control.

1. Community

A) In their own voices:

1. “The people from the community working in the health service to help our people. Also having a say in how we can improve our services through the processes of an elected Board, which are made up of community members.”
2. “Community control means exactly that community should control, the community are our employers.”

3. “That the service for the local Aboriginal community is of the people, for the people, by the people.”

4. “Control at all levels by community people.”

5. “Decisions regarding any needs of the community is made by the Board members following feedback from people in the community.”

6. “The community has the ultimate say on the care that is given to them.”

7. “It means listening to the community for direction on how to best run the service.”

8. “Run by the community, for the community via consultation and involvement.”

9. “When a community determines their own health needs and requirements and can have direct input into the functioning of the service offered within.”

10. “The community influences the Aboriginal and Islander Community Health Service’s very existence and all its operational procedures.”

11. “Community involvement is the central principle.”

12. “Sense of community ownership, sense of ‘this is our place’, community participation is valued and the community is given a voice, community is involved in the setting of the services agenda – vision and it meets our needs.”
13. “It’s run by the community people—being the Board and the staff and community—people can have their say in running the place.”

14. “The community directs and prioritises the community health issues and acts accordingly.”

15. “Basically it is the community and the community Board members that run the whole place”.

B) Analysis and interpretation

These responses connect community access to health services and community democratic input into those services. They also link democratic service structure and the delivery of better health outcomes. Within these responses the participants articulated that the “Aboriginal and Islander community” have an active role in the service. This is unlike mainstream health service provision. For example, in one response the participant articulated the link that “the community are our employers”. This is unique to the theory of community control and is not the experience of mainstream health service providers. I would argue that non-Indigenous people accessing a doctor or a family health service do not feel that they control the health practitioner or have a sense of input into the provision of health services.

Clearly, the responses show a depth of understanding in their articulation of “community control”. Respondents link the community and its role within service provision, which is paramount to community control theory.
These responses strongly reflect the theory of community control as outlined by peak state and federal Aboriginal and Islander health bodies.

2. Election processes

A) In their own voices:

1. “It means there is a community elected Board to help run the service. This means there is good representation of the community and their needs and it allows decisions to be made by the community.”

2. “That they are managed and run by the community, when elected.”

3. “Community control means that the Aboriginal and Torres Strait Islander community members are the decision makers at all levels of the particular service. Aboriginal and Torres Strait Islanders are the Board who are our community members. We decide.”

4. “It means that the Board members have been voted in by the community and that the service has to answer to the community. It means that the community has a say in how the service operates.”

B) Analysis and interpretation

As outlined in Chapters 3 and 4 community control theory clearly identifies that the Board of the service provider must be made up of Aboriginal or Torres Strait Islander community members from within the community the service represents. This allows for
true community representation in the administering of the service. Within these responses, good representation on an elected board is linked to good provision of services. The responses note that this principle of community control is achieved via appropriate election processes, which have direct links to community representation and impacts on service outcomes. A board that has to reflect community needs and concerns and answer to those accessing the service is understood to improve health outcomes. Thus, a poor election process could be linked to poorer provision of health services, possibly eventuating in poorer health outcomes. This essentially links overarching structure and personal health outcomes, which emphasises how community control theory is reflected in everyday practice.

3. Appropriate service provision

A) In their own voices:

1. “That we are in control, that I have a say in services provided. As a member I should be able to obtain minutes of meetings and receive a newsletter each month with information that tells me our service is running to our people’s requirements.”

2. “Being part of the decision making that impacts on providing cultural holistic health care.”

B) Analysis and interpretation

These responses again reflect a good working definition of community control. Significantly, they reflect both criticism of existing practice and a deep underlying
commitment to the ideal of community control. Depth of analysis is demonstrated in the second response, which articulates that the inclusion of community members impacts on care given to the community. Again, this is unique to community control; non-Indigenous consumers of a mainstream health service would arguably not articulate their impact on health service provision.

3. Racism

A) In their own voices:

1. “Ideally that each section of the community participates in, and has influence over, the operation of the service. Also that racist or otherwise culturally inappropriate behaviour is actively stamped out. There is also inclusion of gender appropriateness.”

2. “Black ownership, management, control being able to decide matters for ourselves. Making our own decisions, choices and being involved in our own health problems. No white man telling us what to do!!”

B) Analysis and interpretation

It was only among this group of responses that a link between racism and community control was articulated. Although small in number these responses explicitly link community control empowerment and the wider structures of white race privilege. These responses suggest that Indigenous services are more likely to improve health because of the absence of white racism and the associated poor interpretation of community issues.
by non-Indigenous health service providers. This analysis of racism and the need for empowerment is central to community control theory. Indeed, the establishment of Indigenous services was directly motivated by the racism faced by Indigenous peoples in accessing health and other services that delivered better outcomes for whites.

Overall findings and conclusions

The four themes that emerged among respondents with a high knowledge of community control were community, election processes, appropriate service provision, and racism. These themes demonstrate that almost half of the participants could give a clear and concise definition of community control as articulated by both state and federal Aboriginal health bodies, while all of the responses quoted above were concise in articulating community control theory in general.

The wide-ranging themes highlighted by the participants emphasise their diverse knowledge, but consistently reflected a full definition of community control theory via their identification of most of the fundamental principles of community control. Interestingly, this group also identified racism as an issue, which was the original motivation for the establishment of community-controlled services. In particular, a core group of staff have demonstrated themselves as good sources of knowledge about community control and maybe a resource for strengthening community control understanding in the wider community.
Knowledge Area 1 Group 2

Partial knowledge of community control definition as outlined by NACCHO and QAIHF.

Table 19

Group 2 age/gender (17 participants)

<table>
<thead>
<tr>
<th>group</th>
<th>age</th>
<th>teens</th>
<th>20s</th>
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<td>males</td>
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<td>3</td>
<td></td>
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</table>

Participant responses

The four identified themed responses for Knowledge Area 1 group 2 are:

1. community
2. control
3. appropriate service provision
4. board
1) Community

A) In their own voices:

1. “The Aboriginal and Islander Community Health Service is there working for the community.”

2. “Community working together.”

3. “Run by the community [people] who work there.”

4. “It means feeling more comfortable because there’s a community feel and ownership.”

5. “Community working together.”

6. “Run by the community not just placed in the community.”

7. “Self-esteem and our community gets a say in the running of the organisation.”

B) Analysis and interpretation

The community theme—identified by those within Knowledge Area 1, group 1—was also identified by group 2. However, in this group the link between the structure of the organisation and health outcomes for the community is less clear, because of an inability to link community control structure to direct service provision and, therefore, health
outcomes. These responses know it works together, but lack any articulation of how this is occurring.

2) Control

A) In their own voices:

8. “Control their health [blackfellas].”

9. “Totally controlled by Aboriginal and Torres Strait Islander people.”

10. “It’s controlled by community.”

11. “Controlled by us.”

12. “We have a say when it comes to our health.”

13. “Control by community people.”

B) Analysis and interpretation

The above responses highlight a high level of attachment to the idea of Indigenous people controlling Indigenous health, but there is no practical idea of how this is achieved in the organisation. Interestingly, this group do not identify racism in health provision as clearly as the prior group did. However, I would argue that it is still evident in the subtext of their responses. For example, one response on control states that it is “totally” controlled by Aboriginal and Torres Strait Islander people. This does not overtly reference racism in service provision, but does not allow room for non-Indigenous involvement and,
therefore, the chance or opportunity for racism to occur within service provision is diminished. Due to the subtler subtext of the issue of racism within the responses in this group it was not addressed as a separate theme, but certainly remains an issue.

3) **Appropriate service provision**

A) In their own voices:

14. “*Helps Aboriginal and Torres Strait Islander people in their health and it means better service provision than mainstream such as transport.*”

15. “*Means caring and sharing in a warm way and understanding the people we service. This is to be able to meet their needs in a friendly environment whether they are black, white, brindle. The people should be able to voice their concerns without problems and ones on the Board should never forget where they came from.*”

B) Analysis and interpretation

Unlike the first group that had a good working knowledge of community control, the above responses interpret appropriate service provision as having better and easier health service outcomes rather than better structure and organisation. In this second group this is evident in responses that identify issues such as transport, which is not available through mainstream health service provision. These responses could certainly be placed within the primary health care context outlined in Chapter 3 and isolate service provision as the core issue. However, they do not necessarily link this to organisational structure or
operation, which would have reflected greater knowledge of community control theory.

2) Board

A) In their own voices:

16. “Board of management representing community interest.”

B) Analysis and interpretation

Although there is only one response dealing with this theme, it is still apparent in the above response that the issue of the Board is significant. However, it lacks clarity in articulating the link between community control practice and an elected board. There is a lack of definition in stating that the Board is made up of community members who are then elected as representatives of the community’s interests through service provision. The response does not reflect an understanding of the correlation between a lack of community representation on the Board and a lack of ability to deliver better health outcomes because of poor community representation and communication.

Overall conclusions and findings

The four themes that emerged among respondents with a partial knowledge of community control were community, control, service provision, and board. These responses are similar to those in group 1, but also differ in important ways. Of the 48 participants, 17 were able to provide a partially reflective definition of community control. The answers of the respondents in this group are shorter and the link between
theory and practice is not clearly understood nor defined. Of this 17, 5 were staff members and 12 were not. Again, this validates Morgan’s argument that “there are staff members of Aboriginal community controlled services whether they be health or otherwise who cannot clearly define community control which is the underlying philosophy of their place of employment”. What these responses highlight, as Morgan suggests, is the general inability of participants to identify a community controlled health service as operated via a governed Indigenous body that is elected by the local Aboriginal and Islander community. This demonstrates a lack of knowledge about what makes a service community controlled. And, while elements of community control were identified, gaps were still evident.

What was also found most significantly lacking was that participants failed to articulate the link between the delivery of a holistic and culturally appropriate health service and democratic control by the community. Indigenous health workers are technically the employees of those accessing the service, which supports better health outcomes, but group 2 could not assert this link.

Another striking finding is the second highest age group represented was in their 40s. Historically, it is this age group that had no access to community controlled organisations until their inception in the early 1970s. It is also within this age group that participants were heavily and actively involved in the development of Indigenous community-controlled services. This finding suggests that this age group is split into two distinct groups. First, those who were activists and have a good working definition, and second, those, especially young mothers, who were caring in the community but did not directly
agitate for health services. While this could also be due to the small number of participants surveyed in this study, I argue that there exists a division in this group between activists and community carers. In order to confirm this finding further research is required to both examine this fractured knowledge and address it.

As outlined in Chapter 4, Morgan was interviewed at length for this research and is an ex-Chief Executive Officer of the Brisbane AICHS from the early 1990s. Interestingly, Morgan stated:

I would be interested to know if you stood up all the staff of community controlled health services and ask their definition of community control and their definitions of health outcomes through community control what their answers would be. A lot of people would be shocked at how little people (community health workers) could articulate “community control” or what they do in their day-to-day role in the medical service and how it impacts on their community. I think this is a problem. We now have community health workers poles and poles apart from the community which in theory are their employees (Interview, Morgan 1999).

I am struck by the fact that while 14 participants who are staff members demonstrated comprehensive knowledge of community control, a further 5 gave only a partial definition. In addition, it is also striking that only 8 non-staff, community participants could clearly articulate a full definition of community control whereas 12 had limited definitions. This both confirms and complicates Morgan’s suspicions.
Morgan’s fears are confirmed in the sense that a majority of staff stand apart from a majority of users in deeply understanding community control. However, this is complicated by two types of cross over. Some staff have a limited definition of community control and some users of the health service have a good working definition. Morgan’s overall concern, that there is a knowledge deficit among users and staff of the Brisbane AICHS around the theory and practice of community control within the health service, is significant. This fear is supported within both the quantitative and qualitative findings of this research.

However, the employees and community members that have a limited understanding of how the service operates also complicate this. This arguably impacts upon the operation of community control. On one hand the Indigenous community not understanding the role that they have in the Brisbane AICHS’s service provision limits their input and, thus, the effectiveness of practical community control. On the other hand, the knowledge deficit among employees impacts upon their ability to advocate for the service and its service provision to the Indigenous community who access it. Staff that are well informed could reduce this deficit.

Clearly, the above group of responses demonstrates that there are identified gaps within the participants’ expression of a community control definition. Morgan expected that this would be the case with some staff members unable to articulate the definition. This problem is one of the major findings unearthed by this research: there are sections of the Brisbane Aboriginal and Islander community who access the AICHS but cannot articulate the operational philosophy of community control, which may inturn limit the
effectiveness of community control.

This point of tension was identified in the quantitative data of the previous chapter and is again reflected here. It raises the question of why there is a lack of knowledge within the Indigenous community of being able to articulate the definition of community control. One significant factor may be the age of the participants, who have had continued access to Indigenous services, with no knowledge of the struggle to establish them or necessarily knowing the operational philosophy of them. This may impact on their inability to articulate community control. As seen earlier with the participants who could clearly articulate community control, only 4 in their 20s could articulate an appropriate definition. All 4 were staff members. Collins gives insight into this problem of experience:

The community is not the same as it was at the time of the development of these services. In the early 70s we had nothing so we had nothing to lose in fighting to establish theses services. As a community we were more adhesive. As young people (in our 20s) we were so much more politically active. We took to the streets and became highly visible. This is not happening as much as it was before Indigenous services. The young, black ones in the Brisbane community today have grown up with access to Indigenous health, legal, housing and child care services. They don’t face the same issues as we did in the struggle to establish community controlled services; they already have them.

(Interview Collins 1999).
The above account highlights the first finding of this research: there is tension because of differences in historical and contemporary knowledge of community control. The older “activists” interviewed for this research had a thorough knowledge of community control not only within an historical context but also a contemporary context. Of course, age impacts upon this ability. Thus, I would argue that within the contemporary context knowledge deficits can be identified among the younger age groups of participants. This could be due, in part, to very little historical material being written on community control history, which this thesis aims to redress. Also, this age group has had access to Indigenous, community controlled services without a struggle. This indicates that there is a lack of community control theory being articulated and passed on to younger Indigenous members of the community as they access the Brisbane AICHS. The lack of knowledge that exists among staff members could also demonstrate the shortage of staff development on the operational and theoretical philosophy of community control.

Chapter 7 will address these deficits.

While the findings among participants in their 20s was expected, the findings among participants in their 40s was not. In order to further investigate this finding, however, further research is required to confirm that older carers who were not direct activists have a unique knowledge deficit. The above findings add depth to the first point of tension raised in Chapter 5—that knowledge has been lost about community control—which further validates this as a finding of this research. Chapter 7 will address this loss of understanding.
As my reflection on each group of quotes shows, there is a noted difference between the participants with a high knowledge and limited knowledge on the definition of community control. With the participants that have limited knowledge there is an inability to see a link between organisational structure and appropriate health service delivery. Within group 2 the same concerns as group 1—or themed responses of community, control, appropriate service provision, and Board/election processes—were identified. However, the fundamental difference is that they are fractured and lack detail. Strikingly, group 2’s responses are less critical of the organisation, less likely to identify racism as an issue that impacts upon service provision, and, therefore, lack the ability to link organisational processes and overall health service provision. This group differs from group 3, who gave ‘no knowledge responses’, in that group 2 at least gave some answer. Group 2 again demonstrated high levels of attachment and support for appropriate service provision and community control; this attachment will be further discussed within Chapter 7.

When read together these themes demonstrate that some participants have a partial definition of community control and that knowledge still exists in the community. In doing this, Morgan’s fears that knowledge has been lost about community control was highlighted but also complicated. However, I would argue that Morgan’s fears fail to reflect the high levels of support for community control among the Indigenous community accessing the service. While there are discrepancies articulated about the service’s operational philosophy with a mixture of both full and limited understandings of the ideas of community control, nonetheless there is still great attachment to the services
offered by and for Brisbane Indigenous communities. One of the key strengths of the service is that they offer far better health outcomes than in white health services. It is seen as valuable and significant that it is a service that is uniquely Indigenous. Indigenous service provision is deemed appropriate by the participants and is seen as worth defending.

Those with a full working definition do worry about the tension between the ideal theory of community control and the everyday practical delivery of Indigenous services for and by Indigenous community members. However, these criticisms are made from within a very strong commitment to the ideal and practice of community control. These criticisms also recognise that whether or not the everyday running of the service is ideally community controlled, health outcomes are still improved and this is vital. Consequently, the central aim of this critique is to improve the service’s structure so that it can be more fully community controlled and health outcomes further improved.
Knowledge Area 1 Group 3

Not reflective at all of the NACCHO/QAIHF definition.

Table 20

Group 3 age/gender (9 participants)

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Qualitative analysis and report of findings

The participants within this group were not placed into themed responses because the response space was left blank, which I interpreted as having no knowledge. Of the 48 participants 9 gave no response. This equates to over 18% of the total participants or 1 in 5 being unable to offer any definition of community control. No staff members were in group 3. Interestingly, 6 of the participants within this response are female and are in their 50s. The remaining 4 participants were comprised of 2 females and 2 males ranging in age from 23-32. The over-representation of participants within their 50s remains interesting. As suggested earlier, this age group is possibly made up of community carers who were not activists at the time the service was established. This gap demonstrates
both that knowledge can be lost and that using the health service does not automatically replace that knowledge or improve understanding of community control. This is an alarmingly high rate of no demonstrated knowledge and again confirms Morgan’s concern that “there is a widening gap between the staff members of the Brisbane Aboriginal and Islander Community Health Service and the wider community”. All blank responses were made by of non-staff members accessing the health service.

One possibility is that the level of parental involvement in creating these community-controlled services may have been limited due to child rearing. As part of an intergenerational loss of knowledge their children would be in their 20s and 30s. This finding could suggest that the participants in their 50s, who are lacking knowledge of community control, cannot pass on what they do not know. Merely accessing the Brisbane AICHS for various health service provision does not automatically increase knowledge of community control theory and practice.

Overall conclusion

The above findings validate the first point of tension in suggesting that there is a loss of knowledge and history on community control. This is demonstrated primarily among participants in their 20s, but also, interestingly, among participants in their 50s. This lack of knowledge among younger participants supports the idea that they have had life-long access to community controlled health services. Young participants have no historical motivation or experience of having to fight for appropriate health service provision. The struggle for this age group is not primarily about starting community controlled services
such as health, housing, and legal. Their struggle is different from some of the older participants of this research. I would suggest that older participants who have an historical context of establishing these services and staff members who understand community control may be a good source of educators on community control who could be asked to improve community knowledge.

These surveys clearly demonstrate that knowledge can be lost and merely seeking health advice will not necessarily add to understandings of community control. These surveys also indicate that knowledge gaps are transmitted from one generation to the next. Intervention may be required to halt the loss of understanding of the benefits of community control. This will be explored further in Chapter 7.

Knowledge Area 2

Knowledge that the Brisbane Aboriginal and Islander Community Health Service is a community controlled health service.
Table 21

Group 1 age/gender (44 participants) - yes

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Qualitative analysis and report of findings

No sub groups or themed responses were required for Knowledge Area 2, simply because the answer only required a yes/no response. The overwhelming response to this question, of 91.7%, was yes. When placing this response into a comparative context with Knowledge Area 1 and its corresponding 3 groups it seems at first glance as if this finding is skewed. However, what this suggests is that even participants with a definite inability to articulate a definition of community control, as outlined by NACCHO and QAIHF, can nonetheless identify that the Brisbane AICHS is a community controlled service. This is apparent within Knowledge Area 1 with 22 of the 48 participants clearly defining community control and a further 17 outlining a partial definition.

Yet, the overwhelming response that the Brisbane AICHS is a community controlled service may suggest several things. First, this could demonstrate that community
members know that it is community controlled but do not necessarily have the knowledge to define community control. Second, it demonstrates great attachment to the service, suggested by the fact that even those with limited or no working definition answer “yes” and are attracted to the idea of having control in some way. The very term “community control” conveys Indigenous agency and is widely supported across high, medium, and low levels of additional experience and understanding of community control.

**Table 22**

Group 2 age/gender (4 participants) - no

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**Qualitative analysis and report of findings**

The above responses are consistent with the earlier findings. Only four participants stated that Brisbane AICHS was not a community controlled service. This group was made up of community members who are in their 20s. No responses are found amongst those without a history of struggle for community control; who have always had access to health services; with inter-generational loss of knowledge being a factor in losing all
attachment to the idea of community control. This finding would validate the quantitative analysis within Chapter 5 and therefore strengthens the finding that there is a point of tension, because there is a lack of knowledge on community control theory and practice among some Brisbane Indigenous community members who access Brisbane AICHS. To this finding I would now add that lack of knowledge, over times and across generations, leads to a loss of attachment to the ideal Indigenous control of Indigenous services.

**Overall conclusion**

The above findings clearly indicate a gap between Knowledge Areas 1 2 which impacts upon the recommendations I make in Chapter 7. Within Knowledge Area 1, Group 1, 22 participants could articulate a clear community control definition. In addition, 17 participants of Group 2 could give a partial definition. Together this equates to 39 participants. What is interesting is that an overwhelming 44 participants, 5 with no demonstrable knowledge, stated that the Brisbane AICHS is a community controlled, Indigenous health service. Indeed, all but 4 participants within this study stated that the Brisbane AICHS is a community controlled, Indigenous health service. However, there is a large gap between identifying community control and being able to articulate exactly what community control is. This inability is evident among both staff and non-staff and arguably validates Morgan’s statement that some staff are lacking core knowledge, but also that the “gap” between staff who understand and community members who do not exists and is widening.
Also interesting is that all 4 participants who could not even identify that the Brisbane AICHS as a community controlled service were all in their 20s. Again, this finding is consistent with what Collins suggested, namely that this age group has grown up with access to many and varying Aboriginal and Torres Strait Islander services, including health. While this group is small, it highlights the risks of losing attachment and commitment to community control through an inter-generational lack of knowledge about “community control”. I argue that a lack of understanding among elder family members leads to a loss of all knowledge in the younger generation who can neither define community control nor identify their health service as community controlled. For this reason the recommendations I offer in Chapter 7 seek to redress this problem by using community members with a good knowledge of community control to assist those without such knowledge.

Knowledge Area 3 Group 1

Knowledge that the AICHS is operated as a community controlled health service.
Table 23

Group 1 age/gender (21 participants) “yes” response

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Qualitative analysis and report of findings

The above group only offered a “yes” response, which did not enable themed groupings. What these yes responses suggest is that only 21 participants articulated that the Brisbane AICHS is operated as a community controlled organisation. This is a striking finding. As I discussed above, in Knowledge Area 1, group 1, 44 participants stated that the Brisbane AICHS is a community controlled health service. However, when asked if its day-to-day operation is community controlled there was a marked decline in those willing to agree. This gap in responses further supports the findings in Chapter 5. Clearly, this group of participants, while acknowledging that the health service is community controlled in theory, express ongoing concerns as to the service’s everyday operation. This is further highlighted in my discussion of group 3 below.
Table 24

Group 2 age/gender (9 participants) “no” response

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Qualitative analysis and report of findings

Table 24 indicates that 9 participants replied that the Brisbane AICHS is not operated as a community-controlled health organisation. The over-representation of participants in their 20s and women in their 50s indicates that this group largely lacked any knowledge, failed to articulate a definition of community control, or identify it as community controlled either in theory or in daily operation and practice.
Table 25

Group 3 age/gender (18 participants) “mixed” response

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Participant responses

It is possible to thematise some of the mixed responses. Again, some answers contained more than one theme, however, the most dominant point was used in determining its final placement. The five themes identified for Knowledge Area 3 group 1 are as follows:

1. Community consultation

2. Funding

3. Board

4. Ambivalence

5. Mainstreaming
1. Community

A) In their own voices:

1. “Yes, but there needs to be more community consultation and involvement in all aspects of the running of the service.”

2. “Somewhat, yes, in that the Board of Management is made up of members from the local community. However, there are no or very little community consultation and input into community strategic planning.”

3. “It used to be in the early days but I don’t think it is as much as it used to. They don’t listen to the community now as much as they should.”

B) Analysis and interpretation

The above responses clearly state that it is a lack of community consultation that stops community control from being better practiced within the Brisbane AICHS. All three responses were ambivalent. All three indicated that it was operated as a community controlled service but ambivalently suggesting that it could be performed better. The responses indicate that the service was not listening to the community as well as it could.
2. Funding

A) In their own voices:

1. “Yes and no. The community have a large say in what happens but the funding bodies are slowly dictating how it is run.”

2. “Not fully as it is dependent on government funding from government and spending as required by government policies.”

B) Analysis and interpretation

This group raises funding as a key issue for the first time within this research. Interestingly, these responses assumed that funding bodies dictate the ability of the service to achieve a better community control practice. This finding is unusual, especially given that when interviewing Watson for this research (discussed in Chapter 4), he stated:

We ran basic programs back in the 70s such as the pig patrol through the Black Panther Party. Myself and Denis Walker and others launched a program that was true community control. We did not receive one cent of government money. We didn’t employ anybody. It was straight voluntary work. Anyway, this I believe was true community control. (1998, pers.comm., 12 March)

In reality both responses are true, albeit to varying degrees. Many programs within AICH’s are dependent on re-current state or federal funding. This essentially means that funding can be cut through processes. For instance, events such as a change of government raise real concerns, as programs that are deemed worthy and needed by the
Indigenous community may lose their funding and cease to exist. Thus, the issue of funding actively impacts on the delivery of community controlled programs. To administer most programs either state or federal funding is needed and obtaining such funding can be an arduous task. It would appear a valid fear of white bureaucrats who have the power to remove programs by not re-funding them or removing targeted services or Indigenous designed programs if they are deemed unsuitable or too expensive.

3. Board

A) In their own voices:

1. “Yes and no. I feel whilst we have a sense of ownership and involvement this influence is restricted or limited in a negative way. The Board need to reflect the community voice and this is not happening. There needs to be mechanisms put into place to ensure this happens.”

2. “In theory yes but I think in practice no. I think the Board at times is stacked. This doesn’t allow for true community representation.”

B) Analysis and interpretation

The board and its election and representativeness emerges again as a theme. The ambivalence in these responses (“yes and no”) is consistent with findings discussed earlier and shows attachment to the service. Further, it also suggests that the board is not truly representative of the community.
This impacts upon service provision in that the widest available community is not being represented or being heard, which therefore impacts on services to the community.

4. Ambivalence

A) In their own voices:

1. “In some respects yes, in some respects no.”

2. “Sometimes.”

3. “Yes in some areas and no in others.”

4. “Only to a very limited extent.”

5. “Yes I do, however, there is always much improvement needed.”

6. “Yes, although sometimes it don’t seem that way.”

B) Analysis and interpretation

The above responses indicate that these participants have a good working definition of community control but are again worried about the everyday practice of it within the Brisbane AICHS. However, they do demonstrate an attachment to the theory of community control within their ambivalent responses. Clearly, they are suggesting that while it is operated as a community controlled service, attention needs to be given to improving this practice in its day-to-day operation.
5. Mainstreaming

A) In their own voices:

1. “To be honest no. Years ago yes. This place has become too bureaucratic, too much white man ways.”

2. “Yes and no. Yes because it has Indigenous management and workers. No because it does not do enough community outreach promotions. And it needs to become more people friendly. Going too much to mainstream.”

3. “It is, but is not run like one. Now it is run like mainstream and pick and choose who should be running it and run in a mainstream way or I should say trying to run it that way, but there black and don’t know how to do it the white way that’s why they’re here because they couldn’t hack it there.”

4. “Yes, although with Board changes and changes of management over the four years a mainstream element has gradually been infiltrated.”

5. “Was perhaps. Not to the degree of days gone by. White departments are having a much larger say these days and if our uniqueness goes the rot sets in for us ‘being more like them’”.

B) Analysis and interpretation

The above responses state that the service has moved away from the wholly Indigenous run service it was initially established as. In defining this shift these participants noted
that the service had become more mainstream. Although all responses articulated that “mainstreaming” was the underlying issue there was a diversity among the responses as to other issues such as “community outreach programs” and a “stacked board”. The respondents’ explanations varied as to why it was too mainstream and why it was problematic. Again, the broader sense of attachment to the service and ideals of community control evident in these responses are consistent with earlier findings. The participants suggest that even though these issues occur and impact upon community control practice, there is a consistent feeling that the practice of community control is still the most effective way for appropriate health services to be delivered to Indigenous peoples. Everyone wants to improve community control and health outcomes.

**Overall conclusion**

The qualitative findings of Group 3 consistently reflect the two points of tension identified in the previous chapter. However, the above 18 participants, who offered a mixed assessment of the service’s practical operations, stated that the “problems” or points of tension for them as consumers of the Brisbane AICHS were varied. Their responses also demonstrate that while they are willing to identify the service as a community-controlled organisation in theory, there is ambivalence surrounding this operational philosophy in daily operation and practice and that theory and practice do not equate as congruently as they could.

Interestingly, there are diverse explanations within Group 3 as to why this might be the case. Issues such as community consultation, funding, and mainstreaming were all
discussed as possible explanations for the service’s failure to achieve community control in everyday practices. This tension is highlighted in the different responses to Knowledge Area 2, where 44 participants stated that the Brisbane AICHS is a community controlled health service, as compared to Knowledge Area 3 where only 21 participants did.

This suggests that some participants see a disparity between the theory and practice of community control as it operates within the Brisbane AICHS. The participants’ mixed responses covered a range of issues which they saw as impacting upon the daily practice of the philosophy of the service. Moreover, it is not those who lack a working definition of community control who have offered a mixed response. It is those with a good working definition who have noted this problem with insight and ambivalence. Morgan adds:

We talk about community control, for example when you look at the Brisbane framework of community control and in particular the health service, now that has over 10,000 people on its records, but you have an Annual General Meeting and you have 50 people if you are lucky turn up. That to me is not community control; that is within Brisbane Aboriginal and Islander community members of a few families. That to me is not community control that is controlled community. So it’s come down to clans and families and not overall community. I think what we saw as community control and evolved out of the 70s hasn’t evolved to make what’s now in the 90s.
Morgan introduces the problem of community control versus controlled community. She believes that through the above processes, of particular family over-representation and wider community under-representation, the Indigenous community are not participating fully in the practice of community control. This practice has, in fact, probably caused the service to be run less effectively because it does not emerge from true community representation.

This problem of skewed representation recognises the link between organisational structure and delivery of appropriate health services. For some members of the community it may be unclear if a more democratic community controlled organisation would deliver a better health service. This is because the doctors and nurses working within the service are providing appropriate service provision. Health professionals were in no way identified by the participants who expressed ambivalence as problematic or providing inappropriate services. To some extent, hard working health professionals committed to community control lessen the immediate impact of uneven representation of the wider community.

This identified point of tension raises many issues. Clearly, participants within this group suggest that the theory and practice of community control do not equate. In some ways it would seem that the theory of community control is the link between the wider community and service provision. However, in reality participants within this group note that the inadequate process of representation on the Board creates positions of power and control over the wider Indigenous community members accessing the service.
A number of the participants directly identified this as the result of a stacked Board.

There are immediate benefits for Board members, such as sitting fees for Board meetings and inclusion of Board status on curricula vitae, which is often viewed favourably. For instance, in job applications to white dominated organisations sitting on the Board is interpreted as being grounded within the Indigenous community as well as having “real” power over the health professionals within the service. Participants also identified nepotism as an issue effecting community control practice. For example, having the board stacked is linked to having the power to employ family members within the organisation. Participants were highly critical of these processes of poor representation and excessive control. There is a high level of community understanding of the existence of this problem.

Foley added that community control as a theoretical philosophy fails to equate to the operational philosophy of many Indigenous services around the nation. When asked to respond to controlled community versus community control as an operational philosophy he stated:

The first thing to be said is in all of the 100 health services Australia wide there is incredible diversity and it is pretty unfair to compare health services against each other. Because there is such diversity and for various other historical reasons I think that some health services function in perfect accordance with the original political philosophies under which health services were created. I think there are others that do not operate in any way, shape, or form resembling what we were
about. These days the way in which community control expresses itself is that at an Annual General Meeting where the elections for the Board of Directors are held and it's been practice of a number of Aboriginal Medical Services to stack the Board. This happens by bussing in the relations in on the night. They’ve got sufficient relations and stooges who will vote them onto the Board and have little else or nothing to do with the health service until the next Annual General Meeting when the voting power will be required again. This process has been happening in this community now for more than a decade. Through this process we have effectively created a middle class (Personal communication).

The above analysis further validates the second point of tension I identified in this study, namely that the model of the elected board adds to the disparity between community control theory and practice. The theory indicates that any member of the Indigenous community within Brisbane can sit on the Board and this is fundamental to community control ideals. However, it would appear in some services that the reality of obtaining a Board position can be problematic due to the issues outlined above, including Board stacking. According to the participants within the mixed response group this is problematic and greatly impacts upon true community control occurring. Unequal representation influences both the community and the delivery of optimal health outcomes. Hence, Morgan’s and Foley’s descriptions of this inequitable process are validated by my research.

When read together the above findings obviously answer the overarching question of this research. The Brisbane participants of this study clearly do not believe community
control is practised as well as it could be within the Brisbane AICHS. However, what is often missing from an analysis of these problems is an acknowledgment of the attachment that the participants still have to both the services and the idea of community control. Undeniably, there is community attachment to the service and its health service provision and improved health outcomes. This is evidenced by the fact that participants’ responses never suggested that the services provided by the Aboriginal health workers, doctors, and nurses were problematic. Though everyday practices of community control were cited as problematic at the time of the questionnaires, Collins, Watson, Morgan, and Foley all agreed that community control is essential in the administration of Indigenous health services. They also stated that community controlled Indigenous health services are still the most appropriate service provision for Indigenous peoples. Indeed, community control still delivers the best health outcomes for Indigenous Australians as compared to white health services delivered to Indigenous individuals.

**Chapter Summary**

Throughout this chapter I have presented a qualitative analysis that has re-interpreted the findings presented within Chapter 5. As outlined within Chapters 5 and 6 the theory of community control practised at the Brisbane AICHS is not as effective as it could be. Two points of tension were identified. First, the uneven knowledge of community control within the wider Indigenous community; and second, the tension between the ideal operation of community control and the reality of its day-to-day operation. Chapter 6 expanded on these points of tension, which were initially raised in Chapter 5, by allowing the reader to be immersed in participants’ expressions and understandings of these points.
of tension.

The qualitative analysis of Chapter 6 also identified several examples of these tensions. A key example of these tensions was the model of the Board election. There was no dispute as to the need for an elected board due to it being a fundamental principle of community control. The identified tension focused on the process of Board election and selection.

I offer a series of recommendations as to how to address these key tensions in Chapter 7. In the future I plan to convey these findings and recommendations to the Board. The Board can then determine what the most appropriate responses are with further community input. This process of critique and improvement is one of the underlying components of community control through representation. In fact, this research is itself part of the process of community control. Through community consultation achieved via questionnaires and the representation of Indigenous concerns by allowing Indigenous voices to be heard, this research has identified issues that are central to improving community control theory and, more importantly, its everyday practice.

In Chapter 7 I briefly draw on my interviews with Collins, Morgan, Watson, and Foley presented in Chapter 4. These interviews confirm that while the theory of community control is not practised as best it could be, it is still essential in the administration of Aboriginal health. These interviewees argue that what is needed—and, indeed, a fundamental principle of community control—is Indigenous communities bettering and improving the practise of community control. I then offer my own recommendations on how to better practice community control within the Brisbane AICHS. These
recommendations are based on participants’ responses, suggestions from the in-depth interviews, as well as my own findings. As such, they draw together a wide variety of Indigenous community knowledge of community control theory and practice so as to further enhance community control, health service delivery, and, ultimately I hope, health outcomes.
Chapter 7

We now need to look at it, is there a better process, are our organisations and the way their structured in the best position to respond to our community needs? So, yes, I think the evolution of community control is not stagnant but has the potential to change dramatically. (Les Collins)
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Introduction

Chapter 7 presents an overall discussion of the findings of this research as well as provides recommendations, which, I argue, could lead to better community control practice within the Brisbane AICHS. I begin by providing brief chapter overviews to frame the proceeding discussion and recommendations. Throughout this chapter, I again draw on the voices of my in-depth interviews. This is consistent with this study’s research method and is imperative for three reasons. First, throughout this study participants and interviewees have consistently articulated a tangible and important attachment to community control, which is essential in administering appropriate Aboriginal health service provision. Second, this method is part of a process of empowering the Indigenous community by focusing on issues that affect us and, as a community, using our abilities and knowledge to better the community control practice of the Brisbane AICHS. Third, these interviews have also allowed me to identify specific ways to improve the efficacy of the Brisbane AICHS’s community control practice, which I discuss later in my recommendations.

After re-presenting the in-depth interviews I then provide a general discussion of the findings of this thesis as a whole. This allows me to discuss some key findings, which collectively emphasise the need for the recommendations I offer later in this chapter. These recommendations address the points of tension that were identified in Chapter 5 and validated in Chapter 6. The recommendations in this chapter include strategies about how to achieve and implement them, alongside a rationale as to why such changes are necessary. Finally, I provide an overarching conclusion that draws together the elements
of this research into community control.

**Chapter Overviews**

Chapter 1 provided an overall introduction to this piece of research and detailed the emergence of the central research question, namely, “what is community control?” It also outlined the Indigenous methodology utilised in this research. Initially, this meant using only Indigenous voices throughout the research. This was reflected in the high representation of interviews from the Brisbane Indigenous community. In addition, the lack of a literature review demonstrated the minute amount of literature that has been written on community control and, in turn, the need for further research. While there is a small amount written on community control from the Indigenous perspective, after an extensive literature review I found no existing research documenting and comparing community control theory and practice that could benefit this research.

In Chapter 2 I utilised both Indigenous and non-Indigenous perspectives to compare the health status of Indigenous Australians and their non-Indigenous counterparts. The latter was presented through a statistical approach, which allowed the reader to measure and understand this complex problem. It provided a comparison between the striking life differentials of Indigenous and non-Indigenous Australians, as well as examined comparisons between Indigenous Australians and the Indigenous peoples of New Zealand, Canada, and the United States. An Indigenous perspective was also used to explain these marked life differentials, which argued that these differentials are the result of dispossession and the colonisation process. It was necessary to present both
Indigenous and non-Indigenous perspectives on health as the statistical approach, drawn from a white health research model, allowed us to measure the problem while the Indigenous holistic perspective allowed us to explain the problem in an Indigenous context. Chapter 2 further considered the pre-invasion health status of Aboriginal people and the post-invasion demise of Aboriginal health, which led to the rise of the community control movement for Indigenous health services within Australia. This chapter was essential in establishing an Indigenous context for further research in this thesis. Chapter 2 also established that community control delivers better health outcomes for Indigenous people than services in the white community.

In Chapter 3 I outlined the documented history of the Brisbane Aboriginal and Islander Community Health Service (AICHS). The purpose of presenting this history was three fold. First, it documented the transition from a voluntarily run health service with a staff of seven to a multi-purpose built facility with a staff of 53, which is now government funded but remains an Indigenous community controlled organisation. Second, while presenting this history I established that community control was practiced before it was articulated as a cohesive theory. This was achieved by drawing upon interviews conducted with three prominent Brisbane Indigenous members, Les Collins, Sam Watson, and Susan Morgan. All three activists were instrumental in the establishment of Brisbane AICHS. Third, I outlined the historical practice of community control so as to establish the basis for a wider theory of community control that has emerged from experiences of Indigenous community members who established community controlled services.
In Chapter 4 I addressed the second underlying research question as to the theory of community control. In presenting the Indigenous theory of community control, I contextualised it within four Indigenous perspectives. First, I drew on the oral histories I obtained from three members of the Brisbane Aboriginal community, all of whom were present at the articulation of community control as an operational philosophy and were instrumental in establishing the Brisbane AICHS. Usually in reporting the findings of interview research a transcript of responses is confined to an appendix. However, I presented these materials in the main body of the text to submerge the reader in the raw data and to allow the reader to better grasp the Indigenous perspective on the theory of community control. This approach also forms part of an empowering process for the community, because this method directly enabled a community consultation process. I argued that this method mirrors one of the fundamental principles of community control as outlined by the Queensland Aboriginal and Islander Health Forum (QAIHF) and the National Aboriginal Community Controlled Health Organisation (NACCHO).

Second, I drew on written texts from the Alukra Congress in Alice Springs and the Sydney Aboriginal Medical Service. It was essential to include these texts on community control as experienced by two distinct community controlled Aboriginal Medical Services. This demonstrated both the variability of practice and the uniform commitment to community control theory among differing communities. This highlighted the differences in practice, as identified by the individual communities, in implementing community control in an appropriate way. Third, I drew on the theory of community control as presented by the QAIHF, the state peak Indigenous health body. Fourth, to complete this I drew on the NACCHO as the federal peak body for community controlled
Aboriginal and Islander Health Services. Using these four pools of Indigenous knowledge allowed me to identify a wider and more complete theory of community control. It also demonstrated the intricate link between community control theory that feeds through and informs all four Indigenous perspectives.

Chapter 5 used the Brisbane AICHS as a case study to analyse the wider community understandings of community control. I used this to compare the theory and practice of community control, which was a core issue that emerged out of previous chapters. To best answer the research question, “how widely is community control theory understood by the Aboriginal and Torres Strait Islander community members?”, a questionnaire was distributed among Brisbane Indigenous community members who have accessed the Brisbane AICHS for varying lengths of time. Chapter 5 presented the findings of these consumer questionnaires, which were completed by 48 such Aboriginal and Islander community members.

The questionnaires are the voices of the community and it is these 48 community members who were able to identify whether the theory of community control, as endorsed by NACCHO and QAIHF and outlined in Chapter 4, was being achieved by the Brisbane AICHS as best practice. This chapter presented the results of these questionnaires within a statistical framework. The relatively small number of participants meant that caution needed to be applied when using statistical analysis. Nonetheless, it was a useful tool for displaying and analysing the findings of this survey as representative of the wider community.
This questionnaire also allowed me to begin to identify if the theory and practice of community control aligned itself within the Brisbane AICHS. Overall, this quantitative analysis pointed to tensions between the theory and practice of community control within the health service. The two identified points of tension were, first, the uneven knowledge about what exactly “community control theory” means within the wider Indigenous community; and second, the tension between the ideal operation of community control and the reality of its day-to-day operation within the Brisbane AICHS. At the same time these findings also identified high and partial knowledge of working definitions of community control. Conversely, some community members accessing the service could not articulate a definition of community control at all.

In Chapter 6 these points of tension were further analysed using in-depth interview responses. My method again required that the voices of the participants be presented and heard as well as analysed. It was in their responses to the in-depth questions that community members identified disparities between the theory and practice of community control within the Brisbane AICHS. This qualitative analysis expanded on the responses and explanations given by the participants and added to the statistical data of the previous chapter.

Chapter 6 also confirmed and retested the points of tension initially identified in Chapter 5. Of particular significance were those participants with a high knowledge of community control theory who expressed a definite ambivalence about the practice of community control. Presenting and discussing these tensions is essential to both addressing gaps in community understandings of community control as well as addressing the gap between
the theory and everyday application of community control in the Brisbane AICHS.

Overall, there is substantial evidence underlying the findings of Chapters 3, 4, 5, 6, of the inherent logic and necessity of community control. Community input leads to better targeted health services and better health outcomes. These three aspects are undeniably causally related. One of the overarching findings of this thesis is the high level of commitment and attachment to community control. Without exception the participants clearly indicated that they did not want to abolish community control, which was closely associated with improved health outcomes for Indigenous Australians. Rather, they wanted to see a better practice of it including, improved community input and appropriate service provision and health outcomes.

Community Voices

In the four in-depth interviews it was essential for me to pose the question, “is community control essential in the administration of Indigenous health services?”; the responses were unanimous in their commitment to community control. While a tangible attachment to community control was identified, survey respondents also sought to improve community control. In response, my conclusions recommend ways to improve the practice of community control. In analysing the four in-depth interviews I have drawn a number of my conclusions from the words of these experienced practitioners. When asked whether community control is essential in the administration of Aboriginal health services, Foley stated:
The point remains that Aboriginal health services must be under community control to be truly effective. It’s really important that people who are on the Boards of Aboriginal organisations are people who live locally in the Aboriginal community. If they’re not then what’s the point of being on the Board? The idea was to have local community people on the Board; that’s why it’s called a community control health service. And when these services were created, and probably why it wasn’t spelt out more explicitly those days, was because we did not have a black middle class in the early 1970s.

Foley’s response demonstrates a fundamental belief in the necessity of Indigenous health services being administered under community control if they are to be effective. However, in stating this he also links the creation of a black middle class to both the operation of the board and the further articulation of community control. Foley argues that the rise of a board-driven black middle class causes a stagnation within the administration of Boards, as privileged non-inclusive family units have been tempted to stack the Boards for power and status. The recommendations that follow address the problem of board stacking as both reducing community consultation and the delivery of services intended to address wider community health needs.

When asked if community control was essential, Collins unequivocally stated:

Absolutely, because there’s no one else that can define the needs of the community better than the community. Community control can be a much better process. Is it good enough to settle for introduced constructs like democracy or
should we be saying this is what constituted our community, it’s not about individuals but it’s about families? One of the best ways we can do this is to ensure every family has somebody be part of the governance of the health service otherwise if individuals go along with no real knowledge of the other person’s capabilities, no knowledge of how they see their responsibility to their community-its about questioning process.

Clearly, Collins also articulates that community controlled health services are essential in the administration of effective Indigenous health. However, Collins suggests that community control could be a much better practice. Collins goes so far as to say that all families should be included in the administration of the service to provide a better practice of community control. This links a more inclusive framework for the service through having more inclusive board representation. Again, this impacts on the recommendations which follow in this Chapter.

When asked the same question as to the need for community control Watson unsurprisingly stated:

Yes, that’s crucial. Without that and going three decades into the background and going back to the point where murri people had to go back to white institutionalised hospitals: we just can’t do that. We have achieved a significant amount in the last three decades and I’ll be the first to pay. However, we must be really mindful that this is incredibly difficult today because what has happened is over the last three decades the community has become more factionalised. We are
not remotely one homogenous community and therefore true community 
representation can be a very hard thing to achieve.

The above responses reflect the continuing strong attachment to community control. At 
the same time the difficulty of achieving this is also noted and reflected in the inability of 
the board of the Brisbane AICHS to fully reflect representation of the wider Brisbane 
Indigenous community.

As expected, when asked the same question about the need for community control 
Morgan stated:

Absolutely. Most definitely, for all that’s gone and the way that I see that 
community control has gone today, I still believe that true community control is 
essential in running or administering any service to any Indigenous Australian. 
You cannot establish anything for Aboriginal and Torres Strait Islander people 
without some sort of community control. In saying that though, it has to be a 
community control not Board control, not workers control nor family or clan control but community controlled and not controlled community.

Again what is evident in Morgan’s statements is that community control is essential. 
Morgan does, however, not that it must be truly representative otherwise we run the risk 
of it being a controlled community through active exclusion from family community 
controlled boards. This reinforces what many of the survey participants have concluded, 
namely, that the operation of community control needs to be better addressed within 
Brisbane AICHS to ensure optimal health outcomes. Morgan obviously believes that this
could occur if the Boards were more representative of the Indigenous community. While these activists are undeniably ambivalent about the operational practice of community control in a broad sense, their concerns also relate to the particular case of the Brisbane AICHS. Strongly identified is a clear link between the Board processes, community control, the quality of the health service, and, ultimately, health outcomes.

**Discussion of Findings**

This research has consistently identified a tangible attachment to community control among the Indigenous community. This attachment is also evident among the four in-depth interviews. Similarly, community control has also been consistently acknowledged as the most appropriate way to administer Indigenous health services. In addition, since the commencement of Aboriginal community controlled frameworks the value and effectiveness of this framework is now espoused through the World Health Organisation as Primary Health Care philosophy, which was endorsed as health policy in Australia in 1979. There is an undeniable logic to community control.

However, this research has also identified that within the Brisbane AICHS the theory and practice of community control do not equate as well as they could. To address this I offer a number of recommendations which address the shortfall between theory and practice of community control within the Brisbane AICHS. The recommendations which follow have been drawn from both my own analysis of community control and the voices of those who participated in this research study of community control and the AICHS.
Recommendations

In establishing recommendations I address each of the two tensions identified in this research separately. Each recommendation is followed by a proposed strategy, which is followed by a discussion of implementation (that is, how to achieve the identified strategies). I follow these discussions with a rationale for the overall recommendations, which has, of course, been validated throughout this research.

First point of tension

Knowledge deficit, especially among young ones, of community control theory and practice.

Recommendation

To increase knowledge of both community control theory and practice among the Brisbane Aboriginal and Islander community, particularly community members in their 20s.

Strategy

1. Development of community resources aimed specifically at those aged 25 and under, to be facilitated by the following:
Implementation

a. the Indigenous youth health section of the Brisbane AICHS. Identify five young ones in their 20s who access AICHS youth section;

b. form a resource development group--which includes the youth worker and coordinator of the service, as both are young Indigenous males, as well as five young people in their 20s and an older male in his 50s who has a good working definition of community control.

c. the workers developing the resource (pamphlet or poster) using the expertise of the young ones to use language and style that is appropriate and suitable to their needs.

d. resources to be used in the youth service, the main service, and also for outreach purposes.

Rationale

This research has demonstrated quantitatively and qualitatively that some members of the Brisbane Indigenous community have knowledge deficits of community control theory and practice. It is, thus, essential to address this knowledge deficit. Using the expertise of the young ones is essential in developing appropriate resources for them. Utilising the historical knowledge of an elder man within the community is seen as essential in the passing on of community control theory and practice. It also resonates with an Indigenous construct of passing on knowledge. Having the process facilitated at the youth section of
the Brisbane AICHS is appropriate given that the service was established for the Indigenous youth of Brisbane.

**Strategy**

2. Board to have 1 identified position designated for someone under the age of 25.

**Implementation**

This recommendation and strategy would need to be addressed at a Board level. Obviously, in raising this issue to the Board appropriate process would need to be adhered to. However, it is an important finding of this research that participants under the age of 25 displayed the greatest knowledge deficit in defining and identifying community control practices. Therefore, it is essential to fill this identified gap. It has traditionally been an integral component of Indigenous cultures to pass on knowledge to younger members of the group. By having an identified position for an Indigenous community member within their 20s this both reinvigorates this tradition and decreases or slows the impact of lost knowledge. Also, for the young person on the Board it is an opportunity for them for peer education. Their role, responsibilities, and functions as a Board member would be discussed among their peers.

**Rationale**

The findings clearly identified that the under-25 age group had an intergenerational knowledge deficit in articulating community control theory and practice. This may lead
to a loss of any attachment to the process of community control. Within traditional Indigenous societies the passing on of knowledge was an integral part of life. Passing knowledge through service provision is not a traditional part of Indigenous life but may be the contemporary essence of passing on knowledge. Therefore, this means that transference should be considered vital to the survival of Indigenous knowledge. The approach may differ but the practice of passing on of knowledge remains. In addition, improving knowledge and understandings of community control and its success in delivering better health outcomes may, in the longer term, work to reduce the gap between theory and practice, which is the second tension discussed below.

**Strategy**

3. Staff development on community control theory and practice held annually.

**Implementation**

The above recommendation would again have to be endorsed by the Board. However, I anticipate that this would not be problematic as the service already has in place staff development that occurs once a month on a Friday. The service is closed from 12 pm for staff development. This can be done through the various sections of the health service or as an overall service. I would suggest that this be done with the whole service and could be administered a number of ways, such as group work and asking the participants to identify what they believe community control is or how to improve it in practice. As my in-depth interviews show it would be invaluable for this education to be facilitated by a community member that was involved in the establishment of the service. Staff could be
encouraged to discuss improvements with the wider Indigenous community seeking health advice, as another aspect of community consultation and feedback on appropriate health services.

Rationale

Obviously, this strategy addresses this study’s research findings that indicated that there were a number of staff who could not give a full definition of community control. This also addresses Morgan’s fears that without adequate knowledge of community control staff may simply advocate for the service as best they can, rather than fully participating in active feedback from the community.

Strategy

4. Development and distribution of a monthly newsletter to the community outlining issues and also education on community control practice/theory.

Implementation

This would be the responsibility of each section’s management. Each section could outline different programs and clinic times and dates. This would also be an excellent format to introduce a different staff member once a month, including outlining their duties and work roles. This, of course, would function to inform the community of valuable health information. This newsletter could also contain information on community control. For example, a different aspect of community control could be discussed every month inviting input and suggestions from readers. The newsletters could
be distributed to the community as they access the service for any service provision and via the mobile clinics. This would ensure further dissemination of the information and improve community consultation.

Rationale

This strategy would enable the Indigenous community accessing the service to always have readily available information about the functioning and running of the service and its varied programs. This strategy also addresses the knowledge deficit of community Indigenous members who could not identify what community control is by decreasing such knowledge deficits. This would avoid any loss of attachment to community control as the best means of delivering appropriate health services to Indigenous people with optimal health outcomes. A newsletter would also mean that the Board would be seen to be more regularly consulting with the wider community.

Second point of tension

Clash between theory and practice of community control.

Recommendation

To decrease the gap between theory and practice of community control within the Brisbane Aboriginal and Islander Community Health Service.

Strategy

1. Board members must not serve more than 2 consecutive Board terms.
Implementation

Once again, the above recommendation would have to be raised at a Board level. The problem of the Board being insufficiently representative was one of the findings identified in this research. This finding could potentially be problematic for the Board. Understandably, this could be interpreted as “Board bashing” or “Board blaming” for complex issues as to why community control has not been achieved at an ideal level. However, it is not the particular members of the existing Board that this recommendation is specifically aimed at. This research alongside the participants of this research have worked to identify best practice of community control. Wider representation through a more diverse Board is key to achieving this. Presenting these research findings may assist the Board in understanding this recommendation.

Rationale

This research has clearly identified the issue of Board stacking. Added to this was Foley’s discussion of the creation of a black middle class through existing board processes. This should not go on unchanged or unchallenged. I argue that this strategy begins the process of addressing better election and Board processes to ensure wider representation. This would increase rotation of community members on the Board, which, I argue, is a fundamental component of achieving true community control and better sharing the status and knowledge that comes from working as a Board member.
**Strategy**

2. No more than 2 immediate family members on the board at any one time.

**Implementation**

In the first instance, this would also have to be raised at a Board level. Again, this strategy has been identified as a result of the research findings. Nepotism and Board stacking were both raised as real issues impacting on the inability of community control being practiced as best it could be and was raised by a significant portion of the research participants. This recommendation could also be perceived as “Board bashing”, however, the participants have demonstrated a tangible attachment to community control. Wider power sharing would improve this process and become part of the solution in addressing this point of tension.

Importantly, for this recommendation to be implemented it would be vital to undertake community consultation among the wider Indigenous community within Brisbane. This is needed to define what constitutes family among the community. The Indigenous family construct is inevitably and markedly different from the white construct. I argue that the Indigenous construct of “family” is much more inclusive within Indigenous communities than white constructs. Indeed, as with many other Indigenous communities around Australia we have families within the Brisbane community that are heavily involved in particular Indigenous issues, such as health, housing, or legal services. This recommendation could, therefore, be problematic in its implementation and would need
to be discussed broadly among the Indigenous community within Brisbane who initially articulated it as a concern.

Rationale

This recommendation was again drawn from the research in facilitating a process which aims to improve the everyday practice of community control within the Brisbane AICHS. The participants clearly stated that community control is essential to deliver appropriate health service provision to Indigenous peoples and that this could be practiced better. The findings have resoundingly stated that there is a logic to community control. Community input leads to better targeted health services and this leads to better health outcomes, which can be best achieved through wider community representation on the Board.

Chapter Summary and Thesis Conclusion

This Chapter drew together the overall findings of this thesis and offered recommendations to address the identified points of tension. In doing so, I have argued that while community control theory is not practiced as well as it could be within the Brisbane AICHS it is still essential in the administration of Aboriginal and Islander Medical Services. This is consistent with the overarching findings of this research.

This research is particularly timely as there is currently considerable national-level reform within many Indigenous organisations. At a federal level funding responsibilities have been removed from ATSIC. At a state and local level many Indigenous organisations are being “investigated” by government agencies because of various
“inappropriate” discrepancies. What makes this research unique and distinguishes it from the investigations and reforms of Indigenous services, including health, is that the debate was placed into the hands of the community.

Through this research the community is taking responsibility for bettering the practice of community control. It is the participants of this research that have clearly identified the reforms required of community control. The community from within can improve community control as a practice within Brisbane AICHS, without suffering white racist interpretations of shortcomings that ignore the strengths and successes of traditions like community control. Community control is a proud Indigenous achievement to which Indigenous Australians are strongly attached. Moreover, it can also offer a model of best practice of community control power sharing from which the white community could also learn.


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APPENDIX 1

QUESTIONNAIRE

1. Gender
   □ Female   □ Male

2. Age

3. Postcode

4. Do you use the Aboriginal and Islander Community Health Service?
   □ Yes     □ No
   If no, go to Question 14.

5. How long have you used the service?

6. How often do you use the service?

7. Why do you use the service?

8. Are you aware that the Aboriginal and Islander Community Health Service is a community controlled service?

9. What does community control mean for you?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

1
10. Do you think that the Aboriginal and Islander Community Health Service is operated as a community controlled Indigenous health organization?

________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

11. If it is not a community controlled health service, how do you think it is organized?

________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

12. What do you think is good about the health service?

________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
13. What do you think is bad about the service?
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

14. If you don’t use the service, why not?
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

15. What other health services do you access?
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

16. Are the questions clear? □ Yes    □ No

17. Is the language easily understood? □ Yes    □ No

18. Do you think there are any questions that need to be added? If so, what? □ Yes    □ No
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

3