Aboriginal Community Controlled Health Services: Controlled or Controlling their own Destinies?

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This thesis was originally submitted in fulfilment of the requirements of the degree of Doctor of Philosophy, December 2014
Re-submitted after Minor Revisions March 2016
Abstract

The Indigenous people in Australia are the Aboriginal and Torres Strait Islanders. Since colonisation in 1788 this population has diminished significantly. Following years of advocacy addressing inequitable government policies towards Aboriginal and Torres Strait Islanders, the first Aboriginal Medical Service was established in Redfern, New South Wales, in 1971. From this one Aboriginal Medical Service there grew many more across Australia; in some jurisdictions they are referred to as Aboriginal Community Controlled Health Services (ACCHS). This study was designed to examine the bureaucratic and organisational structures, functions and operations of these ACCHS, and how these services meet both the organisation's requirements and the community's expectations when delivering a culturally-appropriate health service to Aboriginal and Torres Strait Islander people.

This research applies a case study method within a qualitative paradigm for the depth needed to explore the research aims. Following discussions with the Queensland Aboriginal and Islander Health Council, the sites for this research were identified in central and southern Queensland. The three sites were vastly separated by distance but at the same time subjected to similar historical abuse. The participants drawn from these sites were Aboriginal and Torres Strait Islanders and the research attempted to capture their perceptions. Each case was subjected to a conceptual and thematic analysis to draw out the key themes and concepts and thence to develop a theoretical model of how the ACCHS balance their organisational requirements and community expectations.

The main findings were that, 40 years later, the ACCHS continue to operate according to the principle ‘of the people, by the people’, a collective approach that is represented within the Indigenous worldview. These Aboriginal health services are designed to maintain a sustainable connection with their communities to deliver a model of primary health care that is unique to the ACCHS and their staff. They develop and deliver health programs with their
own people and by their own people. The Community Board of Directors and the Aboriginal and Torres Strait Islander staff generally come from the local community, bringing with them cultural knowledge and the sustainable connection to the people and the country. However, in this mix is the western dominance, in the form of government attempts to develop and deliver health programs with little or no community consultation, and the constant reminder of the abusive history and inequalities forcibly imposed on Aboriginal and Torres Strait Islander people. Aboriginal health organisations are required to demonstrate that their community-controlled health services meet government requirements over community expectations to access government funding and to demonstrate their capacity to adhere to accountability.

The western domain of control continues to subject the ACCHS to continuous cycles of organisational change. These changes are intrinsically linked to the governance model of the organisations, the community and their collective culture. This thesis found that the approach taken to organisational change processes by the ACCHS is one that includes the perspectives of both non-Indigenous and Aboriginal and Torres Strait Islander people. An extensive evaluation of all the Aboriginal community-controlled health services and non-Indigenous organisations that receive Indigenous health funding, across Australia, from the perception of the community, the Aboriginal and Torres Strait Islander staff and the non-Indigenous staff, would provide essential evidence for a model of Indigenous primary health care. This type of collaboration would ensure sustainability within the health system and a sustainable connection to community, a necessity if the Commonwealth Government’s policy of Closing the Gap between Indigenous and non-Indigenous health and life expectancy is to be met.
Statement of Originality

This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

(Signed)____________________________
Vanessa Sharon Lee
Dedication, translation in Meriam

Able PhD pardar mir ikeredi Kari Koskir Kaiedira, Emily Ah Mat. Emily dali Meriam Koskir Zenadh Keslam, abra tonar, e kikeme lu odasmerer.

‘Wi baotapreda wi nako meriba buaira tugar upi oditilare’, ‘Kara neur, ma bakiamu yaba mir brewer, nerweredere yabi miru meriba tonar, abkoreb wi umele oberare nako upi atidar merbi buaira tugar.’

Ka dudumge kebi mir atkarti, ‘ka! Mara mitkar napa uridli. Naluglam ka?’ E kirimu wau atkarti, egremada Op Deudai-em a atkarti;

‘Bakiamu, ma sakakya nauwer. Gedya mena wairdireder nade ma takomer.’

E no able mir detauti a batawirkda gedubga idger. Kari Koskir Kaiedet mitkar urutlampe kari meriba tonar nerwerli. ka umele nadepe e mir atrumli, e au akepwarlampe detautli. no pedike, nole ko nerutmir ko nagriwerteda atautem.

Ka able mirlam debe niainiai nakweireder abi gedubge, oka batagrer kaidet nalugem able mir atrumda. Gerger baraikdarda, muige six meb, ka bautari Master of Public Health, ikeredi kara Education degree a Nutrition program ge-kaka ditarer Zenadh Kes omaskerem. Ka keub warge bautari kara Doctor of Philosophy gaka dorge ikerer Griffith University kebu bakiamuda newerda Sydney University-ge future health professionals kolera tonar pako Aboriginal and Torres Strait Islander buaira health history. Sydney-ge, emetu koka akaida kikem National Aboriginal and Torres Strait Vice-President Public Health Association of Australia, ka ditarer kara able ziawalira mop ‘thesis’. Ka oka iski Koskir Kaiedira mir, dimirwarti a umele baida kaka able dorge ikeli naluge e kari namsi.
Thank you also to Uncle Benny Mabo who obtained permission for me to have this dedication translated in my Grandmother’s language of Meriam. A special thank you to the Elders, from Mer, who gave permission for me to publish the dedication in my PhD thesis in English and Meriam language.
This PhD was inspired by the wise words of my Grandmother, Emily Ah Mat. Emily was a Meriam woman of the Torres Strait who had the gift of foresight. For me, it began as we were gardening one day, in 2004, listening to the TSIMA radio discuss the health of Aboriginal and Torres Strait Islanders and in particular the gap in life expectancy. From a crouched position of pulling weeds my Grandma stood up and faced me, saying:

‘They don't understand how to help our people about their health. Nessa, you have to go and learn their language, teach them our culture in their language so that they can help our people with health.’

I quickly responded with a shriek, ‘Me! You have lots of Grandchildren. Why me?’ She nodded and motioned with her head to the South and said, ‘Go. You will be fine and home will still be here when you come back.’ She then went back to her gardening and that was the end of the conversation. My Grandmother had spent a lot of years teaching me about our culture and I knew that once she spoke and her mind was made up, then that was that. There would be no further discussion on the topic.

I stood in the garden for a long time after that conversation trying to understand what she meant. However, it took a lot longer than that day to work it out. Six months later, I enrolled in a Master of Public Health based on my education degree and the nutrition programs I had implemented for the children in the Torres Straits. Following the Master of Public Health, I enrolled in my Doctor of Philosophy and worked full-time at Griffith University. I then moved to the University of Sydney, lecturing future health professionals about colonisation, history, and Aboriginal and Torres Strait Islander peoples’ health. It was in Sydney, after becoming the first National Aboriginal and Torres Strait Islander Vice-President of the Public Health Association of Australia and as I was writing my final chapters of this thesis, that I began to understand what my Grandmother's words meant and I realised I was doing what she had
asked of me.

My Grandmother never saw me graduate with my Doctor of Philosophy as she passed away in 2011. Although her body has passed from this earth her spirit remains strong within me, her teachings and her memories are etched within my mind and her love is etched within my heart. I am and will always be eternally grateful to have had the opportunity and the guidance of such a wise woman as my Grandma, Emily Ah Mat, and I dedicate my thesis to her memory and her teachings. Thank you, Grandma.
Acknowledgements

I thank and pay my respects to my Ancestors and Elders for their wisdom, guidance and strength. I particularly thank my Ah Mat Grandparents, Aunty Phyllis, Aunty Pearl, Aunty Bonnie, Aunty Mary, Uncle Jim, Aunty Mary-Anne, Uncle Tommy, Dad and Elaine, Aunty Barbra and Uncle Jeff.

I am very, very grateful for the loving support, honesty and laughter of my sons Thomas Jack and Wesley Paul, Aunty Marie (who see’s me), Lorraine (who believes in me), Ema and Wads (who both saw me and believed in me) Aunty Sharon (who has faith in me), Darryn, Christopher, Usop and Crystal (Lorenzo and Izaiah), Jodie, Josh, Mike, Karen, Joey, Stephen, Linda for never wavering from their faith, belief, and patience in my completing this thesis.

I wish to pay my respects and extend my sincerest gratitude to the staff and Community Board of the Queensland Aboriginal Islander Health Council (QAIHC), who trusted me and supported me throughout this whole research.

This thesis has taken nine years, three years full-time and the remainder part-time. During this time I have had nine non-Indigenous supervisors who had the best intentions to guide my research through its process. To all my past six supervisors, however short and difficult our time together, I say ‘Thankyou’. To my colleague, Dr Claire Brown, I really appreciate all that you have done for me, given the circumstances.

A special thank you to my supervisors who supported and guided me through to graduation, Professor Deborah Black (USyd) and my co-senior supervisors Professor Clare Tilbury (GU), and Dr Fiona Rowe Minnis (GU), to whom I am extremely appreciative for all that they have done for me throughout the final stage of this thesis process. I also extend my thanks to the numerous colleagues from the various networks and institutions that I have worked with.
over the years towards achieving a common goal of equity and self-determination for Aboriginal and Torres Strait Islander peoples.

I would like to pay my respect and extend my sincerest gratitude to my fellow academics from the University of Sydney, especially those within the Faculty of Health Sciences, who have guided and supported me through the final five years of my thesis.

To those who never doubted me: Leanne, Collin, Ollie, Wolfie and KoKoshka; Mario Soki; Wilo Mawuda; Miss Shannon Jackson; Sylvia, Helen, Lethia-May; Vinnita Mosby (Keane); Kim Selling; Lynn Short; Ben Selling; Maria Barbagello; Norrita; Sonia and Jocita, thank you, I really appreciate your support.
Australian Aboriginal and Torres Strait Islanders are the Indigenous peoples of Australia. Aboriginal people have inhabited the Australian continent for over 40,000 years (Miller and Speare, 2012; Eckerman, Dowd, Chong, Nixon, Gray, Johnson, 2010; Smith, 2007; Arabena, 2009; The Australian Law Reform Commission [TALRC], 2012). The word ‘indigenous’ refers to the original or first-recorded inhabitants of a country (Stephens, Porter, Nettleton, Willis: 2006). Following colonisation, Aboriginal and Torres Strait Islanders were defined by their skin colour or percentage of Aboriginal and Torres Strait Islander blood (Australian Human Rights Commission [AHRC], 2008). However, these definitions have been replaced by the Commonwealth Government and are now based on ancestry and identification as someone who:

- is of Aboriginal/Aboriginal and Torres Strait Islander/Torres Strait Islander descent;
- identifies as an Aboriginal/Aboriginal and Torres Strait Islander/Torres Strait Islander person, and
- is accepted as an Aboriginal/Aboriginal and Torres Strait Islander/Torres Strait Islander by the community in which he or she resides.

(AHRC, 2008)

Aboriginal and Torres Strait Islanders are not a homogenous group. They have distinct culture, traditions and languages (Arabena, 2009; AHRC, 2008) and are the first nation peoples of Australia. The term ‘indigenous’ is recognised under international law as it acknowledges the relationship that first nation people have with the country from which they originated (AHRC, 2008). Throughout this thesis all Aboriginal and Torres Strait Islanders will be referred to as ‘Indigenous’ unless the literature or participants specify the use of the term ‘Aboriginal’ or ‘Aboriginal and Torres Strait Islander’. The term ‘Indigenous’ should not be read in this thesis as a term that fails to recognise the diversity and specific identities of Aboriginal and Torres Strait Islander people. Instead, the term is used to recognise the collective dimensions of the cultural identities of Aboriginal and Torres Strait Islander people.
'Non-indigenous' is used to refer to those who do not identify as an Aboriginal or Torres Strait Islander.

Terminology used for the Aboriginal Medical Service (AMS) is dependent upon the state or territory of Australia and the different definitions in the literature. The peak body of Aboriginal Community Controlled Health Services is the National Aboriginal Community Controlled Health Organisation (NACCHO). All state or territory peak bodies are an affiliate organisation of NACCHO and are an Aboriginal Community Controlled Health Organisation (ACCHO). However, they are referred to by their state or territory affiliate name, for instance:

- In Queensland, the ACCHO is called the Queensland Aboriginal and Islander Health Council (QAIHC)
- In Victoria, the ACCHO is the Victorian Aboriginal Community Controlled Health Organisation (VACCHO)
- In New South Wales, the ACCHO is the Aboriginal Health & Medical Research Council (AH&MRC)
- In South Australia, the ACCHO is the Aboriginal Health Council of South Australia (AHCSA)
- In the Northern Territory, the ACCHO is the Aboriginal Medical Service Alliance Northern Territory (AMSANT)
- In Western Australia, the ACCHO is the Aboriginal Health Council of Western Australia (AHCWA)
- In Tasmania the ACCHO is the Tasmanian Aboriginal Centre (TAC).

Each of these ACCHOs has its own members, who choose to be affiliated with the organisation, and these are known as Aboriginal Community Controlled Health Services (ACCHS). As this thesis focused on the ACCHS in Queensland, and due to the ethical obligations requiring protection of anonymity of services and participants, all the Aboriginal Community Controlled Health Services involved in this study are referred to as ACCHS.
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List of Abbreviations

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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics (federal level)</td>
</tr>
<tr>
<td>ACCHO</td>
<td>Aboriginal Community Controlled Health Organisation</td>
</tr>
<tr>
<td>ACCHS</td>
<td>Aboriginal Community Controlled Health Services</td>
</tr>
<tr>
<td>AHW</td>
<td>Aboriginal Health Worker</td>
</tr>
<tr>
<td>AH&amp;MRC</td>
<td>Aboriginal Health &amp; Medical Research Council</td>
</tr>
<tr>
<td>AMSANT</td>
<td>Aboriginal Medical Service Alliance Northern Territory</td>
</tr>
<tr>
<td>ATSIC</td>
<td>Aboriginal and Torres Strait Islander Commission (federal level)</td>
</tr>
<tr>
<td>AHMAC</td>
<td>Australian Health Ministers Advisory Council (federal level)</td>
</tr>
<tr>
<td>AHPA SA</td>
<td>Australian Health Promotion Association South Australia</td>
</tr>
<tr>
<td>AHRC</td>
<td>Australian Human Rights Commission</td>
</tr>
<tr>
<td>AIDA</td>
<td>Australian Indigenous Doctors’ Association</td>
</tr>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare (federal level)</td>
</tr>
<tr>
<td>ASGC-RA</td>
<td>Australian Standard Geographical Classification – Remoteness Area</td>
</tr>
<tr>
<td>CEE</td>
<td>Centre for Epidemiology and Evidence</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CATSI Act</td>
<td>Corporation Aboriginal and Torres Strait Islander Act</td>
</tr>
<tr>
<td>CATSI Bill</td>
<td>Corporation Aboriginal and Torres Strait Islander Bill</td>
</tr>
<tr>
<td>COAG</td>
<td>Council of Australian Government (federal level)</td>
</tr>
<tr>
<td>CIRCA</td>
<td>Cultural &amp; Indigenous Research Centre Australia</td>
</tr>
<tr>
<td>DoHA</td>
<td>Department of Health and Aging</td>
</tr>
<tr>
<td>FAHCSIA</td>
<td>Department of Families, Housing, Community, Services and Indigenous Affairs</td>
</tr>
<tr>
<td>FHCS&amp;IA</td>
<td>Families, Housing, Community Services and Indigenous Affairs</td>
</tr>
<tr>
<td>GMSBML</td>
<td>Greater Metro South Brisbane Medicare Local</td>
</tr>
<tr>
<td>GUHREC</td>
<td>Griffith University Human Research Ethics Committee</td>
</tr>
<tr>
<td>HREOC</td>
<td>Human Rights and Equal Opportunity Commission</td>
</tr>
<tr>
<td>KVC</td>
<td>Kanyini Vascular Collaboration</td>
</tr>
<tr>
<td>NACCHO</td>
<td>National Aboriginal Community Controlled Health Organisation (federal level)</td>
</tr>
<tr>
<td>NAHS</td>
<td>National Aboriginal Health Strategy (federal level)</td>
</tr>
<tr>
<td>NATSIHS</td>
<td>National Aboriginal and Torres Strait Islander Health Survey</td>
</tr>
<tr>
<td>NRHA</td>
<td>National Rural Health Alliance</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>NTER</td>
<td>Northern Territory Emergency Response</td>
</tr>
<tr>
<td>OATSIHS</td>
<td>Office of Aboriginal and Torres Strait Islander Health Services (federal level)</td>
</tr>
<tr>
<td>ORIC</td>
<td>Office of the Registration of Indigenous Corporations</td>
</tr>
<tr>
<td>ORRG</td>
<td>O’Brien Rich Research Group</td>
</tr>
<tr>
<td>QAIHC</td>
<td>Queensland Aboriginal Islander Health Council</td>
</tr>
<tr>
<td>QAIHF</td>
<td>Queensland Aboriginal &amp; Islander Health Forum</td>
</tr>
<tr>
<td>RRGP</td>
<td>Rural and Remote General Practice Program</td>
</tr>
<tr>
<td>RHWA</td>
<td>Rural Health Workforce Alliance</td>
</tr>
<tr>
<td>SCRGSP</td>
<td>Steering Committee for the Review of Commonwealth Service Provision</td>
</tr>
<tr>
<td>TALRC</td>
<td>The Australian Law Reform Commission</td>
</tr>
<tr>
<td>VACCHO</td>
<td>Victorian Aboriginal Community Controlled Health Organisation</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>WHOCSHD</td>
<td>World Health Organisation Commission on Social Determinants of Health</td>
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</table>
Chapter 1

Introduction

1.1 Background

A history of dispossession and dispersal has had strong repercussions on the health of Indigenous Australians (Paradies, Harris, Anderson, 2008). It has led to high rates of chronic disease, high mortality and high morbidity (Couzos and Murray, 2008). To address imposed policies as a result of colonisation and the lack of health services available to Indigenous Australians, Indigenous health services have been developed ‘by Indigenous people for Indigenous people’ (Brady, 2000; National Aboriginal Community Controlled Health Organisation [NACCHO], 2003). These health services are an essential component in achieving better health outcomes for Indigenous people and are an integral part of the process towards Indigenous Australians achieving self-determination; that is, that Indigenous people maintain the right to determine their own destinies.

Following decades of social change, the first ACCHS was established in Redfern, New South Wales, in 1971 (Bartlett, 2005; Brady, 2000). The ACCHS was a response to the mistreatment and disadvantage of Indigenous peoples. This treatment had become a global human rights issue and represented an act of self-determination by Indigenous people (Brady, 2000; Couzos & Murray, 2008) in their struggle to achieve better health outcomes. This first ACCHS set a precedent in its approach to health care by making it more relevant to the Indigenous population, and at the same time it maintained a holistic approach to primary health care (Brady, 2000; Couzos & Murray, 2008; NACCHO, 2003; Taylor & Guerin, 2008). For this reason, the service considered the physical, social, emotional and cultural aspects of health and well-being as important factors for addressing Indigenous peoples’ health.
It has been argued that throughout the years Aboriginal community-controlled primary health care organisations have established themselves as an appropriate means of providing health care to Indigenous people (Couzos and Murray, 2008; Queensland Aboriginal and Islander Health Council [QAIHC], 2007). The peak national body of the ACCHS is the National Aboriginal Community Controlled Health Organisation (NACCHO). This peak body represents all the 148 ACCHS within Australia at a national level and has established itself by ensuring that the state affiliates the Aboriginal Community Controlled Health Organisations (ACCHO), and its members, the ACCHS, maintain the philosophy of self-determination and a holistic view of health. This is defined as:

*Aboriginal health is not just the physical well-being of an individual but is the social, emotional and cultural well-being of the whole community in which each individual is able to achieve their full potential thereby bringing about the total well-being of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life.* (National Aboriginal Health Strategy [NAHS], 1989, in National Aboriginal Community Controlled Health Organisation [NACCHO], 2008 URL http://www.naccho.org.au/about-us/vision-and-principle/).

The representation of the ACCHS at a national level ensures that Australia’s Indigenous peoples health, including the access to and delivery of effective health care, is continually maintained and supported (NACCHO, 2008). Self-determination is the key characteristic that is evident throughout the ACCHS (Brady, 2000; NACCHO, 2003; NSW Nurses Association, 2010; QAIHC, 2009). This is demonstrated through the opportunities that are offered to the local Indigenous community by community-controlled health services and includes planning, implementation and service evaluation by the people for the people (NAACH, 2008; NACCHO, 2003; QAIHC, 2007; QAIHC, 2010). The key characteristics that identify an ACCHS include:

- it is an incorporated Aboriginal or Islander organisation;
- it is initiated by the local Indigenous community;
• it is based in an Indigenous community and may have branches throughout the local area;
• it is governed by an Aboriginal and/or Islander body that is elected by the local Indigenous community (sometimes referred to as the council of management);
• it is responsible for delivering a holistic and culturally-appropriate health service to the community that controls it;
• it is a provider of diagnosis and treatment of illnesses and/or diseases and making referrals as appropriate;
• it is a participant in population health programs (as they apply to the local community);
• it is a provider of emotional and social well-being services, and
• it is a provider of advocacy and community support roles.

(NACCHO, 2008; QAIHC, 2008)

It has been argued that even today the ACCHS continue to maintain all aspects of health, that is, they offer an holistic approach to primary health care for Indigenous people (NACCHO, 2008; QAIHC, 2010). The holistic approach means that the body, mind, spirit, land, environment, customs and social and economic environment work together and need to be taken into consideration holistically when addressing health (World Health Organisation [WHO], 1978; 1979; 1986). This approach requires the ACCHS to maintain a relationship with the government to meet required accountabilities and at the same time maintain accountability to the local Indigenous community. This involves having a good understanding of the knowledge of the community, the health issues within the community, and then working with the community to address these health issues through the provision of health promotion, preventive, curative and rehabilitative services (NAACHO, 2008; QAIHC, 2010). These organisations are in a unique cross-cultural position that requires an understanding of not only the community but also the underlying culture of the health organisation and the integral part this plays within the delivery of holistic health to the Indigenous community.
1.2 Research Aim and Question

The aim of this research was to investigate the balance of the expectations of the community and the requirements of the organisation within Aboriginal Community Controlled Health Services.

The specific research question was:
How does an ACCHS balance its organisational requirements and the community’s expectations when delivering culturally-appropriate health services?

The specific objectives were to:
1. investigate participants’ understanding of bureaucratic and organisational structures and functions of the ACCHS.
2. explore the relationship between the ACCHS organisation and its Community Board.
3. review the history and community focus of the ACCHS, and explore the cultural factors influencing its operations.

ACCHS employ both Indigenous and non-Indigenous health staff and are supervised by both Indigenous and non-Indigenous managers (Dwyer, Shannon, Goodwin, 2007; Howard, 2006). The overarching manager of the ACCHS, the Chief Executive Officer (CEO), is elected by a Community Board, the members of which are themselves nominated from the local Indigenous community (Dwyer et al., 2007; Howard, 2006; NACCHO, 2003). Below the CEO are the middle managers. These middle managers work closely with the allied health staff and the Aboriginal Health Worker (AHW) who in turn work closely with the community. All areas of management, the allied health staff and the AHW within these organisations are responsible for meeting organisational and funding requirements of the Commonwealth Government and the expectations of the local community (Dwyer et al., 2007; Shannon, Carson, Atkinson, 2006; Taylor & Guerin, 2008). This means that the people employed by these organisations need to understand the western (Australian)
health system and at the same time incorporate a holistic (Aboriginal and Torres Strait Islander) approach for effective health service delivery.

The participants in this research are Indigenous Australians who are ACCHS staff. To date there has been little research undertaken to understand how ACCHS staff work within the organisational structure in delivering health services to Indigenous people, let alone by either Indigenous or non-Indigenous researchers. This research will provide information to enhance the Australian health system’s approach to the way it delivers health care to Indigenous people. This will provide better management in health services and therefore better health care for all.

1.3 Overview of Thesis:

The overview of the thesis is provided below:

In Chapter 2, literature is presented from several bodies of knowledge, including public health bodies. More specifically, they are Indigenous health, the social determinants of health, primary health care, social policy, Aboriginal community control, Indigenous health service management and Indigenous health workforce organisations. From this literature review a conceptual framework was developed that outlines the theory of the various influences on the ACCHS.

Chapter 3 presents the methodology and methods. The methodology for this research was a qualitative case study design. There were three case studies in total of different ACCHS located throughout Queensland. The ACCHS were purposefully selected based on their association with QAIHC and their identification as an ACCHS. Formal ethics was obtained through the Griffith University Ethics Committee and informal approval was obtained from the Queensland Aboriginal and Islander Council (QAIHC), the peak body of the ACCHS in Queensland. A pilot was conducted and analysed prior to the commencement of the three ACCHS under investigation. The ACCHS were
investigated using in-depth interviews and following these in-depth interviews, focused interviews (a certain set of questions within a limited time) and observations. The data collection occurred over a 12-month period. The qualitative data were analysed in two stages. Firstly, a conceptual analysis software tool called Leximancer was used to assess the semantic and relational dimensions of the text (Smith and Humphreys, 2006) and objectively draws out the key concepts and identified in-text data relevant to the research question. This in-text data was then subjected to a thematic analysis (Paton, 1987) to develop themes to answer the research question.

The results of each ACCHS case study are outlined in Chapters 4, 5 and 6 for case studies 1, 2 and 3 respectively. Relevant methodological procedures specific to each ACCHS are also documented in the relevant chapters. The key findings from the case studies were combined to form a theoretical model of how the ACCHS balance their organisational requirements and community expectations.

Chapter 4 presents the results on an ACCHS with over 40 staff. At the time of this research this ACCHS had just been through a changed management process. During this process it was emphasised that the employment of a local community person was an important cultural brokerage role towards community empowerment because they spoke the same language and understood the culture. Another important finding was that governance training became a prerequisite of all Community Board members.

Chapter 5 presents the results of Case Study ACCHS 2, in Southern Queensland. The CEO had been in the position for a little over a week and although there was a time span between CEO’s the ACCHS the model of Indigenous primary health care ensured that the community remained at the centre of service delivery. To overcome the difficulty of delivering a health service to a variety of clan groups the ACCHS had a policy in place whereby no one on the Community Board could be directly related to any of the staff.
within the ACCHS so that governance decisions were not directly influenced by the staff, and were made based on the health needs of the community.

Chapter 6 presents the results of an ACCHS that was situated outside of a large town. This ACCHS was the only one in the research that included a child protection advisory officer as part of their health service. Meeting the community’s needs was at the forefront of this ACCHS service delivery and their governance included the staff having regular education and training.

Chapter 7 provides a theoretical model and discussion of the contribution that this research has made to theory about how the ACCHS system delivers culturally-appropriate health service to Indigenous people. The research outlines the demands placed on the ACCHS by the organisational requirements and the community and how these services balance these demands. These ACCHS are in a unique cross-cultural position requiring them to deliver a health service to Indigenous people by combining of the Indigenous worldview and the western organisational domain.

Chapter 8 draws the thesis to a conclusion by discussing the contribution of the research to the broader body of knowledge in this area and provides directions for future policy and research. The research develops knowledge and understanding of ACCHS organisational structures and its culturally-safe approach – an important and significant factor for ‘closing the gap’ in Indigenous peoples’ health and life expectancy.
Chapter 2

Literature Review

2.1 Chapter Overview

This chapter sets the scene in which the research occurred and describes what has prompted this research on the ACCHS in Queensland. This literature review argues that the inequalities deriving from the macrosocial factors of colonisation and government policy and imposed on Indigenous people and communities, denied Indigenous people access to appropriate services; this lack of address of the social determinants led to Indigenous people developing their first ACCHS. The literature and the broader literature on primary health care in Australia, health promotion and the people-centered primary health care approach in relation to the ACCHS is also discussed. The chapter examines the governance and the organisational structures of the ACCHS.

2.1.1 Why is this research important?

*It is not credible to suggest that one of the wealthiest nations of the world cannot solve a health crisis affecting less than 3% of its citizens* (Calma, 2005, cited in Human Rights and Equal Opportunity Commission [HREOC] 2005b, p. 7).

This statement by Calma (2005) provides a stark reminder of the dilemma that Australia faces itself in, with regards to its Indigenous peoples’ health, namely, that Aboriginal and Torres Strait Islander people continue to have the poorest health and limited access to appropriate healthcare (Councilor, 2003; Podger, 1999; Wakeman, 1999).
There is a significant disparity between Indigenous and non-Indigenous people in relation to population health indicators (Centre for Epidemiology and Evidence [CEE], 2012; Steering Committee for the Review of Commonwealth Service Provision [SCRGSP], 2011) in Australia. Numerous reports continue to emphasise the necessity to close the gap in these indicators and the importance of Indigenous people having control of their own health (CEE, 2012; Department of Health and Aging [DoHA], 2013; SCRGSP, 2011). There has been slow progress however in achieving equitable health outcomes. The slow growth in closing the gap highlights the importance of addressing the health needs of Aboriginal and Torres Strait Islanders within a culturally-safe environment (CEE, 2012; DoHA, 2013; SCRGSP, 2011) and one that provides a holistic approach to health service delivery.

The aim of this chapter is to explain why it is important to research the Aboriginal Community Controlled Health Services and the approach that these organisations take to ensure a holistic health service delivery for better health outcomes in Indigenous communities.

### 2.2 Snapshot of Indigenous people's health

This section provides a snapshot of the inequitable health outcomes experienced by Indigenous people and the gap in life expectancy between Indigenous and non-Indigenous people. Although decades of change have occurred within the Australian health system such as the development of the Medicare system which provides a full range of medical services for all Australians (Jackson Pulver, Haswell, Ring, Waldon, Clark, Whetung, Kinnon, Graham, Chino, LaValley, and Sadana, 2010), there still remains a gap of disadvantage and inequality between non-Indigenous and Indigenous peoples’ health; demonstrating the inadequacy of the Australian healthcare system to address the health needs of Indigenous peoples (Council of Australian Governments [COAG], 2010; Paradies et al., 2008; Podder, 1999; Wakerman, 1999). The Social Justice Report released in 2005 (HREOC, 2007) called for the Australian Government to commit to increasing
Indigenous life expectancy to that of non-Indigenous Australians within a generation, 25 years (Miller, Speare, 2008). This issue was further highlighted in 2009 when a United Nations official, Dr Anand Grover, compared the health of Aboriginal and Torres Strait Islander peoples living on communities to third world countries stating that it was worse than in some third world countries (Sharp and Arup, 2009, p.1). Arguably the above statement and the reporting of the health disparities experienced by Indigenous Australians have been recounted endlessly over the years (Australian Bureau of Statistics [ABS], 2010; Australian Institute of Health and Welfare [AIHW], 2005; Podder, 1999; Eckermann, Dowd, Chong, Nixon, Gray, Johnson, 2010; Wakerman, 1999). The evidence from research continues to include such findings as:

- Indigenous peoples have higher death rates than non-Indigenous peoples across all age groups. Between 2007-2011, Indigenous people aged 35-44, died at 5 times the rate of non-Indigenous people (AIHW, 2014; AIHW, 2010).
- Indigenous mothers are more likely to deliver their babies at a younger age and Indigenous children aged 0-4 years died at more than twice the rate of non-Indigenous children in 2012 (AIHW, 2014; ABS, 2010; AIHW, 2006; AIHW, 2011).
- Indigenous children are 10 times more likely to be taken into out-of-home care than non-Indigenous children (AIHW, 2013).
- Chronic diseases such as circulatory diseases, diabetes, respiratory disease, kidney disease, and mental and behavioural disorders are experienced proportionally higher among Indigenous Australian compared to non-Indigenous Australians. Chronic disease accounts for about 80% of the mortality gap (in terms of lives lost) (ABS, 2010; AIHW, 2011; COAG, 2010, AIHW, 2015b).
- The diseases that contributed most to the gap between Indigenous and non-Indigenous people were cardiovascular disease (contributing 27% of the gap), cancer (contributing 15% of the gap), injuries (contributing 14% of the gap) and endocrine disorders (contributing 10% of the gap). In 2010 these diseases accounted for two-thirds of the gap in the burden of disease between Indigenous and non-Indigenous people (AIHW, 2015b).
• Indigenous young people were 16 times more likely to be under the youth justice system (AIHW, 2013).
• The unemployment rate of Indigenous Australians, in the range of 15 – 64 years, remains four times higher than that of non-Indigenous people. (AIHW, 2013).
• About one in four Indigenous people aged 15 and over reported having problems accessing health services in 2008 (AIHW, 2014).
• About 12% of Indigenous households were overcrowded in 2011 compared to 3% of non-Indigenous (AIHW, 2014).
• In 2011, the rate of homelessness for Indigenous people was 14 times higher than that of non-Indigenous Australians (AIHW, 2014).

As shown in Table 2.1, the largest proportion of Indigenous people, 31%, reside in New South Wales compared to 32% of non-Indigenous people. Half of the Indigenous population reside in two states: Queensland and New South Wales, demonstrating that the geographical size of the state/territory does not reflect the population distribution (Walters, 2008). The smallest proportion of Indigenous people in a state or territory is in Victoria, whose Indigenous population is only 0.9%. By contrast, the population of Indigenous peoples in the Northern Territory is 29.6% of the total. However, regardless of the population distribution Indigenous people continue to remain one of the most disadvantaged groups within Australia with poor health and limited access to health services (ABS, 2010; ABS, 2009b; AIHW, 2006; ABS, 2013; ABS, 2014; Walters, 2008, AIHW, 2015).
Prior to 2005 the life expectancy for Indigenous people was 17 years less than that of non-Indigenous people (AIHW, 2008; ABS, 2008). In 2009, however, the ABS changed the methodology by which it measured life expectancy and by doing so was able to report that in 2005 – 2007 the life expectancy for Indigenous people was not as low as previously stated (Jackson Pulver, Haswell, Ring, 2010; ABS, 2009, Coleman, Fortune, Lee, Griffiths, Madden, 2015). There has been little overall change in the life expectancy for Indigenous people between the estimates provided in 2005-2007 and those of 2010-2012 (Table 2.2), however it was a small improvement.

### Table 2.1: Indigenous and non-Indigenous Population by state / territory

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Aboriginal &amp; Torres Strait Islander</th>
<th>Percent</th>
<th>% Aboriginal and Torres Strait Islander proportion of population</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>220,902</td>
<td>31.0</td>
<td>31.9</td>
</tr>
<tr>
<td>Victoria</td>
<td>50,983</td>
<td>7.1</td>
<td>25.3</td>
</tr>
<tr>
<td>Queensland</td>
<td>203,045</td>
<td>28.5</td>
<td>20.0</td>
</tr>
<tr>
<td>South Australia</td>
<td>39,800</td>
<td>5.6</td>
<td>7.2</td>
</tr>
<tr>
<td>Western Australia</td>
<td>93,778</td>
<td>13.1</td>
<td>11.0</td>
</tr>
<tr>
<td>Tasmania</td>
<td>28,845</td>
<td>3.6</td>
<td>2.1</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>72,251</td>
<td>10.1</td>
<td>0.8</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>6,707</td>
<td>0.9</td>
<td>1.7</td>
</tr>
<tr>
<td>TOTAL Australia</td>
<td>714,589</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

### Table 2.2: Aboriginal and Torres Strait Islander Life Expectancy

<table>
<thead>
<tr>
<th>Years</th>
<th>Male Life Expectancy</th>
<th>Female Life Expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005-2007</td>
<td>67.5</td>
<td>73.1</td>
</tr>
<tr>
<td>2010-2012</td>
<td>69.1</td>
<td>73.7</td>
</tr>
</tbody>
</table>

Source: Coleman, Fortune, Lee, Griffiths, Madden (2015). Sydney Centre for Aboriginal and Torres Strait Islander Statistics.

As shown in Table 2.3, the ABS (2009) estimated that for the period from 2005 to 2007 the life expectancy of Indigenous males at birth was 67.5 years, 11.5 years less than for non-Indigenous males. For Indigenous females the life expectancy at birth is estimated at 73.1 years, 9.7 years less than for non-Indigenous females. It is alarming, however, that in 2006, 70% of all Indigenous deaths were before the age of 65 compared to 20% of non-Indigenous Australians (ABS, 2008; AIHW, 2006). Notably life expectancy varies across the states and territories. The life expectancy for Aboriginal and Torres Strait Islander males was highest in NSW and lowest in the Northern Territory and a similar pattern existed for Indigenous females.
The population pyramid in Figure 2.1 demonstrates that the Indigenous population is much younger overall than the non-Indigenous population. The higher percentage of Indigenous population in the earlier years indicates Indigenous people have a higher fertility rate than non-Indigenous peoples. However, from the 35-39 age bracket onwards the ratio of the Indigenous population compared to the non-Indigenous population begins to decrease at a very fast rate, indicating a higher mortality for Indigenous peoples.
Within the Indigenous Australian population itself, it is estimated that 90% are of Aboriginal origin, 6% are of Torres Strait Islander origin and 4% identify as both Aboriginal and Torres Strait Islander (ABS, 2010). The population estimates in Tables 2.1, Table 2.2, Table 2.3 and in Figure 2.1 were current at the time of the data collection for this research, 2010. In 2014 the ABS estimated a gradual increase in the Indigenous population (ABS, 2014), and in that year, Indigenous people accounted for 3% of the total population (AIHW, 2015), demonstrating that its population ratio had increased from the 2006 ratio of 2.5% of the total population in (ABS, 2006). Even though this small population of Indigenous peoples is slowly growing, it continues to be one of the most disadvantaged groups within Australia (AIHW, 2006; Carson, Dunbar, Chenhall, Ballie, 2007; Podder, 1999; Wakeman, 1999; Walters, 2008; Eckermann et al., 2010; AIHW, 2013; Jackson Pulver et al, 2010).
2.3 Social determinants of health and Indigenous people

The social determinants of health explain the relationship between social factors impacting on a person’s life and their health status; in other words, how the conditions of daily living determine a person’s ability to maintain good health (Carson et al., 2007; Marmot, 2007; Marmot, 2005). Building on social epidemiology Marmot and Wilkinson’s (1999) contribution to the World Health Organisation report (Wilkinson and Marmot, 2003) on the social determinants of health laid the foundation towards demonstrating the importance of the determinants of health (Baum, 2008; Carson et al., 2007).

Descriptions of the determinants of the health of whole populations include a number of different societal features including social and economic factors and their interrelatedness. These factors should be considered as the basis on which to effectively develop policy to address the health of populations and most importantly that health is a matter that goes beyond the provision of health services (Marmot and Wilkinson, 1999. p. xi). In other words, the focus of the social environment and social factors will increase a person’s opportunity to gain and maintain good health (Baum, 2008; Carson et al., 2007).

The social determinants of health are not just about an individual’s risky behaviour (for example smoking); they are about the ‘the causes of the causes’ (Marmot, 2007). Social factors that impact on a person can have major influences on their health across their lifespan (Carson, et al., 2007). Figure 2.1 demonstrates the levels of social factors that influence a person’s health. The macrosocial level includes political economy, discrimination, history, culture and institutions. The social factors at the macrosocial level have, over the past 200 years, contributed to the daily living of Indigenous Australians (Baum, 2008). As shown in Figure 2.2 an individual is conceived and born into these social circumstances at conception and the impact continues throughout their entire life to old age. The influence of these social factors have resulted in risky behaviours that have led to a high burden of
chronic disease, and in turn chronic disease has become the main focus of health promotion, prevention and early intervention efforts that are being addressed across Indigenous communities (Baum, 2008; Carson, et al., 2007; Couzos and Murray, 2008).

For example, an Indigenous person’s smoking behaviour it is not just about an individual smoking a cigarette. It is about the personal stressors such as unemployment, addictions, social inequality, societal influences and sustaining behaviours to be part of social connectedness, that include lack of employment opportunities, lack of education to find employment and tobacco advertising that all encourage a person to smoke (Carson et al., 2007). These layers influence not only the individual, they also influence the community through the distal social connections (Figure 2.2) in which the individual resides. Indigenous people as a collective have been further influenced by factors from their history, culture, political economy, discrimination and social institutions, the structural macrosocial factors that determine health (Structural macrosocial factors, Figure 2.2) (Carson et al., 2007; Marmot, 2007).

A person’s smoking behaviour could be associated with the health inequalities that they have experienced over the course of their life, beginning at the macrosocial factors level. However, the fact that social structures such as the workplace and neighbourhood can interact with a person’s biological and genetic makeup can explain why some individuals can escape the poor health profile that others, in similar socio-economic positions, cannot (Carson et al., 2007). Arguably, therefore, programs or interventions that target only the risky behaviour will have very little effect on the individuals ability to discontinue the behaviour, whereas programs that focus on the social factors that have influenced their behaviour are more likely to increase their health and well-being (AIHW, 2006; Carson et al., 2007; Jirojwong, Liamputtong, 2009).
Social factors affecting an individual are different across countries and the influence of the determinants on an individual is determined according to the levels of economic development in that country (Wilkinson & Marmot, 2003). The 10 most powerful social determinants of health, identified by the World
Health Organisation (Wilkinson and Marmot, 2003), that concern Australia are:

- The social gradient (the relationship between work and health)
- Stress
- Early life
- Social exclusion
- Work
- Unemployment
- Social support
- Addiction
- Food
- Transport

These social determinants represent the highest point of influence the social environment has on an individual. The social determinant with the highest predictor is the social gradient, that being income, education, place of residence, and where you stand on the social gradient ladder will determine whether you live a long and healthy life (Carson et al., 2007; Wilkinson & Marmot, 2003).

One of the most influential studies in public health social epidemiology is by Marmot and Wilkinson, (1999). Known as the Whitehall Study (Marmot, 2000). This study examined, in particular, the relationship between work and health by tracking the health outcomes of British civil servants over a couple of decades (Stansfield, Head, Marmot, 2000). The relationship they identified is now known as the social gradient (Stansfield et al., 2000), a concept used to define the variation in health outcomes across a social hierarchy (Stansfield et al., 2000; Carson et al, 2007). Focusing on work, economic production and health outcomes (Stansfield et al., 2000) the gradient shows that those people who had higher paying jobs had better health than those in lower paying jobs. Indigenous Australians have high unemployment compared to their non-Indigenous counterparts (AIHW, 2011) and the majority is at the juncture of the welfare economy and the labour market (Carson et al., 2007, p.12). Additionally, the Indigenous Australians continue to experience the influences
of structural macrosocial factors, making it difficult to determine whether or not the social gradients theory is relevant to adequately address the inequalities, such as the discrimination and history, experienced by Indigenous society.

The flow-on effect from colonisation in Australia has been evident in the inequalities in society, specifically the circumstances in which people are born, grow, and live, resulting in turn in inequalities in health (Baum, 2008; Marmot, 2005; Marmot, 2011). These circumstances are the result of the policies of successive states and commonwealth governments that disempowered Indigenous people and provided insufficient access to necessary resources to address these determinants (Baum, 2008; Carson et al, 2007; Marmot, 2005; Marmot, 2011). Based on the theory that societal inequality is the key determinant impacting on a person’s health, the World Health Organisation Commission on Social Determinants of Health argue that it is possible to close the health gap within a generation (Baum, 2008; World Health Organisation Commission on Social Determinants of Health [WHOCSHDH], 2008). This would of course take substantial long-term financial and legislative commitment by the Australian Government to make it achievable.

Social equality is a basic human right (Venkatapuram, Bell, Marmot, 2010). Inequalities include not having basic essential needs met such as adequate housing, safe drinking water and sanitation, food security and access to education (Mallinson 2010; Marmot, 2005). These are social determinants that further exemplify the significant gap in health inequalities between Australian Indigenous and non-Indigenous people (Carson et al., 2007; COAG 2010). A reduction in health inequalities can occur only if poverty is addressed and investment into communicable and non-communicable diseases is increased (Marmot, 2005). This requires a redevelopment of the health system to ensure that there is transparent understanding of social determinants with reference to how they operate, and how the social determinants can be addressed to reduce health inequalities. Therefore it is vital to link knowledge with action by ensuring that policy makers consider the
evidence from the social determinants of health literature, particularly the macrosocial factors in legislation, and other policy areas, for Indigenous people (Carson et al., 2007; Marmot, 2005; Sheehan, Martin, Krysinska & Kilroy, 2009; Wilkinson & Marmot, 2003). Access to health services is a social determinant and a human right; today’s appalling statistics on Indigenous peoples health and well-being is a reflection of the lack of culturally-appropriate health services to address the needs of Indigenous people (ABS, 2010; AIHW, 2011; Australian Human Rights Commission [AHRC], 2008; Smith, 2007; Thomson MacRae, Burns, Catto, Debuyst, Krom, Midford, Potter, Ride, Stumpers, Urquhart, 2010) and the lack of consultation with Indigenous people about their long-term objectives and goals for their communities (Harris, 2012).

2.4 Policies impacting on Indigenous people’s health

Governments make policies for two main reasons; firstly, to define the way that they manage populations and secondly, to improve the health and welfare of their people. However, these reasons are not always compatible. From colonisation until the present day, policies have been developed at the macrosocial level (see Figure 2.1) that have continued to impact on the health and well-being of Indigenous Australian people. Churches, institutions, state and territory governments and the Commonwealth Government, have developed and implemented these policy decisions. The complete history of the Indigenous people of Australia has been one of policies that impose control over most aspects of life (Carson et al., 2007; Fredericks et al., 2012) and these have continued to the current day. What is discussed in this next section of the review are those inequitable policies that prompted the development of the first ACCHS and the policies that continue to influence the functioning of the ACCHS.
2.4.1 Colonisation

When Captain James Cook sighted Australia in 1770, he expressed the idea that there were no visible signs of civilization created by Indigenous people; therefore, land was claimed as uninhabited, or terra nullius (AHRC, 2008; Carson et al., 2007; Smith, 2007). Following the claim of terra nullius any form of resistance by Indigenous people was termed a form of rebellion (Eckerman et al., 2010; Smith, 2007). Terra nullius also marked the beginning of land dispossession and the appropriation of Indigenous homelands (Smith, 2007). Before colonisation Indigenous peoples health care consisted of an assortment of traditional remedies and traditional spiritual healers (Couzos & Murray, 2008; Miller & Speare, 2012) provided by their own people. However, as colonisation increased so did the introduction of new diseases, which traditional healers could not comprehend.

While colonisation expanded, continued health services and health policies to support Indigenous people did not. The limited understanding of and confidence in western medicine by Indigenous people, together with the lack of medical care and appalling living conditions contributed to the significant decline in the Indigenous population, in this early period (Eckerman et al., 2010; Couzos & Murray, 2008). The exact number of the Indigenous population at this time is unknown as the first federal constitution did not consider “Aboriginal natives”- those people of full Aboriginal descent – to be citizens therefore they were excluded from the population census’ (Couzos & Murray, 2008, p.2).

2.4.2 Protectionism

The next era of Australia’s shared history, 1890s to 1950s, is known as ‘protectionism’ or ‘segregation’ (Queensland 1897; Taylor, Guerin, 2010). This policy allowed the government to remove the Indigenous people who had

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survived the impact of colonisation to reserves or missions (AHRC, 2008; Miller, Speare, 2012; Smith, 2007; Taylor, Guerin, 2010). The health policy of that time reflected the belief that full descent Aboriginal people were dying out, and that limiting the rights of Indigenous people and separating them from society on missions and reserves would protect European health interests (Couzos & Murray 2008; Queensland, 1897; Smith 2007; Taylor, Guerin, 2010;). In this period, the state governments controlled Aboriginal and Torres Strait Islander affairs and made decisions that were thought to be beneficial to them. An example of this was the appointment of the Chief Protector of Aborigines who activated the forced removal of children, and had the power over Indigenous peoples whereabouts and movements, marriages, wages and bank accounts (Smith 2007; Queensland, 1897; TALRC, 2012).

This Act of Parliament, of protectionism, ensured that Indigenous people were not permitted to receive social benefits, vote or drink alcohol. Also prohibited was the use of traditional language and lore, customs and rites on missions or reserves, the stated reason being in case Indigenous peoples injured themselves (Queensland, 1897; Smith, 2007). Although Aboriginal & Torres Strait Islander policies differed between states and territories, in Queensland the cost of health services for Indigenous people was expected to be repaid by Aboriginal Affairs to the Queensland Health Department (Couzos & Murray, 2008). Needless to say, it also contributed to the removal of those Indigenous peoples with infectious diseases to quarantine settlements with horrendous living conditions (Couzos & Murray, 2008).

2.4.3 Assimilation

Towards the end of this period the influence of the ‘protectionism’ period, a swing began towards an ‘assimilation’ policy as it became evident that the Indigenous Australian populations were not in fact dying out (Couzos and Murray, 2008; Smith, 2007; The Australian Law Reform Commission [TALRC], 2012). The objectives for this policy began in 1936, whereby ‘the absorption of Aboriginal peoples other than natives were assimilated into
"Australian Citizens’ (TALRC, 2012). However, it wasn’t until the 1950s that the commonwealth, states and territories adopted ‘assimilation’ as a policy and later defined it in 1961 at the Native Welfare Conference of Federal and State Ministers as follows:

The policy of assimilation means in the view of all Australians that all aborigines and part-aborigines are expected to attain the same manner of living as other Australians and to live as members of a single Australian community, enjoying the same rights and privileges, accepting the same customs and influenced by the same beliefs as other Australians. (Hasluck, 19612, p.1)

At the conclusion of the Native Welfare Conference it was emphasised that the government could do only so much for Aboriginal and Torres Strait Islander people and the measurement of the success of assimilation would be dependent on the Australian community as a whole.

This ‘assimilation’ policy did not change the high levels of segregation that existed with many country hospitals continuing to refuse admission to Aboriginal and Torres Strait Islander people for treatments sometimes providing healthcare by the installation of an inadequately subserviced ‘native’ wing’, consisting of a tin shed out the back (Carson et al, 2007; Couzos & Murray, 2008). As added barriers, doctors billed a fee-for-service care and hospital boards installed user-pays billing services. In Queensland, hospital segregation continued well into the 1960’s (Kelly & Lenthall, 1997). It was evident that the White Australia policy from the protectionism era that marginalised and excluded people based on their ethnicity and race and resulting in systemic racism (Smith, 2007) was still firmly entrenched (Couzos & Murray, 2008). The effect of this policy was to disenfranchise recognition of Australia’s Indigenous culture, language or traditions (TALRC, 2012)

2.4.4 Stolen Generation

The term ‘Stolen Generation’ refers to the policy, from the late 1800s to the 1960s, of the forced removal of Indigenous children, ascertained as those having ‘mixed blood’ (from Indigenous and non-Indigenous parents), from their families (AHRC, 2010; HREOC, 1997; Smith, 2007; TALRC, 2012). The removal of children by compulsion, duress or undue influence, was a nationally coordinated plan endorsed by the governments of the day (AHRC, 2008; HREOC, 1997; Queensland, 1897; Smith, 2007). Table 2.4 shows the duration of the forced removal of children across each state and territory, and what is obvious is that the years of lawful forced removal of children coincide with the policies of ‘protectionism’ (from the 1890s to the 1950s) and ‘assimilation’ (from the 1950s to the 1960s).

<table>
<thead>
<tr>
<th>State &amp; Territory</th>
<th>NSW &amp; ACT</th>
<th>N.T</th>
<th>QLD</th>
<th>SA</th>
<th>VIC</th>
<th>WA</th>
</tr>
</thead>
</table>

(In Adapted from the AHRC, 2008; HREOC, 1997)

In Queensland, well into the 1960s, Indigenous children were removed from their families to mission environments with appalling conditions. A recollected account of these living conditions, by Kidd (1994), describes them, as being so bad that the bush toilet was safer practice (HREOC, 1997, p. 62). The enforced institutional living conditions have been seen to contribute to the breakdown in the health, self-assurance and well-being of Indigenous people. The Queensland Government was continuously warned that its systemic failures contributed to Indigenous poverty; however, they chose to do nothing until instructed to address the issue in the 1960s by the Commonwealth Government (Smith, 2007). These changes occurred in the laws and policies surrounding the removal of Indigenous children. The laws and practices from past policies that forcibly removed Indigenous children from their families, across all Australian jurisdictions, have clearly had a detrimental effect on the health, life circumstances and well-being of Australian Indigenous people and
that continues to resonate in the lives of people in Indigenous communities today (AHRC, 2008; HREOC, 1997; Smith, 2007; TALRC, 2012).

In recognition of the pain and suffering experienced by Indigenous people from past government policies, and as a way to demonstrate that his government cared, in 2008, the then Prime Minister Kevin Rudd delivered a National Apology to those of the Stolen Generation and to Indigenous people in general (Fredericks et al., 2012; Rudd, 2009; Taylor & Guerin, 2010). The Apology acknowledged the ties that Indigenous people have with the land and it accepted that Indigenous people were valued citizens in Australia (Rudd, 2009). The Apology, however, did not adequately consider the rights of children from the ‘Stolen Generation’ and essentially what the ‘Stolen Generation’ meant to them and their families (Jackson Pulver, Fitzpatrick, 2008). To consider the rights of Indigenous Australian children is to do so through an holistic lens that involves engaging with communities, developing partnerships and recognising the need for future developments (Australian Indigenous Doctors’ Association [AIDA], 2010; Fredicks et al., 2012; Jackson Pulver, Fitzpatrick, 2008; Taylor & Guerin, 2010). This process would need to occur across all levels of Australia and include continued engagement with human rights principles for policy development and implementation (Jackson Pulver, Fitzpatrick, 2008). As this process did not occur with the Apology, it’s impact on the health, life circumstances and social-emotional well-being of Indigenous Australian people is unknown.

2.4.5 The referendum and Aboriginal health

The resistance to change in Indigenous affairs by the Federal Government in the 1950s continued the perpetuation of colonial approaches (Couzoz & Murray, 2008) whereby the states and territories maintained control of Indigenous affairs. As Australia neared the 1960s, the government turned towards Asia for future trade. It was the Asian neighbours, such as Singapore who found political relations and trade with Australia a barrier due to the ill treatment of Indigenous Australian people. A push by Indigenous Australians
for equal rights and self-determination had become global knowledge and an urgent human rights issue (Couzos & Murray, 2008).

As Indigenous people continued to push for their voices to be heard against the discriminatory treatment placed on them by the Australia’s state governments, a referendum that allowed Indigenous people to be counted in the 1967 census brought about awareness regarding the treatment of Indigenous people to the international public arena (Hollows, 2005; Kunitz, 1995; Smith, 2007). The referendum represented a turn in Australian history that moved the power to enact laws effecting Indigenous people from the states to the Commonwealth Government. This empowerment for Indigenous people not only allowed them to be counted in the census (although it did not become compulsory in the same way as for the general population until 1984) (Turale, 2006) it also allowed the Commonwealth to pass legislation on Indigenous affairs. It was also around this time the Commonwealth Government introduced Aboriginal health programs and began training Aboriginal Health Worker (AHW) (Couzos & Murray 2008; Smith 2007). Indigenous health and social researchers began to document evidence of Indigenous ill health that revealed the association between economic disadvantage (Taylor et al., 2008) and the environmental factors impacting on Indigenous people’s health. Appropriate change in the Australian health care systems in addressing the health of Indigenous Australians has however been very slow in its implementation.

2.4.6 Self-determination

In 1972, the self-determination policy was adopted by the then Prime Minister Gough Whitlam. This policy was about government recognition that Indigenous Australians had the right to be involved in the decisions that were of concern to their lives (AHRC, 2008; Ranzijn, McConnochie, Nolan, 2009; Smith, 2007). To achieve this policy the Commonwealth Government established the federal Department of Aboriginal Affairs so that national policies could be developed in consultation with Indigenous people.
Queensland refused this offer to recognise Indigenous people in its policies and continued implementing assimilation policies until 1982 (Smith, 2007).

**2.4.7 Native Title**

In 1982, the High Court of Australia handed down the Mabo decision to grant titles of land on Murray Island in the Torres Strait Islands in Queensland. For Indigenous people this was an empowering decision as the High Court recognised the continuing connection that Indigenous people have with their land in accordance with their customs and traditions. For the first time it was decided that *terra nullius* did not apply (AHRC, 2008; Ranzijn et al., 2009; Smith, 2007). Following the Mabo decision the Commonwealth put in place processes for Native Title legislation and by 1993 the Native Title Act became law. This law provided for an independent National Native Title Tribunal and the Federal Court began making decisions in favour of native title claims and compensation (Ranzijn et al., 2009; Smith, 2007). For the Australian Government to accept native title was an important milestone for Indigenous people in that it had implications for the government’s support of reconciliation, Indigenous identity and Indigenous self-concept (Ranzijn et al., 2009).

**2.4.8 Self-management**

Policies of self-management followed in the 1990s when there were major changes in health policies, strategies, inquiries and reporting regarding Indigenous health (Table 2.5). Aboriginal decision-making was recognised in Aboriginal affairs (Eckermann et al., 2010; Smith, 2007) under the policy of self-determination. These policies and reports, outlined in Table 2.5, have contributed to some of the major developments for Indigenous peoples health (Couzos and Murray, 2008; Eckermann et al., 2010; Smith, 2007) that occurred following the 1967 Referendum. Table 2.5 summarises these policies and their outcomes, strategies, reports and inquires.
<table>
<thead>
<tr>
<th>Year</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>National Aboriginal Community Controlled Health Organisation (NACCHO) was developed.</td>
</tr>
<tr>
<td>1994</td>
<td>National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) conducted by the Australian Bureau of Statistics (ABS).</td>
</tr>
<tr>
<td></td>
<td>Evaluation of National Aboriginal Health Strategy (NAHS).</td>
</tr>
<tr>
<td>1995</td>
<td>Indigenous health was transferred from Aboriginal and Torres Strait Islander Commission (ATSIC) to the Commonwealth Health Department.</td>
</tr>
<tr>
<td></td>
<td>The Ways Forward: National Aboriginal and Torres Strait Islander Mental Health Policy National Consultancy Report released.</td>
</tr>
<tr>
<td>1996</td>
<td>The Aboriginal and Torres Strait Islander Health and Welfare Unit undertook a review to develop national plan for Aboriginal and Torres Strait Islander health information.</td>
</tr>
<tr>
<td></td>
<td>National Aboriginal and Torres Strait Islander Social and Emotional Well-Being Action Plan launched.</td>
</tr>
<tr>
<td></td>
<td>National Aboriginal and Torres Strait Islander Hearing Strategy approved.</td>
</tr>
<tr>
<td>1997</td>
<td>Bringing Them Home Report (HREOC, 1997) released for publication.</td>
</tr>
<tr>
<td></td>
<td>ABS and Australian Institute of Health and Welfare (AIHW) released the first report of the Health and Welfare of Australia’s Aboriginal and Torres Strait Islander Peoples.</td>
</tr>
<tr>
<td></td>
<td>National Indigenous Sexual Health Strategy released.</td>
</tr>
<tr>
<td></td>
<td>National Employment and Training Strategy for AHW and health professionals.</td>
</tr>
<tr>
<td></td>
<td>National Aboriginal and Torres Strait Islander Health Performance Indicators</td>
</tr>
<tr>
<td>Year</td>
<td>Event</td>
</tr>
<tr>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>1998</td>
<td>AIHW and National Centre for Epidemiology &amp; Population Health (NCEPH) release expenditure on health services for Indigenous people.</td>
</tr>
<tr>
<td>1999</td>
<td>The National Audit Office released the National Aboriginal Health Strategy (NAHS).</td>
</tr>
<tr>
<td></td>
<td>The Community Housing and Infrastructure Survey was conducted by the Australian Bureau of Statistics (ABS) for Aboriginal Torres Strait Islander Commission (ATSIC).</td>
</tr>
<tr>
<td></td>
<td>House of Representatives Standing Committee into Community and Family Affairs tabled its final report ‘Health is Life’ on Indigenous health status inquiry.</td>
</tr>
<tr>
<td>2000</td>
<td>Corroboree 2000 – the Council for Aboriginal Reconciliation passed the national reconciliation recommendation documents to government.</td>
</tr>
</tbody>
</table>

Adapted from Smith, 2007, pp. 35-39.

This timeline, shown in Table 2.5, demonstrates the institutionalised racism imposed on Indigenous people at that time; these policies, strategies, reports and inquiries were largely developed by the government and with minimal community consultation (Eckermann et al., 2010; NACCHO, 2012; Paradies et al., 2008; Ranzijn et al., 2010). These strategies, reports and inquiries show inconsistency in data collection related to Indigenous health and highlights the lack of action on the economic and social determinants that
have continued to impact on Indigenous people’s health (Couzos and Murray, 2008; Eckermann et al., 2010; Smith, 2007). During this period (in 1993), the first Aboriginal and Torres Strait Islander Social Justice Commissioner, Tom Calma, was appointed to the Human Rights and Equal Opportunities Commission (HREOC, 2005) as part of a government initiative to give Indigenous people a voice towards having the same attainable standards as non-Indigenous people (AHRC, 2008; HREOC, 2005).

2.4.9 Reconciliation

The Council of Aboriginal Reconciliation, a reconciliation peoples’ movement, was established as a statutory authority following the final recommendations of the Royal Commission into Aboriginal Deaths in Custody (1987 to 1991). The Council for Aboriginal Reconciliation Act, 1991, found that social-emotional well-being in Indigenous communities was a major factor for Aboriginal deaths in custody (Council for Aboriginal Reconciliation, 1993; Eckermann et al, 2010; Ranzijn et al., 2010). Its purpose was to achieve a practical reconciliation to address the social and emotional well-being of Indigenous people in Australia’s history (AHRC, 2008; Eckermann et al., 2010; Ranzijn et al., 2010). The publication of the ‘Bringing Them Home Report’ (HREOC, 1997), that brought the horrific truth of the institutionalisation and abuse of Aboriginal children of the Stolen Generation into sharp national focus enhanced government support for this practical reconciliation (Eckermann et al., 2010; HREOC, 1997). This allowed the Indigenous peoples’ movement to have a small voice in the decisions of health, education, housing and employment for Indigenous people (AHRC, 2008; Eckermann et al., 2010). The Council for Aboriginal Reconciliation (1993. p.1) voiced the words ‘…united Australia which respects this land of ours; values the Aboriginal and Torres Strait Islander heritage; and provides justice and equity for all…’ and committed itself to achieving this in to years (Ranzijn et al., 2010). The Council was closed down in 2001 due to budget cuts (Eckermann et al, 2010); another Council of Reconciliation, part
government and part non-government funded, was formed with renewed commitments and is now known as Reconciliation Australia (AHRC, 2008).

2.4.10 Northern Territory intervention

From the year 2000 onwards there were many more policies and reports released in relation to the health and well-being of Indigenous people. They highlighted unemployment rates, lack of education, drug and alcohol fuelled violence, lack of housing, child abuse, sexual abuse, the high rates of drug and alcohol intake in Indigenous communities, and the high rates of suicide (AIHW, 2003; AIHW, 2002; AIHW, 2005; SCRGSP 2003; SCRGSP, 2005). By May 2006, public awareness was again raised through media coverage about the awareness and concern about child sexual assault in the Northern Territory (AIDA, 2010). Added to this, a confidential briefing paper prepared by the Federal Government was leaked to the media, revealing widespread abuse, rape and murder of women and children in Central Australia (AIDA, 2010).

These rates were compared to the number of similar types of violence in the general Australian population as a whole, without appropriate standardisation of the Indigenous population size, and ignored possible confounders such as the origin of the perpetrators (AIDA, 2010). The ‘problem’ was, in short, inappropriately presented. It led to further, wide consultation that resulted in the publication titled ‘Little Children are Sacred’ (Wilde, Anderson, 2007). This report (Wilde, Anderson, 2007) was mainly anecdotal and identified that there was a sexual abuse crisis in the Northern Territory. It included several recommendations’, none of which was to send in the army. In particular the Ampe Akelyernemane Meke Mekarie ‘Little Children are Sacred’ report (Wilde, Anderson, 2007) recommended:

\[ \text{That Aboriginal child sexual abuse in the Northern Territory be designated as an issue of urgent national significance by both the Australian and Northern Territory Governments, and both governments immediately establish a collaborative partnership with a Memorandum} \]
of Understanding to specifically address the protection of Aboriginal children from sexual abuse. It is critical that both governments commit to genuine consultation with Aboriginal people in designing initiatives for Aboriginal communities. (Wilde and Anderson, 2007, p.22)

Following the submission, of ‘The Little Children are Sacred’ report, the response by the Northern Territory Government was limited (AIDA, 2010). This sparked a federal government response that involved developing a consolidation bill entitled the Families, Community Services and Indigenous Affairs and other Legislation Amendment (Emergency Response Consolidation) Bill 2007 (Families, Housing, Community Services and Indigenous Affairs [FHCS&IA], 2007a). This Bill allowed for a package of acts to be imposed on Indigenous people in the Northern Territory with no community consultation. The Bill has become known as the Northern Territory Emergency Response (NTER) and includes:

- **The Northern Territory Emergency Response Act 2007**, which dealt with the use of alcohol, the use of computers, land and property, sentencing laws, and specific measures related to community stores and the provision of food (Office of Legislative Drafting and Publishing, 2007)
- **The Social Security and other Legislation Amendment (Welfare Payment Reform) Act 2007**, which dealt with social security amendments, welfare reforms that included management of welfare payments, types of payments and criteria for people accessing payments and their bank accounts (FHCS&IA, 2007c)
- Changes to the **Racial Discrimination Act 1975** whereby the government declared that the Northern Territory Emergency Response (and related legislations) were ‘special measures’ and therefore were excluded from Part ii of the Act (AHRC, 2011). The suspension of Part ii of the Act meant that ‘special measures’ were put in place so that Indigenous communities
affected by the Northern Territory Emergency Response were denied the protection of the Racial Discrimination Act to which every other Australian citizen was entitled (AIDA, 2010; AHRC, 2011).

There was some general support for the levels of political commitment and the resources linked to the Northern Territory Emergency Response by the Indigenous community. However, there has been widespread concern as to the process by which the Northern Territory Emergency Response was developed and implemented (AIDI, 2010). Even though the ‘Little Children are Sacred’ (Wilde, Anderson, 2007) report identified a need for community collaboration the government imposed its own decisions on the well-being of Indigenous people (AIDA, 2010; AHRC, 2010; McGlade, 2012; Wilde, Anderson, 2007). The Health Impact Assessment of the Northern Territory Emergency Response, by AIDA in 2010, summarised the Australian Government’s response into the Northern Territory as placing heavy emphasis on the physical, social and environmental determinants as a means to improve health outcomes. However, the process of introduction and implementation of the policy has contributed to high levels of inequality, trauma, disadvantageous life circumstances, and consequently the burden of disease, experienced by Indigenous people (AIDA, 2010; Phillips, Franklin, Viswanathan, 2011).

From the time of implementation of the Northern Territory Emergency Response implementation there has been a significant:

- decrease in Indigenous peoples mental health/ social-emotional well-being;
- lack of infrastructure to address the social determinants of health;
- increase in racist policies;
- increase in intentional self harm, especially in girls, and suicidal behaviours in children and young people; and
- increase in adolescent suicides in the Northern Territory (ABS, 2010; AIDA, 2010, Fredericks et al., 2012).
Over the years the Northern Territory Emergency Response has changed its title to ‘Stronger Futures’ and the government has released many evaluation reports and independent research reports (Cultural & Indigenous Research Centre Australia [CIRCA], 2011; Department of Families, Housing, Community, Services and Indigenous Affairs [FAHCSIA], 2011a; FAHCSIA, 2011b; O’Brien Rich Research Group [ORRG], 2011) highlighting the amount of resources that have been invested into this targeted area (CIRCA, 2011; FAHCSIA, 2011a; FAHCSIA, 2011b; ORRG, 2011). The gap between Indigenous and non-Indigenous people’s health remains substantial (AIHW, 2011; ABS, 2010), however. The reality is that the Australian Government overlooked the need to engage with Indigenous people at all levels of the decision-making processes for the Northern Territory Emergency Response/Stronger Futures policy and in doing so demonstrated a lack of respect for the centrality of human dignity to health (AHRC, 2010; AIDA, 2010; McGlade, 2012; Phillips et al., 2011; Wilde, Anderson, 2007). Had the government engaged effectively with the Indigenous people and their communities of the Northern Territory, and listened to them prior to implementation, the process from development to implementation could have been achieved with Indigenous people maintaining self-determination and less loss of social-emotional well-being.

While this intervention was initially implemented in the Northern Territory under the premise of protecting abused Indigenous children these policies have had flow-on effects to other states, including Queensland (Buckmaster, Ey and Klapdor, 2012). An example of this is the rollout of income management (or welfare quarantining) from the Northern Territory, which is now being implemented in Queensland. Income management, is drawn from an approach known as ‘the new paternalism’ which aims to regulate the supply and demand of welfare to control the disadvantage experienced by Indigenous people from low socio-economic areas. This is based on the premise that Indigenous people in these areas don’t understand the necessary western social values and norms (Buckmaster, Ey and Klapdor, 2012) or the processes of the western welfare system. Income management
that has been implemented in the Northern Territory has been rolled out in Cape York in Queensland. The Basics Cards (or Place based Income Management) that withholds 50% of a person’s welfare income and is connected to child protection policies in the Northern Territory has also been implemented in areas of Queensland with high Indigenous populations (Buckmaster, Ey and Klapdor, 2012). Part of this implementation has involved some of the ACCHS who have child protection officers sitting within their services (Aboriginal and Torres Strait Islander Legal Service (QLD) LTD, 2013).

2.4.11 Corporations (Aboriginal and Torres Strait Islander) CATSI Bill

The first draft of the CATSI Bill was introduced in 2005 by the Department of Immigration and Multicultural and Indigenous Affairs and was passed by the Commonwealth Parliament as an Act to provide for Aboriginal and Torres Strait Islander Corporations and their related purposes (Corporation Aboriginal and Torres Strait Islander Bill [CATSI Bill], 2005). This Bill was created specifically for Indigenous people as a special measure for their advancement and protection and enabled the Commonwealth Government to regulate the operations of the corporations and the duties of Indigenous people employed within them. In 2006, the Office of the Registrar of Indigenous Corporations was established with an independent statutory office-bearer responsible for administering the Corporations Aboriginal and Torres Strait Islander (CATSI) Act. It ‘governs Aboriginal and Torres Strait Islander Corporations’ and previously replaced the Aboriginal Councils and Associations ACT 1976 (CATSI Act, 2006; Office of the Registration of Indigenous Corporations [ORIC], 2010). Since the CATSI Act was passed, the Commonwealth has been able to play a pivotal role in Indigenous corporations whereby Indigenous corporations are provided with guidance, support and training to deliver modern corporate governance standards (CATSI Act, 2006; ORIC, 2011; ORIC, 2009; ORIC, 2010). The CATSI Act is registered as the Office of the Registrar of Indigenous Corporations (ORIC).
To register with ORIC, a corporation must have the words Aboriginal/ Torres Strait Islander or both in the registered corporation name. The corporation must have at least five members and can choose to allow non-Indigenous people as members or directors. In so stating in their constitution, however, there must always be a majority of Indigenous people, and Indigenous people must always control the corporation (ORIC, 2010). ORIC maintains a public register of Aboriginal and Torres Strait Islander Corporations that provides information about each of its registered corporations; this includes the Indigenous peak bodies such as NACCHO and for the ACCHS, in the Indigenous health sector (ORIC, 2010; ORIC, 2009).

The registration of the ACCHS with ORIC, enables the ACCHS to access the same benefits, support, information and training as other Indigenous corporations, including developing and implementing their corporate rule books (CASTI Act, 2006; ORIC 2010; ORIC, 2009). The rule book is where the registered corporation documents then roles, duties and responsibilities of all members and staff of the corporation (CATSI Act, 2006; ORIC, 2009). ORIC will issue warnings to corporations, and in some instances investigate breaches, if they do not follow the CASTI Act or rule book (CATSI Act, 2006; ORIC, 2009). It is not compulsory for an Indigenous corporation to register with ORIC; however, for those that do a lot of information and support is provided to improve the corporate governance of the registered corporations and their members (ORIC, 2009).

2.4.12 ‘Close the Gap’ or ‘Closing the Gap’

‘Close the Gap’ is an Indigenous health equality campaign that is run by more than 50 health and human rights peak bodies and experts under the leadership and guidance of the Aboriginal and Torres Strait Islander Social

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Justice Commissioner and Oxfam Australia (AHRC, 2008; HREOC, 2007). The campaign follows a similar direction to that of the 2003 National Strategic Framework for Aboriginal and Torres Strait Islander Health (National Aboriginal and Torres Strait Islander Health Council [NATSIHC], 2003) and was initiated following the release of the Aboriginal and Torres Strait Islander Social Justice Commissioners Social Justice Report in 2005 (HREOC, 2007; Fredericks et al., 2012). In March 2006 the health and human rights peak bodies with the Aboriginal and Torres Strait Islander Social Justice Commissioner met as the ‘Close the Gap’ Steering Committee (Fredericks et al., 2012).

The campaign was publicly launched in April 2007 calling on the Australian Government to commit to achieving:

• equity in health status and life expectancy of Indigenous and non-Indigenous people;
• equal access to primary health care and health infrastructure for Indigenous people;
• increased support for the development of the Indigenous health workforce;
• increased focuses on early childhood development, maternal health, chronic illness and diseases; and
• increased support for the other building blocks to good health such as adequate housing, access to a nutritional diet and other social determinants of health.

(AHRC, 2008; HREOC, 2007)

These health inequalities experienced by Indigenous people have been highlighted in numerous government reports (ABS, 2007; ABS, 2008; AIHW, 2008; AIHW, 2005). Since its launch in 2006, the ‘Close the Gap’ campaign has obtained approximately 145,000 signatures and been an effective policy driver for Aboriginal and Torres Strait Islander health equality (AHRC, 2008; Fredericks et al., 2012). Signing the ‘Close the Gap’ campaign is about signing a pledge to close the gap between Indigenous and non-Indigenous people and it calls on the government to take action. In 2008, the ‘Close the
Gap’ campaign was responsible for obtaining a commitment from the Australian Government for the largest injection of funds, $1.6 billion, into Aboriginal and Torres Strait Islander health over four years (Fredericks et al., 2012; Rudd, 2008).

In November 2007, the Council of Australian Governments (COAG) agreed that the almost-20 year life expectancy gap between Indigenous and non-Indigenous Australians needed to close (Fredericks et al., 2012). This was followed by an official government ‘Apology’ to the ‘Stolen Generation’ in February 2008 by the then Prime Minister Kevin Rudd (Rudd, 2008). In March 2008 the Australian Government began to take action and with other significant Indigenous and non-Indigenous people, and other organisations signed the ‘Statement of Intent to Close the Gap’ (AHRC, 2008b). The preamble of the Statement of Intent of the document was based on Rudd’s (2008) Apology:

> Our challenge for the future is to embrace a new partnership between Indigenous and non-Indigenous Australians. The core of this partnership for the future is closing the gap between Indigenous and non-Indigenous Australians on life expectancy, educational achievement and employment opportunities. This new partnership on closing the gap will set concrete targets for the future: within a decade to halve the widening gap in literacy, numeracy and employment outcomes and opportunities for Indigenous children, within a decade to halve the appalling gap in infant mortality rates between Indigenous and non-Indigenous children and, within a generation, to close the equally appalling 17-year life gap between Indigenous and non-Indigenous when it comes to overall life expectancy. (AHRC, 2008b, p. 1)

Both this preamble and the document highlight the commitment of the signatories, including the Australian Government, to work together to achieve equality in health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by year 2030 (AHRC,
In March 2008, the government began to take further action, by responding to the Commissioners Social Justice Report 2005 (Australian Indigenous health/infoNet, 2013) and endorsing a strategy, Closing the Gap, through COAG. Arguably, it is now several years on and the results are still disappointing (ABS, 2010; AIHW, 2011; Thomson et al, 2010) as the Australian Government still fails to involve Aboriginal and Torres Strait Islander peoples and communities effectively in all aspects of the decision-making processes about their health and well-being (AIDA, 2010; Drape, 2011; Fredericks et al., 2012; Wilde, Anderson, 2007).

The Closing the Gap strategy follows the COAG commitment to the ‘Statement of Intent to Close the Gap’ with the above-mentioned investment of $1.6 billion dollars into Aboriginal & Torres Strait Islander people’s health (Fredericks et al., 2012; Sharp and Arup, 2009). The aim of the Closing the Gap strategy is to reduce Indigenous health inequality within 25 years, a generation (Australian Indigenous health/infoNet, 2013), as per the recommendations from the Close the Gap campaign (AHRC, 2008; HREOC, 2007). Six key targets that form the Closing the Gap strategy objectives:

I. Close the life expectancy gap within a generation
II. Halve the gap in mortality rates for Indigenous children under five within a decade
III. Ensure access to early childhood education for all Indigenous four-year-olds in remote communities within five years
IV. Halve the gap in reading, writing and numeracy achievements for children within a decade
V. Halve the gap for Indigenous students in year 12 attainment or equivalent, attainment rates by 2020, and
VI. Halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade.

(FAHCSIA, 2009)

These six targets formed the baseline for measuring the progress in Indigenous health and reforms each year. This in turn has required improvements in statistical collection services, within the ACCHSs and other
health providers to Indigenous people, to allow the key outcomes to be monitored (Australian Health Ministers Advisory Council [AHMAC], 2012; COAG Reform Council 2012; FAHCSIA, 2009). These statistical collection services are intrinsically linked to Indigenous identification and studies have shown that under-identification of Indigenous people in administrative data sets often skews statistics (Madden, Tickle, Jackson Pulver & Ring, 2012; AIHW, 2005; Madden, Al-Yaman, 2005), therefore impacting on funding allocation. Correct identification is a necessary pre-condition for participation in the ‘Closing the Gap’ strategy (AHMAC, 2012; COAG Reform Council, 2012; COAG Reform Council, 2013; FAHCSIA, 2009; NACCHO, 2013; Royal Australian College of General Practitioners [RACGP], 2011).

Funding is allocated according to the area of need, such as program funding and service delivery for health and education (COAG, 2010). The total allocated funding agreed to by COAG was $4.6 billion for targeted reform measures in the national partnership between the Commonwealth and the states and territories (FAHCSIA, 2009). Of this $4.6 billion, the health sector received $1.57 billion over four years (FAHCSIS, 2009). To access these resources all health providers have to demonstrate a sustainable commitment to measuring the progress of the identified ‘Closing the Gap’ key targets (COAG, 2010; COAG Reform Council, 2012; COAG Reform Council, 2013; NACCHO, 2013). This sustainable commitment involving assessing of the improvements in the health and well-being of Indigenous people (Australian Indigenous health/infoNet, 2013; COAG, 2010; FAHCSIA, 2009). The assessment of Indigenous peoples health has involved a lot of data collection from different agencies; however, there is minimal data that aligns outcomes with the COAG ‘Closing the Gap’ commitments (Productivity Commission, 2015). Furthermore, as a means of meeting the ‘Closing the Gap’ targets, COAG agreed to seven strategic platforms or building blocks (FAHCSIA, 2009):

- Early childhood
- Schooling
- Health
• Economic participation
• Healthy homes
• Safe communities; and
• Governance and leadership

These seven building blocks were specified as the most important based on statistical evidence suggesting that they require priority (ABS, 2010; AIHW, 2011; FAHCSIA, 2009) and that addressing them would have a higher impact (in the short term) than other priority areas (FAHCSIA, 2009). However, Hoy (2009) argued that a focus on short-term measures was not a solution to a long-term problem, and that what was required was a primary health care approach, meaning, that there should be a uniform availability of quality primary care within nine years and this should be non-negotiable (Hoy, 2009, p. 543). This argument is supported by evidence presented in a number of reports (ABS, 2008; ABS, 2007; AIHW, 2005; AIHW, 2008).

In its commitment to ‘Closing the Gap’ the Government further declared that it would achieve its objectives by allocating the funding through national partnerships that involved the employment of more nurses, doctors, other health professionals, health managers and welfare officers (FAHCSIA, 2009). A majority of these are non-Indigenous, with traineeships for Indigenous people. Several years on, and the Government has barely achieved two of the initial objectives (iii and v) of the strategy (FACHSIA, 2013). Of the money invested into Indigenous health, about 80% is channeled into mainstream programs (Productivity Commission, 2015). The Australian Government investment would be better received if the funding were to go directly to the ACCHSSs, the primary health care organisations that take a holistic approach to health and well-being and are an established authority in delivering and understanding Aboriginal primary health care (COAG, 2010; Couzos and Murray, 2007; Fredericks and Pearce, 2008; NACCHO, 2003; NACCHO, 2013; Smith, 2007; Taylor et al., 2008).
Over many decades the policies that have impacted on the health and well-being of Indigenous people in Australia have been derived from a biomedical approach to health focused narrowly on the presence or absence of pathogens and the failure of body functions, namely clinical illness (AIHW, 2012; Carson et al., 2007; AIHW, 2015b). However since the development of the concept of the social determinants of health from the WHO report (Wilkinson and Marmot, 2003), policies affecting health have changed (Dugdale, 2008). Current health policies, including health-promotion policies, are becoming more of a reflection of the holistic health concepts that are endorsed by the ACCHSs primary health care organisations (Dugdale and Arabena, 2008; NACCHO, 2003; Smith, 2007). What remains constant is that governments continue to pay little attention to evidence when developing and implementing policy that targets Indigenous people (Cox, 2011). This results in the implementation of inequitable policies imposed on Indigenous people and the perpetual cycle of economic disadvantage that seems to haunt them. Inequitable policies inevitably continue to both live in the memories of Indigenous people and contribute to current attitudes of health professionals (Fredericks et al., 2012). The legacy of colonisation is reflected in the policies and the socio-political and economic deprivations that Indigenous people have endured over the last 220 years and it continues to permeate aspects of government approaches to Indigenous peoples health in the broader Australian health system.

2.5 Primary health care and health promotion

In 1948 the World Health Organization (WHO) was established as an agency of the United Nations (UN) to be responsible for international health issues (Talbot, Verrinder, 2010). In that same year, the WHO produced a definition of health: health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (Talbot, Verrinder, 2010, p.2). What was not considered was the amount of monetary investment that some of these countries decided to put into health technologies rather than basic health care services (Talbot, Verrinder, 2010). Prior to 1971, more than
half of the world’s people had no or limited access to healthcare (Cueto, 2004). By the late 1970s, medical and public health disciplines highlighted the limited benefits that the new medical technologies had on the health of most individuals and in 1978 the WHO adopted the major principles of primary health care delivery (Cueto, 2004; Jirojwong & Liamputtong, 2009; Smith, 2012).

Primary health care is different from primary care. Primary care is drawn from the biomedical model that focuses on personal health and individual health. Primary health care, a strategy of public health, is derived from the social model of health and is upheld by the Alma-Ata Declaration (Keleher, 2000; Schaay, Sanders, 2009; WHO, 1978, 1979, 1986). According to WHO, the values to achieve primary health care are; better health for all, social justice, participation and solidarity (WHO, 2008) - a set of values that have been globally difficult to achieve due to the divergent interpretations of the Alma-Ata Declaration for primary health care (Baum, Saunders, 1995; Schaay, Sanders, 2009). Nonetheless, the Declaration of Alma-Ata and the major principles set out in the Declaration remain as (Talbot, Verrinder, 2010, p.3):

- equity
- social justice
- empowerment

This has been the key to enabling vulnerable populations around the world to obtain a level of health that could lead to socially and economically productive lives (Talbot, Verrinder, 2010). However, since the Declaration is global, countries will interpret it according to their needs, making it difficult to reduce health inequalities as a common standard across all countries.

In Australia, primary health care is a part of the health care system that is governed by the Australian federal system (Willis, Reynolds and Keleher, 2012; Taylor et al., 2008). The major responsibility of the Commonwealth is funding for medical services, including the ACCHS, high-level residential care and health research (Ducket, 2007; Taylor et al., 2008). The Commonwealth is also responsible for the development and funding of the national public
sector health insurance system known as Medicare introduced in 1984 and founded on the principles of universal access to health care (Ducket, 2007; Taylor et al., 2008). The private sector of health care also facilitated by government policy, has seen rapid expansion between 1999 and 2001 when tax incentives were introduced to encourage individuals to take out private health insurance and attend private hospitals (Ducket, 2007; Taylor et al., 2008).

The states and territories are responsible for community health services and share the funding for public hospital services including staff salaries, facilities and infrastructure. The states and territories also share the costs with the Commonwealth Government of the Pharmaceuticals Benefit Scheme (PBS), introduced in 1948 to underpin the right of Australian citizens to affordable medicines (Taylor et al., 2008; Willis et al., 2012). Local governments play a very minor role compared to the federal state/territory governments; their focus is more centred on the provision of preventive services such as immunisations, communicable disease control, maternal and child health services, and support, home and community care for the elderly (Taylor et al., 2008).

The Australian Government has been ongoing in its commitment to high-quality health care provision since the 1970s (AIHW, 2006) and a large majority of people who reside in Australia have access to quality health services (AIHW, 2006; RHW, 2007). Access to higher quality healthcare, however, is not consistent across the Australian population (Podger, 1999; Wakerman, 1999); the inequity in the health status of Aboriginal and Torres Strait Islander populations remains a significant issue in the Australian health system, especially for those in rural and remote communities. Aboriginal and Torres Strait Islanders continue to have the poorest health and most limited access to appropriate health care services (Kunitz, 2002 cited in Councilor, 2003). ACCHS, as a primary health care organisation is an important commodity in the delivery of primary health care including health-promotion
programs to Indigenous people (Howard, 2006; Taylor et al., 2008; Wakeman, 1999).

For primary health care to be at the forefront of a country’s health system, including Australia there is a requirement for people to be at its centre (WHO, 2008). What this entails is that through a public health lens, the family and the community are the focus and the upstream social determinants of health, through health promotion, are the emphasis (Keleher, MacDougall, Murphy, 2007; Smith, 2007; Schaay, Sanders, 2009; Waters, Petticrew, Priest, Weightman, Harden & Doyle, 2008). Figure 2.3 is a framework that brings social determinants theory (outlined previously in Figure 2.2) into practice. Figure 2.3 outlines upstream social or distal determinants of health, distal referring to those that are distant either in time or place from any changes in the health status (Waters et al., 2008). Upstream determinants target population groups rather than individuals, making interventions and/or health-promotion initiatives paramount, because they address the social structural conditions such as equity, poverty, social exclusion, racism, discrimination, housing, and social environments (Waters et al., 2008). In turn, these lead to improvements in health (Waters et al., 2008). These social structural conditions are commonly experienced among Indigenous communities, and are addressed by the ACCHS across Australia by employing health-promotion practitioners to deliver culturally-appropriate health-promotion programs within their communities (AHPA SA, 2009; Smith, 2012; Willis et al., 2012).
Figure 2.3: Social determinants framework of health promotion

<table>
<thead>
<tr>
<th>Upstream</th>
<th>Downstream</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Material factors, social structural conditions</strong></td>
<td><strong>Psycho-social factors</strong></td>
</tr>
<tr>
<td>• Poverty</td>
<td>• Social support</td>
</tr>
<tr>
<td>• Social gradient</td>
<td>• Social isolation</td>
</tr>
<tr>
<td>• Equity</td>
<td>• Low job attributes</td>
</tr>
<tr>
<td>• Racism and discrimination</td>
<td>• Depression</td>
</tr>
<tr>
<td>• Housing</td>
<td></td>
</tr>
<tr>
<td>• Social environments</td>
<td></td>
</tr>
<tr>
<td>• Institutional structures</td>
<td></td>
</tr>
<tr>
<td><strong>Levels of action</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Upstream</strong></td>
<td><strong>Midstream</strong> – Programs to address:</td>
</tr>
<tr>
<td>Programs to address determinants of health:</td>
<td>• Smoking</td>
</tr>
<tr>
<td>• Inequities and poverty reduction</td>
<td>• Alcohol misuse</td>
</tr>
<tr>
<td>• Healthy public policy</td>
<td>• Drug addiction</td>
</tr>
<tr>
<td>• Gender equity</td>
<td>• Physical activity</td>
</tr>
<tr>
<td>• Social exclusion</td>
<td>• Weight control</td>
</tr>
<tr>
<td>• Strengthen community action</td>
<td>• Child development</td>
</tr>
<tr>
<td>• Racism and discrimination</td>
<td>• Diet/ nutrition</td>
</tr>
<tr>
<td>• Access to housing</td>
<td>• Interpretation of health information</td>
</tr>
<tr>
<td>• Universal childcare</td>
<td>• Personal coping skills and individual capacity</td>
</tr>
<tr>
<td>• Education pathways</td>
<td></td>
</tr>
</tbody>
</table>

Sources: This framework was developed from a combination of frameworks. (Smith, 2007; Keleher, MacDougall, Murphy, 2007).

‘Health promotion’ was a term that emerged in the late 1970s and was later used by health-promotion practitioners to describe the combination of health education and specific interventions in the early 1980s (Jirojwong & Liamputtong, 2009). Following the Alma-Ata Declaration, in 1986, the WHO held its first international conference to develop a charter that was based on the achievements of the Declaration to achieve ‘health for all’ (Smith, 2012;
Talbot, Verrinder, 2010; WHO, 1986) in disease prevention. This charter is known as the Ottawa Charter and it defines health promotion as

*The process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being* (WHO, 1986, p.1).

The Charter clearly states that the prerequisites for health include social justice, equity, peace, and a stable ecosystem (WHO, 1986). In addition, the Ottawa Charter highlights five health-promotion strategies. These are:

- building healthy public policy;
- creating supporting environments;
- strengthening community action;
- developing personal skills and;
- re-orientating health services towards population health improvement (WHO, 1986).

The Ottawa Charter in itself highlights the empowerment of individuals and communities as the central purpose of health promotion (Smith, 2012) therefore aligning with the concept of people being at the centre of health care (WHO, 1986).

Health promotion in Australia began to grow after the establishment of the Charter Declaration and the establishment of the Australian Health Promotion Association (AHPA) in 1988 (Smith, 2012). This led to the development of some key strategic documents utilising the role of health promotion in particular the National Aboriginal Health Strategy (1989), which endorsed the
importance of ACCHS having control over their own people’s health (NACCHO, 2012).

The self-determination of health, for Indigenous people, is very different from the biomedical approach to health understood by western society. For Indigenous people the concept of health is instead embedded in the holistic concept that constitutes cultural well-being and the interrelatedness of spiritual, environment, social-emotional (mental) and physical factors (Carson et al., 2007; Couzos & Murray, 2008; Eckermann et al, 2010; Smith, 2007; Swan, Raphel, 1995). This holistic concept was evident in the types of lifestyles that Indigenous Australians enjoyed prior to colonisation. Their societies were complex, self-governing and holistic; this was reflected within their culture and lifestyle that included hunting, gathering of foods, spiritual practices, birthing and medicine (Fredericks, Lee, Adams & Mahoney, 2012; Thomson et al., 2010). Their social determinants were fully met. The biomedical approach of western society, although useful in addressing and identifying diseases in individuals, lacks the population-wide approach that is necessary to address the social determinants of health, including the macro-social-level determinants, required by Indigenous Australians.

In 2003, health-promotion stories from the ACCHSs were published (AHPA SA, 2009) highlighting best practice examples of the population-wide approach that addressed the social determinants of health through the ACCHS and the importance of health-promotion activities according to primary health care principles (Talbot, Verrinder, 2010, WHO, 1986). This exemplifier of good practice using health promotion to close the life expectancy gap between Indigenous and non-Indigenous people came from the peak body of the Aboriginal community-controlled organisation of South Australia, the Aboriginal Health Council of South Australia Inc. (AHPA SA, 2009). The health-promotion programs from which these stories came followed an Aboriginal engagement process and partnership. The criteria for publishing of the stories include (AHPA SA, 2009) programs that:

• were ongoing;
showed evidence of need;
showed evidence of effectiveness; and
showed evidence of community support and engagement.

These criteria and the Indigenous engagement process, which incorporates the primary health care principles of equity, social justice and empowerment, are a reflection of the primary health care philosophy that encourages health workers to work with communities to enable them to identify their needs and address their own needs (Talbot, Verrinder, 2010). This was achieved by using approaches that emphasised participation in decision-making, health-promotion activities and providing services with the community that were and are affordable and sustainable (Talbot, Verrinder, 2010; Treloar, Jackson, Gray, Newland, Wilson, Saunders, Johnson & Brener, 2015). Health services can contribute to closing the gap in Indigenous life expectancy through the holistic lens for health and well-being that recognises the importance of improving mental, physical, social, cultural and spiritual health delivered by community control (AHSCA, 2010). A challenge for health promotion practitioners within the ACCHS is to keep abreast of the increasing diseases and injuries pertinent to Indigenous people such as cancer and drug use (AIHW, 2015), similarly, prevention education to address increasing health issues needs continued grounding in social relationships (Fraser, Treloar, Bryant & Rhodes, 2014).

2.5.2 People-centred primary health care and Indigenous health

The community-controlled primary health care model of the ACCHS has similar features to that of the international people-centred primary healthcare model for Indigenous peoples (Dwyer et al., 2007; WHO, 2008). The people-centred primary health approach is one whose health care services put people first, ensuring that health care is effective, equitable, efficient and safe (WHO, 2008). Primary health care services that have developed these attributes provide a basis for connecting individuals and communities, together with continuity and comprehensiveness of care. These are features
of primary health care and are something that evidenced-based care cannot ensure (WHO, 2008). It is demonstrated in Table 2.6, which illustrates the differences in care between the people-centred primary health care approach and the care provided in conventional settings.

Table 2.6: Differences in care between conventional settings and people-centred primary health care

<table>
<thead>
<tr>
<th>Conventional ambulatory medical care in clinics or outpatient departments</th>
<th>Conventional Settings – GP clinics, hospital outpatient departments</th>
<th>People-centred primary care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus on illness and cure</td>
<td>Focus on priority diseases</td>
<td>Focus on health needs</td>
</tr>
<tr>
<td>Relationship limited to the moment of consultation</td>
<td>Relationship limited to program implementation</td>
<td>Enduring personal relationship</td>
</tr>
<tr>
<td>Episodic curative care</td>
<td>Program-defined disease control and interventions</td>
<td>Comprehensive, continuous and person-centred</td>
</tr>
<tr>
<td>Responsibility limited to effective and safe advice to the patient at the time of consultation</td>
<td>Responsibility for disease-controlled targets among the target population</td>
<td>Responsibility for the health of all in the community along the life cycle; responsibility for tackling determinants of ill health</td>
</tr>
<tr>
<td>Users are consumers of the care they purchase</td>
<td>Population groups are targets of disease-control interventions</td>
<td>People as partners in managing their own health and that of their community</td>
</tr>
</tbody>
</table>

Adapted from: WHO 2008, p.43.

The people-centred model of health care organisations recognise that people become patients and that they need to be informed and empowered in promoting and protecting their own health (WHO, 2007, p. 5). The people-centred approach focuses on relationships with both individuals and the community within a spirit of self-determination and is a necessity for the improved health outcomes of Indigenous peoples worldwide (Dwyer et al., 2008; WHO, 2007; WHO, 2008).

The ACCHSs integrate the people-centred model of primary health care with the principle of community control that requires the ownership and
management of the health service to be vested in the local Indigenous community (Dwyer et al., 2007. p.2). This arrangement is necessary in order to give the local community with a sense of self-determination; it allows for the community to decide on their policies, priorities and management structure, staff and services profiles, in accordance with government funding guidelines (Dwyer et al., 2007).

2.6 Aboriginal Community Controlled Health Services

Historically, the establishment of the Redfern Aboriginal Medical Service in 1971, a primary health care organisation based on community participation, came after the 1967 Referendum. It was where Aboriginal activists struggled and pushed for a focus on Aboriginal health issues (Bartlett, 2005). The Redfern health service marked the beginning of Indigenous community-controlled health services and organisations Australia wide that were initially established by Aboriginal communities with little or no funding (Brady, 2000; Bartlett, 2005; Hudson, 2009).

The core aim of the ACCHS was to provide a service that was culturally sensitive and encompassed a holistic approach to health care, where decisions were (and are) shared by the community within the community, and at the same time were (and are) independent and autonomous of each other and the government (Brady, 2000; Councillor, 2004; Foyley, 1975; NACCHO, 2003). As discussed and outlined previously in Figure 2.1, since colonisation, macrosocial factors have impacted on the health and well-being of Indigenous people. These macrosocial factors include government policy, discrimination and institutionalisation, and have denied Indigenous people their self-determination. The development of the ACCHS, a non-government organisation, was a historic event in Australian history as it was pivotal in the political struggle for self-determination (Jackson Pulver et al., 2010) and was a means for Indigenous people to take control of their health. The philosophy of community control within the ACCHS predates and supports the Alma-Ata Declaration of 1978, where community participation in health and health care
became valued and promoted throughout the world (Brady, 2000; WHO, 1978; WHO, 1977). For those involved in the struggle to attain a community-controlled health service, there was a desire propelled by self-determination, but with very little funding, among Australia’s Indigenous people but with very little funding (Brady, 2000; Councillor, 2004).

The concept behind community-controlled care is that this is more culturally appropriate than mainstream services because it is Indigenous-owned and operated (Hudson et al, 2009; NACCHO, 2003). As Figure 2.4 shows, from the ACCHS service level (local ACCHS AHW at the bottom of the figure) the local Indigenous community influences the health organisation ensuring that the local Indigenous cultural values and health needs of the community are represented on the governing Board and via the AHW (Howard, 2006; Hudson, 2009). This knowledge is then transferred to the ACCHO (the organisational level), which is the state or territory affiliated body of the ACCHS, and then up again to the NACCHO, the umbrella organisation or peak body of the ACCHS and whose role it is to support and find or advocate for funding for the ACCHS (Hudson, 2009; NACCHO, 2003). NACCHO not only approves funding allocations (or not) but also holds the mandate to speak to the government on health issues for Indigenous peoples (Dwyer et al., 2007; Shannon, Carson, Atkinson, 2006; Taylor et al., 2008). However close the similarities between the conventional models of health organisations to that of the community-controlled health organisations may be in the ACCHS model of service delivery, the decision-making over healthcare is transferred from the community and entrusted to members of the community-elected Board, whose decision-making responsibility is for the health of their community (Dwyer et al., 2007; Howard, 2006; NACCHO, 2003).
Over the years ACCHSs have spread throughout Australia and consist of a national network of more than 140 such bodies across all states and territories (Jackson Pulver et al., 2010). The overarching body for the ACCHS in Queensland is the Queensland Aboriginal Health Council (QAIHC) (Dwyer et al., 2007; Fredericks and Pearce, 2008; QAIHC, 2005). Since the first
ACCHS was established in Queensland in 1972, there numbers have grown to 20 (Dwyer et al., 2007). The QAIHC itself was established in 1990; prior to that it was referred to as the Queensland Aboriginal & Islander Health Forum (QAIHF). The services offered by ACCHSs range from large multi-functional services employing several medical practitioners in urban areas, to small services in rural areas with minimal medical practitioners; here, the AHW and/or nurses to provide the bulk of primary health care services often with a preventive, health education focus (Dwyer et al., 2007; Rural and Remote General Practice Program [RRGP], 2008). Even though the growth in the number of services has resulted in alterations to service delivery, there has been little change to the governance model. This comprises an elected Board of members from the local Indigenous community that work with the CEO to identify community priority needs (with government expectations) that need to be funded (Dwyer et al., 2007; Howard, 2006; QAIHC, 2005; Taylor et al., 2008). This structure is set out in Figure 2.5.

From 1972, the Commonwealth Government gradually began accepting that ACCHSs were a key component of future developments for Aboriginal health; which represented a milestone for the ACCHS (Bartlett, 2005). In 1973, the Aboriginal Medical Service (AMS) in Redfern was included in a funding round for community-based, multidisciplinary health services that received funding from the Australian Government as part of its commitment to invest in primary health care, and received its first Commonwealth grant of $20,000 (Couzros and Murray, 2008; Talbot, Verrinder, 2010). However, it was not until the 1980s that significant funding from the Commonwealth Government was available to the ACCHSs across all of Australia (Couzros and Murray, 2008). Funding to the ACCHS still remains messy and multi-faceted, and the unmanaged complex contractual environment that emerged has grown over the years (Dwyer, O'Donnell, Lavoie, Marlina, Sullivan, 2009). An ACCHS today may receive funding from at least 25 different sources, with 25 different applications, for only seven different services or programs. Reporting requirements place an enormous extra burden on the ACCHS as a whole (Dwyer et al, 2009; Hudson et al, 2009).
In some circumstances, the ACCHS must apply for the small pools of funding across a number of sources, as there is no single large pool of funding to apply for (Hudson et al, 2009). The complexities around obtaining funds for programs are demonstrated in Figure 2.5. The major funding bodies and policy influencers are at the top and include the Commonwealth Government, and other Commonwealth agencies such as the Department of Health and Aging (DoHA), the Office of Aboriginal and Torres Strait Islander Health (OATSIH), Medicare and the Pharmaceutical Benefits Scheme (PBS) (Dwyer et al., 2007; Hudson, 2009; Shannon et al., 2006). They provide funding to the ACCHS for the programs that have been identified by the Commonwealth as the area of high priority and are informed by QAIHC through input with NACCHO (Dwyer et al., 2007; Howard, 2006; Hudson, 2009; Shannon et al., 2006). Prior to applying for funding that addresses community needs, the ACCHSs follow a similar process to that of non-Indigenous organisations whereby the CEO of the ACCHS consults with the Board and refers to applications from ACCHS staff as to their perception of community funding needs in line with Commonwealth funding and policy guidelines (Dwyer et al., 2007; Shannon et al., 2006). The funding model for the ACCHS requires compliance with governance and stringent reporting processes. Health service managers or the CEO must be able to incorporate as much Aboriginal cultural understanding into the health service as possible to ensure a culturally competent and culturally-safe service is being provided for Indigenous people (Howard, 2006, Hudson et al, 2009; Wakerman, Matthews, Hill, Gibson, 2000).
2.6.2 Accountability

As the ACCHS may receive funding from different funding sources, it is difficult to determine how much funding it actually receives (Hudson, 2009).
Many ACCHSs lack up-to-date technology and have inadequately trained staff, including Board members who may have attained only a Year 8 or 9 school education level (Howard, 2006; Hudson, 2009). This makes record keeping and reporting difficult. The government has established regulated bodies which non-profit organisations must register with, giving the ACCHS a choice of either the Australian Securities or Investment Commission or ORIC. A majority of the ACCHSs choose ORIC as it provides for the different registration requirements with which ACCHS have to comply, compared with organisations for non-Indigenous people (Hudson, 2009).

The ACCHSs that are registered with ORIC have more flexibility in their model of governance and are able to implement rules that best suit their individual Indigenous culture and circumstances (ORIC, 2010). At the same time, there are internal governance rules that the ACCHS have to comply with, such as the CEO being Indigenous, or in some circumstances non-Indigenous, and the Board having at least five members who are Indigenous (ORIC, 2010). These provisions have to be recorded in the ACCHS rulebook. The CEO plays an integral role in the quality of governance with the Board of management to ensure the sustainability of the service. ACCHSs are also responsible for the effectiveness of their staff, including recruitment and retention, important attributes that are vital to any health organisation (National Rural Health Alliance [NRHA], 2004; RRGP, 2008; Shannon et al., 2006). For an Indigenous CEO, employed within the ACCHS, an added responsibility to his or her managerial obligations is that to the community; to ensure that they meet the Indigenous community’s needs and expectations and ensure the delivery of a high-quality health service (Dwyer et al., 2007; Shannon et al., 2006), a complex balancing act.

Management structures of organisations exist to ensure accountability and that compliance is maintained in terms of organisational performance (Collins, 1993; Harris, 2006). In health care organisations it is important for managers to ensure that compliance with rules and regulations extends to include the organisation’s culture and philosophy, for two reasons (Harris, 2006). Firstly, it
is a people-orientated environment where the hands-on service providers have made a lot of the immediate decisions in regards to clients (Harris, 2006). Secondly, the manager has to ensure the culture or ethos of the organisation supports this decision-making process and at the same time provides excellence in accountability (Harris, 2006).

Within health care organisations accountability structures are dependent on ownership (Harris, 2006). That is, whether it is publicly owned and managed; publicly owned and managed independently; whether it is a private not-for-profit organisation; private for-profit small business or private for-profit investor-owned (Harris, 2006). Regardless of the type of ownership, the senior manager(s) or CEO of ACCHS reports directly to a governing Board (such as a Community Board) (Harris, 2006; Taylor et al., 2008). The Board of Directors managing the ACCHS is elected from the local community (Dwyer et al., 2007; NACCHO, 2003; QAIHC, 2005; RRGP, 2008; Taylor et al., 2008), and is referred to as either the Community Board or the Board. The Board has a variety of roles that include employing staff, making the high-level policy decisions and, at the same time, ensuring that the organisation remains accountable to the local Indigenous community (NACCHO, 2003; QAIHC, 2005; RRGP, 2008).

When employing staffs, the Community Board need to ensure that they recruit the best possible staff within their community and that they are able to uphold a sense of mutual respect between them. In addition, the Community Board and the CEO are responsible for ensuring that the staffs are provided with ongoing support and training (RRGP, 2008). This can make it challenging for the CEO if Community Board members have not had an appropriate education to understand good governance and to assist their communities to make effective use of the Australian health system. This can reflect on the management skills of the Community Board when employing staff (Dwyer et al., 2007; RRGP, 2008; Taylor et al., 2007). Both the Community Board and the CEO, together with the ACCHS staff, need to be able to combine both the non-Indigenous health organisational requirements with the community and
their cultural values, including Aboriginal and Torres Strait Islander protocols; this is especially important if they are to meet the needs of the community and the ACCHS regulation requirements (Aboriginal Medical Service Alliance Northern Territory [AMSANT], 2007; ORIC, 2010; RRGP, 2008).

In general, governing Boards are responsible for overall operations and for achieving appropriate outcomes in their health care organisation (Harris, 2006). What is important for effective governance is the way a Board moulds these responsibilities and functions to meet its own objectives (Harris, 2006; Taylor et al., 2008). The Indigenous primary health care model, developed and delivered by the ACCHS, has an established partnership between the Community Board of Directors, who are elected by the local community, and a CEO (selected by the Board) to oversee the management and operations of the organisation (Dwyer et al., 2007; Shannon et al., 2006; Taylor et al., 2008). However, even though the ACCHSs are Indigenous organisations funded by the government and governed by a Board elected at all levels by the local community, the CEO is responsible for the daily operations of the organisation that has to be consistent with the directions of the Board and also includes understanding of the funding guidelines (Dwyer et al. 2007; Harris, 2006; Shannon et al., 2006; Taylor et al., 2008).

The Aboriginal community control model has similar features to the governance structure of public hospitals, community health centres and other mainstream health organisations and draws on some of the same democratic decisions for a sustainable governance model (Dwyer et al., 2007; Shannon et al., 2006). Even though there have been few changes to the community control model of governance, it has not been without its challenges for CEOs, such as recognising the substantial differences between western culture and the Indigenous culture. This means that the ACCHS needs to balance maintaining accountability to the mainstream government sector and work in the western management system within the Indigenous domain (Coombe, 2008). Furthermore, there has not been one single governance model that is suitable for all Indigenous communities (Coombe, Haswell-Elkins, Hill 2008).
Especially in small communities where the economic scale is usually small as well, the ACCHSs struggle to develop and sustain observable health outcomes therefore leading towards a more regional model of governance (Coombe et al., 2008; Dwyer et al., 2007), meaning that members for the Board come from the regional areas that the ACCHS provides a health service to rather than, however in the larger ACCHS there members are local therefore their governance model is focused locally.

Coombe et al., (2008, p. 611) argue that regardless of whether the governance model implemented by the ACCHS is local or regional, it needs to be more of an integration model that has supplementary strategies and continues the collective use of minority services, rather than minority services working individually. This helps ensure that cultural priorities are maintained and community engagement with the mainstream sector is encouraged to enhance continued positive economic relations within the service.

It has already been stated that as non-government organisations, ACCHSs rely on the funding of various government bodies including Department of Health and Aging (DoHA) and OATSIS. While this is similar to mainstream health services that also rely on government funds, the ACCHSs are more able to work within the requirements of the Indigenous community (Dwyer et al., 2007; Taylor et al., 2008; Wakerman et al., 2000).

Some of the developments of the ACCHS model of health care for Indigenous peoples have been around policy and service provision (Anderson, 2004; Dwyer et al., 2007). These have included the integration of medical and clinical care, dental care, nutritional and an array of promotion and prevention activities (Dwyer et al., 2007; RRGPS 2008). This primary health care approach that the ACCHSs take is important in developing preventive approaches to combat chronic disease and other illnesses in Indigenous peoples. The treatment and management programs offered are provided by both qualified and culturally competent Indigenous and non-Indigenous health professionals, a combination that mainstream services often do not offer (Dwyer et al., 2007; Howard, 2006).
2.6.3 Culturally safe service delivery

The ACCHSs, similar to some mainstream services, are made up of Indigenous and non-Indigenous staff, including those from other cultures, making them susceptible to cross-cultural challenges. An important challenge in addressing the health of diverse cultures, including Indigenous people, is the provision of culturally-appropriate health service staff (Calma, 2010; Taylor et al., 2007; Turale, Miller, 2006). Mainstream health services struggle to combine the biomedical approach and the holistic approach to healthcare that the ACCHS take for treating Indigenous clients (Couzos & Murray, 2007; Taylor et al., 2007; Turale, Miller, 2006). The use of the term ‘culturally-appropriate health services’ indicates that a health service delivering health to Indigenous people understands the local Indigenous culture, includes Indigenous people in decision-making processes, and understands what culture means to Indigenous people, so as to provide the necessary service (AHRC, 2008; Eckermann et al., 2010, Harris, 2012). A culturally-appropriate health workforce delivering culturally-appropriate health services contributes greatly to the implementation of health policies and strategies needed to improve Indigenous peoples’ health (Banks, 2007; Bourke et al, 2004; Taylor et al., 2007; Turale, Miller, 2006).

Having a culturally competent health service is not just about staff being aware that someone is of a different culture than himself or herself. Cultural competence includes understanding what constitutes, and has influenced, different cultural perspectives (AHRC, 2008; Ranzijn et al., 2009; Taylor, Guerin, 2010). Cultural competence is a process that takes a long time to develop (Taylor, Guerin, 2010). It is about ensuring that Indigenous and non-Indigenous staff are able to work with a culturally-safe and culturally-sensitive practice. This means that Indigenous and non-Indigenous health professionals are competent in reflecting on their own attitude against that of someone from another culture therefore being able to work in an environment that doesn’t challenge or deny either of them their identity or discriminate.
against who they are or what they need ((Bourke et al 2004; Fredericks, 2008; Paradies, 2006; Ranzijn et al., 2009; Taylor, Guerin, 2010).

Being culturally competent is a long process, and is one of many frameworks for health professionals to consider for culture in health (Taylor, Guerin, 2010) and essentially includes cultural safety, cultural respect, cultural awareness and cultural sensitivity, Box 2.1. Essentially, cultural awareness and cultural sensitivity are the steps towards providing a culturally-safe service.

**Box 2.1: Culture in health**

**Cultural Safety:**
Originally an approach to nursing practice that was developed in New Zealand. It requires care to be determined by the recipient of care whereby the health professional is required to reflect on their on culture and power and seeks to provide a culturally-safe service from the cultural safety of the service it self.

**Cultural awareness:** is the first step towards cultural safety and it is about being aware that there are differences between people and not everybody is the same. This includes foods people eat, communication styles, interpersonal skills, modes of dress and so forth.

**Cultural sensitivity:**
Is the second step towards cultural safety and it is about accepting that there are cultural differences and then applying that understanding to ones service delivery realising that individuals are entitled to hold differing world views, values, knowledges and beliefs.

**Cultural respect:**
Is considered a ‘shared respect’ and is achieved when the health system is a safe environment. Cultural respect was developed as a principle in policy development and service delivery, by the government, in response to the appalling health outcomes of Indigenous Australians. The government continues to apply the ‘cultural respect’ framework to some policies.

Adapted from Taylor, Guerin, 2010, pp. 10 - 25

These frameworks or approaches ensure that the ACCHS and other health services provide a service to Indigenous people that are culturally respectful (NHMRC, 2006). In Indigenous culture there was never a separate and specific word for health. The sense of being Indigenous encapsulated that health was about the physical, social, emotional and cultural well-being of the individual and the community together with the individuals relationships and spiritual connections (Australian Health Promotion Association [AHPA] (South Australian [SA] Branch), 2009; Sheehan et al, 2009; Thomson et al, 2010).
It has already been demonstrated in this chapter that the social determinants of health and health inequalities can be attributed to the circumstances of people’s lives and the access they have to available health services. It has also been noted that policies and economics shape the health care system and impact on the worldviews of people’s circumstances and their cultural way of ‘knowing and doing’. Thackrah and Thompson (2013, p. 35) argue that the result of the two world views colliding in health services, peoples’ circumstances and their cultural ways of knowing and doing, is represented in the way clients’ lived realities frame their understanding of models of illness and the clinical decision-making. Highlighting the importance of cultural competence training to both the Indigenous and the non-Indigenous health workforce. The ACCHS aim to provide a culturally-safe and respectful approach towards addressing the health inequalities and disparities experienced by Indigenous people and at the same time are able to practice the principles of self-determination within their actual operations (NAACHO, 2003; QAIHC, 2008; RRGP, 2008).

2.6.3.1 Organisational culture and change

Culture itself has existed for many thousands of years, but its relevance and use within organisations is fairly recent (Vecchio, 1996). Inside an organisation, ‘culture’ is about having clear rules and beliefs that are automatically in place, helping each person to understand themselves therefore determining how each person relates to one another and the organisation (Taylor et al., 2008; Vecchio, 1996). The culture of an organisation stems from effective and efficient management and therefore influences the attitudes and behaviours of the staff (Robbins, 1998; Vecchio, 1996). The abilities of staff members are represented by the attitudes and behaviours as presented by the organisation; that is, whether it is rigid or flexible, unfriendly or supportive, innovative or conservative (Robbins, 1998; Vecchio, 1996). These attributes highlight the workings of the internal culture within the broader social culture of the organisations and provide a shared belief and values that guide the behaviours of staff that distinguishes it from

The system of shared meaning within an organisational culture is governed by seven key characteristics that are interrelated and capture what organisational culture is about. These include innovation and change, attention to detail, outcome orientation, people orientation, team orientation, aggressiveness and stability (Robbins, 1998; Robbins, Millet, Cacioppe, Waters-Marsh, 2001; Robbins, Millet, Waters-Marsh, 2004). These characteristics attempt to capture the essence of organisational culture and provide a basis of how things are perceived within the organisation itself (Robbins, 1998; Robbins et al., 2001). The organisation's culture can consist of a dominant culture and a set of sub-cultures (Robbins, 1998; Robbins et al., 2004).

Dominant culture refers to a majority of the members having a shared set of core values. Sub-cultures are a reflection of similar problems, experiences, predicaments or situations that may be unique to groups of people within the organisations while still maintaining the core values of the dominant culture (Robbins, 1998; Vecchio, 1996). Some sub-cultures can influence positive or negative behaviours and if organisations consisted only of sub-cultures there would be little or no representation of appropriate and inappropriate behaviours. This is because it is the shared meaning (a characteristic of culture) that makes culture so important in guiding and shaping organisational behaviour (Robbins, 1998; Robbins et al., 2004).

Another term used to ascertain whether an organisation’s culture is held and endorsed is known as strong (versus weak) culture (Robbins, 1998; Vecchio, 1996). While not the only call to loyalty, strong culture reduces any tendencies among employees to leave the organisation, and maintains a high level of consensus among the members themselves as to what the organisation may stand for, consequently building commitment, cohesiveness and loyalty in the organisations culture (Robbins, 1998; Vecchio, 1996; Robbins et al., 2004).
Robbins however also believes that the strength of organisational culture can be challenged by the strength of national culture, (Robbins, 1998, p. 600) and states that the national culture has a greater impact on employees than does their organisation’s culture. In terms of community control, the Indigenous culture, in this case, is the dominant national culture and the culture of primary health care is delivered within this worldview.

The ACCHSs consist of both Indigenous and non-Indigenous staff, where the highest turnover of staff is that of the non-Indigenous health professionals (Dwyer et al., 2007; Hill et al., 2001). Each ACCHS organisation functions within two domains, the first being the Indigenous domain, the strong culture that represents the traditional culture of the community and the Indigenous staff. The second, dominant western culture represents health and social policy, historical abuse, legislation, reporting, funding and the non-Indigenous staff could be representative of this culture (Dwyer et al., 2007; Couzos and Murray 2007; Coombe, 2008; Eckerman et al., 2006; Howard, 2006). The ACCHSs operate in the changing environment of funding rounds, policies and resources, and they are constantly challenged to meet their community’s needs and expectations and deal with the high turnover of non-Indigenous staff. Having this adaptive culture to cope with the changing organisational environment highlights the strength of the Aboriginal culture within the ACCHS organisational culture (Dwyer et al., 2007; Coombe, 2008; Hill et al., 2001).

As much as the culture within an organisation performs a number of functions, it can also act as a liability for an organisation and become a barrier to change (Robbins, 1998). This can happen when the strong culture within an organisation ignores the potential and unique strengths of people from various backgrounds and ethnic groups (Robbins, 1998). The ability of an ACCHS CEO to respond to these barriers influences the organisation’s ability to perceive and respond appropriately to changes within its own environment (Robbins, 1998; Vecchio, 1996). For these CEO their roles includes the development of a cultural ethos that is supportive across all areas of staffing
to ensure quality organisational performance is maintained and at the same
time ensure advancement in the Indigenous primary health care of the
community that it serves (Harris, 2006; Taylor et al., 2008). This requires the
ACCHS to stand in two cultural domains, one being the Indigenous culture
and the other being the western business philosophy; therefore, the CEO has
to consider both cultural domains before making any sudden changes within
the organisation (Coombe, 2008).

This western business philosophy has contributed to the shift between the
private and public system in health reform and the traditional western
managerial organisational culture (Micklan, Boyce, 2006). This shift has
brought about a necessity for organisational change among health care
providers whereby managers have to deal with policy, structural and funding
changes on top of their daily work practices (Micklan, Boyce, 2006). Unlike
other organisations (and as healthcare becomes more specialised), for the
ACCHS there is no room for error, as they have to balance these changes in
the western system along with the Indigenous cultural domain. Among these
challengers are the professional and clinical service sub-groups within the
organisation, which can potentially divide loyalties (Micklan, Boyce, 2006).
This makes it difficult for managers to maintain control during organisational
change and at the same time makes it necessary for managers to view
organisational change as an integral responsibility. This also means that
managers need to demonstrate to their employees the need and want to
change as they facilitate the change process within the organisation
(Ivancevich, Konopaske, Matteson, 2011).

Change can be complex; however, in its simplest form it can be defined as
moving from one state of being or understanding to another; it can be positive
or negative as perceptions, shared meaning, circumstances or functions shift
(Johnstone, Dwyer, Lloyd, 2006). For organisations, change occurs when the
organisation itself responds to pressures, whether environmental, structural or
people-orientated to take advantage of an opportunity, or when someone
within the organisation initiates the need for change to solve a problem
(Johnstone et al., 2006). Arguably, change can be seen as a pervasive, persistent and/or a new permanent condition for an organisation (Ivancevich et al., 2011) and it can happen at its own pace, whether swift, timely, dramatic or prolonged. On the other hand, however, if an organisation is forced into change mode, then it is likely to become anticipatory and can look broadly at environmental influences and opportunities for its growth and survival (Johnstone et al., 2006).

2.6.3.2 Indigenous workforce

There are many challenges facing Indigenous health in Australia, including the rural and remoteness of Indigenous people — the majority live approximately 100 kilometres from a hospital and their only accessible health care is an ACCHS (Turale, Miller, 2006). In addition, the Australian health workforce is at an acute shortage and the current geographic spread of the workforce does not reflect the distribution of the Indigenous and non-Indigenous population; and in some rural and remote areas the distribution of GP service provision is either inadequate or non-existent (Banks, 2005; Mason, 2013).

According to the 2011 census, 8,500 Indigenous people were identified as working in health-related occupations, representing 5.7% of the total Indigenous population aged 15 and over. Seventy-two per cent (and 72%) were women (AIHW, 2015). Of this Indigenous health workforce population, the biggest category, 33%, was identified as other (health service managers, nursing support workers, personal care workers, ambulance officers, paramedics and drug and alcohol counsellors). The second biggest category, 26%, included nurses or midwives and the third highest, 15%, were employed as an AHW (AIHW, 2015). Prior to the 2011 census, nursing support workers, personal care workers and drug and alcohol counsellors were referred to as AHWs. Also, apart from nurses and medical practitioners, there is little identification of other Indigenous health professionals in the Australian health workforce except for the AHWs (AIHW, 2011; AIHW, 2015). In 2003-04,
Indigenous people were estimated to be about 70% of the Australian health workforce, the majority being employed as AHWs in the ACCHSs (Rural Health Workforce Australia [RHWA], 2007).

In 1998 and in 2011, a national survey of AHWs found that two-thirds were female aged between 31 – 50 years and worked an average of nine years (Smith, 2007; AIHW, 2015). There is still very little national data on the clarity of the roles, responsibilities, career pathways and registration for AHWs, or indeed other Indigenous employees of the ACCHS (Smith, 2007). The AHWs are selected either by their community or the ACCHS to work within their local community. They understand the culture of the local community and reflect the values and the priorities of that community (Eckerman et al., 2006; Howard, 2006; Smith, 2007; Taylor et al., 2008).

The cultural brokerage role, combining western knowledge and their own traditional knowledge, that the health worker fulfils is not a uniquely Indigenous Australian concept, as health workers have held the cultural broker role internationally for decades (Smith, 2007). For instance, in China, local health workers were referred to as ‘barefoot doctors’ and in South America they were referred to as village health workers (Smith, 2007). The first AHWs role in Australia was developed in the 1950s in the Northern Territory to provide medical assistance to Indigenous clients. As community-controlled health services expanded, their roles became much more defined within the Indigenous primary health care framework (Smith, 2007). Today the AHWs working in the ACCHS are described as:

• Aboriginal and/or Torres Strait Islanders
• working within the Indigenous primary health care framework, and who
• act as cultural brokers between non-Indigenous health professionals and community (Eckerman et al., 2006; Howard, 2006; Smith 2007).

The employment of AHWs in ACCHSs is integral to the process towards achieving self-determination for Indigenous people because they are Indigenous and they understand the culture and how the culture reflects the
priorities and values of the local community (Taylor et al., 2008; Smith, 2007; Howard, 2006). They are also trained within the Indigenous primary health care framework (Eckerman et al., 2006; Howard, 2006; Smith, 2007).

The other integral Indigenous position within the ACCHS is the (normally) Indigenous CEO. Health service managers, or CEOs as they are referred to in the ACCHS, are defined by what they do, and what they do varies from organisation to organisation and the type of management style they use (Harris, 2006). Collins (1993) argues that there is no simple definition for management styles as it is basically about getting things done through people in organisations. Managers do this by employing other people and directing them, in an effective and efficient manner. The attributes and competencies that characterise effective management are a complex mixture of knowledge, skills, personal characteristics, beliefs, values, leadership, communication and education (Collins, 1993; Harris, 2006). Other contributing characteristics of effective managers include vision, competence, commitment to growth and clear goals, energy, enthusiasm, and the ability and readiness to take calculated risks (Collins, 1993).

Unlike other professional organisations there is not any real clear educational path towards health service management (Harris, 2006) other than colleges that offer health service management training. There has been no set licence or registration required to manage an ACCHS and certification has been at the discretion of either the manager of the organisation or in the case of mid-level health service managers, the CEO of the organisation (Harris, 2006). Certification to support CEOs or health service managers has included support and training from professional health service executive colleges, health administrative colleges, and/or health management institutions (Harris, 2006; Taylor et al., 2009). Competencies and qualifications from other disciplines provide CEOs or health service managers with a foundation for leadership and collaboration (Harris, 2006). While it is an advantage for the CEO or health service manager of the ACCHS to have some prior training, it is still not a requirement (Harris, 2006).
Usually the aim of the manager is to improve the purpose of the organisation; however the evolving pressures of society call for differing managerial styles to enhance the performance of an organisation (Collins, 1993; Harris, 2006). Managers cannot be held solely responsible for the organisation’s performance as performance is usually measured by the whole of the managerial team (Harris, 2006). Similarly, in the ACCHS, the organisation’s performance is measured and influenced by a number of members, including the Community Boards, strategic planning groups, health and social policies, and local, state and commonwealth funding (Dwyer et al., 2007; Shannon et al., 2006). Furthermore, the overseeing of the management and the actual operations of the ACCHS organisation are done in partnership between the community, Community Board of Directors and the CEO (Dwyer et al., 2007; Shannon et al., 2006; Taylor et al., 2008).

Currently there is a shortage of Indigenous health workforce, including the AHW and CEO, in the Australian health workforce (Banks, 2005; Smith, 2007). The lack of Indigenous health workers means that Indigenous people may delay using services. This is compounded with the reality that mainstream health services do not sufficiently take into account the Indigenous culture or the holistic view of health (Bainbridge, McCalman, Clifford and Tsey, 2015). A means to address this shortage of Indigenous health workers would be the development of a closer relationship between the health and education sectors guaranteeing two things:

- that both Indigenous and non-Indigenous people to be trained as culturally safe and competent health workers or professionals; and
- that the number of Indigenous people in the Australian health workforce is increased (Banks, 2005).

A closer relationship between the health and education systems would not only be beneficial to the AHWs and the CEOs of the ACCHS, it would also be advantageous to the whole of the Indigenous health workforce where training and retention are needed throughout (Smith, 2007; Taylor et al., 2008; Victorian Aboriginal Community Controlled Health Organisation [VACCHO])
Training for the Indigenous health workforce, in particular, should be an ongoing process because health and education are interdependent and without education there would be no health workforce to address the gap between Indigenous and non-Indigenous health in Australia (Banks, 2005; Calma, 2010, Chapman, 201b; Taylor et al., 2007).

2.7 Prior research addressing different domains influencing the ACCHS

In turning attention to past research that has addressed the different domains that influence the ACCHS, notably most ACCHS research has focused on the CEOs or health service managers. There has been minimal research that has examined the inequalities experienced by the ACCHS or how the ACCHS combine the western health system and the Indigenous cultural domain to deliver the ACCHS model of Indigenous primary healthcare. There are, however, some findings that are presented below.

2.7.1 ACCHS health outcomes

A relevant study by Togni, Rickards, Rowley, Brown (2011) used qualitative methods to conduct a focus group and in-depth interviews of seven Indigenous and non-Indigenous staff from the Urapuntja Health Service in the Northern Territory. This study was part of a larger study that began in 2005, and by combining both quantitative and qualitative research methods they were able to bring together a network of Indigenous and non-Indigenous researchers with the common purpose of improving Indigenous health. The larger study is called the Kanyini Vascular Collaboration (KVC). The section of the study relevant to this thesis is an in-depth exploration of the barriers and enablers of care for Indigenous people with chronic disease. The study results showed that several aspects of the service delivery model were identified as good examples of engagement with Indigenous people, such as:

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4 The Kanyini Vascular Collaboration (KVC) is a collaborative study between the Global Health Research Initiative, the Lowitja Institute, the University of Melbourne, the Elders of the Alyawarr and Anmatjerr Nations and the Central Australian Aboriginal Congress.
outreach, staff orientation, staff training, employment of local people and the incorporation of traditional healers. The enablers of care were based on the attitudes and values of the staff when delivering a health service for the community, as relationships were built upon trust, respect and the effective teaming of the Indigenous and non-Indigenous staff.

This same study, by Togni et al., (2011), further described how the levels of human and financial resources were seen as a vulnerability associated to this model of health service delivery, as these resources determined whether or not the outreach visits could be maintained. Another barrier was health care services were located far away from the community. Clients felt afraid and unable to communicate in unfamiliar environments in the services away from their community, including the hospital system, which did not seem able to address their needs effectively or appropriately. When a family member attended the service with the client, there was a lack of support for the accompanying family member.

In the same report\(^5\), a different study by Rickards, Rowley, Bailey, Jones, Tilmouth, Saraswati, Fitz, Guillemin, Brown (2011) explored local knowledge of health determinants at a health service using focus group discussions to contextualise mortality and morbidity data, and to increase knowledge relevant to chronic disease management. The outcome of the study highlighted the positive aspects about the community to the service provided by Urapuntja Health Service. The importance of the roles of kinship, and the obligations to the health of the community at the Urapuntja Health Service were identified. This study demonstrated that, within their roles, the staffs were able to support the Homelands communities of the Northern Territory, by incorporating traditional lore, cultural protocols and traditional medicine in their practice. These enablers promoted trust, good communication and respect and were important to maintain and further promote preventive health checks.

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\(^5\) The Urapuntja Health Service and Utopia Community, a report to the Teasedale-Corti Comprehensive Primary Health Care Project ‘Revitalising Health For All’ June 2011, on the KVC.
2.7.2 ACCHS CEO or health service manager

A report by Dwyer, Shannon and Goodwin (2007) described the challenges faced by the managers of 13 ACCHSs in Queensland. The authors described both the similarities and the differences in the problems raised by the ACCHS managers. The differences included access and the underfunding of services that had been identified by the government as a Closing the Gap priority but were not necessarily a community priority. The authors highlighted that many of the challenges could be simplified through supportive infrastructure and policies.

Another study about Indigenous managers highlighted the difference between non-Indigenous and Indigenous managers in relation to the cultural domains within which they operated (Hill, Wakeman, Matthews, Gibson; 2001). The researchers interviewed 41 Indigenous health service managers across four jurisdictions and described the organisational context in which these managers operated that included power differentials between the Indigenous domain and the western domain, and the tactics used by the managers to support their community’s interests and cultural protocols. They concluded that these tactics had the potential to become a model for other Indigenous managers in similar situations.

Based on the studies above, it is possible to identify the main concepts influencing the Indigenous primary health care model developed and delivered by the ACCHS. First and foremost is the role of the Indigenous manager in balancing the two domains of the Indigenous cultural worldview and the western organisation worldview. Secondly, the governance and accountability issues placed on the ACCHS impact on all areas of service delivery. These include government policy, regulations, reporting processes, access (for service delivery) and resources. There is minimal literature on Indigenous organisational behaviour or the interpersonal relationships in the ACCHS model of Indigenous health service delivery and that is the gap that this research aims to fill.
2.8 Key concepts from the literature

From the literature it can be theorised that the Indigenous primary health care framework is made up of a number of contributing concepts within the overarching umbrella of self-determination. As Figure 2.6 shows, these concepts include the community, the organisation and the culture. Within these concepts are the overlapping interconnected influencing factors that have been described in this literature review, namely:

- **Community** – history, policy, governance, Indigenous worldview, social determinants

- **Organisation** – accountability, communication, workforce, policy, location, primary health, health promotion

- **Culture** – cultural identity, cultural needs, cultural protocols, Indigenous worldview

The concepts have been shown in the literature to influence the overall structure of the ACCHSs and their decision-making processes. How the organisation manages these concepts determines the effectiveness of its output in delivering Indigenous primary health care. The concepts of community, organisation and culture will be used to provide a framework for this study.
### Figure 2.6: Theory of influencing concepts on ACCHS

**Input:**
- **Community**
  - History
  - Policy
  - Governance
  - Indigenous worldview
  - Social determinants

- **Organisation**
  - Accountability
  - Communication
  - Workforce
  - Policy
  - Location
  - Primary health
  - Health Promotion

- **Culture**
  - Cultural Identity
  - Cultural Needs
  - Cultural protocols
  - Indigenous worldview

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**ACCHS**
- Indigenous Chief Executive Officer
- Indigenous and non-Indigenous staff
- Community Board of directors
- Adequate programs
- Community engagement

**Output:**
- Servicing the health needs of the community
- Meeting the expectations of the Community Board
- Meeting the organisation requirements
- Ensuring cultural inclusion – sensitivity, awareness and safety is maintained

### 2.9 Chapter Conclusion

This literature review has explored the background to the development of the ACCHS and has shown how past policies have influenced the social determinants that continue to impact on the health and well-being of Indigenous people. The literature has demonstrated the ineffectiveness of the Australian health system in providing culturally-safe care that will contribute towards closing the gap between Indigenous and non-Indigenous people’s life expectancy, even though a plethora of funding has been allocated. The inequitable health outcomes have beckoned Indigenous people themselves to
develop an Indigenous primary health care framework, the ACCHS owned and run by Indigenous people, to address their own people's health needs in a culturally-safe environment. An overview of relevant research has been provided. The key concepts of community, organisation and cultural influences, presented in Figure 2.6, are being used to investigate the research aim and objectives.
CHAPTER 3
Methodology and Methods

Aboriginal health services have maintained the delivery of health services to Indigenous people of Australia for more than 40 years. In the previous chapter, information was presented about the history of Indigenous people’s health and the concepts influencing the ACCHS. What is being pursued in this study is a contextual understanding of how these people-centred organisations operate. A qualitative research design and a case study method was adopted. This chapter describes the method, approaches and strategies used to conduct this research.

As stated, the objectives of this research were to investigate the understanding of bureaucratic and organisational structures and functions of the ACCHS and the relationship between the ACCHS organisation and the ACCHS Community Board. The cultural factors of the community influencing the operations of the ACCHS were also explored. This research is not designed from a perspective of knowing what is best for reducing health disparities in Indigenous peoples, nor from the stance that Aboriginal health services are superior in delivering effective health for Indigenous peoples. Rather, it is designed to determine how the ACCHS balance both the expectations of the community and the requirements of the organisation for better health outcomes for Indigenous people.

3.1 Methodological choice

The contribution of research to the development of knowledge is necessary, including the process whereby theories are developed or refined, discoveries are made, events controlled or foreseen and ideas are confirmed or disputed (Morse, 1995). While no single research approach fulfils the requirements of all these processes, the contribution of qualitative research is important and unique to the goals of research in general (Morse, 1995). This research explores a new area with little or no existing theory within the subject area, of
Indigenous health service delivery; therefore it is exploratory rather than hypothesis testing. Furthermore, the research process relies heavily on the words and stories that people have told the researcher within their social world; this includes multiple perspectives of people involved within an ACCHS.

By focusing on the social world of the ACCHS, the experience, meanings and perspectives of the participants about their lived experiences and viewpoints will be captured. The paradigm of inquiry selected is therefore qualitative (Hansen 2006; Liamputtong 2010; Liamputtong 2009; Marshall and Rossman, 1999; Morse, 1995). Within the qualitative paradigm, the researcher will explore a single specific phenomenon, the ACCHS, and concentrate on experiential knowledge of each ACCHS case by paying close attention to the influences of the social, political (Stake, 2008) and cultural context (Liamputtong, 2009) of the ACCHS. The words and stories that the people have used within their social world is the lived experience of those ‘living the case’ (Stake, 2008, p. 121-2). In other words, this research will attempt to capture the life world of the Indigenous staff within an ACCHS and reflect on how they interpret their world.

The epistemological stance of an interpretive approach was applied to draw out how the participants within their ACCHS understood their actions. This was necessary to address the meaningful characteristics of how the participants associated with each other within the ACCHS (Liamputtong and Ezzy, 2009; Travers, 2001). Therefore the research is not about a specific reality of the world, but rather the people’s interpretations of their world (Green and Thorogood, 2004; Liamputtong and Ezzy, 2009). For this research the interpretative approach was utilised to understand the ACCHS world from the view of the participant (staff and Community Board members) and how the members of that organisation or society understood their actions, therefore how the people who work in the ACCHS understood the service, the style of management and how it is interpreted (Green and Thorogood, 2004; Liamputtong, 2009; Travers, 2001; Wills, 2007). This type of approach
emphasises the importance of the participants’ meanings, interpretation and experience of the phenomena (Holloway, 2008; Liamputtong and Ezzy, 2005; Wills, 2007).

To recruit participants purposive sampling techniques were used to seek and explore information-rich cases from whom to gain in-depth understandings and to examine the meanings, interpretations, processes and theories (Liamputtong and Ezzy, 2005; Patton, 1990). Often the trade off between quantitative and qualitative research methods is between the breadth and the depth of the study; where qualitative methods produce an abundance of detailed data via fewer numbers of cases and people (Liamputtong, 2009). This research was not designed to measure or deal with any form of statistical information, nor did it have predetermined sample sizes or sample sites usually associated with quantitative studies (Liamputtong and Ezzy, 2005) because this would have been inappropriate for these study questions. By using multiple sources of evidence, and a mixture of cultural communication techniques, the participants were encouraged to provide their own meanings to their experiences from their own perspectives.

In order to achieve this, a qualitative exploratory case study design was adopted. Stake (2008, p. 119) states that ‘as a form of research, case study is defined by interest in an individual case (or cases), not by the methods of inquiry used.’ Yin (2009, p. 18) adds that a case study as ‘an empirical inquiry investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident and in which multiple sources of evidence are used.’ The multiple sources of evidence used to investigate the contemporary phenomenon may include multiple persons or units (Depoy, 1998). In this research, the multiple sources of evidence included in-depth interviews, focused interviews and direct observations. Using multiple sources of evidence helped to ensure that the findings were conclusive (Yin, 2009). To draw depth into the study, the case study participants included the staff and a Community Board member for each
The participants, given their varied experiences both culturally and educationally, could give insights into the aims and objectives of the research.

3.1.2 Framework for this research

To establish the quality of any empirical social research, such as case studies, it is important that the research design represents a logical set of concepts (Yin, 2009). For this qualitative research, the logical set of concepts includes validity and reliability (Liamputtong, 2009; Liamputtong and Ezzy, 2005; Patton, 1990). The framework for this research, outlined in Figure 3.1, is a summary of Figure 2.6 (Chapter 2, p. 73), which identified the main concepts influencing the ACCHS, the relationship between them and how the information about them came together (Liamputtong and Ezzy, 2005; Maxwell, 2005; Paton, 1990; Yin, 1994). It was not constructed to test a theory or concepts outlined in a setting or population groups, rather, this research utilised a theory-building approach. In other words, the framework acted as a guide to determine which theoretical concepts and relationships were to be investigated in order to develop theory to address the research question and objectives (Glaser and Strauss, 1967; Paton, 1990; Yin, 1994).

To generate the framework, the concepts influencing the ACCHS (outlined in Figure 2.6) were summarised into higher order concepts to link to the research objectives. The ‘community’ concepts (Figure 2.6) are encapsulated as ‘socio-cultural’ factors in Figure 3.1; the ‘culture’ concepts (Figure 2.6) are summarised as ‘community expectations’ in Figure 3.1; and the ‘organisational’ concepts are summarised as ‘organisational requirements’ in Figure 3.1. The identified gap outlined by the ACCHS triangle in Figure 3.1, which this research explores, is how ACCHS staff and the Community Board are able to work within a number of imperatives to ensure that the organisational requirements and community expectations are met, within the socio-cultural context of the ACCHS.
The framework (Figure 3.1) is based on current evidence from Figure 2.6 that summarises the literature and provides a theoretical foundation to guide this qualitative case study research. ACCHSs are required to combine and operate across three unique imperatives, outlined in Figure 3.1 as:

i. the overarching Indigenous cultures that form the identity of the community where they live and work

ii. an understanding of community health needs and associated requirements, and

iii. an understanding of the pragmatics and governance associated with running an organisation.

The triangle with the inner arrows in Figure 3.1 represents this multi-layered and complex task.

The ACCHS formed the unit of analysis of the case study design. An ACCHS is effective as a unit of analysis in that as an Indigenous health organisation, it has developed the relationship between the community, the Indigenous
A multiple case study design of three ACCHSs were selected for the development of a robust study (Yin, 2009). In this research, each ACCHS was treated as a single case, allowing for an in-depth exploration of the relationship between the community, the Indigenous culture and the organisation itself (Stake, 1995; Yin, 2009; Yin, 1994). The similarities and differences between the three cases were then examined to form a theoretical model to answer the research question.

The framework shown in Figure 3.1 allowed for the emergence of themes, patterns and categories from the data due to interpretivist principles and the theory-building approach (Glaser and Strauss, 1967; Liamputtong and Ezzy, 2009; Patton, 1990; Strauss and Corbin, 1990). The process of theoretical sampling assisted in the full exploration of the data, meaning that the participant sample size was not defined prior to the commencement of the research but more so as the theoretical dimensions emerged from ongoing data analysis (Corbin, 1986; Ezzy, 2002; Green & Thorogood, 2009; Liamputtong and Ezzy, 2005). This process was continued in this research until it reached a point where, as the data was analysed after each case study, no new understanding was generated and it had reached a point of saturation (Ezzy, 2002; Green & Thorogood, 2009).

The use of this framework, Figure 3.1, in this research also addresses the issue of generalising the findings. This research used the process termed analytical generalisation, not statistical generalisation (Yin, 2009; Yin, 1994). The difference between the two is that statistical generalisation provides researchers with ready access to quantitative formulas that enable them to determine the degree of confidence with which generalisations can be made (Liamputtong and Ezzy, 2005; Patton, 1990; Yin, 2009). The analytical generalisation, used in this study, allows a previously developed conceptual theory to become the template from which to explore the empirical findings of the case studies (Yin, 2009). As this qualitative research had multiple cases, the empirical findings allowed greater explanatory power (Yin, 2009; Yin, 1994).
3.2 Validity

Validity of research refers to whether the researcher has accessed and accurately represented the social world under examination (Grbich, 1999). In this study, validity was achieved by triangulating the understanding of Indigenous culture and concepts, theoretical sampling and the identification of researcher bias.

A research design that uses multiple data collection strategies is known as triangulation (Patton, 1987). Denzin (1978) in Patton (1987, p. 60) identified four different types of triangulation: data triangulation, investigator triangulation, theory triangulation and methodological triangulation. Denzin (1978) in Quinn (1989, p. 61) explains, ‘No single method ever adequately solves the problem of rival causal factors…because each method reveals different aspects of empirical reality, multiple methods of observations must be employed. This is termed ‘triangulation’. This research used both methodological and data triangulation. The methodological triangulation involved using multiple methods such as in-depth and focused interviews and observations (Patton, 1990; Yin, 2009) to give strength to the case study research (Patton, 1987; Yin, 2009). The data triangulation involved having data from a variety of interviewee sources providing various points of view (Patton, 1987; Yin, 2009).

Data source triangulation in this research gained the different perspectives of the participants on the same phenomenon (Patton, 1989; Yin, 2009). This meant asking a variety of people engaged with the ACCHS, including the CEO, Community Board member, HR manager, Bringing Them Home counsellors, Health Promotion manager, administration officer, dental assistants and the AHW about their perceptions of the ACCHS world. The different perspectives were represented through the different sources of evidence used in the research.
3.2.1 Aboriginal and Torres Strait Islander cultural concepts

Indigenous knowledge is more than knowledge that is informed by research (Arabena 2008; Fredericks, 2008; Morseu-Diop, 2008; Smith 1999). It is a knowledge that encompasses the essence of Indigenous people’s way of life, ways of knowing and ways of doing (Denzin, Lincoln, Smith, 2008; Morseu-Diop, 2008; Rigney, 1999). To identify as an Indigenous person means that you come from a group of people that occupied lands prior to colonisation and possess a distinct language and culture (Kincheloe and Steinberg, 2008; Morseu-Diop, 2008). The investigator of this research is an Aboriginal and Torres Strait Islander person, from the Meriam Nation in the Torres Strait and the Wik Nation of the Western Cape in Cape York (Queensland), who identifies as an Indigenous Australian.

Researching Aboriginal and Torres Strait Islander peoples, as like other sensitive groups, requires special knowledge and skills (Liamputtong, 2006). Indigenous scholars have the understanding that each Indigenous community has its own interpretation of Indigenous knowledge, values and beliefs (Denzin, Lincoln, Smith 2008; Morseu-Diop, 2008). They bring with them an innate commitment to a set of Indigenous morals (Denzin, Lincoln, Smith 2008; Morseu-Diop, 2008) and display ‘acts of reclaiming, reformulating, and reconstituting indigenous cultures and languages … in the struggle to becoming self-determining’ (Smith, 1999 p. 142). In other words, these scholars are able to give validation and support to their own people’s realities. This requires the researcher, when researching Aboriginal and Torres Strait Islander communities, to have humility and respect, and to listen, observe and adhere to the cultural lore, values, customs, belief systems and traditions with commitment and dedication (Denzin, Lincoln, Smith, 2008; Morseu-Diop, 2008; Smith, 1999).

This researcher began establishing a relationship with QAIHC, the State representative body of the ACCHS in Queensland, through a project that ran parallel to the research, for two years, prior to ethical approval of this
research. The project required the researcher to be in the role of a cultural liaison person and provide occasional lectures and tutorials during the development and delivery of a health service management graduate certificate to QAIHC staff. Having an established relationship with QAIHC made it easier to ‘lift the veil’ (Patton, 2009, p. 75) meaning that as the cultural liaison academic, QAIHC personnel were able to communicate culturally with the researcher, and therefore were aware that she was an Aboriginal and Torres Strait Islander researcher and had an understanding of Indigenous knowledges and world view which is an understandable prerequisite when researching Indigenous peoples (Morseu-Diop, 2008). Therefore, the perceived barriers associated with prior commonness, in this case being the cultural liaison academic and having a prior relationship with QAIHC, to a potential site, the ACCHS, would not have automatically provided the researcher with high regard or inclusion into a site (Marshall and Rossman, 1999). It was that the researcher was an Indigenous Australian and understood the participants’ Indigenous knowledges and worldviews.

3.2.2 Insider / outsider

The fact that the researcher is an Aboriginal and Torres Strait Islander enhanced the validity of this research due to her close proximity to Aboriginal and Torres Strait Islander culture. Indigenous people understand their Indigenous culture in ways that the wider Australian community and international community do not, including the fundamental similarities and differences across the Aboriginal and Torres Strait Islander cultures within Australia (Dudgeon, Wright, Paradise, Garvey, Walker, 2010). In that sense, Indigenous researchers are insiders when researching their own cultural people. For Indigenous researchers, this can create the dilemma of what to reveal within the research, potentially threatening the validity of a study (Castellano, 2004; Denzin, Lincon, Smith, 2008; Fredericks 2008; Morseu-Diop, 2008; Sheehan et al., 2009). This threat, however, was overcome in this research by the researcher using the lens of an academic discipline — public
health — as a basis for the study. As Congalton & Daniel (1976, p. 56-60) argue:

It is usual for members of each society to take for granted that their culture is superior to others … and because of this … in an effort to evaluate someone’s behaviors, there is the danger that you will be evaluating it from your own cultural standards.

To maintain the validity of the study, the researcher therefore, also had to fulfil the role of an ‘outsider’ to neutralise any cultural bias and report accurately the participants’ world under study (Bridges, 2001; Morseu-Diop, 2008; Smith, 1999).

In this study, the insider/outside role was balanced through the researcher, being an ‘insider’, having to maintain the respectful understandings of Indigenous ways of doing and knowing. This meant following the Indigenous protocols for communication whereby it is important to state the Indigenous country the individual is from and his/her family line. The Indigenous participant therefore acknowledges the researcher’s understanding of Indigenous protocols on the participant’s country, as a form of respect.

The researcher fulfilled the ‘outsider’ role when describing the university ethical requirements to participants, providing them with an informant document and obtaining a signed consent form. Open discussions about ownership of the research occurred during the interviews and the participants would often ask for the recording to be stopped and the question rephrased in lay terms.

An advantage that derived from the researcher being Indigenous was the ease of interpersonal communication and understanding with other Indigenous people and the ability to adhere to the western ways of research within an Indigenous context. Conversely, a disadvantage was that sometimes assumptions were made because no two Indigenous cultural groups are the same and knowledges, the sense of knowing and doing of
Indigenous culture, may have been taken for granted without confirming or reflecting. To overcome this disadvantage, the researcher had conversations with the QAIHC personnel before and after each case study about the interpersonal communication observed and the cultural protocols that were unique to each community.

3.3 Reliability

The goal of reliability is to minimise the errors and biases within a study (Yin, 2009). The objective of reliability is to make it possible for another investigator to conduct the study by following the same procedures and arrive at the same findings and conclusions (Yin, 2009). Ensuring reliability within this research consisted of several procedures during the research process. Firstly, a pilot study was conducted and the lessons learnt, such as the wording of questions for participants for example, was recorded and applied to all the case studies.

Secondly, after receiving the transcriptions of the tape-recorded in-depth interviews, the researcher listened to the recordings again to ensure the accuracy of the transcriber. This was necessary because the reliability of transcripts could be weakened by a failure to transcribe (Silverman, 2005) and/or understand the words and cultural pauses, in this case, of the Aboriginal and Torres Strait Islander participants.

Thirdly, all transcripts were cleaned in the same manner, such as the deletion of non-relevant information, to maintain consistency. Fourthly, all the data for each case study was uploaded into a content data analysis tool, Leximancer, in the same manner and according to the same procedure. The three case studies, plus the pilot study, were analysed a second time using the same procedure to ensure reliability of the Leximancer text analysis. Finally, all the transcripts produced by the Leximancer tool were manually analysed to ensure that the full meaning of the text was identified and had not been overlooked by the Leximancer tool (Coombe, Lee, Anders, Muscat, Vally, Robinson, Stewart, 2012).
3.3.1 Audit trail

One strategy to establish compliance in qualitative research is an audit trail (Liamputtong, 2009). An audit trail allows the researcher to demonstrate, with evidence, how the research was carried out and how they came up with their findings and interpretations (Liamputtong, 2009). To protect the data for this research an audit trail, or chain of evidence (Yin, 1994), was established. This was achieved by means of field notes from the initial stage of establishing trust with QAIHC, during data collection and during the data analysis procedure. This documentation allows the exact procedure followed in this study to be available if the study is to be replicated.

3.4 Ethical considerations

Aboriginal and Torres Strait Islanders have a history of being over-researched with invasive and inappropriate research techniques from non-Indigenous individuals and organisations (Fredericks, 2008; Humphrey, 2001; Liamputtong, 2005; Paradies, 2006; Tachacos, 2004). Therefore, it was necessary for this study to have two types of ethical approval. The first was to obtain ethical approval, used for the general population, from the Griffith University Human Research Ethics Committee (GUHREC), Reference: PBH/15/09/HREC (Appendix 1). This approval was conditional to the research. It required that 12-monthly reports during the data collection phase for all population groups, to ensure that appropriate research techniques, as set out by the researcher in the ethics application, were maintained throughout the research process (National Health and Medical Research Council [NHMRC], 2003). These reports required a full description of the research process.
3.4.1 Griffith University approval

The main considerations for approval from the Griffith University Ethics Committee that was especially relevant to the research was the selection of case study sites affiliated with QAIHC and the ownership of research data. These issues were addressed in discussions held with members of the QAIHC Board. The discussion involved a small presentation by the researcher and provision of all documents (Griffith University Ethics Approval – Appendix 1; information sheet - Appendix 2; consent form - Appendix 3) to the QAIHC Board and the CEOs of all the case study sites.

3.4.2 QAIHC approval

The second approval for this research was in the form of support and respect from QAIHC to encourage Indigenous involvement in the research (Humphrey, 2001), and for the researcher to establish an ethical relationship (NHMRC, 2003) with the Community Boards of the ACCHS that were part of the study. Invasive techniques into people’s lives and communities without permission and without regard to Aboriginal and Torres Strait Islander people’s right to participate in research has made trust with Aboriginal and Torres Strait Islander people and community members essential and that must be developed and maintained (Castellano, 2004; Fredericks, 2008; Richards et al., 2011). In addition, because historically research has also been used in history to oppress Aboriginal and Torres Strait Islander people, and because it is outside of their own cultural values and beliefs, for partnerships to exist between the researcher and the Indigenous community there needs to be an established form of respect (Denzin, Lincon, Smith, 2008; Federicks, 2008; Laycock, Walker, Harrison, Brands, 2011; Lowell, 1998; Morseu-Diop, 2008; Tchacos, Valliance, 2004; NHMRC, 2003; NHMRC, 2002).

To maintain respect between the researcher and the Indigenous ACCHS communities, a foundation of respect needed to be established (Denzin,
Lincon, Smith, 2008; Federicks, 2008; Humphrey, 2001; Laycock, Walker, Harrison, Brands, 2011; Lowell, 1998; Morseu-Diop, 2008; NHMRC, 2003; NHMRC, 2002; Tchacos, Valliance, 2004). To achieve this, the researcher made an appointment with the QAIHC CEO\(^6\) to discuss the data collection process. This involved QAIHC nominating someone who would suggest the study sites that could be included in the research. That nominated person would also be able to express any concerns as to whether or not the research techniques would be invasive to the community. This enabled the research to reflect the values and beliefs of the Indigenous Australian people (Fredericks, 2007; Laycock, Walker, Harrison, Brands, 2011). Acknowledgement and respect of the underpinning beliefs and values that are part of the Indigenous Australian culture, such as this, helps to strengthen research with Indigenous peoples (Denzin, Lincon, Smith, 2008; Fredericks, 2007; Humphrey, 2001; Laycock, Walker, Harrison, Brands, 2011; Morseu-Diop, 2008; NHMRC, 2003) within a self-determination framework.

The nominated person from QAIHC suggested which ACCHS sites could be accessed for this research. Such nominated people from the ACCHS are essential when researching vulnerable groups, including Indigenous peoples, as they act as a form of protection against invasive research techniques (Laycock, Walker, Harrison, Brands, 2011; Lee, 2005; Liamputtong, 2009). The suggestion of sites was a form of purposive sampling in that cultural reasons such as ‘ceremonies’ or ‘sorry business’\(^7\) within the community of the ACCHS either prohibited or enabled participation in this research. After consideration and consultation with the nominated person regarding all the ACCHS eligible to participate in the research, four ACCHS were approached and agreed to participate in the study. One ACCHS was a pilot and the other three formed the case studies for this research. After the agreement by the ACCHS to participate in the research, purposive sampling occurred to

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\(^6\) QAIHC like many organisations has a high turnover of CEOs and during the duration of this research they went through three CEOs.

\(^7\) ‘Sorry business’ is the process of mourning undertaken by Aboriginal and Torres Strait Islander people following the passing of an individual, family or community member. This process can be ongoing for several weeks, depending on the respect level of the participant within their community and the way in which they passed away.
interview the CEO, a Community Board member and an AHW, and snowballing occurred to recruit other participants (Liamputtong and Ezzy, 2005). This meant that following a participant’s data collection, the participant was asked to suggest the next person who might be willing to participate in the research. Theoretical saturation occurred when there was no new data emerging. Throughout all of the sampling strategies, voluntary participation and informed consent were always upheld. Several people who were nominated, about two to three participants per case study, chose not to participate, and the reasons given for non-participation was that participation imposed on their personal lunch breaks.

3.5 Data-gathering plan

The research relied on a number of data sources, the relevance of which is shown in Table 3.1 of the research plan. The table demonstrates how the objectives and the methods relate to the conceptual framework shown in Figure 2.6. The focus of inquiry represents the identified influencing factors of the ACCHS.
Table 3.1: Research plan

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Focus of Inquiry</th>
<th>Methods</th>
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</thead>
<tbody>
<tr>
<td>1. Investigate participants understanding of bureaucratic and organisational structures and functions of the ACCHS.</td>
<td>Organisation</td>
<td>• In-depth Interviews (all study participants)</td>
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<td></td>
<td>Leadership</td>
<td>• Focused Interviews (CEO and Community Board member)</td>
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<td>Communication</td>
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<td>Funding structure</td>
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<td>Health promotion</td>
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<td>Workforce</td>
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<td>Location</td>
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<tr>
<td>2. Explore the relationship between the ACCHS organisation and its Community Board.</td>
<td>History</td>
<td>• In-depth Interviews (all study participants)</td>
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<td></td>
<td>Policy</td>
<td>• Focused interviews (CEO and Community Board)</td>
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<td></td>
<td>Governance</td>
<td>• Direct observations</td>
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<td></td>
<td>Indigenous worldview</td>
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</tr>
<tr>
<td>3. Review the history and focus of the ACCHS, and explore the socio-cultural factors influencing its operations</td>
<td>History</td>
<td>• In-depth Interviews (all study participants)</td>
</tr>
<tr>
<td></td>
<td>Cultural identity</td>
<td>• Direct Observations</td>
</tr>
<tr>
<td></td>
<td>Cultural needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cultural Protocols</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indigenous worldview</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social determinants</td>
<td></td>
</tr>
</tbody>
</table>

3.5.1 In-depth interviews

A total of 18 in-depth interviews were conducted with CEOs, members of Community Boards, middle managers, administrators, and AHWs. The exact breakdown is presented in Table 3.2 below.
Table 3.2: Interviews conducted

<table>
<thead>
<tr>
<th>Cases</th>
<th>Category</th>
<th>In-depth interviews</th>
<th>Focused Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilot</td>
<td>CEO</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Community Board</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Middle Managers</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Administrators</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>AHW</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>CEO</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Community Board</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Middle Managers</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Administrators</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>AHW</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>CEO</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Community Board</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Middle Managers</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Administrators</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>AHW</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>CEO</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Community Board</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Middle Managers</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Administrators</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>AHW</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>6</td>
<td>2</td>
</tr>
</tbody>
</table>

The selection process of the interviewees was largely opportunistic. In all the cases, the CEO of each site suggested the participants for the in-depth interviews. The interviews were conducted after an initial meeting and discussion of the research with the CEO. Each CEO organised a room, and a schedule was arranged around each participant’s work so that that person was always covered in the workplace. However, although these arrangements were put in place, each participant nominated the next participant depending on availability this is consistent with snowballing strategy.

The aim of the in-depth interviews was to let the participant’s viewpoint, rather than that of the researcher (Marshall & Rossman, 1999), unfold. All the participants were Aboriginal and Torres Strait Islanders. As the researcher was also an Indigenous Australian, there was an established understanding about cultural sensitivity when communicating with Indigenous peoples; in other words, there was no cultural sensitivity barrier for the participants to
overcome when responding to the questions (Fredericks, 2008; Paradies, 2007; Tchacos, Vallance, 2004).

Key themes that were explored in the interviews included:

• The history of the ACCHS and the local community
• Addressing of health issues within the community
• Community Needs
• Community Board
• Culture (identity, expectations, protocols)
• Leadership roles within the organisation
• Understanding of the organisational structure and requirements
• Types of services offered, and
• Health services approach to meeting client needs.

An interview guide is provided in Appendix 4. All participants were informed of all the ethical obligations of the study, including confidentiality and freedom to withdraw from the study at any time.

3.5.2 Focused Interviews

The purpose of the focused interviews was to allow open-ended questions to be asked of the participants in a short period of time (Yin, 2009). These focused interviews were timed to take no longer than twenty minutes and were undertaken with the CEO and Community Board members to understand the intricacies of the organisation and the qualifications of the Community Board members. The questions asked in the focused interview are provided in Appendix 5. These interview questions were to be asked following the in-depth interviews, or they could provide written responses to the interview questions and mail these back to the researcher or the researcher could collect them later. The participants for the focused interviews consisted of the CEO and a Community Board member for the case study sites, however responses to the focused interviews were only received for two out of three sites as shown in Table 3.2.
3.5.3 Direct observations

For this research there was one direct observation at each of the four ACCHS. The reasoning behind the direct observations was to provide a new dimension to the phenomenon being studied (Yin, 2009), consistent with methodological triangulation. These observations were less formal and were undertaken on field visits to the ACCHS sites during the data collection phase following the signing of the informed consent, and participants were reminded that they could withdraw from the research at anytime. The observations focused on the environment of the ACCHS, including the interactions between staff, and between staff and Community Board members (such as Board members) accessing the service. The steps of the observation involved arriving an hour early prior to the first in-depth interview, sitting in the waiting rooms to observe staff interactions, and collecting samples of health-promotion brochures and any available newsletters. Following the interviews, the observations were entered into a Word document to be included in the analysis. The direct observation criteria are provided in Appendix 6.

3.5.4 Selection and access of sites

At the time of this research there were 25 ACCHS in Queensland, of which 15 were considered by the QAIHC able to participate. Of that 15, four agreed to participate in the research, one as the pilot and three case studies. The other 11 ACCHS had a form of ‘ceremony’ or ‘sorry business’ at the time allocated for this study’s data collection. The pilot and the three case studies were located mainly in Central and South-East Queensland.

These sites were a considerable distance from each other, each covering their own local regions. The sites varied in population and access to general services and facilities. There were two overarching constraints to the site selection process; one was in accordance with the GUHREC Ethics Approval and the other in accordance with the whole community where the ACCHSs
were based. The constraining factors in accordance with the GUHREC ethics included:

- the ACCHS had to be affiliated with QAIHC
- the ACCHS had to be in Queensland
- upon receiving ethical approval, the CEO, the Community Board and the staff of the ACCHS had to agree to participate in the study and had to accept that the researcher owned the data.

The constraining factors affecting all sites selection from the community perspective included:

- whether or not there had been some recent deaths or suicides; or
- if the community was coping with a Black Death in Custody; or
- if the community was dealing with Land Rights; or
- if there were major underlying issues from the Stolen Generation; or
- if there was a major change of staffing in the ACCHS; or
- if the community was currently affected by a natural disaster.

Even though these factors may not have overtly inhibited the ACCHSs that were involved in the research at that time, it is not to say that they were not affected by any of these factors at any time during the data collection. Upon arrival at some of the sites, it was found that the ACCHS were either commencing a change management process or completing one, therefore accounting for a major change in staffing.

Following the QAIHC suggestion of the ACCHS sites, a request was sent to the CEO and Community Board of Directors of each site. The speed with which the Boards agreed to accept the research varied, from a six-week to a three-month turn-around from the initial letter of invitation to approval. As the CEO was the key person within the ACCHS, it was essential that the research catered to his or her schedule and availability (Yin, 2009).

The snowballing strategy was applied at each site through the CEO. Following a meeting with the CEO of the nominated ACCHS, that CEO would then
nominate the next participant and they in turn nominated the next participant. Snowball sampling is a technique used when the people being studied are well networked (Liamputtong and Ezzy, 2005) and in the case of this research the participants were drawn from the ACCHS and they in turn came from the community for which the ACCHS provided the health service. As the focus of this research was the ACCHS and the ACCHS are organisations initiated and controlled by Indigenous people (NACCHO, 2003) - a unique characteristic for a medical service - the snowball sampling in this research resulted in a largely homogeneous sample (Liamputtong and Ezzy, 2005).

In all cases the same ethical protocol was followed. Information about the study was provided in writing and signed consent was given by the participants to participate in the research. Following the consent and explanation of the research, all in-depth interviews were recorded using a recording device, to ensure that the recordings remained systematic and to provide accurate transcripts (Marshall, Rossman, 1999, p. 148). Participants were reminded that they could withdraw from the research at any time without any repercussions to themselves or their community. Consent to conduct observations was obtained only from the CEO on the provision that confidentiality was maintained, and on the basis that ethical obligations pertaining to data storage were upheld.

The management of the data was ongoing throughout the research. All the collected data, including the in-depth interviews, the focused interviews and the observations, were stored on a computer file to which only the researcher had access. Coding of the data was continuous throughout the data collection process. This consisted of numeric codes for the different case studies (1, 2, 3) with common identifications used for the different participant positions. These included CEO, Community Board, HR (Human Resources manager), BTH (Bringing Them Home counsellor), AHW (Aboriginal Health Worker), Rec (Administration person). This was done within each ACCHS to differentiate the employment categories of the participants. This was an efficient process for preserving data and the meanings on tape and when pooled together
through transcriptions increased the efficiency of the data analysis (Marshall & Rossman 1999). All these evidence sources were analysed in a similar manner (Yin, 2009) to reduce any bias and enhance the reliability of the study.

3.6 The pilot site

The first ACCHS was the pilot for this research. The purpose of the pilot was to refine the data collection plan, meaning that both the content of the data and the procedures to be followed were appropriately aligned with the data collection plan (Yin, 2009). Even though the Australian Standard Geographical Classification – Remoteness Area (ASGC-RA) classified this site as remote, it was based close to the city, making it easy to access. Classified as RA4 under the ASGC-RA reflects the moderate population level and its physical closeness to a capital city, with limited transport options (Greater Metro South Brisbane Medicare Local [GMSBML], 2011). The person nominated by the QAIHC organised the pilot with the Community Board and the CEO. This person had a prior relationship with the health service as it was situated within their home community, therefore making access convenient (Yin, 2009). The pilot data proved useful in respect of the basic issues being studied within this research (Yin, 2009) and for making the necessary changes to the research procedures when communicating with the participants and the ACCHS organisation. Only one in-depth interview was conducted at this site, with the CEO of the ACCHS, and one observation was completed.

The pilot transcript and site observation were analysed, using the Leximancer software tool to identify common concepts and conceptual links (Smith, 2003; Smith, 2000) in the data. To ensure the accuracy of the Leximancer analysis, a second data analysis, which was thematic, was conducted on the pilot transcript. This thematic analysis was undertaken to identify any important insights from the text that were not identified in the concepts identified by the Leximancer software (Coombe et al., 2012). This required highlighting the
recurrent or common themes and summarising and prescribing codes as they emerged, a common process in qualitative research (Green and Thorogood, 2004; Liamputtong and Ezzy, 2005; Marshall and Rossman, 1999). The thematic analysis was able to draw out essential meaning of themes and concepts (that had been identified in the conceptual Leximancer analysis) the Leximancer could be manually programmed to identify similar themes and concepts, providing a visual concept map of data that connected to the text.

Following the pilot, a discussion was held with the nominated QAIHC representative; this set a precedent for the discussions that the researcher would hold with the QAIHC representative following data collection at each of the ACCHS case study sites. The discussions were about the sites themselves and the researcher’s communication techniques; no participant names were referred to. The communication centred on whether or not the researcher had adhered to the Indigenous ways of knowing and doing, and was able to maintain respect. The preference was for a verbal discussion rather than a written report, as a written report would be submitted to QAIHC and would conflict with the confidentiality surrounding the ethics of this research. Following the first discussion, the QAIHC nominee then provided a list of suggested ACCHS to participate as case studies. The data from these sites were collected from February 2010 to December 2010.

3.6.1 Data analysis

A two-stage process achieved the analytical strategy for this research: Leximancer content data analysis (Smith, 2003) and thematic analysis (Marshall and Rossman, 1999). The content data analysis was manually programmed to draw out concepts based on the frequency with which words were mentioned together. Following this, concepts linked together on developed pathways were then explored to see which pathway produced the most data that could answer the research question. These data were then thematically analysed to add depth and to explore the relationships to best address the research question and aims.
3.6.1.1 Data cleaning

Before analysing the data, all collected data were cleaned, meaning that all the transcripts and observation were de-identified. One-word answers such as ‘yeah’ and ‘nar’ were removed, as participants were encouraged to elaborate following a one-word response, and these open-ended responses were used in the analysis. Being asked to rephrase a question was common throughout all sites. Any questions, from any participants, that asked for a question to be rephrased were removed from the analysis so that these questions would not be mapped into the text. The participant’s responses to the rephrased questions, however, were included in the analysis. The word ‘facilitators’ was also removed from the analysis.

3.6.1.2 Leximancer analysis

Following data cleaning, the data analysis underwent a two-stage process. The first stage of data analysis was through Leximancer, a computer-assisted qualitative data analysis program (Smith, 2003), as previously noted. This involved a soft copy of each transcript being separately uploaded into Leximancer. Leximancer rapidly maps a text document using concept dimensions or themes, to produce a concept map (Smith, 2003; Smith, 2000). The user requirements for the text can be manually entered or they can be chosen automatically without any suggested changes to the different stages of processing. Both processes, either manual or automatic, produce a representation of the concepts present in the data (Smith and Humphreys, 2006; Smith, 2003; Smith, 2000).

An automatic analysis of the data from the pilot study involved uploading the transcripts and pressing the auto generate button on the Leximancer site to create the concept map. From this, it was determined that manual programming was needed to provide a more comprehensive analysis of the data and add more depth to the analysis. The analysis tool was therefore manually programmed through the different stages of processing to generate
an output, in the form of the concept map shown in Figure 3.2, with concepts that represented the uploaded data.

The concepts identified by the Leximancer software tool and shown in Figure 3.2 consist of the collection of words that travelled together throughout the uploaded text (Smith, 2003; Smith, 2000). For example the concept of ‘service’ may contain the key words ‘service’, ‘health’, ‘money’, ‘outcomes’, ‘funding’ and ‘client’ (represented by the bold text in the ‘service’ circle). The concept ‘service’ is identified as occurring most frequently in the text. The words ‘health’, ‘money’, ‘outcomes’ and ‘funding’ are the words that ‘service’ most frequently travels with. This process presents both all the concepts that are contained in the text and their relationship to each other; for example in Figure 3.2, the concepts are those in other circles, such as ‘organisation’, ‘Board’ and ‘others’.

![Figure 3.2: Example of a concept map](image)
The map in Figure 3.2 contains the main concepts that have occurred within the text. The brighter the concept label (for example, ‘service’) the more frequently the concept occurs in the text. The brighter the colour of the concept labels (again, such as ‘service’ in Figure 3.2), the higher its percentage of connectivity to other concepts in the map. Table 3.3, outlines an example of the concepts and the percentage of their connectivity to other concepts. For example, using the concepts from Figure 3.2, the concept ‘service’ is 100% connected to sub-concepts of ‘service’, ‘health’, ‘money’, ‘funding’, ‘outcomes’ and ‘clients’. The concept ‘community’ is 71% connected to the sub-concepts of ‘community’, ‘people’ and ‘needs’. The concept ‘organisation’ is 46% connected to ‘organisation’, ‘position’ and ‘provide’.

**Table 3.3: Example of concepts**

<table>
<thead>
<tr>
<th>Concept</th>
<th>Connectivity</th>
<th>Sub-concept</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
<td>100%</td>
<td>Service, health, money, funding, outcomes, clients</td>
</tr>
<tr>
<td>Community</td>
<td>71%</td>
<td>Community, people, needs</td>
</tr>
<tr>
<td>Organisation</td>
<td>46%</td>
<td>Organisation, position, provide</td>
</tr>
<tr>
<td>Board</td>
<td>38%</td>
<td>Board, staff, work</td>
</tr>
<tr>
<td>Individual</td>
<td>15%</td>
<td>Individual, job</td>
</tr>
<tr>
<td>Role</td>
<td>12%</td>
<td>Role, leader</td>
</tr>
<tr>
<td>CEO</td>
<td>9%</td>
<td></td>
</tr>
</tbody>
</table>

The lines on Figure 3.4, illustrate the connectivity between concepts; these connections represent ‘pathways’ or relationships between specific concepts. To produce the pathway from one concept to another concept requires clicking (on the Leximancer software) on a start and end concept point involving the concepts with the highest percentage of connectivity. When the pathway is clicked on, it produces queries from within the text in relation to those particular concepts that show in-text data that support the identification of that pathway. An example is given in Figure 3.4, p. 120, where the start
point is ‘funding’ in the concept ‘service’ (Table 3.3 shows that it has the highest connectivity) and the end point is ‘CEO’.

**Figure 3.3: Example of a concept map pathway**

The aims and objectives of this research guided the selection of pathways in the concept maps to investigate. The queries resulting from the exploration of the pathways produced the most in-text data, as shown in Box 3.1, p. 121. The purpose of using either a concept or a sub-concept is to ensure that enough queries were produced after manual programming the Leximancer. The colouring of the circles was not a focus in this analysis as it was more about the connectivity, concepts and sub-concepts, and the pathways that produced enough queries.
Table 3.1: Example of query results

<table>
<thead>
<tr>
<th>Query Results</th>
<th>FILE: case 1 a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Query: WORD: community AND WORD: organisation AND WORD: Board</td>
<td>But it's not the broader community; it's members of the organisation. So a mainstream version is that the shareholders of BHP vote in the Board.</td>
</tr>
<tr>
<td></td>
<td>Here the shareholders of the organisation, the membership base - you have to pay and apply to become a member - that membership base vote in somebody from the membership base. So you couldn't go, I'm a community member; I want to be a Board member.</td>
</tr>
<tr>
<td></td>
<td>The Board members will pick one, the chair of the Board is the elected member of the elected representation from that community. Once they're voted in and put there, then it's their job to provide the strategic direction of the organisation on behalf of the community.</td>
</tr>
<tr>
<td></td>
<td>So what should happen between the Board - and I can only talk for limited time here, but I can only talk from my perspective again - what should happen is that an elected community Board is responsible for the strategic direction of the organisation, for the medium to long term.</td>
</tr>
</tbody>
</table>

To ensure data triangulation and the validity of the research, it was necessary to explore a variety of pathways until one was found (such as one similar to that in Figure 3.3) that had generated enough queries that further took into account a variety of different participant perspectives in each case study. The queries were then reviewed by going back to the participants’ transcripts to ensure that the manual programming reflected their views.

3.6.1.3 Thematic analysis

Although, the Leximancer content data analysis software tool identified typical concepts that related to the conceptual pathways (Smith 2003; Smith 2000), a second data analysis process was conducted to identify detailed themes within the concepts to answer the research question. This addressed the limitations of Leximancer, namely that it was unable to identify the complexity of themes and relationships that best reflected the data (Coombe et al., 2012). This thematic analysis produced recurrent or common themes that were evident in the queries within each selected pathway of each case study. The themes were developed from the categories formed from the queries - one of
the most common approaches in qualitative research (Green and Thorogood, 2004; Liamputtong and Ezzy, 2005; Marshall and Rossman, 1999).

This thematic analysis was then conducted to draw out the essential meaning of the themes that could contribute to the development of a theoretical framework once all the case studies had been analysed. Key findings from each of the case studies were combined to form a theoretical model of how the ACCHSs balance their organisational requirements with community expectations.

3.7 Conclusion

This chapter has provided an overview of the research methodology and methods used to investigate the aims and objectives for this research. This qualitative case study research design has been described along with methods to ensure the validity and reliability of the research. The research was conducted from both an academic researcher view and an Indigenous standpoint. Based on the framework for the research outlined in Figure 3.1, the analytical procedures for this research using the Leximancer content data analysis tool, along with thematic analysis, were outlined. The next three chapters present the findings of the ACCHSs investigated.
Chapter 4  
ACCHS 1 Case Study

This chapter presents Case Study ACCHS 1. As with all the following chapters of findings, this chapter is presented in five sections:

• **Section 4.1** describes the geography and the demographic characteristics of the ACCHS community.\(^8\)

• **Section 4.2** provides a discussion of the case study selection criteria and the data collection procedures relevant to this particular case study.

• **Section 4.3** provides details of the data cleaning process used for this case study.

• **Section 4.4** presents the detailed findings, and

• **Section 4.5** highlights this case study’s key findings to contribute to the development of the theoretical framework.

4.1 Community context

The ACCHS for Case Study 1 was (and is) located in Central Queensland and has a rural outreach service that extends towards the Queensland and Northern Territory border. At the time of this research, this outreach service catered to a clientele of around 5000 people throughout the region, including both Indigenous and non-Indigenous people\(^8\).

The region’s total population, comprising both Indigenous and non-Indigenous people, was below 150,000\(^8\), and of that population, approximately 0.8% were Indigenous, and half of that Indigenous population resided in one of the region’s major towns. Of the total population (Indigenous and non-Indigenous)  

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\(^8\) Due to the ethical considerations of the participants and their communities, there are no in-text references that could potentially identify the community. All references used are listed together in the References section at the end of the thesis.
26.7% were under 17 years and 19.7% in the 60-years-and-over age group. The average individual income per fortnight was between $930 and $951, placing this region and its surrounding districts in the middle of the low socio-economic disadvantage index.\(^8\)

The impact of colonisation dates back to the 1850's in this region and included warfare and violence between the Indigenous and non-Indigenous peoples. This area in Queensland in fact endured colonial warfare from 1853 for more than 100 years (Darumbal Enterprises, 2016; Gumoo Woojabuddee Section Fact Sheets – Australian Commonwealth N/D). Issues such as these have had a longstanding and profound effect on the Aboriginal and Torres Strait Islander community, causing this ACCHS to provide extra services to accommodate these effects. The ‘ Bringing them Home’ counsellors to promote social and emotional well-being as a result of the Stolen Generation are an example of such a service.

4.1.2 ACCHS community

This community-controlled health service had more than 40 staff across an on-site clinic, including 14 on-site AHWs, two AHWs in each mobile clinic, and a mobile outreach. There were three mobile outreach clinics that covered this ACCHS rural region. The staffing on-site consisted of:

- a CEO with a personal assistant
- a finance manager with two support staff
- a health promotion manager with six team managers, each managing two AHWs
- A human resources manager with two staff
- two receptionists and two drivers, and
- two - three general practice (GP) locums, two nurses and two AHWs

For each mobile clinic there was a manager, an administration person, a nurse, two AHWs, one GP locum, and a ‘ Bringing them Home’ counsellor. The services offered on-site included:
• GP services
• a well person’s health check
• nutrition program
• ‘Bringing them Home’ counsellors
• mums and bubs program
• sexual health program
• diabetes clinic
• cardiovascular disease clinic
• smoking program
• immunisation program
• asthma program

The mobile clinics offered a GP service, the ‘Well Person’s’ health check and other minor services depending on where the clinic was situated. The layout of the on-site clinic included a reception area and a general practice area with the GPs, nurses and AHWs worked. There was an area where health-promotion services (e.g., other programs and clinics) were advertised, this being a wall display of brochures at the entrance to the ACCHS.

4.2 Case selection and data collection procedures

The time from the first email inviting the ACCHS to participate in the research to their agreement to participate took approximately four months. All correspondence for this case study was done through the CEO, who had been in the position for eight months. Within the first two months of communication, the CEO made the decision to take all the information pertaining to the research to the Community Board and obtained approval for the research to be conducted. In this initial stage, the CEO requested via a phone call that the research team wait until approval had been obtained from the Community Board before coming to the ACCHS, and this protocol was adhered to. The approval for the research to be conducted was granted following the ACCHS general meeting and notification was done via a phone call. In this same phone call, dates were set for the data collection to be held two months later, in September 2010.
For the data collection process, the CEO provided a list of names of the staff who were scheduled to be on duty for the days allocated to the research. Prior to the commencement of the research, the CEO informed all the staff that research was taking place and provided an information sheet about it. All Indigenous staff, six in total, participated in the research. Following an in-depth interview, the first participant (nominated by the CEO) was asked to nominate another staff or Community Board member for the research. Prior to commencement of each in-depth interview, participants were reminded once again that they could withdraw at anytime without penalty, and nobody did. It took three days to complete the data collection of six in-depth interviews, five with staff, one with a Community Board member, an observation and one focused interview with the CEO. Even though several emails and phone calls were made to encourage the Community Board member to return for a second focused interview, they were not returned.

4.3 Data Cleaning

To answer the research question, ‘How does an Aboriginal Medical Service balance its organisational requirements and the communities’ expectations when delivering culturally appropriate health services’, the data was cleaned in accordance with the process outlined in Chapter 3, Methodology, before being uploaded into the Leximancer content data analysis tool. The first map produced concept labels that did not enable pathways to be developed to answer the research question. Therefore, extra instructions were manually entered to remove words such as ‘doing’, ‘stuff’, ‘use’, ‘think’, ‘sure’ and ‘see’, that were not directly connected to the research question. This ensured that Leximancer would not include these words as concepts.
4.4 Data analysis

4.4.1 Leximancer findings

The Leximancer program was programmed to produce a concept map according to the procedures outlined in the Chapter 3. The concept map produced is displayed in Figure 4.1, showing concept labels relevant to the research question for this case study.

Figure 4.1: Concept map - ACCHS 1

The names of the circles in Figure 4.1 represent the key concepts that emerged within this concept map. In Table 4.1 the key concepts are listed and the percentage of connectivity with other sub-concepts is also presented.
In Table 4.1 the most connected concepts are ‘community’ and ‘people’ and the least connected is ‘Board’. From these concepts a number of sub-concepts emerged, the most relevant being ‘community’, ‘organisation’, ‘role’, ‘issues’ and ‘past’. However, on examination of the links produced within the concept of ‘community’, it was found that the queries produced were insufficient to answer the research question. A pathway therefore was created within the concept map to capture the links between concepts and sub-concepts would answer the research question.

The pathway that produced the most logical links (and with sufficient queries) by Leximancer is shown in Figure 4.2. This pathway begins at a concept with low connectivity, ‘Aboriginal’ to ‘worker’, ‘health’ and runs through the concepts with the highest connectivity, ‘community’, ‘organisation’, ‘role’ and ends at ‘CEO’, the least connected concept. This pathway successfully links the concepts together.
The creation of this pathway produced enough in-text queries that could be thematically analysed to answer the research question. These themes are discussed in the next section.

4.4.3 Thematic findings

The concept map Figure 4.2 identified ‘community’ as the concept with the highest degree of connectivity. Following the thematic analysis, it was identified that this ACCHS put its community at the centre of the organisation as a means to balance the organisational requirements and the community’s expectations. During an organisational change, this ACCHS involved the community in the decision-making processes to ensure effective policy and processes were adapted to meet both the community’s needs and the Commonwealth Government’s requirements. The main themes that came out of this case study revolved around an organisational change that had been implemented several months prior to the data collection. The restructure that occurred during this change produced a number of benefits. These were:
1. it increased the communication between the ACCHS and the community.
2. it brought about clearer identification of the roles and responsibilities of the Community Board members, including a criterion for compulsory governance training.
3. a re-orientation of service delivery, to be more health-promotion focused, and
4. a more defined role for the staff.

The biggest challenge to balance organisational requirements and the community’s expectations in this ACCHS was maintaining the community’s trust during the organisational change process. The themes of how this ACCHS balanced its organisational requirements and the community’s expectations are outlined below.

4.4.3.1 *Organisational change that gave the Indigenous staff more responsibility*

Prior to the organisational restructure, this ACCHS had a non-Indigenous CEO and a middle management team that consisted of qualified non-Indigenous staff. Non-Indigenous staff delivered the services offered to the community and the AHWs were encouraged to participate in reception duties. After the resignation of the non-Indigenous CEO, an Indigenous CEO with an undergraduate degree in nursing and a graduate certificate in health service management successfully applied for the position. The new CEO did not come from the community or country where the ACCHS was based, but all the other Indigenous staff and the Community Board did. At the time that the new CEO took up this role, all ACCHS staff were encouraged to re-apply for their positions and in the job selection criteria they were asked to demonstrate how they delivered a culturally-safe service. As a result of this re-application process, a lot of the non-Indigenous staff from upper, middle and lower management positions resigned, including the doctors.
The resignation of the non-Indigenous staff allowed the Indigenous staff to move into the vacated higher positions, following governance training and up-skilling with courses from local registered training organisations (RTO), so as to effectively fulfil the requirements of their new positions. As the training was local, there were only one or two staff absent on training at a time. For specific health professional roles, services such as specialised nursing, GP services and allied health professionals were shared with the hospital, and the ACCHS maintained the position of two non-Indigenous registered nurses. The organisational change included changing such simple things within the work culture as ‘everyone clocks in at the same place and the same time, and there is no separate lunchroom for middle managers and AHW or receptionists - everything is achieved together’. This simple restructure of policies and processes associated with their organisation saw a change in the organisation’s culture and in the community. This cultural change occurred as the majority of staff came from the community; therefore, in a sense, members of the community were involved in the change.

The results of this change were that Indigenous staff had more responsibility and provided services that they were trained to deliver in the ACCHS. Additionally, the community saw that the Indigenous staff could fulfil those roles. In the community, it gave the Indigenous staff a sense of empowerment, contributing towards self-determination as they took ownership of their own health service delivery. It also heightened the input and needs of the community into the health service. The impact of the organisational change on the staff and community is illustrated in the quote below from the CEO.

*Within the organisation there’s always been a very negative culture here, it’s not been a good culture, I don’t know what the word for it would be, but it’s been negative. It’s not been a culture of teamwork and growing skills and people in the past. But now we are. So we’re giving people the opportunity to act in higher positions if the need arises, regardless of whether they’ve got the qualifications. The culture is now one of teamwork, we’re one organisation working together. Our values are being portrayed to staff now around we’re a culturally sensitive service and we want to ensure that we never forget that. The culture’s changed in the last six months from that of a very negative*
one to a very positive one now. Even when one of the clients came in about a month ago they said I actually saw a black face when I walked into clinic today. Because in the past health workers have never been used for what they’re supposed to be used for. They’ve been in the background doing filing and all that while the nurses have been doing all the care. The idea is that health workers are supposed to be doing the care because it’s about people seeing that black face and wanting to feel comfortable with the service. If it was about the services offered [because] they could go to any GP they want. It’s about what extra [culturally] we can offer. The culture has changed. We have now got a culture of teamwork and leadership through the whole organisation not just with managers. So it’s about health workers showing leadership and initiative as well. Quality, our culture is quality at the moment. [CEO]

As this quote by the CEO highlights, the impact of the organisational change had now provided the ACCHS staff with a sense of teamwork.

4.4.3.2 Increased communication between the ACCHS and the community

During the organisational change, it was identified from the large turnover of administrative and clinical staff and the cost cutting associated with the restructure that ‘the community had lost faith in the organisation’. The cost cutting included withdrawing mobile outreach services from rural areas with low Indigenous populations and high non-Indigenous populations, as the state government would not fund the ACCHS to provide a service in these areas. To address the broad criticism of this withdrawal of services in these rural areas, the ACCHS realised that the Indigenous and non-Indigenous community needed to be engaged. In this way, they could be reassured that the restructure of the ACCHS meant that it would still provide services to meet community needs and expectations. An important part of reassuring the community was to outline how their expectations would be met in line with government health data, illustrated by the quote below from the CEO.

"Trying to match up community expectations with government expectations and the funding that comes with that into what they [community] want to see. So that’s been really challenging, trying to match up what you get funded to do with what the community want you to do… It’s trying to manage - how do you tell them the data’s not showing them that they’re important, but they are important."
This quote highlights the difficulties experienced by the ACCHS to provide services that the community deemed important and instead providing only the services that the Commonwealth Government would fund. This was difficult to communicate to the community, because they lived and experienced the reality of the health of their own people. The process of communication to engage the whole community effectively included disseminating information through community meetings, redeveloping MOUs with other organisations, disseminating information through email networks and a monthly flyer. Increasing the community’s awareness about what the ACCHS were funded for and what they weren’t was essential to maintain the community’s expectations, as illustrated by the following quote from a Board member:

... Being on the Board for the last two years has been a bit of a challenge with community expectations. I think community want a good service that will meet them out there. That’s what they want. How they want it, it’s really how they [ACCHS] make that happen for them [community]. We have a good team here and staff are doing the best they can to meet the needs out there in the community in a lot of the stuff they do – it’s from the health education to nutrition to all the health programs that they’re running out there with their own client groups and also linking with other services too, like QLD health and other non-government organisations...But I think community – I mean we have a newsletter that the CEO puts out every once a month, a monthly newsletter. That’s a positive thing for the community as well. So that shows them what the ACCHS actually does and the future that the ACCHS is taking us towards...it’s an excellent way to make sure the community known how we are moving forward and what direction to take.

The participants could not stress enough the need to ensure that the community were constantly engaged during and after the restructure and about the direction that the ACCHS was taking. This was particularly important as the majority of staff and the Community Board members all came from the community that the ACCHS serviced.

4.4.3.3 Expanded roles and responsibilities of the Community Board

Ordinarily, the role of the Community Board is to oversee the strategic directions of the ACCHS and to manage the CEO within the boundaries of the
policies and their budget constraints. During this ACCHS restructure, ‘the Board went through an ORIC (Office of Registrar Indigenous Corporations) and an OATSIH risk assessment’ to determine the risks, such as poor fiscal responsibility. During the risk assessment it became obvious that the Indigenous families in this community had divided themselves into ‘two factions’ and these two factions ‘made up the majority on the Community Board’ therefore influencing the risk assessment from two different angles and therefore two different agendas. One faction had one agenda and the other faction had another agenda. The representation of the community through these factions had resulted in instability and in-fighting within the community and on the Board, which prompted the CEO and members of the Community Board to put in place a directive that ‘all Community Board members, upon accepting their nominations, were to have governance training’.

This training enabled the Community Board to understand and interpret the necessary processes and policies to contribute to ‘the strategic direction of the ACCHS’ in line with the requirements set by the Commonwealth Government. This expanded understanding of the policies and procedures of the ACCHS, as well as the Commonwealth Government’s reporting requirements, made the Board’s role and responsibilities more than just providing the community’s view on the strategic direction of the ACCHS. These expanded roles and responsibilities of the Board are illustrated in the quote from the CEO below:

*Be the spokesperson of the community in terms of what they want to see as outcomes in health. The expectation of a Community Board is that they will manage that with what the expectations of government are and try to blend them together.*

In a community sense, as described by the participants who came from the community and that country, ‘the organisation looks after the community and the community is regarded as family’. In other words, during the restructure, the responsibility of the Community Board had been to maintain a relationship with the community, by aligning the policies and processes of the strategic plan effectively, to ensure that the ACCHS continued to provide a service that
addressed their needs. Through this process, the Board also had to ensure that the community’s needs were acknowledged by the ACCHS and be the bridge between the community and their ACCHS to ensure that the community’s expectations were balanced with the organisational requirements.

4.4.3.4 Re-orientaion of service delivery to meet community needs

In the organisations change process, the restructure included the way services were delivered and the training of the staff to deliver the services. In the past the services had been delivered completely from the on-site organisation; however, this changed during the restructure to better meet the community’s needs. The ACCHS started to offer a clinic with doctors, nurses and AHWs who did clinical work rather than office duties. A health-promotion team of six, three ‘Bringing them Home’ counsellors and a driver were employed. The health-promotion team and the ‘Bringing them Home’ counsellors offered services both within the on-site ACCHS and out in the community for those who had difficulty accessing the service. The ACCHS employed a driver and purchased a vehicle to further ensure that the clients could access the service as ‘they (a driver and an AHW) can pick up the clients, bring them in, do their blood and sugar checks, bulk bill and transport them to another service (if authorised by the doctor)’.

The reorientation of service delivery, the establishment of teams, and the increase in Indigenous staff has seen an increase in the number of Indigenous clients accessing this ACCHS. The shift in service delivery and having Indigenous people employed in positions was considered culturally-appropriate and, according to one Community Board member, enabled the community to access the services within the ACCHS:

I think it’s because I can see our mob sitting there in the reception. Like you walk in the front door, you see sister girl sitting there, you know. Straight away you feel comfortable. Whereas you walk into an emergency department and there’s a non-Indigenous person there. You don’t know what you are going to say half the time. You feel really uncomfortable and there are issues there. Feel like you’re not
comfortable in that area. But I think it’s a sense of you seeing your own people running the service within the community. You feel more comfortable to go and access those services.

The re-orientation of service delivery, as part of the restructure, demonstrates the commitment of the ACCHS to the Indigenous community and its expectations. Having Indigenous people moved into positions that place them as the front-line service providers was an important part of this process.

4.4.3.5 Connection of Aboriginal Health Workers to the community

Following the restructure, the responsibilities placed on the AHWs changed from behind-the-counter administration to a clinical responsibility, a shift that included an increase in training and up-skilling. For the community it meant that, instead of a non-Indigenous person, they saw an Indigenous person attending to their dressings, antenatal, chronic disease ailments, vaccinations, wounds and sexual health and nutrition programs. This was an important step for the ACCHS, as the Aboriginal Health Worker lived in the community, socialised in the community and came from the community. Therefore, the AHW heard from the community first about its responses to the restructure, what they thought about the ACCHS in general and what it meant seeing their own [Indigenous] people in employed positions. In a sense, it gave the community a type of ownership of the health service and self-determination, as it now had control of its own health needs. This relationship between the community and the health services occurred at different levels through the ACCHS organisation and is illustrated below in a quote from the CEO:

Aboriginal health is about us empowering our people to take care of themselves on a number of levels. One level is yes we’re trying to empower the clients to take better care of their own health, so if you’re diabetic we want you to be active in healthy eating, exercise and stuff like that. But as an organisation we want to empower our own people to come in to work to help people. We don’t want to pay $50 an hour for a nurse to come in and do a dressing when our health worker can come in and do that. For me it’s about empowering our people at all levels to better the health of our people through mentoring, training and all that sort of stuff.
Within the ACCHS, itself the connection that the AHW has with the community is also essential to break down the barriers of discrimination between the usually non-Indigenous doctor and the Indigenous client. The AHW not only comes from the community but also understands the cultural protocols of communication for the Indigenous people of the country where the community is based and is aware that a lot of the English language has no meaning in their Aboriginal language. For the ACCHS, this means that they have staff who know the people, as acknowledged by the ‘Bringing them Home’ counsellor in the following quote:

…we have Aboriginal Health Workers that know people, that can talk the same language, can break down doctor’s language barriers. Most of the doctors are pretty good but unless we have the Aboriginal Health Worker some of our clients still leave not knowing what was the full message.

The AHW provides a cultural communication link between the ACCHS and the Indigenous community. Their ability to communicate across both domains, Indigenous and western health, was essential for this ACCHS in ensuring that the health service met the community’s needs and expectations.

4.5 Key findings contributing to theoretical framework

The findings from this case study highlight that by having Indigenous people from the local community employed within and leading the ACCHS organisation was a form of empowerment, whereby local people had some form of power over their own people’s community health. What is interesting is that it took a complete restructure of the organisation to bring this awareness to the local community and the local Indigenous staff. The involvement of community was important for the governance of the ACCHS; specifically the Community Board contributed holistically towards establishing a sustainable infrastructure of service delivery within the ACCHS. This model of service delivery to the community reinstated trust with the community and provided staff with the opportunity to be trained into higher positions and to be utilised for their skills and training. For the Community Board, having governance training as a prerequisite was an important turning point within the ACCHS. It
allowed the representatives of the community to become much more involved in the strategic planning process to facilitate their understanding of Commonwealth requirements and policies and therefore making a contribution to the ACCHS’ ability to balance organisational requirements and community expectations. The findings of this case study cannot highlight enough the need to maintain engagement with the community; a vital step in meeting the community’s needs and expectations. By having the community involved in the restructure, whether through meetings, Community Board or staff, ensured a sustainable health service infrastructure is both ensured and supported by the community for effective health service delivery.

The next chapter will provide the results from the second case study for this research.
Chapter 5
ACCHS 2 Case Study

This chapter presents Case Study ACCHS 2. The chapter is presented in five sections:

- **Section 5.1** outlines the geography and the demographics of the ACCHS community.

- **Section 5.2** describes this case’s selection criteria and the data collection procedures.

- **Section 5.3** provides an overview of the data cleaning process for this case study.

- **Section 5.4** presents the detailed findings, and

- **Section 5.5** highlights the key findings that have been identified within this case study to contribute to the theoretical framework.

5.1 **Community context**

This case study took place in a community in Southern Queensland, where it sits in close proximity to cities yet its relative remoteness makes it unique. Like many Indigenous communities throughout Queensland, this community was established under the Aboriginal Protection Act of 1897. The main history of this community is that it was established as a reserve community for those Indigenous people who were forcibly removed from their homes and families. As a result, there are currently 30 different Indigenous language groups in this community<sup>9</sup> which at the time of this study had grown to a population of 1,213. In 2008 the highest proportion of the age groupings was in the 0 to 14 years age group (39.0% of the total population); the second

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<sup>9</sup> In Aboriginal culture the language groups were also considered family groups and the removal of people to reserves through the policy of ‘segregation’ and ‘assimilation’ (Smith 2007) meant that the removed people had to leave their customs behind and acquire the laws and traditions of other Australians with the aid of a church that administered such reserves.
highest was in the 25-to-44 age group (26.1% of the total population); following this was the 15-to-24 age group (17.4% of the total population); next was the 45-to-64 age group (14.4%) and the lowest percentage of the total population were those aged 65 and over, consisting of 3.1% of the total population of this community. This demonstrates that the largest population representation within the community are those between the ages of 0 to 44 years, therefore making this a ‘young’ community compared to the rest of Queensland.

The largest employer in the community was public administration and safety (63.2% of the community was employed in this industry). The other two major employment sectors were health care and social assistance (employing 14.3% of the total population) and education and training (employing 7% of the total population). Even though there was relatively high employment it still remains within quintile 1 of the socio-economic index – the most disadvantaged quintile in comparison to the rest of Queensland.

5.1.2 ACCHS community

The ACCHS is situated within the middle of the community and offers the following services to address the health needs of the community:

• child health checks
• young person health checks
• adult health checks
• chronic disease management
• GP services
• weight management
• men’s health, and
• social and emotional well-being.

This ACCHS also offered visiting specialists who specialised in:

• eye clinic

10 In line with the ethics obtained for this research the identity of the participants, the community and the ACCHS are to remain confidential therefore all references pertaining to their identity are in the references at the end of this thesis.
• optometry
• orthopedics
• general counselling
• physiotherapy
• diabetes
• dentistry, and
• women’s health.

The community services were (and are) offered at the ACCHS itself. In special circumstances, the services were delivered within a person’s home. For services that are not offered at this ACCHS, the ACCHS provides clients with a vehicle to obtain their health requirements from other nearby facilities. Most of the participants in this case study came from this community and in some way had been exposed to its history\textsuperscript{11}. Some of this history is reflected in their responses.

5.2 Case selection and data collection procedures

This case was selected with the QAIHC Elder according to the same procedure as outlined in the methodology (Chapter 3). The difference between this ACCHS and the other case studies was that it had such a high turnover of CEOs, meaning that all correspondence regarding this research was between the researcher, the personal assistant of the CEO and the receptionist. The CEO was not actually aware until the morning the research began that the ACCHS would be participating in the research. Furthermore, approval for the ACCHS to participate had been negotiated between the researcher, QAIHC personnel, the CEO’s personal assistant, the receptionist and the Community Board via email and telephone calls.

Contact with the CEO was not made until the day before the scheduled interviews were to begin. On arrival at the ACCHS, the receptionist and the personal assistant were on hand to direct the researcher and enable the CEO to be involved with what was happening in the ACCHS. Following the interviews with the CEO, the CEO handed the researcher a piece of paper
with the names of the participants to be involved in the research. However, the receptionist, upon seeing the list, threw it in the bin and directed the researcher to an area of the ACCHS away from the administration and asked each subsequent staff member to nominate someone else. In total, the data collected for this case study consisted of six in-depth interviews, one focused interview and one observation.

5.3 Data cleaning

To answer the research question ‘How does an Aboriginal Medical Service balance its organisational requirements and the community’s expectations when delivering culturally-appropriate health services’, the data was cleaned and followed the same process as outlined in the methodology (Chapter 3). The first map produced concepts based on words that were frequently used by the participants in their responses, such as ‘nar’, ‘yeah’, ‘stuff’, ‘believe’, ‘probably’, ‘coming’, ‘sure’, ‘guess’, ‘okay’, ‘la’. Leximancer was then manually programmed to remove these frequent words. At this same stage the program was instructed to merge words that displayed similar meanings, namely ‘Indigenous’ and ‘Aboriginal’, ‘people’ and ‘peoples’, ‘organisation’ and ‘organisations’.

5.4 Data analysis

5.4.1 Leximancer findings

The data analysis for this case study followed the process outlined in the methodology (Chapter 3) and, once it was manually programmed, Leximancer produced a concept map, shown in Figure 5.1, displaying concepts that were relevant to the research.
The concepts that emerged within this concept map, Figure 5.1, were ‘service’, ‘people’, ‘Board’, ‘culture’, ‘CEO’, ‘position’. On further investigation into the concept ‘service’ – the most connected concept – it was found that the participants referred to this ACCHS as a ‘health service’ or ‘this service’ more so than as the ‘organisation’. Within the concept ‘people’ it was found that the participants referred to the word ‘people’ more than to ‘community’; therefore Leximancer was programmed to recognise ‘people’ as a concept within the text.

Table 5.1 lists the concepts with their percentage of connectivity. The higher the percentage, the more frequently the concept appeared and the lower the connectivity, the less frequently the concept appeared.
Table 5.1: ACCHS 2 key themes

<table>
<thead>
<tr>
<th>Concept</th>
<th>Connectivity</th>
<th>Sub-concept</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
<td>100%</td>
<td>Service, health</td>
</tr>
<tr>
<td>People</td>
<td>47%</td>
<td>People</td>
</tr>
<tr>
<td>Board</td>
<td>13%</td>
<td>Board</td>
</tr>
<tr>
<td>Culture</td>
<td>11%</td>
<td>Culture</td>
</tr>
<tr>
<td>CEO</td>
<td>10%</td>
<td>CEO</td>
</tr>
<tr>
<td>Position</td>
<td>0.9%</td>
<td>Position</td>
</tr>
</tbody>
</table>

The concept with the highest connectivity, as shown in Table 5.1, was ‘service’, with 100% connectivity; the concept that Leximancer produced with the lowest connectivity was ‘position’. The concept of ‘service’ was the only concept produced by Leximancer with sub-concepts; apart from the concepts ‘service’ and ‘people’, Leximancer showed low connectivity (less than 20%) for the other concepts. Pathways were generated through concepts with high and low connectivity to produce the queries most relevant to the research question. The conceptual pathway that produced the most queries within the conceptual map, Figure 5.2, began at the sub-concept of ‘health’ within the dominant concept of ‘service’; the pathway then travelled to the concepts of ‘service’, ‘people’ and ‘Board’.
The queries identified through the pathway in Figure 5.2 are analysed thematically below.

### 5.4.2 Thematic Findings

While content analysis identified ‘service’ as the concept with the highest connectivity within the concept map (Figure 5.2), the thematic analysis of this case study identified the policies, processes and procedures implemented by the Community Board as the core of what this ACCHS was about in order to balance organisational requirements and community expectations. This ACCHS had had a high turnover of CEOs in a short time and the CEO that participated in this research had been in the position for a little over a week. The interesting theme that emerged, based on this high turnover, was that the ACCHS itself had policies, processes and procedures in place to deliver a primary health care service to the community, regardless of the CEOs. These policies were firstly, and bearing in mind the cultural difficulties of delivering a health service to people from different clan groups, was that no one on the Community Board could be related to any staff in the ACCHS. This was to ensure that governance decisions were not directly influenced by the staff and
were made based purely on the health needs of the community. Secondly, training and up-skilling were a key component for all staff, as well as for the Community Board members, to ensure compliance with Commonwealth Government requirements. Both these policies ensured that the ACCHS functioned consistently and that it met community needs and expectations. The biggest challenge that was identified by the staff of this ACCHS was maintaining communication with the visiting allied health specialists. These specialists found it difficult to provide a reliable schedule and didn’t respect the community and cultural protocols when delivering their services.

Regardless of the turnover of CEOs, there was evidence of the combining of the two cultures, western and Aboriginal and Torres Strait Islander, whereby the staff followed western reporting protocols and at the same time delivered of a health service through a holistic model of Indigenous primary health care, thereby managing to balance community expectations with the organisational requirements of the ACCHS. The themes of the case study are presented below.

5.4.2.1 Embedded organisational process and procedures

As previously noted, this ACCHS had employed a new CEO, who at the time of this researcher’s first visit had been in the position a little over a week. Regardless that this CEO was the eighth CEO for the year, this research found the ACCHS continued to deliver services to the community. This was due to the organisational processes and procedures that were in place, regardless of the changeover of CEOs. The staff and the Community Board were aware of the constant cycle of CEOs and the senior staff of the ACCHS and the Board had worked with QAIHC to ensure that these procedures were in place and were adhered to by all staff.

The aim of these policies and procedures was for staff to maintain ‘best practice’ in delivering services to the Indigenous community. Essentially, ‘best practice’ was about ensuring that all clients received the quality of care that
they had been used to, regardless of the changing CEOs. This meant that all of the staff were aware of the processes in place from the moment a client made an appointment. The receptionist described the ‘best practice’ process as:

*Best Practice is - what it is. Like when the clients ring up for an appointment, their name is up on the system already. Just click it in and I check their details and all that, then we book them in for a doctor. There’s a lot of stuff on there. I’m still learning a bit of it now. We’ve just made like a flow chart on how the process of each patient, when they come in and what happens. How they’re going to be treated. They’re making certain methods up and running so that everyone knows, if we get a new staff member, if we get a new doctor, they can’t just change how it - they have to work in with us, I believe, so that the patient gets the best care I think, and we’ve got the CEO and the nurse and some input from the doctor, well mainly from all staff. They all make one up and then all staff have a say on it, how it goes, so that all aspects are covered on how to treat a patient.*

These processes ensured detailing the information of each individual client, and involving all the staff, to achieve continuity of care. The ACCHS also had set policies and ‘procedures for the operational side of the organisation’, including ongoing training that was written into each staff member’s contract, and fully-established reporting lines were in place. The reporting lines meant that each staff member had to report to another staff member above them and then the reports were compiled and given to whoever was in the CEO position. For the current CEO this meant that:

*It’s working with the team on the operational side of things to make sure that the house is in order as far as clinic and other sorts of things and also working with the Board on the strategic direction…we may not necessarily be adequately resourced but we do have direction and we have a vision which we’re working towards. So I think we’ve got a good foundation for what could be the lead ACCHS in the state.*

The new CEO therefore had walked into an established and operational ACCHS with a clear vision put forth by the community and a procedural foundation to support that vision.
While the constant changing of CEOs were not the fault of the staff, the staff felt the impact of these changes in terms of the different management styles of each new CEO. These different management styles often determined who kept their position and who didn’t or whether or not a service offered needed a set number of staff. At times, staff members were relocated to other areas of need as seen by the incoming CEO. The health promotion officer expressed concern about changing CEOs withdrawing health-promotion services from the community and it was hoped that the new CEO would bring positive change to past decisions, as follows:

*Changing roles or acting CEOs and all that. With the health workers there wasn’t much of services being offered in the community… I hope it does change, ’cause the health workers don’t get the opportunity to go out there and to offer what they have to offer to them. Not how they used to. There used to be a lot of health workers here.*

The community and the Community Board also felt the different management styles of the changing CEOs, to the point where the Board had taken on a lot of the responsibilities of the CEO. This would happen when the ACCHS was in the middle of changing its CEOs and included such responsibilities as the hiring and firing of staff. The Community Board member believed that it was time that the Board stood back and let the new CEO take on the responsibilities of the ACCHS, as follows:

*I think it needs a change. I think like I was saying before, like we need to let the CEO run the daily running of this place and staff and the Board just sit back and do what the Board got to do.*

This view by the Community Board member suggested that trust in the current CEO was needed.

*5.4.2.3 The Community Board procedures to support governance*

Due to the changing CEOs, the Community Board of this ACCHS had procedures in place that included the governance process. Thus, the CEO
knew that the Community Board employed them and when the ACCHS was changing CEOs, the staff also answered to the Board. For the staff this meant that every month they each had to submit a report to the Community Board outlining what that they had achieved as per their employment contract. The CEO held the responsibility of working with the Community Board on the strategic direction of the ACCHS. The Board also worked with the CEO on the hiring and dismissal of staff. On the operational side, one AHW reported that the staff submitted reports:

\[
\text{\ldots to their line managers and then if it's not solved you go to your CEO and still, if it's not resolved, then you go to your Board and put it forward.}
\]

As this case study community was historically a place where people had been removed to, it was necessary for this Community Board to put in place criteria to prevent any over-representation of one family in the ACCHS. The receptionist of the ACCHS reported that:

\[
\text{If you’re on the Board you can’t have a direct relative working in this centre. So if - what did they say - like the mother or father or siblings of that person, can’t be on the Board. Just so it’s not a conflict of interest and stuff like that. It’s just because, well everyone’s sort of somehow related out here so I think, it just makes sense, it seem more fair for those who don’t have relations up here. So, if there’s something wrong then it doesn’t really reflect on the family.}
\]

The Community Board member also confirmed that this criterion enabled the Board members to stay on task and ensure ‘that they got the job done’.

\[
\text{5.4.2.4 Maintaining communication pathways between community, ACCHS and specialists for effective service delivery}
\]

The relative geographic isolation of this ACCHS meant that it employed no permanent doctors or health specialists. Therefore the communication lines between the community, the ACCHS and the visiting non-Indigenous specialists needed to be open and clear, a task that the new CEO at the time of the research was finding challenging. The CEO identified that the allied
health specialists were not what was considered as ‘process-driven’. This is as shown by the following quote that illustrates the short time frame of a few hours for the ACCHS to contact clients from the community for the visiting non-Indigenous specialists:

…When I say process-driven, I need to know well [in advance] specialists these are the dates you are coming. These are the patients, I’ve got a patient list, we know who you need to see so that we can make that run smoother. I guess that what I am getting at is trying to make sure that this service is running as smoothly and efficiently as we possibly can in order to meet patient’s need. So you know, like someone’s sending me an email on Monday morning with two pages of paper. So we’re going to be there at nine o’clock on the same Monday morning, we need to see these people. It does not work.

These insufficient lines of communication made it difficult to contact clients at short notice for specialist appointments. Most of the staff expressed concern about the poor lines of communication between the Indigenous community and the non-Indigenous health professionals, as they believed that it reduced the trust between the ACCHS and the community and affected the organisation’s ability to meet the community’s needs. The poor lines of communication were not just between the organisation and the health specialists; they were also between the health specialists and the Indigenous clients. The health specialists employed by the ACCHS were non-Indigenous and would often see the Indigenous clients without an AHW. This seemed to cause concern to the community and in particular to the staff who came from the community, as the receptionist pointed out:

_Having the Aboriginal Health Worker here makes it better to have someone advocate or talking for them and helping them with their health, because sometimes they [Indigenous clients] won’t say stuff to a doctor [or specialist]. You know some of us, we don’t really have much understanding on health services itself unless our own Aboriginal Health Workers go out there and explain the way we are talking, the way that we will understand._

Effective communication between the ACCHS and the community ensures trust is maintained and the health needs of the community are met. Maintaining the trust of the community was an important process for this
ACCHS, and was one that the non-Indigenous health professionals in this case study jeopardised.

5.4.2.5 Balancing western and Indigenous cultures

Meeting government funding requirements is considered by the ACCHS as balancing the ‘western’ culture of applying for funding and reporting on the use of it to sustain the ACCHS service. At the time of this research, one of the main requirements of the ACCHS was to comply with the COAG initiatives. In accordance with ORIC and OATSIA (defined in Chapter 2), this ACCHS undertook a gruelling reporting process every time it received funding, and if they did not provide enough supporting information, the funding could be withdrawn. Due to the changing nature of CEOs in this case study, the Community Board took on the role of applying for funding and this resulted in the community being very aware of what the government identifies as its needs and what they could access funding for to ensure appropriate service delivery at their ACCHS. When this ACCHS applied for funding, it did so under the banner of ‘Aboriginal health in primary health care’. However, other health services in the area were also applying for funding under the ‘Primary Health Care’ label. Due to the competition from GP services, the funding available to the ACCHS became constrained, limiting the ability of the ACCHS to provide a service that met the needs and expectations of the Indigenous community. The impact of government funding requirements on the ACCHS is highlighted in the quotes from the CEO below:

*Why I say it’s challenging is just the things like the COAG initiatives where health has become a very competitive environment now with the general practices and what they can do, that sort of thing. That change of mindset into how we need to operate now because if I can say this without being too bold. Health now is a big industry; it’s big business. When we’re talking about black health, that’s big bucks. Yeah, everyone wants a slice of the pie so very competitive and I think that, and this is just my view of how I see what the Government has done. It’s taking a lot away from aboriginal medical services, the primary health care services and it’s really – it seems to me to be putting more support in there for general practices and divisions, places like that. Aboriginal people when it comes to choices and that sort of thing, they want to go to their own aboriginal medical services and they want to be*
looked after by their own people. So whilst choices are good, it would have been – I would have seen it to be more helpful if we’re talking about closing their gap and life expectancy and those sorts of things. I just think that the aboriginal medical services are the vehicles that should be the driver of primary health care services...when it comes to Aboriginal health it should be Aboriginal health services...because...when you are going to be moving into primary health care services, how can you give the best possible care to Aboriginal people. Because it’s not a 15-minute consult.

For this ACCHS, and certainly this CEO, to ‘close the life expectancy gap’ (a prerequisite of the COAG) between Indigenous and non-Indigenous people and ‘to effectively address the health needs of Indigenous people’, the services needed to be delivered by Indigenous people for Indigenous people. Being the driver in their community to provide Indigenous people with their own health services meant that not only did this ACCHS have to work hard to obtain government funding and meet their requirements but it also had to work within the time parameters of the funding and continue to maintain engagement and trust with the community. This task has proven to be difficult, as government funding requirements do not consider Indigenous culture and history, for example, the time frames allocated to Indigenous community members to engage with government funding services, when they have historically been so negatively impacted by them. These discriminatory funding requirements are reported below:

*With our people it’s really hard a lot of times to get them to start off to get them into coming into things. Then they just get started and going good, you know it will take a while. It’s not like a lot of mainstream, they like the new thing or have a new thing and a lot of people will go to it. It will take a long time to build it up for them to come. Then it will start and then this program finishes or there’s no money for the program to keep going. This organisation here tries to support us, like the workers, with more training and to up-skill and all that but also tries to keep that cultural appropriate sort of stuff. I think there’s a lot of lack of understanding from mainstream people as to what an Aboriginal health service is. The general population don’t, well, this is open to anyone, like, mainstream and Indigenous people but a lot of people have got a strange concept about going to an Aboriginal health service. I think they think it’s not good, I don’t know, like it’s a second-rate sort of service because ‘it’s run by Indigenous people’. (Health Promotion Officer)*
This type of perception by the Indigenous staff demonstrates the challenges and the discrimination experienced by this ACCHS when working within government funding requirements to meet community needs and expectations. This is compounded by the historical nature of the community that has been negatively impacted by government policy and adds to the difficulty of delivering a culturally-safe service to them.

5.4.2.6 *Combining Aboriginal culture and primary health care to meet community needs*

The Aboriginal culture influencing the health service delivery within this ACCHS consisted of a number of clan groups who were brought to the area under duress more than one hundred years ago as a result of government policy and all clan groups, although they maintain their own cultural traditions, share a common socio-economic and policy history. The staff who participated in this research acknowledged their Indigenous identity and the Indigenous policy history that brought them and their families to this community, including such things as ‘holding onto their grandfather’s hand as he was shackled, chained and marched’ to this ‘now’ community. This type of historical experience contributes to social determinants impacting on a community’s health. It has also affected the way in which the ACCHS staffs deliver services to the community, in that the Indigenous staffs understand ‘how’ to deliver an effective, culturally-safe and sustainable service to the community. When delivering health-promoting services, the participants believed that the most appropriate way to deliver such services to the people was to take a whole-of-community approach, meaning that:

… *Murri things are holistic to do education - education around STIs, sexually transmitted diseases, blood-borne viruses – to get that word ‘knowledge’ out to people. Engaged educational programs, promotion, health promotion [and] as well as screening support for people. We try and engage with the whole family…The Aboriginal Health Workers are involved in other aspects of the community too. Workers are involved in other things with schools, with all other Indigenous services, but within the community.* (Health Promotion Officer)
Delivering primary health care in an Indigenous community health setting is what constitutes this ACCHS. It is a setting where everyone knows everyone else, culturally and historically, and is supportive of each other’s roles and responsibilities. The primary health care aspect, which the CEO sees as the core business of the ACCHS, is provided to the community with limited funding and extensive government reporting requirements. To ensure that the ACCHS meet the community’s needs it was important:

... that the community wants a health service that’s accessible. To feel as though they can come here, the staff are approachable and one that they can have community control. I think they [community] want one [medical service] that’s got good staff, competent good doctors, have a permanent doctor and, yeah, have ownership of that little bit of place...so we could quite easily fall into that general practice mode and be reacting [to health outcomes only]. We’ve got the culture of who we are and what we’re about, what we’re doing, why we’re here and all that sort of thing. If that’s firmly implanted in all of us than we’re going to be heading in the right direction. So I think that culture of an organisation and then the culture of the organisation can extend to your work out there, how we’re doing things. In what way we’re actually delivering, you know. What others things can we look at so that we can build it into a business and have the proper structures in place...just make sure our house is in order and, yeah, how we work that in with the primary health care side of things to get that sort of [combined] culture for the best service that we possibly can give. (CEO)

For this ACCHS to combine Indigenous culture and community primary health care in a holistic sense was to essentially meet the community’s needs.

5.5 Key findings contributing to the theoretical framework

This ACCHS was established in an Indigenous community where the history reflected Australia’s imposed colonised policies. The CEO, who had been in the position for a little over a week, was not from this community and all the staff, who had historically been placed into this community in some form, came from this community. These attributes contributed to the culture of the ACCHS whereby, regardless of the high turnover of CEOs, it delivered its own model of Indigenous primary health care. In this model the staff of the ACCHS had ensured the community were, holistically, at the centre of service delivery, regardless of government requirements. Furthermore, the community and the
ACCHS had two policies in place to overcome the cultural difficulty of delivering the health service to people from different clan groups. One was that no one on the Community Board could be directly related to any of the staff within the ACCHS so that governance decisions were not directly influenced by the staff, and were made based on the health needs of the community. Secondly, all the Indigenous staff had continuous training and up-skilling. The other important finding that emerged from this case study was that this ACCHS had western reporting processes and policies in place and at the same time achieved health service delivery through an ‘Indigenous lens’ or an Indigenous worldview, making this service a sustainable exemplar for a holistic model of Indigenous primary health care.

The next chapter presents the findings of the third case study for this research.
Chapter 6
ACCHS 3 Case Study

This chapter presents Case Study ACCHS 3. The chapter is presented in five sections, similar to the other case study chapters:

- **Section 6.1** outlines the geography and the demographics of the ACCHS community.

- **Section 6.2** outlines the selection criteria and the data collection procedures for this case study.

- **Section 6.3** discusses the data cleaning process for this case study.

- **Section 6.4** presents detailed findings of the case study, and

- **Section 6.5** highlights the key criteria to contribute to the development to a theoretical model.

### 6.1 Community context

This ACCHS is located outside of a major city in a rural area and has outreach services spanning approximately 500 km in radius. The total Indigenous and non-Indigenous population of this area at the time of the 2006 census was 162,057 persons. Of this total population, 4,120 people, or 2.9% of the total population, identified as having Indigenous origin. The age distribution was 21% of persons aged 0 to 14 years, 65% aged 15 to 64 years and 14% aged 65 years or over. The majority of the Indigenous people who resided in this area at the time were between 15 and 25 years, giving this community a higher percentage of younger Indigenous people than other comparable Queensland communities. For the 14% of the total population aged 65 or over, there were 44 aged-care facilities in operation, with a total of 1,652 places. Furthermore, 12% of this region’s employed labour force
worked in the health care and social assistance industries\textsuperscript{11} (Queensland Regional Profiles, 2011). In 2006, there were 48,333 persons aged 15 years and over whose gross weekly income was less than $400. This region had 23\% of its population living in the most disadvantaged quintile and 18.3 \% in the least disadvantaged quintile\textsuperscript{11}.

6.1.2 ACCHS Community

The ACCHS in this case study offered a health service in a large town and mobile clinics that serviced the rural area in its region. The services in the town included:

- **Home and Community Care Programs:**
  - Home maintenance (a service for elderly people to assist them to maintain their homes)
  - Day respite (a service to provide care for dependent clients to relieve carers for a day), and
  - Social care programs (a service that encourages the elderly to interact with the community, for example, cooking classes).

- **Aboriginal Health Checks for:**
  - Diabetes and chronic disease, and
  - Cardiovascular disease, e.g., checking blood sugar levels (BSL) and blood pressure (BP).

- **Dentist**

- **Health Promotion:**
  - nutrition
  - sexual health, and
  - social and emotional well-being

- **Advisor role in child protection**

- **General Practice**

\textsuperscript{11}Due to the confidentiality pertaining to this research, there are no in-text references within this findings chapter that can connect the ACCHS to its community. All references are listed in the references section.
The service offered in the rural areas by the mobile clinic was mostly dental. In some areas, they offered mobile clinics at different locations with similar services to those of the town-based ACCHS. This ACCHS consisted (and consists) of both Indigenous and non-Indigenous staff and clients. A more detailed breakdown of staffing profiles was included in the data collection. The Community Board of this ACCHS drew its representation from across the rural region that the ACCHS serviced.

6.2 Case selection and data collection procedures

On the researcher’s arrival at the ACCHS, the CEO casually informed her that they had waited until they had heard that other ACCHSs had participated within the research and that it was safe for them and their community to participate. To confirm this ACCHS participation in this research, the CEO of this case study made contact with the researcher via QAIHC to confirm their participation in the research. The CEO requested a meeting with the researcher at QAIHC to discuss the research with a Board Elder from QAIHC present. Following this meeting they advised the researcher that they would discuss whether or not this ACCHS would participate via either email or phone call notification the following week. The following week a phone call was received stating that they would like to participate in the research, as long as the Community Board of the ACCHS agreed. From the first email inviting the ACCHS to participate in the research to the agreement by this ACCHS to participate took roughly six months. All correspondence was through the CEO and once the Community Board granted approval the dates were established for the data collection to commence in 2010.

6.3 Data cleaning

The data were cleaned using the same process as outlined in the methodology described in Chapter 3. Following the first map, with words that did not reflect the research objectives, a set of instructions were entered to exclude words such as ‘doing’, ‘probably’, ‘talk’, ‘take’, ‘look’, ‘yeah’, ‘stuff’, ‘use’, ‘think’, ‘sure’ and ‘see’. As with the other case studies, the program was
instructed at this stage to merge words that displayed similar meanings. These words were ‘Indigenous’ and ‘Aboriginal’, ‘oral’ and ‘dentist’, ‘people’ and ‘people’s and ‘organisation’ and ‘organisations’.

6.4 Data analysis

6.4.1 Leximancer findings

The data analysis followed the process as outlined in the methodology. After the merging and removal of words, the Leximancer produced a concept map, Figure 6.1, displaying concepts that were then used to develop a conceptual pathway.

The most frequent concepts, outlined in Figure 6.1 and Table 6.1, produced by the Leximancer for this case study were ‘service’ and ‘Board’, with ‘dentist’ being the least frequent. The concept ‘service’ was the only concept that
produced the most sub-concepts by the Leximancer, these being ‘service’, ‘health’, ‘community’, ‘organisation’, and ‘people’. The concept ‘service’ showed the highest percentage of connectivity to the other concepts. When creating the pathways for this case study, it was necessary to generate them through concepts and sub-concepts with both high and low connectivity.

<table>
<thead>
<tr>
<th>Concepts</th>
<th>Connectivity</th>
<th>Sub-concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
<td>100%</td>
<td>Service, health, community, organisation, people</td>
</tr>
<tr>
<td>Board</td>
<td>14%</td>
<td>Position, Board, CEO, family</td>
</tr>
<tr>
<td>Work</td>
<td>13%</td>
<td>Work, staff</td>
</tr>
<tr>
<td>Time</td>
<td>8%</td>
<td>Time, dental</td>
</tr>
<tr>
<td>Child</td>
<td>5%</td>
<td>Child, issues</td>
</tr>
<tr>
<td>Culture</td>
<td>4%</td>
<td>Culture</td>
</tr>
<tr>
<td>Dentist</td>
<td>2%</td>
<td>Dentist</td>
</tr>
</tbody>
</table>

To find the pathway with the queries most relevant to answering the research question, it was necessary to begin at the sub-concept ‘people’ within the concept of ‘service’, going through ‘work’ and ending at ‘culture’. This pathway is shown in Figure 6.2.
6.4.2 Thematic findings

The content analysis identified ‘service’ as the concept in the concept map with the highest connectivity (Figure 6.2). The thematic analysis identified the service as utilising a ‘hands-on approach’ to empower the community to balance the organisation’s requirements and the community’s expectations. It was shown that the ACCHS service re-orientated its focus to focus specifically on meeting community needs (a challenging task given the geographical location of the ACCHS), and this enabled the ACCHS to provide sustainable service delivery to the community. The geographical location was also at times a challenge when it came to Community Board representation; however, the connection that the AHWs had to the rural communities and the connection that the CEO had with the Community Board members enabled the voices of the rural communities to be heard.
6.4.2.1 ‘Hands-on’ approach to organisational empowerment

The CEO of this ACCHS had been in the position for more than five years and came neither from the country nor from the ACCHS community. All the other staff at the ACCHS came from the country and their families resided in the community. The staff saw the ACCHS as ‘the pillar of the community whereby the health service is here to look after the Aboriginal people in the community’ and that it was ‘up there looking after everyone [community] down below.’ This view meant that the ACCHS had to be sustainable and transparent while considering the views of the staff and the community to ‘work hand-in-hand with the services’ that they provided to the community (HACC, dental, child protection and primary health care). For the CEO this meant having ‘an open-door policy and taking a hands-on approach’ within the organisation itself. The hands-on approach was not without its challenges, as the CEO pointed out:

>You do get those who sort of push it a bit far sometimes with the flexibility with leave and stuff like that. But I’m pretty straight up and I just say to them, ‘if you don’t think this is where you want to work well you need to go home and have a really good think about it.’

Being direct is how the CEO ensured that the staff understood what was expected of them. The CEO, whose qualifications consisted of ‘nursing and a Graduate Certificate in Health Service Management’, continued training by undertaking the necessary training that AHWs are required to fulfil as per their contract and position. The CEO believed that by having training in:

>Primary health care, I have the Cert III right to the advanced diploma, because I think to lead them [staff] I need to know what is expected of them to go forward also.

This hands-on approach to organisational empowerment ensured that staff enabled staff to know exactly what to expect from the training and what was expected of them, therefore community needs and expectations into the service provided by the ACCHS.
6.4.2.2 Strategies to address government funding inequities

This ACCHS was funded for the services it provided to Indigenous people and these include Home and Community Care (HACC), dental, child protection and primary health care. The health services provision covered a large geographical area. Nor did meeting the community’s needs according to government requirements stop at the Indigenous community; it also extends to the non-Indigenous community. Being in a rural setting meant that there were minimal services within a certain distance, so both Indigenous and non-Indigenous people had to rely on what services were available and many non-Indigenous people accessed the ACCHS. The ACCHS provided (and continues to provide) this service to non-Indigenous people even though the Commonwealth Government funding did not extend to non-Indigenous people. To overcome these inequitable policies in the funding of service delivery, this ACCHS is forced to charge a small fee to all clients, Indigenous and non-Indigenous. This is illustrated by the following remarks from the CEO:

...we service Aboriginal and non-Aboriginal people because of the access. Well there’s no access I suppose. They can’t keep their doctors in those towns through the state system. But our clientele is just growing and [including] the non-Aboriginal people, even though we - well we have a fee-for-service [for all], which is $10 per person or $20 for a family of four. But the non-Aboriginal people, nine times out of 10, they give us a donation; it might be like $200 for the use of our services. Those fees go back into the supplies part of the budget so that it keeps – re-used to fund more supplies as we go along.

Rather than denying a health service to non-Indigenous people, this kind of ingenuity to try and maintain equality to the whole community of Indigenous and non-Indigenous people balances community expectations at a broader level. These strategies to address government funding inequalities, notwithstanding the challenge of obtaining funding appropriate to the community’s needs, are highlighted by the following quote:

...trying to get the extra dollars we need into providing more services and appropriate services. It’s no good having an ad hoc program, you need to be able to run it all the time and if you haven’t got the dollars, well!
This statement by the CEO exemplifies the issue of access that is common within the community, that is, access to services and access to funding to continue to provide a sustainable Aboriginal health service that meets community needs.

6.4.2.3 Majority of Indigenous staff delivering a culturally-appropriate service

For this ACCHS to meet government requirements and the needs of the community, it had to have a large majority of Indigenous staff in order to deliver a culturally-appropriate health service. It is this that contributes to the infrastructure of maintaining sustainable health service delivery to the Indigenous community, as well as, at times, to the non-Indigenous community. The importance of having a majority of Indigenous staff employed in the ACCHS is illustrated by the following quote from the CEO:

*This health service offers the community a very open culturally-appropriate service. You can come in here and people feel comfortable. The monopoly of faces in this workplace are black. They’re all Aboriginal people. I think we may have - it’s probably more of our professional staff, which is our dentist, our 2IC in finance - they’re probably the only white faces you see in here… I believe you can be an Aboriginal health service, but if you’ve got all white faces about, to me that’s not making them [community] feel comfortable.*

The CEO also recognised the importance of families who come from the community and the communication that they bring. This is important in determining what health needs should be addressed for the community by the organisation. This is illustrated in the following quote:

*…families … because it’s those families that can make or break an organisation or a community…Overall, the issues are addressed and their health needs are identified. We’ll never get it 100 per cent - I don’t think anybody can do that - because once you meet the needs on one health issue, something else comes along. It’s like a trend; you never get them all at the one time.*

These family needs often competed with, and varied from, what the government had identified as a community health need to be funded. Meeting
the community’s needs was a never-ending battle that was perpetuated by an ongoing cycle of accumulated health issues across the geographic area.

6.4.2.4 Re-orientation of services to meet community needs

This ACCHS provided a number of services to the community funded by the government, such as the HACC (Home and Community Care) program that particularly addressed chronic disease by providing health-promoting services. The way the ACCHS delivered the program had to be in line with government reporting processes; however, this ACCHS re-orientated its services to focus on the community’s needs to ensure that its services empowered the community. What this meant was that, although the funding often did not meet what the community identified as a need, the community still came to the ACCHS with what they regarded as a need and then the ACCHS would work with the community to meet that need. An example of this was provided by the CEO, in the quote below:

*The senior group’s a prime example. They’d come to us and said, ‘Look, we used to do this. But the other organisation doesn’t do it now. Is there anything the organisation can do now?’ Well, I think it costs us $20 a week to run a water aerobics program for these old girls and they love it. We get like 10 to 15 women there. Where are you going to get black fellas to go to a pool and - you know what I mean? They’re mixing and it’s also their social and emotional well-being. Yes, they love it. The physical activity side of it…So they do their exercise, they come in and one of the ladies will cook a healthy meal up and they all sit around and eat it and they have interaction. It costs us, for the lady to run the program, $20 we pay her, and probably $30 in ingredients. So $50 a week for one day to ensure these people are getting exercise… In terms of this organisation, ‘our driver is health’. It’s not oral, it’s not primary, it’s anything that’s out there. If we can try and address it, we will.*

This health-promotion approach to service delivery contributes to empowering the community.
6.4.2.5 Links and communication to all communities that the ACCHS services

Due to its geographical location, this ACCHS had its main organisation within a large rural town and at the same time provided an outreach dental service. As part of this outreach service, an AHW always accompanied the van. The AHW had a dual role in the rural areas. One was to provide health assessments for people in the rural area; the second was to deliver any issues or ideas that those communities had to the organisation’s Community Board. The CEO explained the community role that the AHW played as follows:

*After the issues was taken to the Community Board and whatever the outcome was, it was then transferred back to the Aboriginal Health Worker who would then take it back to the rural community.*

The AHW took on this role due to the wide dispersal of the rural communities that the ACCHS serviced, thus ensuring that the needs of these communities were respected and included in the ACCHS operations. Further to these links to rural communities through the AHW, the Community Board also has representation from these communities, as reported by the CEO in the following quote:

*…with the Board members, they're made up of people from the areas of which this health organisation covers. The people represent the regions, that way they bring their issues to the Board from that specific region. So their role's basically to bring their issues in. They give me direction on the strategic direction of the - well I implement their strategic directions of the organisation and they oversee myself running the organisation. Because of our regional set up, we have quarterly meetings. That’s where all the decision-making and directions are given to me to implement how they see fit. But also we have day-to-day contact with our chairperson. If we need any immediate decisions we will talk with him.*

Whatever the geographical difference, this ACCHS worked very hard to ensure that communication was maintained with all the different communities to which they provided a health service. Having community involved in all
decision-making processes is what kept this ACCHS sustainable and balanced to meet community needs and expectations.

6.5 Key findings contributing to theoretical framework

The key theme that came out of this case study was that the communities that this ACCHS serviced were at the centre of its governance processes. This ACCHS had a long-term CEO, who, even though he or she did not come from this country, had established trust with the community and worked with the Community Board to have processes and policies in place that supported all the staff and therefore the community. The aim of the CEO was for the ACCHS to do the best that it could and promote self-determination, by focusing on the community’s needs, regardless of any access issues it might face. Meeting the community’s needs was at the forefront of this ACCHS’s service delivery, which translated into a culturally-safe, sustainable and balanced service delivery.

The next chapter presents the theoretical framework and discussion.
Chapter 7

Theoretical Framework and Discussion

This chapter presents a theoretical framework, which is an amalgamation of the key findings from the three case studies described in Chapters 4, 5 and 6 respectively. This theoretical framework builds upon the conceptual framework (Figure 2.6, Chapter 2, p. 95) and the framework for the research (Figure 3.1, Chapter 3, p. 101) that guided this research to understand how ACCHSs balance their organisational requirements with community expectations. A discussion of the findings and the contribution to knowledge will also be presented. This chapter then identifies the strengths and the limitations of the research.

7.1 Theoretical framework

The conceptual framework, Figure 2.6 (Chapter 2, p. 95), for this research presented the theory of the concepts influencing the ACCHS. The framework showed how the input of community (history, policy, governance, Indigenous worldview, social determinants), organisation (accountability, communication, workforce, policy, location, primary health, health promotion) and culture (cultural identity, cultural needs, cultural protocols, Indigenous worldview) influenced each ACCHS. Each ACCHS consisted of an Indigenous CEO, Indigenous and non-Indigenous staff, a Community Board of Directors, various programs and community engagement; however, for this research only the Indigenous staffs were interviewed (this is discussed in Chapter 3). The input of the ACCHS produced the output in the framework (Figure 2.6, p. 95) of: servicing the health needs of the community, meeting the expectations of the Community Board, meeting the organisation requirements and ensuring that cultural inclusion, sensitivity, awareness and safety, were all maintained. The evidence from Figures 2.6 (p. 95) and Figure 3.1 (p. 101) provided a theoretical foundation to guide this qualitative case study research. From the findings of this research a theoretical framework, outlined in Figure 7.1, has
been developed to answer the research question ‘How does an ACCHS balance the organisational requirements with the community expectations?’

This research has shown (Figure 7.1), that the ACCHS’s main purpose is to deliver to the Indigenous community in three areas: primary health care, strategic direction, and a health-promotion service. In all three case studies, primary health care was seen as the main purpose of the ACCHS, and under that banner they were able to access funding, demonstrate accountability in relation to government requirements and provide a clinical service to the community. All the cases highlighted the importance of having the clinical services delivered with the AHWs who came from the Aboriginal country or clan group and from the community that supported the ACCHS. In particular, in Case Study 1, having the AHWs involved in clinical service delivery was a
means of empowering their own people. In all these services, staff discussed the connection that the AHWs had with people from the community, the person who was the cultural broker who lived and socialised in the community, and who understood the language used by general practice and the specialists and therefore was able to translate that language in a manner that the Indigenous client, from the community, could understand.

In the middle, of Figure 7.1, is the strategic direction of the ACCHS set by the decisions that were made by the Community Board. All cases described how Board members represented different families, clan groups or different communities to whom the ACCHS provided a service to (in particular, see Case Study 3 example) to set the strategic direction of the ACCHS and to ensure that the CEO maintained the service for the community. The Community Board is placed in the centre, of Figure 7.1, and linked to the strategic directions, because from the findings of this research, they were at the centre of the decision-making for the ACCHSs. The Community Board was responsible for ensuring that there were processes and procedures in place for continued service provision by the ACCHS to the community, regardless of any change in CEO. All the case studies had different examples of the policies and procedures to ensure the ongoing provision of services to meet each community’s needs. At the time of this research, Case Study 1, was coming out of a complete restructure and a directive was put in place that it was a requirement that all Community Board members were to have governance training. Case Study 2 already had governance training in place for Board members and had an additional requirement that no one who had a direct relative employed in the ACCHS could be nominated as a Community Board member. Case Study 3 had set policies and procedures in place that catered for the geographical dispersion of the different communities that the ACCHS serviced.

The bottom of Figure 7.1 highlights a health-promotion service provided by the ACCHS and specifically by the AHW. In all three case studies, it was found that health promotion was discussed separately from primary health
care. Primary health care was the terminology usually used by the CEO and the AHWs who participated in clinical services such as working with GPs and clinical specialists. Health-promotion programs were delivered by the AHWs and in all cases it was important that the AHWs came from the community and understood the cultural protocols, identity, needs and the Indigenous ways of knowing and doing to meet each community’s needs when implementing health-promotion programs.

At the top of Figure 7.1, above the ACCHS, is listed ‘Government Funding Requirements’. This is clearly a two-way process, in that the government provides the funding and the ACCHS have to demonstrate how they have contributed to meeting the stated requirements of the COAG for ‘Closing the Gap’ measures, of ORIC, and of OATSIS. All the case studies reported that meeting government requirements was important process for maintaining funding. In particular, Case Study 2 expressed that as Indigenous health had become ‘big business’ in a competitive market, it was becoming increasingly demanding to maintain government reporting requirements and at the same time deliver holistic health. The bold type of this text in Figure 7.1 reflects the importance of government funding requirements.

The words ‘Past Policies’ at the bottom left of Figure 7.1, is a representation of the political power, willing or unwillingly, that government has contributed to in Indigenous history by neglecting to appropriately address the social determinants of health of Indigenous people. In turn this has had an impact on the ACCHSs and the ability of the ACCHS to balance organisational requirements and community expectations. Past policies have impacted and continue to impact on the Indigenous community’s engagement with and trust of health services. This is compounded by discriminatory funding requirements whereby governments do not take Indigenous culture or history into consideration when they fund Indigenous health services. ‘Discrimination’ and ‘Culture’ are also identified at the bottom of Figure 7.1 to reflect the impact of these social determinants on the ACCHS. The implications on the ACCHS from past policies and discrimination and culture (social
determinants) were evident at some level throughout all the participants’ responses in all three case studies, and were particularly evident in Case Study 2.

In the middle of Figure 7.1, a square connects the ACCHS and the community to each other. This square represents the balance between organisational requirements and community expectations. In all the case studies the Indigenous cultural domain and the western system domain were evident. The Indigenous domain included the different clan groups, Indigenous protocols and a holistic approach to health. The western domain involves reporting, accountability and a biomedical approach to health. While both approaches were evident in all the case studies, it was in Case Study 2 particularly that both ‘cultures’ combined to provide a health service that best met the community’s needs.

7.2 Discussion

The findings presented within the theoretical framework, Figure 7.1, refer to the ability of the ACCHS to operate in the Indigenous and the western domains to deliver a culturally-appropriate health service to Aboriginal and Torres Strait Islander peoples. This is achieved through the involvement of the community at all levels, most importantly the representation and inclusion of the Community Board and the AHW/s, for service delivery, policy, procedures and processes of the ACCHS. These findings are compounded by discriminatory government funding processes, shown by this research to impact on the ACCHS in terms of funding timeframes that ignored Indigenous protocols, particularly in communities that have experienced negative historical influences and are very distrustful of health services. The identification of history and discrimination are important influencing factors on the ACCHS today and are an important outcome of this research in terms of contribution this knowledge can make to the operation of the ACCHS in the community.
The communities in this research all had a demographic history that reflected protectionism, the White Australia policy, and assimilation policies; namely, people were forcibly removed from their own land or country to the community that exists today (Smith, 2007). The Indigenous culture is an oral culture (Ranzijn et al., 2009) and the negativity and racism associated with the implementation of these policies had been transferred across generations through the sharing of stories. This type of historical experience continued to impact on the daily living of Indigenous Australians (Baum, 2008) in these communities and the interactions of Indigenous staff and Community Board members with the ACCHS and non-Indigenous staff.

The non-Indigenous staff in the ACCHS consisted of doctors, nurses, nurse clinicians, nurse practitioners and allied health staff. In some cases, the workforce issues were linked to hidden forms of discrimination, whereby, for example, the non-Indigenous staff were employed in higher positions and were paid higher salaries, and those that were employed as specialists did not or would not follow the simple processes of the ACCHS. An example of this is the advance notification prior to the day of arrival so that the ACCHS would have time to notify the community; what instead allied health professionals did was notify the ACCHS on the same day as arrival and expected the ACCHS to have the community clients ready. This type of power dynamics that Hill et al., (2001) describe means that those in the dominant culture define their space by employing strategies to ensure their control. These types of power dynamics however do not earn these allied health professionals respect from the ACCHS or the Indigenous communities, and also demonstrate that these allied health professionals do not have an understanding of the cultural protocols required to work with Indigenous communities or the ACCHS.

The Indigenous culture and the Indigenous worldview were reflected throughout the ACCHS and involved their interactions with each other, in the perspective ACCHS, and more so with their community. Togni et al. (2011) discuss in their research findings that culture is part of the core for health and well-being in Indigenous people, as it is based on people’s beliefs, values and
worldviews. Therefore, how people are respected, trusted, recognised and considered in their communities was reflected in the understanding the ACCHS health service showed towards the Indigenous culture and worldview. The peak body NACCHO (2008) captured the Indigenous cultural worldview on health in its overarching philosophy for the ACCHS when it described Aboriginal health as the ‘social, emotional and cultural well-being of the whole community’. This understanding representation of the Indigenous cultural worldview embraces the notion that the health delivered by the ACCHS is for the Indigenous people and is delivered by the Indigenous people; this philosophy empowers Indigenous people and in turn their communities – a necessity towards closing the life expectancy gap between Indigenous people and non-indigenous people.

The non-Indigenous domain in the ACCHS was represented through a number of criteria, the main one being able to meet COAG requirements to access the ‘Closing the Gap’ funding. For the ACCHS, this meant having effective processes and policies in place to ensure accountability was maintained. This included establishing lines of best practice, whereby systems were put in place in the ACCHS to ensure that all Indigenous staff understood that their main objective to obtain funding to meet the community’s needs was to meet government requirements.

In its reporting requirements, the COAG has linked Indigenous identification with funding allocation by making it a necessary pre-condition to participate in the ‘Closing the Gap’ strategy (DoHA, 2010). What the Indigenous community perceived as ACCHA services that were needed to address their underlying need resulting from their social determinants not being met was not always measured in the recorded data. Rickards et al., (2011) highlights that data on the social determinants of health were collected in relation to the physical influences on health and not the social and cultural factors, such as the discrimination and historical influences shown by this research to have been experienced by Indigenous people. This makes the interpretation of this biomedical data problematic, in the sense that funding is allocated to
programs that are not sustainable and do not address the ‘cause of the cause’ (Marmot, 2007), a much-needed approach towards ‘Closing the Gap’ in Indigenous life expectancy.

The CEOs from the ACCHS participating in this research did not come from the community where they were employed, and therefore were not exposed to that particular community’s political history. However, this is not to say that they were not exposed to or experienced any such history; as Indigenous people they would have come to the ACCHS with a shared understanding and knowing of the Indigenous worldview. The philosophy of the ACCHS, discussed above, empowers the Indigenous people as a whole community and that was reflected throughout the organisational changes that the three ACCHSs went through. In her 2008 paper, Coombe maintains that the open and transparent communication between the ACCHS and the community places the ACCHS in a strong position to implement change effectively. This was exemplified by the three services that were the subject of the case studies in this research; each maintained community connections through their staff and Boards, thereby enabling ongoing communication.

In western management culture, organisational change is achieved through the leadership of the CEO; that is, leadership is determined by the status of one’s position in an organisation. However, in Indigenous culture, leadership is connected to the responsibility that a person carries in their community (Hill et al., 2001). Coombe (2008) points out that the Indigenous CEO and the Indigenous staff are already considered natural leaders in their communities, thereby making the ACCHS very well placed for any organisational changes. To implement organisational change effectively requires a whole-of-community approach; this ensures community empowerment is maintained and at the same time western accountability is met. Hill et al., (2001) explain that this kind of tactic is referred to as an oppositional tactic, whereby the CEO is obligated to maintain a western organisational framework and to operate in the community which requires the employment and training of local
Indigenous staff, thus demonstrating that their primary commitment is to the Indigenous community.

Demonstrating commitment to the community means that the ACCHS has to ensure that it maintains a sense of loyalty to the whole community. This research has highlighted various factions in communities and the difficulties in addressing all their needs during organisational change. In their research, Hill et al., (2001) demonstrated that the association between government and Western culture could define loyalties in the organisations. As the CEOs did not come from the local community and as the organisations went through their changes, the Community Board was encouraged to be the bridge between the ACCHS and the local community. This strengthened the ability of the ACCHS and the community to cope with the change and at the same time maintained western organisational requirements.

This research found that the importance of governance training benefited the Community Board and was highlighted as part of the process in the ACCHS accountability and organisational changes. Further related to governance was that some of the ACCHS ensured that direct relatives were not employed in the same ACCHS as they feared this could influence their governance processes. However, the integration of Indigenous culture into these governance processes ensured that the community was brought along with the organisational change. This combination of western governance training and Indigenous culture contributed to the sustainability of the ACCHS model of Indigenous primary health care.

It is not unusual for a health service to go through an organisational change and it is becoming much more common in the ACCHS. Johnstone et al. (2006) explain that organisational change can happen due to a number of factors; however, if an organisation is forced into change, as experienced by the ACCHS in this research, the organisation may then begin to look for external support. In Case Study 2, the implementation of the organisational changes came from the community and was in place regardless of multiple
changes in CEO. This was due to the role that the community played in the organisation, namely, that it was the community to which the ACCHS provided a service and it was the source of the Community Board members and the AHWs. Acquiring external support is a necessity for the ACCHS so that the community have access a combination of vital services.

The language barrier between the non-Indigenous health professionals and the Indigenous clients contributed to how the Indigenous clients accessed the ACCHS services. If Indigenous clients cannot understand the non-Indigenous health professionals, then they are unlikely to access the service. The study by Togni et al. (2011) shows how the gaps in understanding between non-Indigenous staff and Indigenous clients, and between the non-Indigenous staff and the Indigenous staff, can create misunderstandings. These gaps create issues of access, affect the way health is delivered to Indigenous people and the way health is interpreted for Indigenous people. Because of the impact on the decisions Indigenous people make about their own health, this highlights the importance of the AHWs to bridge the cultural gap in health service delivery.

The findings about the AHWs are important as they identified the AHW as instrumental not just in linking Indigenous clients with non-Indigenous health professionals but also in linking the ACCHS with the community. The AHWs come from the community and have been trained, and continue to receive education and training, to deliver health-promotion programs for the identified areas of need to the community. These health-promotion programs are delivered through the ACCHS and include addressing chronic disease, diabetes, social-emotional well-being, sexual health, nutrition, and mums and babies’ well-being, etc. The WHO (1986) definition of health-promotion (from the Ottawa Charter) is underpinned by the empowerment of community and individuals as its central purpose (Smith, 2012). Togni et al. (2011) describe a similar model of health-promotion programs delivered by the Utopia Northern Territory health service that contributes to the culturally accessible model of primary health care. This model also employs local Indigenous staff in a
service that is underpinned by the local Community Board of Directors. This model is not dissimilar to the ACCHS model in Queensland, which ensures that communities are at the centre of primary health care, thereby making the delivery of Indigenous primary health care by the ACCHS community-driven and sustainable.

This research found that the collectivist, rather than the individualist, approach of the Indigenous culture, to the decision-making processes in the ACCHS was representative of the principles of community control whereby the ownership and strategic direction of the ACCHS was established by people from the local Indigenous community. This was achieved by having local Indigenous people from the community on the Board of Directors, or in some jurisdictions Indigenous people making up the quorum of the Board of Directors. In the study by Togni et al. (2011), the participants highlighted that having a Board of Directors from the local Indigenous community demonstrated how much people of the community cared about their own people’s health. In the study by Dwyer, Shannon and Goodwin (2007), the authors explain that the lack of governance training of the Board of Directors accounted for inadequate decision-making in the ACCHS.

7.3 Research reflection

This section of the chapter discusses the strengths and limitations of the research.

7.3.1 Strengths and limitations of the research

This research had a number of strengths and limitations. The main purpose of this research was to investigate how, using western research methods and an Indigenous standpoint, three ACCHSs delivered a primary health service in and to Indigenous communities. The focus of the research was on the perspectives of the Indigenous employees. The employees were invited to provide their stories of their experiences, understandings and perspectives on
the community, and the cultural and organisational concepts that influenced the service delivery of the ACCHS.

The strength of the research is that the ACCHSs in the study were part of a larger body of ACCHSs that had been delivering their Indigenous primary health care model to Indigenous people for more than 40 years with the same belief of ‘for the people by the people’. The ACCHS selected for this study were established in their communities about 20 years ago and the Indigenous staff had been part of their communities most of their lives. They therefore had an intricate knowledge of the ACCHS organisations and this was reflected in the data. Apart from the CEOs, the participants for this research were drawn from that pool. None of the CEOs in the research came from the community of the ACCHS that they managed; this was a strength for the ACCHS, as they couldn’t be involved in the family politics from within the communities and therefore be biased in their responses.

A further strength of the research was the ongoing contact with a member of QAIHC that ensured the Indigenous ways of knowing and doing were maintained throughout. Before the commencement of data collection at every site, the Indigenous introductions were upheld. Following the completion of research at a site, the QAIHC member would ask the researcher about Indigenous protocols and how they were upheld and a discussion was held as to what forms of respect were required for the next site. This was done in conjunction with and consideration for the impact of history on the community. The discussion with the QAIHC member also included how the questions of the research were posed and the participants’ cultural, or non-verbal, communications were discussed to ensure the accuracy of the data. This was a process that could not be achieved with individual participants, as time constraints were applied to the CEO of each ACCHS and there was a high turnover of CEOs, in the ACCHS. In addition, the multiple Indigenous clan groups made it difficult to administer such discussions.
Indigenous communities and people have a history of being over-researched and at the same time disrespected in the process. Compounding this are the inequitable policies placed on Indigenous peoples. The Indigenous identification of the researcher, Meriam and Wik, was important and a strength to this research in her understanding of the Indigenous ways of ‘knowing and doing’ (Denzin, Lincoln, Smith, 2008; Morseu-Diop, 2008; Rigney, 1999).

The strength of the case study is that it allows for a contemporary phenomenon to be studied in-depth in a real-life context (Yin, 2009). In this research the use of multiple sources of evidence was relied on to draw depth into the study from the viewpoint of the ACCHS employees. This included listening to the Indigenous ACCHS employees tell their stories through in-depth interviews, providing an opportunity of western confirmation with focused interviews and applying a cultural way of learning through observation. Each case study site had a different cultural history and therefore a different story. All the multiple sources of evidence followed the western discourse and at the same time were influenced by the researcher’s Indigenous worldview. Therefore, the cultural nature of the research in the case study design required flexibility and encouraged attention to be placed on how best to convey questions and discussions, rather than change the actual nature of the questions and discussions that were held.

The main limitation of this research was that it was conducted with limited funding; it would have benefited from more substantial funding, which in turn would have enabled the researcher to stay longer in the communities and observe the implementation of programs. Due to the workload placed on the Indigenous ACCHS staff, there were time constraints for each ACCHS interview. However, in saying that, the participants did not rush their responses and were respectful of the need to respond honestly and openly to the questions put forward for this research.
The non-return of some of the focused surveys was a limitation. There were also limitations to the snowballing strategy in the ACCHS as sometimes the CEO would provide a list of names of those to participate in the research rather than encouraging each participant to invite another. However, usually the participants ignored the list and invited the next participant.
Chapter 8

Conclusion

This chapter concludes this thesis by summarising the findings of the research and making suggestions for future directions for research and policy development.

This study investigated three ACCHSs in Queensland, with a particular focus on their responsiveness to organisational requirements and community expectations. Prior to the outset of this research, the relationship between the community and the organisation in Queensland, or the implications of government policy on the ACCHS, had not been reported in the literature.

The application of case studies in a qualitative research paradigm and the understanding of Indigenous ways of knowing and doing, provided a strong basis from which to investigate the ACCHSs. The ACCHSs operate in three specific paradigms: the organisation, the community and the culture. To provide a culturally-safe space, with culturally competent staff, and deliver sustainable primary health care for Indigenous people. The rich and in-depth analysis of this research contributed to the existing knowledge and understanding of the complex socio-cultural world of the ACCHSs. The research provides health professionals with an opportunity to understand how these organisations have placed themselves as leaders in ‘closing the gap’ between Indigenous and non-Indigenous people’s health.

Theoretically the phenomenon under investigation, the Aboriginal Community Controlled Health Service, follows the principle that it is ‘for the people, by the people’. The literature highlighted the influencing concepts on the ACCHS and as a result it is clear that the ACCHS functions similarly to other primary health care services in Australia whereby they have to register their organisation and maintain accountability for its operations. What is different in the ACCHS story is the history of racist policies imposed on Indigenous
people that led to the development of the first ACCHS. For more than 40 years, these organisations have carved a place for themselves in the Australian health system as sustainable, holistic models of primary health care for Indigenous people. Little has changed on the policy front, as ACCHSs are still forcibly committed to follow a set government agenda that is set up uniquely for Indigenous people, in the form of Acts, regulations, set funding requirements and reporting, policy and legislation. Yet ACCHSs continue to function to provide a culturally-safe environment for Indigenous communities, using a model of care that continues to engage and involve the whole community.

The results of this research demonstrate how these ACCHS have balanced government requirements and community expectations to maintain the delivery of a culturally-safe Indigenous primary health care service. The study concludes that to balance the western domain (in the form of bureaucratic and organisational structures and functions) and the Indigenous domain (of culture and worldview) requires the complete involvement and engagement of the community. Importantly, to provide a culturally-appropriate health service model of delivery requires the recognition and understanding of Indigenous ways of knowing and doing, coupled with the necessary support of Indigenous staff and Community Board members to respond effectively to the processes and procedures required to fulfil their organisational obligations and meet their communities’ needs. The ACCHS model of Indigenous primary health care is sustainable due to the empowerment of the community in the form of community involvement and engagement in their own health decision-making. Self-determination of the whole community is what propelled the establishment of the first ACCHS and continues to be the essence of an ACCHS, regardless of the continuous cycle of racist policies and legislations still imposed on Indigenous people today. In theory, ACCHSs are Aboriginal community-controlled; however, the depth and breadth of western culture assumes place in Indigenous primary health care.
Finally, this last section of the thesis provides suggestions for policy development and recommendations for future research.

8.1 Suggestions for policy development

These recommendations for policy development are directed at a number of responsible institutions that play an instrumental role in the policy decision-making of the ACCHS. These institutions include NACCHO, AIHW, ABS, all universities and all levels of government.

1. Increase the levels of leadership and governance education and training for Indigenous health service managers and members of the Board of Directors to ensure they can understand and report in a western framework of accountability.

2. Develop and deliver a nationally-registered qualification to support the valuable role of the AHW. This qualification should be recognised across all jurisdictions and could be used as a pathway to university-level higher degrees (similar to others who do an apprenticeship).

3. Federal, state and territory governments should work with Indigenous people/organisations to form a multilateral agreement for the development and delivery processes of all policies that will impact on Indigenous people’s health and that of their communities.

4. The ACCHSs should have certainty of long-term funding agreements, developed and implemented in collaboration with the ACCHS.

5. The funded programs delivered by the ACCHS should require both biomedical data and Indigenous community consultation to ensure that what is being implemented and reported on addresses the ‘cause of the cause’.

6. All staff, including those from mainstream organisations, working in the ACCHS should be provided with ongoing cultural competency training, in particular the visiting non-Indigenous staff.

7. There should be support for the ACCHS to consider policies such as (i) ensuring that the Board of Directors represents different family or clan
groups in the area to reduce any form of bias in the decision-making processes in the ACCHS, and (ii) that no community member can be elected to be on the Board if he or she is a first-generation relative of any ACCHS staff member.

8. Non-Indigenous service providers should be evaluated and monitored, similarly to the ACCHS, against key policy measures for ‘closing the gap’ to ensure competent and sustainable service delivery to Indigenous people.

9. The ACCHSs and mainstream Indigenous health workforce require continuous up-skilling and qualified staff with a focus on staff retention to ensure consistency and sustainable service delivery.

Finally, it is recommended that the development of polices for Indigenous peoples, and specifically government funding requirements for the ACCHSs, needs to incorporate the very people that it will impact on, as it encourages ownership through empowerment and sustainability.

8.2 Recommendations for future research

First and foremost, this research revealed the need for further evaluative research of the services offered by the ACCHS across other Australian jurisdictions to determine how these other services balance their organisational imperatives and their community expectations. This thesis has presented the findings of three case studies in one jurisdiction and prompts the need for a more extensive research evaluation of the health business model that other services have adopted to deliver sustainable models of primary health care to Indigenous people. This research would further benefit from the perceptions of other members of the community and non-Indigenous staff to ensure sustainability in both the connection to community and in the ACCHS organisational system.

In Chapter 2, reference is made to Fredericks et al. (2012) and Smith (2007) discussing how the complete history of the Indigenous people of Australia has
been one of control and government policy, and how this has contributed to the breakdown of personal decision-making by Indigenous people. This discussion points to a failure in Australian policy to protect the rights and well-being of Indigenous people and contributes to their loss of self-determination.

Future research into the ACCHS could consider this context with a particular focus on health service delivery and specifically the social and emotional well-being services needed to address the historical issues as a result of Australia’s colonisation.
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Appendices

Appendix 1: Ethics certificate (Original and at time of data collection)

Griffith University
HUMAN RESEARCH ETHICS COMMITTEE

ETHICAL CLEARANCE CERTIFICATE

This certificate generated on 30-08-2009.

This certificate confirms that protocol 'What impact does Indigienity have on the CEO management of an Aboriginal medical Service (AMS)?' (GU Protocol Number PBH/15/09/HREC) has ethical clearance from the Griffith University Human Research Ethics Committee (HREC) and has been issued with authorisation to be commenced.

The ethical clearance for this protocol runs from 19-06-2009 to 30-12-2012.

The named members of the research team for this protocol are:
  Dr Gary Day
  Prof Donald Stewart
  Ms Vanessa Lee

The research team has been sent correspondence that lists the standard conditions of ethical clearance that apply to Griffith University protocols.

The HREC is established in accordance with the National Statement on Ethical Conduct on Research Involving Humans. The operation of this Committee is outlined in the HREC Standard Operating Procedure, which is available from www.gu.edu.au/or/ethics.

Please do not hesitate to contact me if you have any further queries about this matter.

Dr Gary Allen
Manager, Research Ethics
Office for Research
Bray Centre, Nathan Campus
Griffith University
Phone: 3735 5585
Facsimile: 3735 7994
Email: g.allen@griffith.edu.au
**ETHICAL CONDUCT REPORT**

University Research Ethics Database Protocol Number

| PBH / 15 / 09 / HREC |

The protocol number must be provided, or please write the name of the protocol on this report.

1. **Type of report:**

   Please tick the relevant report category or set the shading for the relevant block at 25%.

   ✓ Annual  ❑ Final  ❑ Renewal

2. **Senior Investigator:**

   Please tick the relevant statement or set the shading for the relevant block at 25%.

   ✓ No Change from approved protocol
   ❑ Change in contact details for senior investigator
   ❑ Proposed change in senior investigator

   Please provide details of any changes from the approved protocol (either in terms of contact details or a proposed change to the Senior Investigator).

3. **Research team:**

   Please tick the relevant statement(s) or set the shading for the relevant block at 25%.

   ❑ No Change from approved protocol
   ❑ Additions to the research team
   ✓ Removals from the research team

   Please list the current members of the research team. Please mark with (+) any proposed additions to the research team and (-) any removals from the research team.

   Vanessa Lee
   Donald Stewart
   Bernadette Sebar (+)
   Gary Day (-)
Appendix 2: Information Sheet

Information Sheet of Interview for staff

Project Title
How does an Aboriginal Medical Service balance community and organisational requirements when delivering health services?

Senior Investigator
Prof. Donald Stewart
Head of School
Public Health
Logan Campus,
Griffith University

Primary Investigator
Dr Bernadette Sebar
School of Public Health
Logan Campus,
Griffith University

Assistant Investigator
Vanessa Lee
PhD Candidate
School of Public Health
Logan Campus,
Griffith University

About The Researcher
This research is a PHD research project of the assistant investigator Vanessa Lee. Vanessa is an Indigenous woman from the Torres Strait, who has a Masters of Public Health majoring in Indigenous health from the University of Queensland. She will be collecting the data herself as per the ethical guidelines for her PHD within the School of Public Health, Griffith University.

What is required of you as a participant?
As staff member of an Aboriginal Community Controlled Health Service you are being invited into this research as a participant to be interviewed for a case study. The reason for this is to encourage you to share in answering some questions in regards to the Aboriginal Community Controlled Health Service where you are employed. This research is not intended to harm anyone we are just hoping to find any additional information in regards to the Aboriginal Medical Service in your area. Some light refreshments will be provided and it should only take about an hour and a half of your time. The research is outlined below.

Purpose of the research
The aim of this project is to determine how the AMS balances community and organisational requirements when delivering health services.

Background
Aboriginal Medical Services (AMS) were established to provide better health services for Indigenous people, as part of the struggle for better health outcomes through the sheer act of self determination (Brady 2000; Dwyer 2007; Howard 2006). The first Aboriginal Medical
Service (AMS) was established in Redfern NSW in 1971 (Bartlett, B., and Boffa, J., 2005; Couzos 2007; Dwyer 2007; Howard 2006). These services were established following decades of social change that were felt globally, as a new awareness of the treatment and disadvantage of Indigenous people became a human rights issue (Couzos 2007). In 1973, following the election of the Whitlam government, the Commonwealth government forwarded grants to the states, that were then passed onto the community controlled health sector. These grants supported the development of 175 Aboriginal Community Controlled Health Sectors (ACCHS) by 1994-95. At the end of 1996, the Department of Health & Aged Care took responsibility to ensure the health needs of Indigenous Australians were being met within the health system. From then on a new national strategic approach for Indigenous health was introduced.

**Risks**
The main risks to the participant in this research could be:

- Individual life histories might be disclosed during the interviews or focus groups.
- History of the AMS and the community of which it serves could be uncomfortable to discuss for some participants.
- The project encourages the participants to look at their own workplace this may be uncomfortable for some of the participants.

To overcome these risks, and out of respect to the participants, information will be provided of where to obtain any support that you may feel is necessary following your participation in this research.

**Benefits**
From this research it is hoped to draw information as to how the AMS balances community requirements together with organisational requirements in delivering health services to the community. It is anticipated that from this research recommendations can be made to the Public Health Association of Australia as to how to support the AMSs towards achieving better health outcomes. The project hopes to provide Aboriginal and Torres Strait Islander health services with a deeper understanding of the operations within the organisation, therefore, increasing professional integration into the Aboriginal Health Workforce. The project will also provide some recommendations to QAIHC in regards to improving management within Aboriginal Medical Services, therefore providing better health services to Indigenous Australians.

The findings of the study will be incorporate into the thesis of Vanessa Lee, to be submitted for a Doctorate of Philosophy at Griffith University.

**Confidentiality**
Your information in regards to this research will be kept confidential. All data will be kept in the possession of the investigators. If the results of the study are published in a health journal, your identity will not be revealed. Participants will not be referred to by name during research reports or during discussions. All records will be stored in a locked filing cabinet with restricted access for a minimum of five years in a private office. All computer records are restricted by password. All interviews and group settings will be audio-taped to ensure accuracy of data collection. All records will be destroyed after transcribing dialogue onto the computer.

The data obtained from this research will only be used as outlined within this information sheet and where consent has been given.

**Contacting the Investigators**
If you have any queries at all in regards to this research, please contact Prof. Donald Stewart on (07) 338 21487, Dr Bernadette Sebar (07) 33821122 or Vanessa Lee (07) 338 21040.

**Feedback**
There will be a summary of the study results made available to interested participants upon completion of the research.

**Voluntary Participation**
Participation is voluntary, and anyone who wants to participate may refuse to answer questions, may withdraw from the study at any time without giving any reason and without affecting any relationship with the researcher of Griffith University. If withdrawing after response to some questions, earlier responses may be modified at your request or you may request them to be omitted, otherwise they might be incorporated into the data, as "anonymous", as all responses will be.

Whether you decide to participate in the study or not, your decision will not prejudice you in anyway. If you do decide to participate you are free to withdraw your consent during the research process and discontinue your involvement in this research at any time without any repercussions.

**Complaints Mechanism**
Griffith University conducts research in accordance with the *National Statement on Ethical Conduct in Human Research*. If potential participants have any concerns or complaints about the ethical conduct of the research project they should contact the Manager, Research Ethics on 38755585 or research-ethics@griffith.edu.au.

**Legal Privacy Statement**
The conduct of this research involves the collection, access and / or use of your identified personal information. The information collected is confidential and will not be disclosed to third parties without your consent, except to meet government, legal or other regulatory authority requirements. A de-identified copy of this data may be used for other research purposes. However, your anonymity will at all times be safeguarded. For further information consult the UniversityÆs Privacy Plan at www.gu.edu.au/ua/aa/vc/pp or telephone (07) 3735 5585.
Appendix 3: Consent form

Informed Consent Staff Interview

Project Title
How does an Aboriginal Medical Service balance community and organisational requirements when delivering health services?

Assistant Investigator: Vanessa Lee

Senior Investigator: Prof. Donald Stewart
Primary Investigator: Dr Bernadette Sebar

Institutions: Griffith University, Australia

I __________________________ (Print Name) hereby agree to participate as a volunteer in the above named research, as a __________________________ staff member. I am a member of the __________________________ Community.

I understand that the study will be carried out as described in the information sheet, a copy of which I have retained.
I agree to participate in the study entitled “How does an Aboriginal Medical Service balance community and organisational requirements when delivering health services?”
I understand that the interviews and will be recorded, and at completion of this research the recordings will be destroyed.
I understand that although the result may be published, my name and/or identity will not be included in the publication.
I have also been given the contact address of project staff if I have any queries or problems in the future.
I realise that whether or not I decide to participate is my decision and will not affect my treatment.
I also realise that I can withdraw from the study at any time and that I do not have to give any reasons for withdrawing. I have had all questions answered to my satisfaction.
I have read the information sheet and the consent form.

Signatures: __________________________ (Participant)

______________________________ (Researcher)

Date: __________/______/________
Appendix 4: In-depth Interview questions

Aboriginal Medical Services: Organisational requirements and community expectations

<table>
<thead>
<tr>
<th>Interview 1 A B C D E</th>
<th>Case Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal:</strong></td>
<td></td>
</tr>
<tr>
<td>How do you identify yourself?</td>
<td></td>
</tr>
<tr>
<td>How are you identified within this community?</td>
<td></td>
</tr>
<tr>
<td>Is this your community? Where is your community?</td>
<td></td>
</tr>
<tr>
<td>How are you identified within this health service?</td>
<td></td>
</tr>
<tr>
<td>How many staff are there?</td>
<td></td>
</tr>
<tr>
<td>When did you start working here?</td>
<td></td>
</tr>
<tr>
<td>How did you find out about the position?</td>
<td></td>
</tr>
<tr>
<td>Describe your position?</td>
<td></td>
</tr>
<tr>
<td>Why do you work here?</td>
<td></td>
</tr>
<tr>
<td>What are your expectations of this health service?</td>
<td></td>
</tr>
<tr>
<td>Are your expectations being met? How or why?</td>
<td></td>
</tr>
<tr>
<td>What do you feel is the most challenging aspect of your work? Why?</td>
<td></td>
</tr>
</tbody>
</table>

**Community Needs and Expectations:**
- Does this health service have a community board?
- What do you see as the role of the community board?
- How do the community board and the health service work together?
- Describe what you think are the health needs and/or issues of the community?
- How do you know this?
- What do you think this health service offers the community?
- What do you think is the communities’ expectation of this health service? Why?
- How does the health service communicate with the community?
- Do you think that this health service is meeting the needs and/or expectations of the community? How?
- Do you think that the health service and the community have a good relationship? Why?

**Organisational Requirements:**
- How do you define an organisation?
- How do you describe this health service in terms of an organisation?
- When did this health service start (year)? Why?
- How does this health service approach the needs of the patients/clients?
- How would you describe your culture?
- Does your culture affect how you do your job?
- How do you treat and/or communicate with other staff members?
- Do you communicate differently with clients to that of staff?
- How would you describe the organisations culture?
- How do you define leadership?
- Is there anyone in this health service that you would consider a leader? Why?
- What do you thing is the most challenging aspect of the organisation in meeting the health needs of the community?

What do you think could be done differently in terms of making sure that the health service meets the needs of the community?
Appendix 5: Focused Interview questions

Aboriginal Medical Services: Organisational requirements and community expectations

Interview 2 A B

<table>
<thead>
<tr>
<th>Case Code:</th>
</tr>
</thead>
</table>

**Personal:**

Q1. What is your age group?  
☐ 20 to 30  
☐ 31 to 40  
☐ 41 to 50  
☐ 51 to 60  
☐ 61 plus

Q2. What is your gender?  
☐ Male  
☐ Female

Q3. How do you identify yourself within the community?

Q4. How do you identify yourself with this health service?

Q5. What is your role or position within this health service? How long have you been in this position?

Q6. What experience or training have you done towards preparing yourself for this position? (year, title, type etc)

Q7. How did you find out about your current position?
Q8. Describe what you do within your position as the CEO or community board member?


Q9. Describe what you feel is the most important aspect of your role or position within this health service?


Management and community:

Q10. Do you see yourself as a leader in the community or in the health service? Why or why not?


Q11. Describe the way in which you feel that you contribute to the management of this health service?
Q12. What do you see as a requirement to ensure appropriate health service delivery to the community?

Q13. What type of services does this health service offer to the community?

Q14. How do you know that this is the type of health service that this community needs?

Q15. What do you see as the top five priorities for this health service, within your position?
Appendix 6: Direct Observation Schedule

Direct Observation Criteria – Vanessa Lee

The observation for each case study followed the same criteria, this included observing the:

- Structural and organisational features – what the landscape and buildings looked like, what information of other services was available ie. Health Promotion; specialist clinics.
- People – interpersonal communication and cultural protocols.