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Building Capacity for Indigenous Community Control in Health

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&

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Introduction by Associate Professor Cindy Shannon

It has been argued that proper investigation into the meaning of community capacity building and its application in an Indigenous Australian context is overdue (Taylor 2003). The concept of community capacity and associated discourse has permeated all levels of public policy and research in recent times, and clearly, in an Indigenous Australian context, it is inextricably linked to issues of governance.

The Housing of Representatives Standing Committee on Family and Community Affairs, in its *Health is Life* Report (2000), found that “Indigenous communities easily attract criticism for financial mismanagement, but that they have considerable difficulty in accessing the administrative support they need to address these problems”¹ They concluded:

“the important thing about community control is that the community has the capacity to do it. It is no good just suddenly hurling a whole bunch of money into a community and saying “you have community control now”, when the people in the community do not necessarily have the capacity to do that...”²

Comments such as this require consideration of what is meant by capacity, the responsibilities of the whole health system (not just Aboriginal people), and the current accountability requirements.

¹ Health is life p.45

² p.44

While there is not a universally accepted definition of capacity building, it seems that there are a number of consistent dimensions and these will be explored in this Thomas Aquinas lecture. The Community Capacity, Health Inequalities and Sustainable communities Network in Australia identifies the common themes as being: participation and leadership

- skills (such as planning, co-ordination, advocacy, management, problem solving, and conflict resolution)
- social and inter-organisational networks
- sense of community (belonging, influence, emotional connection)
- resources (both access to resources :financial capital, social capital, and technology, and the ability to use them prudently)
- understanding of community history
- community power (amalgamation of sense of community, leadership, shared concern)
- community values (how consensus of values is achieved)
- critical reflection

Mum will talk about a number of these themes and I will then specifically talk about the links between some of these themes and community governance and the impact this has on community capacity.

Joan Hendriks

As we move further into the third millennium the past decade will be recorded as the period when Reconciliation was forged in an endeavour to right the wrongs of past poor relations between the Aboriginal and Torres Strait Islander peoples (the Indigenous people of Australia) and the wider Australian society. Whilst policy and practice has been upgraded and finetuned to meet the needs of Indigenous peoples, there is the realisation that change is moving at a pace that is not parallel to the increasing poor health and low standard of living that perpetuates as a result of a conditioned way of life. Indigenous people have the right to enjoy the same lifestyle and life expectancy as other Australians.

Cindy will discuss the time line travelled in the lead up to the past twenty years of addressing Indigenous health issues and working through what is best practice in determining more positive outcomes. Thus providing a better future for all peoples of Australia, with a particular emphasis on the holistic health and well being of the Indigenous peoples of Australia.

The influence of History and Politics has determined the aftermath of the living conditions and poor health that perpetuates today's way of life for Indigenous peoples.

This component of tonight's presentation allows the opportunity to reflect on the seeding of the roots that have produced a way of life that thrives on loss of identity that in turn, determines devaluation of self. A way of life that is entrapped in the cycle of the inherited way of life accorded to community; and how communities founded on reserves and missions have been disempowered by past government policies of assimilation and the subsequent procedures according to so called protectionism.

The state of poor health of community is the result of whether the community has survived the depression of the Historical Association by removal to a Reserve or Mission or is a community that has remained affiliated to their land of heritage. This inherited way of life is symptomatic of the problems and those problems needs to be addressed accordingly. The layers of removal from place of belonging, separation of families and institutionalisation over several generations is the core issue that needs to be taken into consideration when addressing process, practices and partnership in realising positive outcomes in health.

Thus living life in community has been severed, ruptured and controlled through the clash of cultures that has taken place in this country.

Culture is here, there and everywhere, and has been defined as

A view of the world that has meaningA blue print for all human behaviour. Culture is the sum or totality of man's learned or behavioural traits in an identifiable society. Culture is more than 'a people's way of life'. Culture tells us what is pretty and what is ugly; what is right and what is wrong; culture influences our preferred way of thinking, of behaving, of making decision.³

The Old Way is still with us today

Peoples and Places are of great importance in the moulding of our spiritual connectedness with Creator God. Who's your family and Where you come from' is

³ Binang Goong page 6.7

the essence of Aboriginality, and central to the holistic approach that determines self-worth and well-being of body mind and spirit and gives a sense of belonging to Community.

It's about the relationship with God through God's whole Creation. and respecting that we are a mere part of that Creation. It's about being custodians of the land and respecting that all living things matter.

Living in community creates the well-being of belonging to Family and being community; and appreciating being spiritually affiliated with Creator God as a stable human being. A way of life that nurtures the interaction of relationships, respect and responsibility.

Indigenous peoples have lived with the myths of creation in accordance with the stories as handed down from generation to generation for thousands and thousands of years. There is depth in the paralleling of the Dreaming and the Genesis stories of creation. A journey such as this provides the opportunity to accept and live in accordance with the image of *Love thy Neighbour* as sister and brother.

The Dreaming is interwoven into every aspect of way of life

Patrick Dodson in an address "The Land Our Mother, The Church our Mother spoke these words:

Sacred sites help to make present the powers of "The Dreaming" and so help to sustain people in the present. They are vital for the continuance of religion and culture, for the maintenance of kinship ties and environmental balance, and to be a source of continuing pride and self respect. Clearly Aboriginal

religions have a beautifully worked spirituality complete with a full and coherent sacramental theology.⁴

The paper also offered reflection on Indigenous way of life in these words:

*You would husband the land. You would burn the grasses to promote new growth and to make sure that the delicate balance of nature that has been created is preserved. There is a rich and complicated legal system which is administered by elders and to which all are bound The blind, the lame, the mentally defective are all to be looked after. Your spiritual and religious life is as rich as your material life is simple. The children are more deeply loved than perhaps any children on earth. Until puberty and initiation they can do not wrong. They are cuddled not chastised They learn from love and from example. The children grow in security and confidence. They are tutored in the life of the spirit, in respect of the elders and kinship and the ways of the country.*⁵

A Clash of Cultures and the non resolution of this situation up until the referendum of 1967 has clearly played a major role in the disintegration of family, poor health and devaluation of self.

Two entirely different structures came together and from the onset could not establish common ground. The family based consensus decision making of the Indigenous people and the monarchical, hierarchical societal structure that came together where oceans apart.

Western way of life and the Indigenous peoples value of living relationships are founded on two very different cultures.

⁴ Patrick Dodson, Compass, 1 no 2 -1988

⁵ Patrick Dodson. Compass, 1, no 2 1988

Breakdown of Communication has caused a clash of cultures and continues to block living relationships

Traditionally oral communication and visual art was the means of learning. Language enables effective communication to take place; and can either block or build relationships.

Language ensures that tradition, law and culture are passed on effectively (including music, song, art and story). In an attempt to break down the culture and traditions of the Indigenous people traditional language was forbidden and English became the forced language for the Indigenous peoples. This act has added to the fracture and fragmentation that is part and package of today's inherited problems.

Leadership within oneself being in community within a society is vital to living relationships

Our attitude is a priceless possession and can play a major role in exercising culturally appropriate leadership. This is important to both Indigenous and non-Indigenous leadership. There needs to be an awareness of the characteristics of living in community and dealing with different levels of attitudes towards what is best practice.

Attitudes differ within communities and this relates directly back to the passage through life that has been the lot of particular families. People are returning to communities in an effort to rebuild their links with the land and life in community with family. As a result of the lifestyle that has engaged them for many years some of these people return with a different outlook on what is appropriate ways when living specifically in Indigenous community. and working through problematic issues.

Today there are people who want to move on and forget about past experiences and start a new beginning. Others have endured the past and continue to emerge their innermost depression in whatever comes to hand, in an attempt to alleviate the despair; only to eventually succumb to death through psychological breakdown or poor health.

All in all there is much work to be done and time is needed to open the doors to work on relationships within the boundaries and culture of communities. What has happened in the past cannot be mended overnight and required justice in our dealing with one another; gently caring in an effort to build relationships; and throughout the journey of working and living in community be ever ready to follow the protocols as outlined by the community.

Community empowerment must be the vision if community is to determine their own destiny of a healthy, stable and viable community holistic leadership. Self empowerment is of little value if this is not channelled to community empowerment by those in a leadership role.

Shared leadership is culturally appropriate.

Shared leadership calls for individual leadership working collectively to build partnership that will determine more positive outcomes in building community capacity to meet the challenges that we are faced with. Indigenous leadership is much more complex and less manipulative than western way of life which caters for the structured in the box mode of resource for delivery of outcomes.

Also it needs to be understood that the human resources differ from community to community according to the cultural ways of each community. Relationship to land and the environmental resources available particularly in the interest of healthy ways of life needs to be fine tuned in setting in place a means of producing positive outcomes.

Consideration of this factor determines what resources are available within the community. Policy and procedures govern allocation of funds but with appropriate community leadership methodology can be finetuned according to the needs and aspiration and vision of each community. .

The 339 Recommendations of the Royal Commission into Aboriginal Deaths in Custody included 53 recommendations (246 – 299) that related specifically to improving Health and Strategies for Change; providing evidence of the need to address the aftermath of the conditioned way of life that has been embedded in a way of life instituted by Government Policy.

Recommendation 339 stated

*To this end the Commission recommended that political leaders use their best endeavour to ensure bi-partisan public support for the process of reconciliation and that the urgency and necessity of the process be acknowledged.*⁶

In 1994 Queensland Health identified the need to

*“improve Aboriginal and Torres Strait Islander health so that the differences in health status between Aboriginal and Torres Strait Islander people and the rest of the Queensland population are eliminated “.*⁷

⁶ Recommendations of the Royal Commission into Aboriginal Deaths in Custody

⁷ 1994 Queensland Aboriginal and Islander Health Policy

In 1997 The Federal Race Discrimination Commissioner identified the disadvantaged way of life for Indigenous people highlighting the areas of Health, Education.

Employment and the Criminal Justice System. The report states

“Poverty, poor living conditions and health problems in Aboriginal families mean that many Aboriginal children are severely disadvantaged, specifically in education”⁸

The report further relates that

“Untreated ear disorders stop children from hearing the teacher properly; untreated eye disorders interfere with vision and malnutrition gets in the way of concentrating in class. All of these affect attendance.”⁹

Corroboree 2000: Towards Reconciliation Australian

Declaration begins with

We, the peoples of Australia, of many origins as we are, make a commitment to go on together in a spirit of reconciliation.¹⁰

The key words being go on together *in a spirit of reconciliation*.

The declaration concludes with the vision of

a united Australia that respects this land of ours; values the Aboriginal and Torres Strati islander heritage; and provides justice and equity for all.¹¹

⁸ Face the Facts page 23

⁹ *ibid*

¹⁰ Corroboree 2000: Towards Reconciliation Statement

The Search for Common Ground: The Two World View

A search for common ground lies in the margin in-between. Lee looks at the margin from the perspective of Race and Culture. This analysis indicates that the marginal person has to live in these two worlds which are not only different but often antagonistic to each other

If there is to be a future that provides justice and equity for all then we have to move from our comfort zones of *who we are* to the edge and work things out together. We can build on the positives of both worlds; and there in lies the hope for justice and equity for all peoples of Australia.

Living relationships is the essence of being one in union with the whole of creation

Central to the creation of practical solutions and measures towards empowering Indigenous communities, is the need to regain self worth and a value of living and being an integral part of community. This can only be achieved when the spirit within is provoked to become one with the Spirit.

The reality today is that we are one, but we are many. Together we can ensure quality life for all peoples if we follow the steps that have been put in place by the Council for Aboriginal Reconciliation. In response to recommendation 339 of the Royal Commission into Aboriginal Deaths in Custody, a unanimous decision was made in federal parliament in 1991 that the Council for Aboriginal Reconciliation be set in place. This was a critical move towards better race relations in Australia being

¹¹ Corroboree 2000: Towards Reconciliation Australian Declaration page 3

channelled through reparation and restoration of a way of life that would create wellbeing for the Indigenous peoples of Australia.

Taking into consideration the massive destruction that has taken place by dispersal and dispossession of the first peoples of this land there is much to be considered. A 10 years timeline that was put in place by federal government handicapped the movement for reconciliation. On conclusion of the Council for Reconciliation term in 2000 there was an indication that true Reconciliation will take 20 -30 years on.

The legacy that we the peoples of Australia are now left with is the *Unfinished Business* of Reconciliation. We must continue to be a Peoples Movement. There is much work to be done in the reparation of wellbeing of way of life for the Indigenous peoples of Australia. Our journeys must be driven by education with a focus on the health and well being of the Indigenous peoples of Australia as of prime importance, if we as Australians together are to pride ourselves of being a multicultural Australians society.

In the God of all creation we must trust. Peoples and Places are important to all of us. Living relations is vital in building community capacity. Together we can make a difference.

Cindy Shannon

Background to why the issue is important

In the past twenty years, there has been little evidence of any significant improvement in the overall health of Australia's Aboriginal and Torres Strait Islander people. For the period 1999-2001, the life expectancy for Indigenous males was 56 years and for Indigenous females 65 years, somewhat lower than the 77 years and 82 years recorded for all Australian males and females respectively (ABS & AIHW 2003). The underlying causes of poor health in the Indigenous population have been well documented. In summary, they include dispossession, poor socio-economic status, and low levels of education, lifestyle factors, prejudice and discrimination, substandard environmental conditions, inadequate and inappropriate service provision, and a lack of involvement of Indigenous people in policy and decision-making processes.

It is only in the last decade or so that there has been any real understanding of the need for a framework to promote Aboriginal and Torres Strait Islander health, and Commonwealth, State and Territory governments have formulated policies in this regard, the basic aims of which are self-management and self-determination for Aboriginal and Torres Strait Islander people. In the health arena, self-determination has been expressed in various ways, including:

- the development of community controlled health services,
- Indigenous-specific health policies and programs,
- increasing participation of Indigenous people within the health professions,
- the development of more sensitive and collaborative approaches to health research and

- the acknowledgement of the importance of primary health care as a mode of health improvement in keeping with a self-determination political framework

Historical context and evolution of Aboriginal Medical Services

For Aboriginal and Torres Strait Islander communities, the period from the end of the 1960's to the end of the 1970's represents a period of turmoil and change between two distinctly different worlds (Hunter E 1993). The 1960's began with assimilation as national policy and, following the 1967 referendum, the decade ended with a national policy of self-determination for Indigenous people. The referendum results also transformed the landscape of Aboriginal affairs, making the Commonwealth a key player by providing for it to legislate in an area that had previously been controlled by States. New politics were emerging among Aboriginal people, which specifically called for rights and autonomy. This resulted in the formation of Aboriginal community-controlled organisations, and the establishment of the first Aboriginal Medical Service (AMS) at Redfern in Sydney in 1971.

One of the major reasons community-controlled services developed was the perception that mainstream services were not responding to community needs.

The Referendum had been passed during a Liberal-Country Party coalition government, but with the subsequent election of the Whitlam government enormous changes were set in train with substantial increases in funding, expansion of social security and the rapid withdrawal of State governments from positions of control over Indigenous missions and settlements which were, overnight, transformed into 'communities'. There was little preparation or planning in this process of 'deregulation' (Hunter, 1997), with predictable uncertainty, confusion and tension.

“These were heady days; and the distribution of government funds by an enthusiastic Australian government, motivated by a sincere wish to give a financial impetus to the much-publicised policy of ‘self-determination’, was often thrust upon groups which were unable to cope administratively with the sudden transition from poverty to comparative riches ... The losers in the long run were the Aboriginal communities themselves – not the swollen ranks of consultants and helpers that mushroomed in the night. (Long, 1979: 363)”

Sadly, more than 20 years after this observation was made, the capacity of some organizations and communities to cope with this transition remains problematic. It is now more than 30 years since the first Aboriginal Medical Service was established in Redfern in Sydney, and yet the crisis in Indigenous health continues. Clearly, Aboriginal medical services only represent one sector of the health system with responsibilities in Indigenous health, yet they tend to attract the most attention when government is seeking to explain this lack of progress.

Structure of AMS's

The community-controlled model operating within the Aboriginal health services is unique in terms of its structure and governance, because unlike mainstream health services in which the individual consumer is the client, in this case, the Aboriginal community is regarded as the client of the organization. As noted by Dwyer et al (2003), the following issues are of significance in terms of governance in Indigenous community-controlled health services:

- It essentially requires that ownership and management of the health agency is vested in the local Indigenous community, generally through the mechanism of a local Indigenous board of management

- This arrangement aims to enable the local community to decide on its priorities, policies, management structure, staff and service profile, within funding guidelines, when most of the funding comes from governments.

Governance

The growing interest in Indigenous community governance in Australia is largely due to the proliferation of new institutions and statutory frameworks at a local, regional, state and federal level. Bell (2002) suggests that it is best to think of an “institution” as a process or a set of processes that shape behaviour, rather than as a “thing”, and that they can thus be defined as anything from a formal organizational arrangement to forms of behaviour that operate through roles, rules and (partially) scripted behaviour. Drawing on these explanations, community control and self-determination in health can be regarded as institutions, and the Aboriginal community-controlled health services, along with the peak bodies with which they are affiliated, are organizations

The recent Queensland Government White Paper on New Laws for Aboriginal Community Governance (2003) suggests that the need to improve community governance was a consistent theme in the consultations with communities in the development of the Paper, and in particular suggests a need to build the skills and capacity of Aboriginal Community Councils (or Boards of Management). It also notes that a common criticism of the current legislation and processes is that they impose on Aboriginal communities an alien model of governance, which is fundamentally at odds with Aboriginal cultural norms related to political authority. In this regard, the Cape York Justice Study Report (Fitzgerald 2001) found that “the current systems of community governance are not serving the needs of communities where more effective leadership is needed in addressing major concerns (vol 1. p.173).”

More specifically, Fitzgerald identified three key areas that can be analysed to examine the factors that influence outcomes related to Indigenous community governance: community resources, representation and responsibility.

Community Resources

According to Fitzgerald (2001), there exists an inherent conflict over resources at a community level that often creates an unrepresentative structure – this was concluded because many of the assets made available for use by the entire community were managed by a Board or Council that may comprise family members and other related parties. In this regard, Taylor (2003) argues that Indigenous communities need to have confidence in their local social and political and governing institutions and processes. This may be reduced by repeated allegations of nepotism, mismanagement, embezzlement and intimidation.

The allocation of resources at the community level raises particular issues in relation to power; who has power, how power is acquired, how it is exercised, how it is transferred, how it is lost, as well as who gets what, when and how.

Arguments against the current models of community governance suggest that it is a poor fit with Indigenous communities, leading to the concentration of power in the hands of community elites, with the inevitable problems of lack of accountability and corruption. However, it also needs to be recognised that a key policy issue over the past decade has been the perennial struggle for Aboriginal organizations to meet standards of accountability expected by governments for the use of public monies. Very little attention has been paid to the accountability of governments for improving outcomes in relation to Indigenous health. Accountability is often regarded as a central principle in any model of good governance. However, it involves more than obtaining and reporting information. "It sets up relationships

based on assigned responsibilities and expectations, and assumes a standard of behaviour, often peculiar to the circumstances of the structure, which is largely aimed at protecting the interests of a community and its members (DATSIP, 2003 p.17).”

Representation

Fitzgerald (2001) also suggests that the appropriateness of the current models of governance as a vehicle for legitimate representation of diverse community interests needs to be assessed. For example, key interest groups in the community, such as the aged, women or young people may be marginalised or alienated from participating because their activities do not routinely involve administrative structures. In this regard, Nelson et al (1998) identify certain recurrent tensions that are associated with citizen participation in governance. One of these tensions is that of participation versus representation. However, it also raises questions about the extent to which “community” and “individual” interests can be adequately represented, given the power relationships that exist, and the potential for dominance by a small number of families or factions within in a community setting. So, while evidence of community participation in decision-making processes may exist, this does not necessarily reflect management decisions that represent the views and priorities of the community.

The arguments made by Noel Pearson in the implementation of current Indigenous policy are also relevant. Pearson suggests that there must be a severance of the relationship between the welfare state and the Aboriginal individual, and that power is to be devolved to, and program implementation is to take place at a sub-regional, “community” or “family” levels, as appropriate (Martin D.F. 2001). These units are seen as having the moral and political authority in terms of the distribution and consumption of resources. Reciprocity or mutual obligations between the individual

and his/her family or community are key components of these arguments. However, Martin points out that Pearson has devoted “surprisingly little space to the conceptualisation of what constitutes the “community” or for that matter the “family”(p.14) in the Aboriginal context (p.14)”.

This issue therefore, also raises questions about how the term “community” is defined in an Aboriginal context. The White Paper on New Laws for Indigenous Community Governance (2003) highlights a key problem in looking at Aboriginal community governance as being the problematic concept of “community”. It points out that what are now considered “Aboriginal communities” are relatively recent and artificial creations in Aboriginal history, a legacy of the protectionist policies that brought together widely dispersed groups of Aboriginal people onto reserves and missions. It further suggests that the word “community” suggests a common interest or shared identity, as well as a sense of social and political unity among a group of people located together. As Rowse (1996) notes, various anthropological studies would suggest that Aboriginal people might be more likely to affiliate themselves with their kinship or tribal group than the community in which they live, which raises the question of whether a “community government” is the best means of progressing interests.

Responsibility

For many Aboriginal organizations, responsibility now extends beyond what they were initially set up to do. For example, it is difficult to define boundaries in relation to the operations of Aboriginal health services. They have been set up primarily to deliver comprehensive primary health care services, which include the following key elements (NSFATSIH, 2002):

- **Clinical care** – including emergency care, treatment of acute illness and management of chronic conditions

- **Population health programs** – examples include antenatal services, immunisation, screening programs for early detection of disease, and specific health promotion programs (eg. physical activity)
- **Facilitation of access to secondary and tertiary care** – including the improvement of linkages across a range of services that would otherwise be inaccessible to many Aboriginal and Torres Strait Islander people, such as specialist medical care.
- **Client/community assistance and advocacy** – includes an advocacy role where health risk factors and health determinants fall outside the direct ambit of the health system.

Given the holistic view of health adopted in Indigenous health policy, there exists considerable scope for the expansion of Aboriginal health services. Many are now offering specific services for example, in relation to child protection, drug and alcohol programs, aged care, housing and infrastructure and schools-based programs. This has significant implications in terms of multiple funding sources, administering a wide range of programs, increased staff size and skill mix, physical infrastructure required and complex reporting requirements.

Issues related to capacity

There is a dependency upon funding from other sources and “soft money” for many services. This is reflected in an inability to plan beyond funding periods and to offer secure tenure to staff. It also acts as a barrier to developing sustainable approaches to service delivery. Clearly, the gap between core recurrent funding and total funding for many services represents the significant degree of uncertainty under which they are operating, or the extent to which they are dependent upon non-recurrent and one-off grants to sustain their ongoing operations.

This means that organizational capacity, to a large extent, depends upon the ability of the service to respond to multiple funding sources and associated accountabilities, along with the need to be able to demonstrate short-term outcomes without a long-term commitment to funding. In summary, a number of health system influences have contributed to the increased funding opportunities, along with a fragmentation of funding sources. These include the following:

- Specific policy development and implementation
- Program review
- Commissioned reports or government enquiries
- A review of Medicare and PBS funding

Clearly, the implementation of new policy and program initiatives in Indigenous health over the past decade, have resulted in significant implications for the workforce in Aboriginal Health Services. Despite workforce being specifically identified as a critical component of policy initiatives, little additional resources have been allocated to support the associated workforce needs and professional development. This is perhaps the most critical aspect of building capacity within the services.

The dependency upon government funding for service operations makes it difficult to plan strategically and develop workforce plans accordingly. Rather, the services find themselves in a position of responding to health system changes through the application of additional funds to the employment of new workers. In summary, the significance of the Aboriginal and Torres Strait Islander health workers cannot be underestimated. However, there remains concern about the skill level of health workers, pressures placed upon them when working in their own communities, rates of staff turnover, lack of a consistent approach to employment and training, and role

relationships with other health professionals. There remains considerable scope for a more planned approach to funding and workforce development in Indigenous health. However, funding increases alone are not the solution to improving Indigenous health, and there is a danger in providing increased levels of funding to those services that clearly do not yet have the capacity to deliver outcomes, particularly in relation to the skill level of the workforce. Another important component of this argument is the extent to which administrative arrangements and other processes used within the services have the capacity to utilise resource inputs to the best advantage

Conclusion

Finally, in terms of health outcomes, realistic timeframes are needed to achieve outputs and outcomes.

In the **short term**, it is unrealistic to expect that some of the barriers to access and service delivery can be overcome and sustained, particularly within existing funding levels and where current capacity is extremely low. For example, workforce planning and development is essential in the short term, but the likely impact is medium to long term, given the lead-time required to train staff and develop experience for leadership positions. It is also unrealistic to expect that the health sector should take responsibility for prevention of the underlying causes of ill-health in Aboriginal and Torres Strait Islander communities, and that while a whole-of-government approach is critical, it is also important that realistic goals are set within the health system.

In the **medium term**, with more funding, and reliable and accurate data, it should be possible to demonstrate evidence of sustained efforts in Indigenous health and building of capacity within the service and health system more generally (against

some agreed upon indicators of capacity). In addition, it may be then possible to establish achievable benchmarks and clear strategies for meeting them. Reviews of policy and programs will be critical and should inform future planning and development. Ongoing efforts to consolidate linkages which are beginning to be formed will be critical in terms of providing comprehensive primary health care, and in particular in managing chronic disease in Indigenous communities. Such linkages are often dependent upon personal relationships, which may not lead to sustainable outcomes in the long-term. This process should, therefore, link closely with staff recruitment, retention and development strategies.

In the **longer term**, it is clear that the goal is for equitable outcomes in terms of Indigenous health, and this will be made possible through:

- long term commitments of additional funds;
- addressing the fundamental underlying causes of ill-health in Indigenous communities and being able to demonstrate sustained achievements against social, environmental and economic indicators;
- incremental and sustained development of capacity in community-controlled health services, particularly in terms of management practices, composition and skill level of the workforce and improved process for monitoring and review.

In terms of the three key areas raised by Fitzgerald as important issues to examine in relation to capacity, responses to the following questions will inform conclusions about capacity:

- Is government providing sufficient resources to the community to provide adequate services and meet needs?
- Are appropriate linkages being fostered and developed by other service providers to improve service delivery and health outcomes?

- Does the organization have the management and workforce capacity to utilise its resource inputs to the best advantage?
- Are the structures and services in place representative of community views?

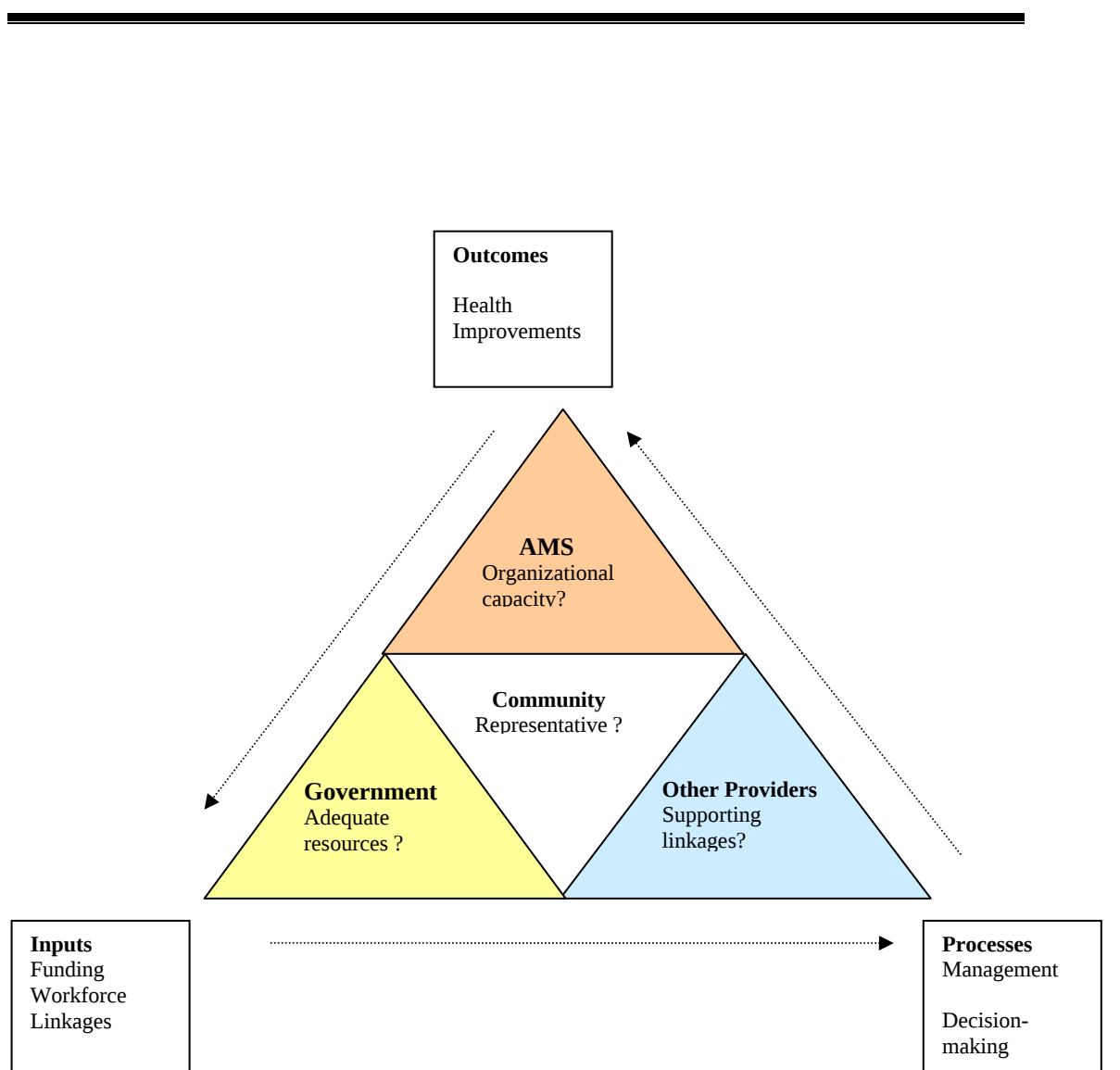


Figure 1 Summary of capacity issues using model of community governance in health

Finally, a point made in the Cape York Justice Study Report (2000) is clearly relevant here:

“The overwhelming scale of the problem almost invites the dispirited reaction that nothing can be done to change anything unless we can somehow change everything. This is a counsel of despair, or at best magical thinking. Strategies to relieve the suffering and improve the lot of people in these circumstances may be arduous and slow, but they are not without precedent, and we can learn much from instances of success locally and in other places (p.210)”



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