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**Submission to the  
House of Representative Standing Committee on  
Aboriginal & Torres Strait Islander Affairs-  
Inquiry into Capacity Building in Indigenous  
Communities.**

**August 2002**

## Introduction

For close to thirty years since its establishment in 1973, Congress has been a strong advocate for the rights and needs of the Aboriginal people in Central Australia. Congress is an organisation of Aboriginal people for Aboriginal people, controlled by Aboriginal people. As such we have a demonstrated history of supporting capacity building within the Aboriginal population of central Australia. Congress has supported the establishment of many of the other Aboriginal community-controlled health and other organisations within our region. Congress established a health service in 1975, and now runs a comprehensive primary health service that includes: a medical (clinic) service, community health programmes, a women's health service and birthing centre (the Congress Alukura), a dental clinic, a child care centre, an education and training branch for Aboriginal Health Workers, a social and emotional wellbeing centre, a youth outreach programme and a bush mobile medical service (servicing outstations within 150km of Alice Springs). Congress has an active public health section, dealing with policy development and research, as well as providing an evaluation and strategic planning function for our programmes.

## Defining capacity building.

As a short hand, the term 'capacity building' often suffers from a lack of definition. It is a term that can mean many things to many people. The term capacity building is often used as a way of explaining those ingredients needed for people to take control of a situation or to succeed in undertaking a task.

The ingredients formula focuses on tangible and often measurable factors such as the availability of physical and financial resources and the human capital theory inputs of individual knowledge and skills. The drawback of this approach is that it does not place these factors within a real community framework or context.

While these are necessary components, they are inadequate unless people take on the responsibility to take on the task (control the situation) and have the authority to carry them out.

Within a health programme framework this has been described as '*capacity development for programme implementation, (through) actions to develop and sustain the ability of a country's own personnel and institutions to successfully undertake policy development, advocacy, design, implementation, management, monitoring, and evaluation of health programmes. The components of capacity to perform tasks are:*

- *Accept responsibility to carry out the tasks;*
- *Have the authority to carry out the tasks;*
- *Have access to and control of resources necessary to perform the tasks; and*
- *Have the knowledge and skills to perform the tasks.'* [Sanders 2002].

This more holistic approach locates action within an implementation framework. It identifies the social and community structural aspects of authority and responsibility, as being necessary requirements in order for the inputs of resources and knowledge and skills to be usefully applied.

It is this approach to capacity building, which recognises the need for authority, responsibility, control of resources and knowledge and skills development that the Congress submission will utilise in addressing the Committee's terms of reference. Congress recommends that the Committee consider this approach in considering its recommendations on Indigenous capacity building.

## Terms of Reference 1 & 2- Individual and Community Organisation capacity

### ***The relationship of comprehensive primary health care to capacity building- authority and responsibility***

Congress and other Aboriginal organisations have for many years argued for a holistic understanding of Aboriginal health. We see that the needs of the population must be addressed with due consideration to the conditions in which Aboriginal people are living. Congress has argued that the debilitating effects of the physical, cultural, economic and emotional environments in which many Aboriginal people live must be considered in health planning if there is to be any prospect for creating long term improvements in the health status of the Aboriginal population [George & Liddle 1991, CAAC 1991, Bell 1995a & b, CAAC & AMSANT 1998].

This position is supported by the recommendations and findings of a considerable body of research conducted over several decades, including work by the National Aboriginal Health Strategy, the World Health Organisation and the Royal Commission Into Aboriginal Deaths in Custody:

*“Health is not just the physical well-being of the individual, but the social, emotional and cultural well-being of the whole community”* [NAHS 1989: ix].

*“Health . . . includes attributes of social justice, well-being and equity”* [NAHS 1989: 219].

This definition is very similar to that adopted by the World Health Organisation:

*“Health . . . is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity . . . [it] is a fundamental human right”* [WHO 1978: declaration 1].

This holistic approach to health, as adopted at the WHO Alma Atta Conference 1978, has been embraced in the term ***comprehensive primary health care***. The different approach of (comprehensive) primary health care from that of primary medical care (or selective medical care) can be easily conceptualised in the following table.

***Table 1. From Primary Medical Care to Primary Health Care***

Adapted from Sanders 2002

<b><i>Level</i></b>	<b><i>From</i></b>	<b><i>To</i></b>
Focus	Illness	Health
	Cure	Prevention & care
Contents	Treatment	Health promotion
	Episodic Care	Continuous care
	Specific problems	Comprehensive Care
Organisational	Specialist	General practitioners
	Physicians	Other Personnel Groups
	Single-handed Practice	Team
Responsibility	Health Sector Alone	Intersectoral Collaboration
	Professional Dominance	Community participation
	Passive Reception	Self-responsibility

This definition shows that at the level of responsibility there has been a marked change in the understanding of how different stakeholders are involved in health care. The move away from the health sector as being seen as the only sector responsible for health status to a recognition that there are a range of social determinants that impact upon health requiring collaboration across those sectors to achieve health gain. That professional dominance of the health area must be replaced with community participation in health delivery. And that individuals must move beyond passive reception of health services delivery to active self-responsibility for dealing with health care.

The NCEPH in adopting a set of core principles for primary health care services identified intersectoral collaboration for health gain and consumer and community involvement as being fundamental to having successful primary health care services [NCEPH 1992].

In a growing body of academic literature on the social determinants of health, the connection between the degrees of control individuals can exercise over their lives and their health status is being clearly articulated. [Wilkinson & Marmot 1998; Marmot & Wilkinson 1999; Evans, Barer & Marmor 1994]

*“The health differential between Aboriginal and other Territorians reflects both poverty as well as social inequality. The health of Aboriginal Territorians will improve when they achieve greater levels of real control over the circumstances of their lives and their communities”* [Devitt, Hall & Tsey 2001].

All of these works confirm what Aboriginal organisations such as Congress have been saying for many years- that our peoples’ health status is formed by a complex and inter-related set of health determinants, and an important factor is the degree of control that we exercise over our lives and the strength of our community-controlled organisation plays an important part in dealing with those factors.

### ***How the Aboriginal community-controlled health organisations embody comprehensive primary health care.***

The Aboriginal community-controlled health services are the strongest representation of the NCEPH principle of consumer and community involvement in health service delivery. Through the governing body, which is directly elected at Annual General Meetings, the consumers of the service have the ultimate control of the organisation. This model has successfully delivered a comprehensive primary health care service to the Aboriginal population of central Australia for close to thirty years. This achievement by Aboriginal people occurred despite a long period of government hostility, poor funding and ongoing social pressure and inequality experienced by the community. Congress now delivers a comprehensive primary health care service for over 7,000 regular clients equating to more than 30,000 separate contacts per year. This model of Aboriginal community-controlled comprehensive primary health service is a successful model. It is a model that has provided stability, consistency and social empowerment at both the individual and community level for many years. Such a track record needs to be accorded due recognition for the great endeavour by Aboriginal people that it represents.

## **The individual and their community-controlled organisations-authority.**

The release of the Commonwealth Governments 5 point plan for Aboriginal Affairs by Minister Phillip Ruddock in March 2002 has re-ignited the debate around individual versus collective rights in Aboriginal policy in this country [Ruddock 2002]. This debate reflects the tension between, on the one hand the liberal ethos of individual rights and autonomy being the central plank of a modern liberal society and on the other, the view that it is the power of the collective to represent the needs and values of a community or society, from which individuals gain their identity and strength. However it is argued that this is false dichotomy. That unless there is a strong cultural community value at work, individuals do not have a basis from which to make moral decision about their actions.

*“The cultural community maintains a particular cultural context; when the cultural community is undermined, shocks to individual identity also undermine individual decision making. The context in which the individual would have traditionally realised his identity is weakened or obliterated.”<sup>1</sup>*

Aboriginal community-controlled organisations reflect this power. Congress was formed by the actions of motivated individuals working within the collective power given to them by their communities. Over 100 people met on 9<sup>th</sup> June 1973 from both bush and town to form their own organisation to represent them in fighting the injustice Aboriginal people faced and to promote their culture [CAAC 1984, Perkins undated]. Those individuals were acting within their authority to create a community-controlled organisation. The Cabinet that is elected at an open Annual General Meeting is representative of the community the organisation is established to serve. As a popularly constituted governing body it is responsive to the needs of the community, both at an individual and collective level. Aboriginal people created this organisation and they maintain it.

The fact that Aboriginal community-controlled organisations acting within their mandate are the legitimate decision-making voice of their community and the most appropriate vehicles to deliver these services has been accepted in numerous inquiries. The Royal Commission into Aboriginal Deaths in Custody, the National Aboriginal Health Strategy and the House of Representatives Standing Committee on Family and Community Affairs report on Indigenous Health [2000] amongst others, all recognise this role. However many people working within the policy or community development arenas fail to accept this authority. When confronted by organised Aboriginal power they attempt to go under these structures, seeking out individuals, with whom they can create their own one-on-one relationship. This approach, which seeks to circumvent the community's organisations, tries to portray Aboriginal community-controlled organisations and their members as not being the real disenfranchised Aboriginal people. This has a number of negative effects. Firstly it stereotypes Aboriginal people in this scenario 'real Aborigines' are not capable of becoming an organised group. Secondly it attempts to divide the community, as individuals from their organisations that they created. The message then is that your organisations don't properly represent you. It is dis-empowering to all Aboriginal people to be told that the organisations we created don't work for us; this then leads Aboriginal people to believe that some one else (non-Aboriginal) can design a system that works. This failure to accept Aboriginal authority undermines one of the primary components of capacity building.

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<sup>1</sup> Kymlicka in Lea 2000 p3.

## **The individual and their community-controlled organisations-responsibility.**

Congress is given the authority by the community to create health policy through the Annual General Meeting process as illustrated by the consistently high turnout to those meetings<sup>2</sup>. With this authority also comes an organisational responsibility to ensure that services are delivered in the most empowering manner. Congress believes that it is vital that the dynamic between collective and individual power is maintained. Aboriginal organisations must ensure that there is active community involvement and control of the organisation. Unless this occurs, community-controlled organisations do not empower the community. Rather they may stifle capacity building. As well as ensuring active individual participation within the decision making structures of the organisation, community-controlled organisations need to promote individuals taking responsibility over those aspects of their lives that are within their control.

Congress has the decision-making power and legitimacy within the community to ensure that individuals take a level of responsibility for their health where, and in ways they can. One such policy decision has led to a change in emphasis in service delivery. Since 1991 there has been a move away from the passive model of health care, to one of expecting people to take up a degree of self-responsibility. Part of this change was manifest in a move away from a mobile service to an expectation that clients should present at the clinic to get quality care. Obviously some clients need support to get to the clinic and a bus service is provided upon request. For a range of targeted groups such as, the frail, aged and disabled, young children and mothers, remote outstation chronic condition patients mobile outreach services are still provided. In addition, the Male Health Programme, Alukura women's health service and the Youth Programme undertake health promotion outreach services.

The recognition that there is a need for individual empowerment through accepting a degree of individual responsibility is not universally accepted amongst the Aboriginal organisations in Alice Springs. For some an over emphasis on the individual as victim of historical process has lead them to adopting an approach to their service delivery which perpetuates a passivity in the client population. Congress believes that this approach perpetuates a cycle of dis-empowerment and despair. At its worst it creates a compliant population, dependent upon the trickle of handouts from those agencies that have their hand upon the welfare tap.

## **The individual and their community-controlled organisations-skills and knowledge.**

### ***Workforce capacity.***

Congress has always recognised the need to ensure skills and knowledge development in its Aboriginal workforce. Two major initiatives that Congress has undertaken was the establishment of its own Aboriginal Health Worker training facility in 1977 and the creation in 1997 of the Central Australian Remote Health Training Unit (CARHTU, now the Central Australian Aboriginal Remote Health Development Service CARHDS) to provide in-service training for our workforce.

Congress has been instrumental in establishing and maintaining the roles of AHWs in the clinical setting in the NT. Under the introduction of the national competencies

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<sup>2</sup> The primary vote of each of the current Congress Cabinet executive members was higher than that of all, but three, of the current Alice Springs ATSIC Regional Councillors.

package, Congress and AMSANT have worked to ensure that these were customised for the NT to include clinical competencies. Congress continues to work with other ACCHOs to establish viable career pathways for AHWs, through the establishment of further qualifications or articulations into other training streams such as nursing.

CARHDS began operations in 1997 after 5 years of lobbying by Congress, Anyinginyi Congress Tennant Creek and other ACCHOs for a new and appropriate in-service training model for the PHC sector in central Australia. The vision was for a work-based training approach, which would respond to employer needs to train the PHC workforce with a particular focus on Aboriginal Health Workers and community health leaders, as well as orientation of new staff. In an alliance with Territory Health Service and the Office for Aboriginal and Torres Strait Islander Health CARHTU was established under an auspicing arrangement with the Institute for Aboriginal Development, which delegated its powers to a management committee. On October 1<sup>st</sup> 2001, CARHTU was incorporated as an independent agency – CARHDS. Today CARHDS represents a best practice model for primary health care support service delivery under majority Aboriginal community-control. CARHDS has developed a literacy and numeracy strategy that outlines the fundamental connection between peoples skills and abilities in these areas and their capacity to engage both at a workforce level and governance level. Congress would commend this Strategy to the Committee and have attached a copy for the Committee's information. Congress would also recommend that the Committee meet with the CARHDS Board at a suitable date to discuss this framework further.

#### ***Leadership capacity.***

From its inception as a political advocacy organisation in 1973, Congress has placed great emphasis on the development of the capacity of political leaders from within the community. In recent years Congress has actively participated in, and as a member of the Aboriginal Medical Services Alliance of the NT (AMSANT) advocated for, the establishment of the NT Health Summits as a regular events, the first being held at the Ilpurla Outstation in central Australia in 1998. At this summit Aboriginal people endorsed the need for “*Political Leadership being able to negotiate with colonial authority imposed on Aboriginal people*” [CAAC & AMSANT 1998], as a necessary component for Aboriginal people to have a healthy life. Since then Congress in conjunction with AMSANT has hosted two more such Summits, (in Banatjarl – Katherine region 1999 and Gulkula –NE Arnhem Land 2000) a further summit is being planned for 2003. These summits have provided the framework for the development of Aboriginal health policy by the Aboriginal community in the NT. These summits have open sessions for non-Aboriginal people to observe and be immersed in these policy debates, many Government representatives attend these sessions. Congress in conjunction with the Central Australian Indigenous Youth Committee hosted an Indigenous Youth Summit in Central Australian in 2002 attended by over 300 young people. At this summit young people articulated their concerns and drafted a range of recommendations for the community organisations, governments and themselves to act upon. Funding for these events has come primarily from the ACCHOs involved and other non-government sources. For our own staff Congress has developed a half-day historical and political economy orientation programme and a half-day cultural orientation. These have been adapted by CARHDS for the orientation of staff for other services within the region. In addition Congress runs an active staff policy development programme that includes workshops, and guest speakers. The development of an Aboriginal governance training programme (through CARHDS) will be invaluable in building and strengthening the capacity of Aboriginal people in taking control of primary health service delivery under the PHCAP.

## **The individual and their community-controlled organisations-resources.**

Congress has played a major role in establishing adequate resourcing for Aboriginal comprehensive primary health care services. In a submission to a previous Inquiry by this Committee, we outlined what we saw as the main achievement of this campaign, it is reproduced here for this Committee's information:

Currently Aboriginal health planning in the Northern Territory occurs under the *Agreement on Aboriginal and Torres Strait Islander Health* (the Framework Agreement). This Agreement is a partnership agreement between four bodies which consist of, the two Government agencies with responsibility for Aboriginal health; the Territory Health Service (THS) and the Commonwealth Office of Aboriginal and Torres Strait Islander Health (OATSIH), and the two representative Aboriginal bodies with health responsibilities; the Aboriginal Medical Alliance of the Northern Territory (AMSANT) and ATSIC.

Under the planning agreement AMSANT represents the Community Controlled Aboriginal Health Services, with responsibility for providing primary health care (PHC) services, and ATSIC has the primary responsibility for funding environmental health issues.

Since the transfer of health funding from ATSIC to the Commonwealth Department of Health & Aged Care in 1995 and the establishment of the Framework Agreements, which Congress was a prime mover in creating, we have seen a four fold increase in the level of funding available for primary health care. The new Primary Health Care Access Programme is going to further increase resources for primary health care in Central Australia, especially for remote communities, up to a level of about \$2000 per person. This should also mean a significant increase for PHC resources within Alice Springs. This will be a vast improvement as Congress is currently under-resourced for the population we endeavour to serve receiving only about \$700 per person based on last year's client population. Overall to date this process has been a positive outcome of Government collaboration with the Aboriginal community regrading primary health care." [CAAC 2000]

Further implications of implementing this Framework Agreement and the PHCAP will be discussed under the Committee's term of reference 3 *The role of Governments in capacity building*.

## **The individual and their community-controlled organisations-Aboriginal culture.**

Congress operates within an environment of active Aboriginal culture. All Aboriginal people involved in Congress are governed by that culture. These values and relationships are an everyday part of peoples' lives. Our practice is informed by this culture. Some aspects are formalised within our structure, such as the provision of separate men and women's programmes. Congress has also given recognition to the special place of the Native Title holders and has expressed this through the establishment of two Native Title holders' positions on the Cabinet, to be chosen by the Native Title holders. However Congress has not incorporated some cultural practices within our structure, such a traditional healers. This has been a conscious decision not to have this form of Aboriginal health practice subject to the scrutiny of non-Aboriginal practitioners or funding agencies. This is Aboriginal business and Congress supports the continued use of these practitioners by Aboriginal people within the Aboriginal society's authority structures within the Aboriginal community..

## **Terms of reference 3- the role of governments in capacity building**

Congress believes that the government's role in Aboriginal capacity building can best be framed within its responsibility to uphold two sets of rights. Aboriginal people have the right to access to properly funded services to ensure that they can enjoy the same health (education, transport, housing and employment and other) status as the non-Aboriginal population. And Aboriginal people as the original owners of this country enjoy particular rights as Indigenous peoples, in particular the right to self-determination.

Since the 1960s in Australia, various citizenship rights have been extended to Aboriginal people that previously were denied them. While government's have accepted the responsibility to extend these rights to Aboriginal people at a constitutional and legislative level, they have failed to deliver them at a service level. Aboriginal people in central Australia have not in the past, and do not today, have access to the same level of primary health care service or education through the provision of schools as the rest of the Australian population, and as a consequence of this and other factors do not have the opportunity to enjoy the same health status as other Australians. [Deeble et al 1998, NTDE 1999]

Governments must also recognise that Aboriginal people have a right to determine how, when and in what form these services are provided. It has been widely recognised that Aboriginal community-controlled organisations are the most appropriate organisations to develop and deliver health (and other) services and policies [NAHS 1989, RCIADIC 1991]. What is not often understood is that it is not just because government has failed to deliver these services, but also because having the community control these services and develop the policy agenda has positive health benefits in themselves. On this point Congress takes issue with the Minister for Aboriginal Affairs when he stated, "how the money is channelled (whether through community-controlled organisations or otherwise) is far less important than how it is targeted". [Ruddock 2002]. Such an assertion completely misses the vital point that:

*"Community-control of services and organisations is not only essential in order to ensure appropriate services, but are an essential ingredient in community development and empowerment; and our right to express self-determination as Aboriginal peoples" [Bell 2002].*

Governments have the responsibility to provide sufficient funding for community-controlled organisations to deliver these services in a manner that the community determines is appropriate. The Government must however ensure that these services actually get delivered. Governments must not only recognise this partnership of responsibility, theirs to provide the funding and the community-controlled organisations to develop the policy agenda and deliver the services, but they (governments) must also ensure accountability for the outputs, otherwise they are in effect abrogating their responsibility for providing citizenship rights to Aboriginal people.

### **Authority**

Congress calls upon Governments to accept the authority of Aboriginal community-controlled organisations to talk for the community on the issues that they are constituted to speak on.

Congress would re-iterate the point we made to the Committee's Inquiry into the Needs of Urban Dwelling Aboriginal and Torres Strait Islander People in 2000, that:

*“All governments and policy makers should recognise that the Aboriginal community in Alice Springs is organised sectorally and ensure that they negotiate at all times with the appropriate forums. When such a process is not established, they should consult with the Aboriginal organisations that have specific sectoral expertise”.* [CAAC 2000]

## **Responsibility**

Congress calls upon Governments to accept their responsibility to provide citizenship rights to Aboriginal people and to respect their right to self-determinant as Indigenous peoples.

Because Aboriginal people and our community organisations often establish successful programmes to fill the void created by Government service inadequacy or neglect, this does not excuse Government from having a responsibility to still provide the original service or in appropriate funding to create a service under community-control. When involved in partnerships with Aboriginal community organisations, governments must not abrogate their responsibility to ensure that all partners are accountable for the outputs they agree to deliver. Having lower expectations of Aboriginal organisations is patronising to Aboriginal people and is doing us a dis-service.

## **Resources and skills and knowledge.**

In order to provide for the citizenship rights of Aboriginal people within the health sector, the Commonwealth should commit to the full funding of the Primary Health Care Access Programme as part of its service delivery obligation, rather than as optional discretionary budget allocations. For the NT this has been costed at around \$64 million. Until this funding is forth coming the Commonwealth will not be providing the adequate funding resource for capacity building within the Aboriginal comprehensive primary health care sector.

As a means of supporting the capacity building initiatives of the ACCHOs, Congress also calls upon the Commonwealth government to support fully the funding of the Central Australian Remote Health Development Service, as a best practice model for community-controlled in-service training for health professionals working within a comprehensive primary health care framework.

As a means to support the development of community political leadership in health care and community-driven health policy development, Government should financially support the AMSANT Aboriginal Health Summits.

## Recommendations:

1. Congress recommends that the Committee consider the approach to capacity building, which recognises the need for authority, responsibility, control of resources and knowledge and skills development in considering its recommendations on Indigenous capacity building.
2. The model of Aboriginal community-controlled comprehensive primary health service is a successful model of governance, service delivery and capacity building and empowerment. It is a model that has provided stability, consistency and social empowerment at both the individual and community level for many years. Such a track record needs to be accorded due recognition for the great endeavour by Aboriginal people that it represents.
3. Congress calls upon Governments to accept the authority of Aboriginal community-controlled organisations to talk for the community on the issues that they are constituted to speak on.
4. Congress calls upon Governments to accept their responsibility to provide citizenship rights to Aboriginal people and to respect their right to self-determinant as Indigenous peoples. And when involved in partnerships with Aboriginal community organisations, governments must not abrogate their responsibility to ensure that all partners are accountable for the outputs they agree to deliver. Having lower expectations of Aboriginal organisations is patronising to Aboriginal people and is doing us a dis-service.
5. Commonwealth should commit to the full funding of the Primary Health Care Access Programme as part of its service delivery obligation, rather than as optional discretionary budget allocations. For the NT this has been costed at around \$64 million. Until this funding is forth coming the Commonwealth will not be providing the adequate funding resource for capacity building within the Aboriginal comprehensive primary health care sector.
6. As a means of supporting the capacity building initiatives of the ACCHOs, Congress also calls upon the Commonwealth government to support fully the funding of the Central Australian Remote Health Development Service, as a best practice model for community-controlled in-service training for health professionals working within a comprehensive primary health care framework.
7. Congress would commend the Central Australian Remote Health Development Service Literacy and Numeracy Strategy Paper to the Committee. Congress would also recommend that the Committee meet with the CARHDS Board at a suitable date to discuss this framework further.
8. As a means to support the development of community political leadership in health care and community-driven health policy development, Government should financially support the AMSANT Aboriginal Health Summits.

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