

Central Australian Aboriginal Congress

Community Control - What does it really mean?

Paper presented by Ben Bartlett *Aboriginal Health - Social and Cultural Transitions Conference*: NT University Darwin, September 30th 1995.

ABSTRACT

This paper examines some of the historical continuities that impact on health service delivery, and the gap between the perceptions of the health sector and Government and those of the Aboriginal community.

The poor health status is related to a cycle of Grief - Anger - Despair which tends to dominate Aboriginal community life, but alludes clear understanding from those outside. It is this understanding which makes community control more than just rhetoric.

The different models of community control are examined and tested against a few basic principles. These principles are related to active community decision making in regard to a Board of Management determined by the community, and active Aboriginal management of the service.

Introduction

Aboriginal adult mortality rates are the highest in the world apart from regions gripped in war. Infant and child mortality remains 3 times that of other Australians, but this has dropped from 8 times over the past 20 years or so. The improved infant/ child mortality reflects what western medicine (and I mean by this all of the practises of the health system including such things as health promotion) is good at - the prevention and treatment of infectious disease. The persistently high adult mortality rates reflect what western medicine is not good at - influencing behaviours, stopping substance abuse, suicides, community violence and determining what people eat. These problems are related to the processes of colonisation that Aboriginal people have been subjected to, resulting in dysfunctional families and communities. I suggest that the infant and child mortality patterns are unlikely to improve until more Aboriginal families and communities become functional as social units. This view of western medicine is not to deny the powerful impact it has had in influencing behaviours and attitudes during this century in many different regions of the world.

But I do not want to talk about these statistics. I want to talk about the strategies to deal with them, and why especially the National Aboriginal Health Strategy has not seemed to improve Aboriginal health. The official evaluation of the strategy conducted late last year concluded, simply, that the NAHS had failed because it had not been implemented. So the question becomes why was it not implemented?

In a nutshell, I believe it was not implemented for two main reasons. One is the lack of funds committed by governments to the implementation of the Strategy. The second reason is because non-Aboriginal institutions, and the people working within them, have continued practises which are based on historic continuities which are institutionalised, and often unknown to the individuals concerned.

Historic continuities - Whose truth?

In essence there are two strands of stories. One strand comes from Aboriginal communities. Their stories tell of the dispossession, the loss of country, forced settlement, the change in diet, and the taking away of the children. It includes stories where access to treatment of the sick was denied to Aboriginal people by the newcomers health system. Their stories continue to be laden with distrust, anger, grief and despair.

The other strand has the stories of the colonisers. These stories include how our health care system is 'good' and benevolent. It is aimed at alleviating the suffering of the sick, and curing the sick where possible. Our domination of this continent and its people was 'historically inevitable'. Our response to the other strand of stories - the stories of the Aboriginal community - well that was yesterday, not today. Things have changed now.

But for the community, the consequences of the past are experienced and felt today - often in ways which are difficult to understand and make sense of. To them the institutions which took away the children, are the same ones which control the health care system.

As non-Aboriginal 'outsiders', and as educated professionals/ academics, we have a great need to make sense of things. We analyse the factors which we think explains the poor health status of Aboriginal communities. We try and make sense of it all. I suggest that we cannot know what this community experience is about. What is it like to know so much death in our families? I certainly do not have this experience. There is a big gap between felt need/ grief/ and resultant community chaos, and the outsiders attempt to understand. This is a very critical point. It is why community control is indeed more than rhetoric, it is why it cannot be delivered from Government, and it is why the challenge of Government and our health care system is to find a way that genuinely supports the community to deal with its own crisis.

Colonialism**Devastation of communities through -**

- Infectious disease (Small pox, TB, Influenza, Measles, etc)
- Massacres
- Dispossession of land
- Forced settlement away from country and with different groups
- Taking the children away

**Grief****Anger****Despair****Dysfunctional communities, families, individuals.****Substance abuse, violence, suicide, poor nutrition, child neglect****Grief****Anger****Despair**

Community control is the foundation for improving family and community function, and as a consequence, better health.

What other solutions are there?

The Grief-Anger-Despair cycle is a chaotic one. It is not easy to appreciate from the outside. Perhaps it is not easy to understand from the inside either. But it is from the inside that solutions might be found. Our professional, bureaucratic and cultural tendencies are to work out the problem and solve it - from the outside. This tendency could be described as 'positivist'. To all problems there is a solution - we just have to understand the natural laws that operate, and apply them. I suggest that it is this aspect of non-Aboriginal - Aboriginal relationships that is at the heart of the failure to implement the NAHS. It is the essence of the continuity of the historical colonial relationships, which too often non-Aboriginal people want to deny or be dislocated from. In not recognising our own continuities with the ugly past colonial relationships, we tend to perpetuate them, albeit in subtle form

Community Control

Part of the recent story from the non-Aboriginal strand includes how the Northern Territory Government agencies have tried to embrace the principles of community control. This is an especially relevant story to the current situation, as the Department is currently asking the Aboriginal Medical Services Alliance - NT (AMSANT) why the 'Grant in Aid' or 'Service Agreement' health services have not been invited to join.

Firstly, lets look at the history of community controlled health services. Community control has been espoused as a key to improving Aboriginal health since the early 1970s. Community controlled health services proliferated around the country beginning with the Redfern AMS in 1971. The first community controlled health service in the NT was Congress which got going in 1973. In the late 1970s and early 1980s community controlled health service continued to proliferate. Wurli Wurlinjang, Mutitjulu, Nganampa Health, Imanpa, Pintupi Homelands, Urapuntja health service were all established. Later Anyinginyi, and then as part of the NAHS, Ampilawaytj, Danila Dilba and Miwatj were established.

COMMUNITY CONTROLLED HEALTH SERVICES IN THE NT

The first service in Australia was established in Redfern, NSW in 1971.

1973 Central Australian Aboriginal Congress, Alice Springs

Early '80s

Imanpa Health Service (200K from Alice)

Mutitjulu Health Service, Uluru (500K from Alice)

Ngaanyatjarra Health Service, WA (800K from Alice)

Nganampa Health Council, Pitjantjatjara Lands, SA (600K from Alice)

Pintupi Homelands Health Service, Kintore (500K from Alice)

Urapuntja Health Service, Utopia (250K from Alice)

Wurli Wurlinjang Health Service, Katherine

Mid '80s

Anyinginyi Congress, Tennant Creek (500K from Alice)

Early '90s

Ampilawaytj Health Service, Ampilawaytj (300K from Alice)

Danila Dilba Health Service, Darwin

Miwatj Health Service, East Arnhem

Government/ Health System Resistance

When Congress first started, the established health service providers which were all Government controlled claimed duplication of their services. There was a resistance to cooperating with Congress, and every opportunity was taken to attack and attempt to discredit the organisation. I guess that the establishment of an alternative did involve an implicit criticism of existing services. If they had been satisfactory why would people have bothered setting up alternatives?

However, over the years Aboriginal community control has won widespread support as a key aspect of health policy. It is the lynch pin of the National Aboriginal Health Strategy; it was strongly supported as an important aspect of self determination in the Royal Commission Into Aboriginal Deaths in Custody reports, and every state and territory Government has supported community control, at least in principle.

Continuities with the Past

In order to understand the current situation, it is worth revisiting some of the past, and to attempt to see the continuities of that past with the present.

I have already given a rough view about the establishment of community controlled health services. And I have mentioned the opposition that the department has put up.

It is interesting to note that the former Chief Medical Officer of the NT Government, Dr Ella Stack presented a paper entitled *'Implications of Policy and Management Decisions on Services for Australian Aborigines'* to an international conference in Pennsylvania in 1986. In this paper Dr Stack gave an overview of Aboriginal health status, described the health services available to Aboriginal people (even down to the detail of DMOs and their 'patches') and concludes with a strong recognition of the need for more Aboriginal control of health issues. However, the existence of 7 community controlled health services is not mentioned except as an aside referring to '*... several Federal Government-funded general practise-type health services have also been established in a small number of rural and urban Aboriginal communities,*'¹

Dr Stack's view of Aboriginal control was limited to strengthening Aboriginal Health Workers working in the Government sector. To describe the community controlled health service as 'GP-type services' shows a gross misunderstanding of these services, and their role in Aboriginal health. At the time, community controlled health services had a national organisation which was a vehicle for policy development and lobbying Government. Congress had produced *Health Business'* and *'Settle Down Country'*. The *'Rama Rama Report'* was nearing completion. The Alukura was being recognised internationally as an innovative model of indigenous women's health service. All of these activities stretch far beyond what would generally be understood in 1987 as 'GP type' services.

But perhaps most importantly, such lack of recognition of the achievements of the community controlled health services can undermine community efforts and make the struggle for better health so much harder.

Another example. In 1988, the then Acting Manager of Rural Health in Central Australia stated in a meeting with Central Australian Aboriginal health services that the Department no longer refused to pick up Kintore patients (who had been flown into Alice Springs for investigations at Alice Springs Hospital) to transport them from the airport to the hospital, but stressed that they did it *out of the goodness of their heart*. Not because Kintore residents were Territory citizens who had a right to services provided by the health department. The Department had previously considered that because Kintore had their own health service they should organise and pay for the transport of their community members requiring hospital services from the airport to the hospital.

But maybe this continuity is even more significant. When the RFDS was established it was clearly for non-Aboriginal settlers, not for Aboriginal people. Health services initially were not established for Aboriginal people at all.

After the National Aboriginal Health Strategy working party had presented its report, a Development Groups was established and it's report was presented to the Ministers at a meeting in Brisbane. The NAHS recommendations (as refined by the Development Group) were unanimously supported by the State/ Territory and Commonwealth Ministers. But the then NT Minister for Health, the Hon. Steve Hatton, publicly criticised the strategy to the media after the meeting.

¹ Stack EM *'Implications of Policy and Management Decisions on Services for Australian Aborigines.'* Pp 113-124. In Raffle MW and NK *'Perspectives on Health Policy: Australia, New Zealand, United States.'* John Wiley & Sons, Chichester, 1987.

In 1990 an independent review of Central Australian health services was conducted on behalf of the NT Government by Prof Charles Kerr. One of the recommendations of that review was:

"That the NT Ministry for Health and Community Services formally recognise the community controlled organisations in Central Australia as playing an important role in the provision of health services and that their representatives be incorporated into regional administrative arrangements for policy formulation and the setting of priorities."

This recommendation has still not been acted upon.

What has since emerged is a Northern Territory version of community control. It involves the appropriation of the language of community control.

The Voice of Politicians.

In 1965 the then Minister for Territories, the Honourable C.E. Barnes stated:

"The policy of assimilation seeks that all persons of Aboriginal descent will choose to attain a similar manner and standard of living to that of other Australians and live as members of a single Australian community." (from RCIADIC Vol2 p515)

Well things have changed since 1965. We have moved away from racist policies of assimilation. We now work under policies of self determination. We all support Aboriginal control in the 1990s.

Well, wait. There is another quote I think we should hear.

"The resolution to Aboriginal poverty as we see it today is to turn them from the have-nots into the haves. By the haves, I mean people who do have a job and strive for the things the rest of us strive for. But in order to do that, Aboriginal cultural ways are of necessity going to have to dissipate, because the two are incompatible." Marshall Perron, NT Chief Minister, quoted in Time magazine, 20 July 1992.

Maybe things haven't changed as much as we would like to think.

Other Territory politicians have made similar statements.

- In February 1994 the Australian newspaper reported on discussions at a dinner in Darwin with Dr Brendan Nelson, then AMA President, and the Hon. Mike Reid, NT Minister for Health and Community Services in these terms:

'...the duplication of services was a major problem for the Northern Territory Government, Reid asserted that Aborigines were quite happy to use the mainstream hospital and that it was a nonsense and a waste of money to fund community controlled health services.'

- The Hon. Dr Richard Lim speaking in the NT Legislative Assembly on 23rd February, 1995 said:

"All I heard are criticisms, whinges and the continual carping that we should pour more and more money into Aboriginal health care. It is like pouring water into the desert sand, it goes nowhere except to all those people working in the Aboriginal industry ... Why do people get renal diseases? ... They become infected because they are not clean, that is what it is."

At the same time Aboriginal people's efforts to get on top of their problems are deemed as politically motivated. Over the past few years there have been bitter confrontations between community controlled organisations - especially Anyinginyi Congress and Danila Dilba, and the NT Government.

So the NT Government's strategy seems to be blame the individuals, condemn collective effort, and appropriate the language of self determination.

The Efforts of Senior NT Health Officials

Despite these explicit political attacks on community controlled organisation by senior Government Ministers, senior officers within NT Health persist in trying to convince people that the Government supports community control of health services. For example, John Wakerman, Pat Field and Helen Stuart, presented a paper entitled '*Community Control in the Government Sector*' at a 1994 CARPA Conference. This is such a fundamental contradiction. How can there be community control within the Government sector? Really what is happening is an attempt by the Government sector to be more receptive and responsive to community needs. But it is not community control.

This is part of NT Health's attempt to re-define community control by creating what were called 'Grant in Aid' services. Now they are referred to as 'Service Agreements' services. I suggest that the available evidence points to these services as 'gammon' community control. Community control is not just a label to put on something.

For community control to mean anything, then the processes and mechanisms of control must be in place and they must be resourced. In the NT Government's version, these processes are not addressed or resourced.

Processes of Community Control

So what are the differences?

KEY PROCESSES AND MECHANICS OF COMMUNITY CONTROL

- an active controlling body (Board) whose membership is determined by the community.
- Aboriginal management of the health service - accountable to the Board and, through the Board, to the community.
- professional (and other) staff are subject to the decisions of Aboriginal management. That is, they are advisory.

Community controlled health services are accountable in the final analysis to their constituent community. For example, Congress has a Board of 13 people all elected by the Annual General Meeting to which any Aboriginal person in Central Australia is welcome to attend and participate. Around 200-300 people usually attend this meeting. The Aboriginal management is accountable to this Board, known as the Cabinet.

NT Health Service Agreements usually run through the Community Councils. Typically they are funded for a number of Aboriginal Health Workers and nurses, pharmacy supplies, and vehicles. At least some of the Community Councils who are in receipt of service agreement funds for their health service have expressed the attitude '*Oh that's clinic business. We don't interfere with that.*' So much for community control in these communities via the Community Council. It is evident that health business in communities requires a dedicated health committee of some sort to take responsibility for the health service and to make decisions about how the health service should run.

The process of managing a health service is the second part of control. To the best of my knowledge none of the 'Service Agreement' communities resource Aboriginal management processes. These processes require resourcing. They, along with the health council or board, are the vehicle for control. Developing control is a process through which communities and health services must have the opportunity to pass. It cannot be neatly delivered by Government agencies. I believe that, in fact, the more Government (or other non-community) agencies attempt to do it for communities, the more dependant such communities tend to become. These issues are currently being debated in regard to French practises in the Pacific.

Without specific experience of health services, what they are, and how they should run, communities are not in a strong position to be in control. The Department appears to be very careful to prevent existing Aboriginal community controlled services to assist communities who may want their own service. Some anecdotal stories help illustrate the problems.

One 'Service Agreement' service in the Top End ran out of essential drugs - the Department's response was to say *'well if they can't manage their budget ...'*. What evidence is there that the budget was adequate in the first place? What experience have community members had in the requirements of health service delivery, what are the costs, etc.? Whilst the Department claims to spend more on these services than the ones it is directly responsible for, it claws back significant sums. For instance in the pharmaceutical area it charges 25% handling fees to non-Departmental services.

Other problems have related to the conditions of employment of staff. A few years ago, Aboriginal Health Workers were granted a rise in wages. However, AHWs employed through Service Agreements did not receive this rise because they were not employed through the Department. Of course, the Community Council did not have the resources to pay the increase. Funding does not include funds for relief to enable staff to participate in service education

But it is the issue of control that is most important. It is a great irony that the organisations that have an active dynamic of community control are ignored, slandered and marginalised. The process of community control requires resources. Community Councils are rarely able to provide the leadership required for the health service. This effectively leaves the Department in control.

Barriers to better understanding and collaborative action

Much of the commentary made in this paper is the result of anecdotal stories. The failure of Governments (NT or Commonwealth) to be transparent in their dealings - to engage the community sector in the development of ideas and collaborative practises - makes progress difficult.

Attempts to develop a collaborative approach to the delivery of a culturally appropriate mental health services in Central Australia illustrates some of these difficulties. Officers in the Department who were opposed to the Congress proposals (which were written down and distributed), in effect refused to write down what their concerns were so that they could be properly considered. In the end the Alice Springs Rural District refused to cooperate with the Congress proposals. Thus the processes of all players working together to better understand what a culturally appropriate mental health service might be like was completely cut short by the Department's unilateral decision. Another opportunity for collaborative action lost.

Thus the decision making of the Department tends to lack transparency. Funding issues lack transparency. Transparency of decision making is fundamental to achieving community control. The Department, by failing to resource the processes of community control, and by failing to allow transparency in its dealings, renders their version of community control illegitimate.

These might be some of the reasons that AMSANT does not include Service Agreement communities as members.

How can we proceed?

So what could be done to improve these processes.

1. There is a need for the development of structures through which communities can be involved in regional decision making. There are no community vehicles for regional planning and decision making despite support for such structures from community organisations, and various inquiries including that conducted by Charles Kerr in 1989. Community controlled services and CARPA² have been trying to get a Central Australian Aboriginal Health Council established for some years. It has been opposed by NT Health who have claimed that such a body would duplicate the work of the Tripartite Forum (TPF). However, there has been an almost unanimous view amongst Aboriginal community participants that the TPF has been a joke. The Department, over the years, has continually attempted to get TPF endorsement of its proposals whilst ignoring decisions made by the TPF which do not fit with the Department agenda. Again it demonstrates the inability or unwillingness of the Department to accept some leadership from the community controlled sector as a means of developing a collaborative and strategic relationship with the community sector.
2. Funding arrangements need to be more straight forward. It is difficult for a Government Department to be in a position where it is both responsible for delivering services, and responsible for funding community organisations to deliver similar services. The potential for cost shifting is enormous, and this is almost certainly part of the agenda for the Department. If it can convince the Commonwealth that 'Service Agreement' communities are community controlled then the Commonwealth can be expected to take some responsibility for the funding. This cost shifting has been a major reason for the failure of Governments to improve Aboriginal health.

A funder-purchaser-provider split such as operates currently in Western Australia might be well worth developing in the NT. This model has had some success in New Zealand where Maori control of health services has increased under this system.

² Central Australian Rural Practitioners Association.

1. Communities should have an opportunity to determine which aspects of their health service they wish to have control over. This could involve a process whereby community members can think and talk about what a health service is and what they want. Again, this planning process is one that requires resourcing. A regional health council could prove a useful forum where people can learn of others experiences. In Canada a two year period is allowed for in a process known as the Indian Health Program Transfer Policy. Dr David Scrimgeour has detailed information about this³.
2. More resources are required. Common mythology talks about all the dollars thrown at Aboriginal health. Mick Dodson⁴ has estimated that whilst Aboriginal people are 1.6% of the Australian population, only 1.26% of Commonwealth health expenditure goes to Aboriginal health. This does not consider the logistic issues or concepts of equity which would certainly justify an expenditure greater than mere per capita equity with other Australians.
3. The Commonwealth needs to assert its constitutional responsibilities to ensure that a genuine strategic approach is developed, and that the cost-shifting and buck-passing stops now.

But maybe, above all, we non-Aboriginal participants need to develop some circumspection about our capacity to develop and deliver solutions. We do not have a good track record. We need to support the continuing development of the community controlled sector so that it can provide us with leadership as a basis for collaborative work.

What about the Commonwealth?

Whilst I have concentrated on the NT in this paper, it is important to stress that the Commonwealth Department of Human Services and Health has had a similar poor history. The Family Resource Centre in Central Australia is an example. It has been established with an appalling lack of process, but has dressed itself up as self determination. I understand that it has a committee or council of more than 50 people. Anyone with management and organisation experience knows that groups of people this large are dysfunctional when it comes to providing direction to projects like this. Thus the Department, and the project staff remain in effective control.

³ Scrimgeour, D 'Community Involvement in Health Services for Indigenous Peoples of Canada, Norway and New Zealand. The Report of a 1994 NHMRC Public Health Travelling Fellowship.' Menzies School of Health Research, 1994.

⁴ Dodson. M. Aboriginal and Torres Strait Islander Social Justice Commissioner 'Second Report 1994.' Human Rights and Equal Opportunities Commission, Canberra, 1995. Health Map attached to back of the report.

With the Commonwealth Department of Human Services and Health now having responsibility for Aboriginal health, they too have much reorganising to do. The Commonwealth Government has an opportunity to assert it's constitutional responsibility under the 1967 referendum to ensure that the bureaucratic maze - the cost shifting, the manipulation, and the lack of transparency - will be overcome.

We need to ensure that a new approach is developed which ensures genuine processes of self determination if the struggle to improve Aboriginal health is to succeed.