

Taking Control.

A case study of the National Aboriginal and
Islander Health Organisation (NAIHO).

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Abstract

Social services, such as health, are often at the centre of political struggles, and are often shaped by the actions of social movements. This thesis examines the politics surrounding the development of grassroots health infrastructures in a colonialist context. In particular, this thesis sets out to examine the way in which struggle and resistance in such a context shape health infrastructures and challenge the policy process.

The methodology employed is a single-unit case study analysis, focusing on the Aboriginal community-controlled health services (ACCHSs) movement in Australia. The rise of such community-controlled social services during the 1970s was one of the manifestations of the land rights movement. The ACCHSs movement developed around some similar concepts to a global Primary Health Care (PHC) movement, which focused on what is now defined as the social determinants of health. This approach argues that poor health outcomes are often derived from social and political causes.

The research relies on a number of primary sources. One such source is activist literature from the time period. Fifty four issues of the *AMS Newsletter*, produced by the Redfern AMS, from the year 1973 to 1991 were located in the course of the data collection. These newsletters offer precious analysis from the point of view of prominent activists in the movement, and unfold some of its political history and development. Other primary sources explored are a variety of official reports, released and unreleased. This research identifies one unreleased report, the 1980 *Program Effectiveness Review on Aboriginal Health*, and the battle over its suppression, as a defining experience in the development of the movement.

The ACCHSs movement started with the establishment of the Redfern Aboriginal Medical Service (AMS) in 1971. The movement has endured, and today there are over 150 ACCHSs across Australia. However, very little information about the movement's history and early development is available. This case study focuses on the national aspect of the movement, and in particular, the establishment of a national umbrella organisation, the National Aboriginal and Islander Health Organisation (NAIHO). The findings of this thesis follow the development of the movement from the history of the first ACCHSs in Redfern,

through the establishment of NAIHO in the mid 1970s, until its mysterious demise in the late 1980s. NAIHO was eventually replaced by the National Aboriginal Community Controlled Health Organisation (NACCHO) in the early 1990s, which still exists today.

The investigation of the development of the movement follows some repeating themes which emerge from the data. Some of the main themes explored include: the theory and practice of community control; the approach of the movement to the social and political determinants of health; the question of funding and its implications to community control; the relationship between the movement and different State and federal departments; and the policy process.

The findings of this research trace the political history of the movement, focusing on its national organisation, through periods of development and change. The ACCHSs movement was able to survive the turn to neoliberalism, and the weakening of the wave of social movements from which it emerged. Yet the movement changed in this process. These changes are identified as a shift from a 'movement' to a 'sector' framework. Furthermore, the findings identify some of the effects such movements have on shaping the policy process. In particular, two competing types of approaches to the policy process are identified: a declaratory process, in which policy is exclusively decided on and dictated by government, and a treaty-like policy process, in which policy is jointly prepared and agreed upon by those affected by the policy.

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Acronyms

AAC – Aboriginal Advisory Committee

ACCCHS – Aboriginal Community Controlled Health Service

AH&MRC – Aboriginal Health & Medical Research Council of NSW

ALS – Aboriginal Legal Service

AMS – Aboriginal Medical Service

ATSIC – Aboriginal and Torres Strait Islander Commission

CDH – Commonwealth Department of Health

CHOGM – Commonwealth Heads of Government Meeting

NACCHO – National Aboriginal Community Controlled Health Organisation

NAHS – National Aboriginal Health Strategy

NAIHO – National Aboriginal and Islander Health Organisation

NAILSS – National Aboriginal and Islander Legal Services Secretariat

NGO – Non Governmental Organisation

NTEHP – National Trachoma and Eye Health Program

NTER – Northern Territory Emergency Response

OATSIH – Office of Aboriginal and Torres Strait Islander Health

PER – Program Effectiveness Review

PHC – Primary Health Care

SRA – Shared Responsibility Agreement

SPHC – Selective Primary Health Care

VAHS – Victorian Aboriginal Health Service

WHO – World Health Organization

Chapter One: Introduction

1.1 Overview of the research

The research for this thesis started with the beginning of the author's PhD candidature, in March 2008, at the University of Western Sydney. At the time, I was living in Australia for a year as an overseas student, studying for an Honours degree in political science at Melbourne University. During that year, my interest in indigenous struggles led me to learn about the current conditions of indigenous people in Australia, as well as the history of the colonial process. My interest was sparked in particular with the announcement of the Northern Territory Emergency Response (NTER) in June of 2007. Later that year I applied for PhD studies and offered a broad research proposal, which aimed to look at the way health and health services provide a stage for a political struggle, in a colonial context. This corresponds with my previous studies and work with the non-governmental organisation (NGO) Physicians for Human Rights, with unrecognised Bedouin villages in the south of Israel/Palestine. I was offered a scholarship with the Social Justice and Social Change Research Centre at the University of Western Sydney, which ceased to exist during the course of my research.

I approached this research with two main, yet possibly contradictory, frameworks in mind. I wished to look into the politics of indigenous peoples' health in a settler-state context to see if the situation here is similar to the situation I studied and worked on in Israel/Palestine. On the other hand, I knew enough about the topic from the Israel/Palestine situation to know that the context and specific conditions dictate that I must approach the Australian case without preconceived notions of what the course of events might be like. This tension, between the will to generalise and the acknowledgement of the uniqueness of a context and its implications, is not uncommon for a case study research (Stake, 1995; Yin, 2003), as examined in more detail in chapter 3. In the rest of this chapter, I wish to present the overview of the thesis, as well as some personal reflection about my own role as a researcher, and the process of the research.

1.2 The topic and the case study

The research question defined early on in the research process is this: how are political struggles, especially in a settler-state context, manifested in the basic infrastructures of society, in particular the health services? I had become closely familiar with the topic through my previous studies and internship at Physicians for Human Rights, in another settler/indigenous context. This topic has roots in a number of scholarship fields, including political science, sociology, and public health. Chapter 2 explores some of the background literature of various aspects of the topic.

I have decided, being based in Australia, to study this topic in a local context. It was only in the initial survey of existing literature that I first found out about the existence of community-controlled health services in Aboriginal¹ communities (which I first read about in Eckermann et al, 2006, pp. 180-182).

I was then surprised to find so little information about the Aboriginal community-controlled health services (ACCHSs) movement, especially regarding its development. At this early stage, I identified three different dimensions of potential focus that the research could take. These dimensions were:

- *Geography*: The focus of the research could either have been on a specific service, the ACCHSs in a specific region or state, or perhaps the organisation of the movement on a national level.
- *Time*: The focus could either have been on historical aspects of the movement, or its present situation.
- *Case study*: The focus could remain either the Australian case, or perhaps a

¹ The use of the term 'Aboriginal' in this thesis follows a basic line of acceptable protocols currently in use (Queensland University of Technology Equity Services, 2010). The terms commonly used in this thesis are 'Aboriginal people', 'Aboriginal peoples' or 'Aboriginal person'. The events discussed in the thesis mostly occur within mainland Australia, and in specific instances, Torres Strait Island peoples will be referred to specifically. In some instances, the term Indigenous is used to discuss the indigenous peoples in Australia as a whole. It should be noted however that terminology is dynamic, and the thesis draws on resources from a wide variety of times. Therefore, often in quotes, terms that are often unacceptable today are sometimes used (for example, 'Aboriginals', 'Aborigines'). In other words, the term 'Aboriginal' in this thesis is mostly used as an adjective, whereas in some quotes from older resources it may appear as a noun. The construction of the concept of an 'Aboriginal' identity is discussed in chapter 2.2.

comparative analysis with other similar cases elsewhere in the world.

After consideration and review of existing literature, I chose to focus on the following aspects:

- *Geography*: It became apparent through the early process of research that each individual ACCHS by itself could become a proper thesis topic. The national coalition became an organisation by itself – the National Aboriginal and Islander Health Organisation (NAIHO), and later the National Aboriginal Community Controlled Health Organisation (NACCHO). As an umbrella organisation, NAIHO focused on the political aspect of the struggle, and at times, has led the relations with the federal government. I therefore chose to focus on the national level of the movement rather than a local ACCHS. Aspects of some specific ACCHSs and regional groupings will be explored as an integral part of understanding the national development of the movement.
- *Time*: Early research also revealed that there are major gaps in existing knowledge, especially concerning the national organisation and the history of the movement. I saw some references to the very early beginning of the Redfern AMS (such as Briscoe, 1974; Foley, 1975; and Foley, 1991. These items are later used in the exploration of the early development of the Redfern AMS, chapter 4) and some information about the services today (mostly in NACCHO, 2008a). The question I became curious about is, what happened between these two different stages? How did the movement develop from its early incarnation to its current one? A more historical focus then seemed appropriate, to fill this apparent gap in available knowledge about how the movement developed.
- *Case study*. Due to the complexity of the issue, I have decided to focus on the case study as a single case, to fully appreciate its complexities. A comparative analysis carries the price of limiting the space for discussion, and worse, limiting the analysis of the particular case study to fit with external comparative parameters. Moreover, there are not many obvious examples of similar movements. Questions of generalisation of the single-unit case study are explored in chapter 3.1, while an overview of some other movements, which hold some similarity and connection to the ACCHSs movement, are presented towards the end of chapter 2.3.

The decision was then made that the thesis will be a single-unit case study focusing on the

national development of the ACCHSs movement and NAIHO in particular, tracing its development and changes from the construction of the first ACCHS, in Redfern in 1971, until its demise in the late 1980s and replacement with NACCHO in the early 1990s. The thesis sets to examine how health infrastructures are an arena for political struggle in a settler-state context. The particular case study is the national development of the ACCHSs movement in Australia.

1.3 The gap in literature

Some of the basic introductory facts of this thesis are well known. Aboriginal and Torres Strait Islander peoples remain today the most marginalised groups in Australia. Perhaps the most commonly quoted statistic that demonstrates this is the life expectancy gap between Indigenous and non-Indigenous Australians, with current estimations of a 9.7 years gap for women and 11.5 years gap for men (Australian Bureau of Statistics, 2009). Such gaps are a result of waves of genocide, a destruction of the natural environment with imported plants, animals and diseases, as well as cultural and political repression: extinction of hundreds of language groups (Amery and Bourke, 1994), mass dispossession from traditional lands (Reynolds, 1987a), and the devastating consequences of assimilation policies, such as the stolen generations (Read, 1981) (the context for the case study is discussed in detail in chapter 2.2).

The historical context of the case study is also generally well known. Until a referendum in 1967, Aboriginal people were still officially counted as part of the 'flora and fauna' of Australia, and not as equal members of the human society (Chesterman, 2005). To a backdrop of a rise in both local and global movements in the late 1960s, the post-referendum Aboriginal civil rights movement focused on land rights and self-determination. One manifestation of this movement saw the setting up of community-controlled primary health care services locally, and organised together regionally and nationally to secure resources, funding, and support. From the first years of operation, these services and similar community-controlled projects were lauded as perhaps the most

significant development of self-determination tactics (Coombs, 1976). The Australian Aboriginal movement towards community-controlled health (ACCH) has made significant achievements, against the backdrop of some of the worst Indigenous health outcomes in a 'rich' country.

However, a lot of the important aspects of the movement, and the history of Aboriginal organisations with their roots in those days, are not very accessible. The gap in the literature is quite wide – there are almost no academic resources about the political aspects of the movement, and almost nothing about NAIHO itself. When I started talking with and interviewing people for the research, I noticed that the history of the movement is not very well known, even to people who are active in the movement. When I had the opportunity to work in the library of NACCHO, the current ACCHSs umbrella organisation, I was very surprised to find only a single document from NAIHO, the previous organisation (the document, NAIHO's Philosophy, is explored in chapter 7). It is of note that records of the early days of NAIHO, as well as individual ACCHSs, were often not kept, or lost. Brisbane-based activist and historian Sam Watson, who was involved with the Brisbane Aboriginal and Islander Community Health Service, commented about his attempts to trace documents from the early days of the service: "I [then] found that company records do not go back to that early period. I conducted searches at the Australian Securities Commission, but I found that all records of the Brisbane AICHS before 1985, have been destroyed" (Watson, quoted in: Best, 2003, p. 11).

The serious gap in available literature about the politics of NAIHO and the first two decades of the ACCHSs movement is one of the main reasons I chose a historical, rather than a contemporary, focus for the case study. In addition, the fact that there exists such a large gap in available knowledge, helped me decide to focus on this as a single-case study, rather than a comparative analysis of several case studies from different contexts.

1.4 The researcher

A research project in the social sciences is different in many ways to a research project in hard sciences. When researching and writing about an issue in the social sciences, it is much harder for the writer to be positioned in a place detached from the topic. This is for a variety of reasons. First, issues in the social sciences are much more directly part of our everyday world. Often, social science researchers are motivated by past experiences, which inevitably shape the way we understand the social world. The social scientific process itself is not dissimilar to the hard sciences, and in both, there may be similar patterns of scientific paradigm dynamics (Kuhn, 1962). The existence of such paradigms make it all the more important for me as a researcher to be open about my own positioning and the events in my life that shaped my decision to take up this particular research as well as shaping the research itself. The examination of the qualitative researcher as a human instrument is considered an important part of qualitative methodology (Maykut and Morehouse, 1994; Merriam, 2009). This and other aspects of the research methodology will be explored in more depth in chapter 3.

I was born in 1982 as the youngest of three children to a Jewish Israeli family in Giv'at Shmuel, a suburb of Tel Aviv. As a child, I was diagnosed with a chronic illness, Ulcerative Colitis, by the age of 11. My mother worked in the hospital as a nurse, and through my mother and my personal experiences with my illness, I learned from an early age about the importance of health services as basic public infrastructures.

Furthermore, my sense of justice developed very early in life. I remember a long argument as a child with my mother, who told me about a monarch of another country (a member of the Jordanian royal family) who was hospitalised in her department, which led to the closure of over half of the department for the duration of the monarch's stay. It bothered me and I could not understand how can a single person, regardless of personal status, be 'worthy' of more health services than any other person.

My sense of justice, which was developed as a child through my own experiences in hospitals and health services, became focused when I was a teenager on the main issue in

Israeli society: the occupation and oppression of Palestinian people. From the age of thirteen, I started to go to protests, at first inside Israel, and later in the West Bank, and started to be aware of the grave injustices and oppression, which is perpetrated by 'my own people'. Activism remains a part of my life today, and my interest in social movements eventually led me to carry out this PhD research.

Back as a teenager, by the time I was eighteen, I knew enough about the social and political situation to know that I did not want to join the Israeli army, whose main task is to maintain the occupation and oppression of Palestinians (mandatory for all Jewish Israelis, three years for men and two for women). Fortunately, I was able to avoid imprisonment due to my chronic illness, which prevented the army from forcing me to join. I was also active in a joint Israeli-Palestinian youth group for peace, and guided the group after I was 18 in several seminars in Israel/Palestine and abroad.

Another strong part of my identity, which shaped in many ways my sense of justice, is the history of the holocaust in the Second World War. My mother's parents migrated to Palestine before the war itself, with my grandmother in particular leaving Europe through one of the ports in Italy in 1938, on one of the last boats of Jewish migrants, who were escape to leave before the war started in 1939. Learning about the holocaust from a young age, the question of personal duty in such circumstances bothered me quite a lot. Especially, I was bothered by the question, how could a whole society take part in the oppression of a particular group, without enough people standing up to stop such injustices?

My activism and interest in political struggles then led me to study for a Bachelor of Arts at the Be'er Sheva University in the Negev/Negeb, the southern part of Israel/Palestine. I studied a double major of Politics and Government, and Geography and Environmental Planning. In my final year I carried two main research projects, which eventually led me to this PhD thesis. During that year I participated in a program offered by the Politics department of internship in political organisations.

I was accepted for an internship with an NGO called Physicians for Human Rights, which aim to assist oppressed populations (Palestinians, migrants, refugees, prisoners, the poor) get the access to health services they deserve. My work at Physicians for Human Rights

took place in the unrecognised Bedouin villages – some forty-six villages of Bedouins, the specific Indigenous group that reside in the Negev. The state refuses to recognise these villages, and is trying to concentrate the inhabitants into much smaller townships, where they cannot perform their traditional economic activities (such as sheep herding and basic agriculture), which makes the townships rife with unemployment, poverty, and consequently, crime. The unrecognised villages, as such, are not allowed to build anything more permanent than a tent or a tin shed. Roads are often not available, nor are basic water, sewage, and electricity infrastructures. The experience of working in the unrecognised villages on health-related matters taught me much about the social determinants of health and the way health services can become an arena for a struggle between oppressed groups and the state. At the end of my final year, I wrote a research paper about the connection between the political struggle for recognition and the struggle for the right to health.

Life as a pro-democracy, pro-Palestinian activist within Israel is often associated with social isolation and constant confrontation with friends, co-workers, co-students, and family members (as evident, for example, in a recent collection of articles by Israeli and Jewish activists, edited by Abarbanel, 2012). Such experiences influenced my decision to try to live overseas, and studies provided a good opportunity. I then applied for an Honours degree in social sciences at the University of Melbourne. My Honours thesis, which I wrote in 2007, examines the rule of law as a concept, specifically asking is there arbitrariness in the way the rule of law is constructed and put in place, and whether radical democratic law is an achievable goal (Gillor, 2007). Despite the interesting year I had researching and writing the thesis, its focus was mostly theoretical, it made me realise that I prefer to focus my future research on ‘real life’ subjects, and not rest in the comfortable arms of theory. Specifically, I developed a strong interest in learning about the realities of local indigenous struggles. In addition, I wished to return to the field of health and politics, which I started in Be’er Sheva through my studies and work at Physicians for Human Rights with unrecognised Bedouin villages.

This personal background, I hope, offers some context into the development of this person and researcher, and hence, the development of the research process. Without this specific background, I would never have come to do this sort of research. It is particularly important for researchers to state their subjectivities rather than suppress or ignore them (this concept is explored in more detail in the methodology section, chapter 3). My

approach to the topic then is based in solidarity with indigenous struggles, and a genuine interest in studying and preserving the experiences of social movements.

1.5 The research process

Back to March 2008, I started to do some broad readings about the subject, to find a specific direction for the research. It took about six months of literature review and general research until a concrete topic and case study were articulated (the particular reasoning was articulated in 1.2). The construction of the research itself had to be flexible, and offer a relatively quick way to finish. This is mostly due to the constraints of my citizenship status of an international student. This status does not allow me to take leave or switch my load to part time, as I would have been forced to leave Australia if I had to do so. After almost five years of living in Australia, writing and teaching issues revolving around Australian society, politics, and history, the threat of deportation upon graduation haunted me as submission became closer.

With these concerns in mind, I have decided to divide my work into at least three cycles of data collection and data analysis: several months of collecting data, from interviews, conversations, and an ever-going search for documents, were followed by several months of arduous analysis of the data. After the first data collection – data analysis cycle, I learned so much about the case study, and I also knew more about which methods of data collection are worth pursuing more than others. This allowed me to decide on the focus of the data collection process in the second cycle. For example, the first cycle of data collection proved that pursuing interviews can often be a hard, long process, and that some of the people I approached did not wish to be interviewed. Furthermore, interviews themselves, while enlightening and enriching, often did not include some of the finer details about the case study. More flexibility with the duration of the research would have possibly allowed me to pursue some more interviews. The decision was made then in the second cycle to focus the research on an intense document research. This decision has led to some great findings. Some of the most exciting data collected in this research comes

from activist literature, which offers unique perspectives on the development of the movement. In addition, other documents of interest were collected, including obscure and unreleased policy reports, which shed light on parts of the case study I could not have accessed any other way.

1.6 Thesis overview

Chapter 2 reviews some of the main literature of both the topic and the case study. The literature review is divided into three main parts: health and health-care, the context of the Australian Aboriginal case study, and the concept of community control.

Chapter 3 looks at the chosen methodology, an intrinsic single-case study. The chapter overviews some main aspects of the approach, examines my own role as a case-study researcher, and offers an overview of some of the main types of resources I collected in the data analysis and the use of them in the context of a case study research.

The next four chapters (4-7) present the findings from this research, as reconstructed using the variety of sources detailed in chapter 3. These four chapters are the bulk of the case study, the history and political development of the national organisation of the ACCHSs movement. As to the structure of the findings chapters, I have followed the events of the case study mostly in a chronological order. However, some issues are amalgamated together to establish a rounder understanding of the context and dynamics of events.

Chapter 4 focuses on the development of the first ACCHS – the Redfern AMS; chapter 5 looks at the roots of NAIHO and its early development in the 1970s; chapter 5 focuses on the Program Effectiveness Review (PER), a report ordered, and later suppressed, by Liberal Prime Minister Fraser in 1979/1980 dealing with funding for Aboriginal health services. I present and explore it as a main event in the development of the movement; the final findings chapter looks at NAIHO after the PER and the subsequent changes, and finishes with the demise of NAIHO and its replacement by NACCHO in the early 1990s.

Chapter 8 offers a discussion of several aspects of the finding of the case study, in the context of the literature review and the topic itself. The discussion is divided into several topics: primary health care and community control, funding, the policy process, and the current state of the movement. This chapter offers an analysis of some of the main points of the findings chapters, and offers some new concepts to elucidate the process of the case study, such as the movement/sector shift, and the treaty-like versus declaratory types of a policy formation process. The discussions of chapter 8 lead to the final chapter, dedicated to some final words and conclusions of the thesis.

Chapter two: frameworks and context

This chapter will present an overview of the literature and a discussion of the premise for the thesis. This chapter also presents and examines some key concepts for the thesis. It is divided into three main parts, offering particular contexts and exploration of distinct themes that emerge in both the topic and the particular case study. Part 2.1 examines health and health-care. It starts with a definition of *health*, a concept that lies at the centre of this thesis. From this, chapter 2.1 discusses some of the main current issues with modern-day health and health delivery from the social/organisational point of view. In particular, the focus is then given to the Primary Health Care (PHC) movement, an important background for both the topic and the case study.

The second part of the chapter (2.2) introduces the context for the case study. It focuses on the deep impact of colonialism and its practices, which still carry a devastating impact on people's health today. The section ends with a discussion of current day perceptions of the term *community*, another central term for this thesis.

The final part of this chapter (2.3) offers a discussion of *community control*, as both a theoretical concept and a lived experience. From a general discussion, the analysis then focuses on community control in a health context, as well as a discussion of issues concerning the national organising of community-controlled organisations. The chapter ends with an overview of some international experiences of community control in the context of health services.

2.1 Health and health-care

Health is a term that is deeply connected to our lived experience, as it is connected to the very concept of life itself. The definitions and understandings of health may vary between

peoples and cultures. Similarly, the social role of health may be conceived in many varying ways. Perceptions of health, as well as the perception of health-care and the way it should be constructed in society are concepts that lie at the very heart of this research. This section offers some exploration of the terms *health* and *health-care*.

What is health?

A good question to start with is, what is health? One way to look at health is as the most intimate, consistent and longest relationship of our lives – our relationship with our own body. It is through our senses, thus through this relationship with our own body, that we experience the physical world, and out of this we develop our perceptions of how the world works and how it should work, or in other words, ideology. This view resonates with many commonplace perceptions, some of which will be explored in this chapter.

The current concern with the social determinants of health has its roots in the tradition of public health (Macdonald, 1992). As post-industrial technological developments made medicine a distinct field of enquiry in Europe, by the mid-nineteenth century, a separate field of enquiry emerged in the social sciences, which explored the connections between the spread of disease and social conditions, such as living conditions. Rudolph Virchow, who is often referred to a founder of social medicine (as well as the father of modern pathology) (Waitzkin, 2001), developed an understanding of the deep connection between political and social structures and health, and was very influential on the leading conceptions of public health. According to Waitzkin (1978), Virchow's contributions have two main themes:

First, the origin of disease is multifactorial. Among the most important factors in causation are the material conditions of people's everyday lives. Second, an effective health-care system cannot limit itself to treating the pathophysiologic disturbance of individual patients. Instead, to be successful, improvements in the health-care system must coincide with fundamental economic, political, and social changes. (p. 264)

In order to promote the ideas of social, or public health, Virchow, a medical researcher, got involved in progressive political movements in nineteenth century Germany. Another writer from that era who had a significant influence over the emerging field was Friedrich Engels, one of the prominent philosophers of the emerging socialist movement. Engels' book, *The Condition of the Working-Class in England* (1845/1844) highlights the connection between living conditions, health, and power structures under capitalism. The book presents a case study based on observations about living conditions of working class people. The book emphasises the detrimental role of living conditions on peoples' health, and presents the direct connection between class and health.

Based on such concepts, the field of social health (which is also sometimes termed *social epidemiology*) developed an understanding of the *social determinants of health*. The concept stems from the idea that “adverse health outcomes are linked to structural problems in society” (Waitzkin, 2001, p. 41).

In the context of this thesis, I refer to the social determinants perception, or perhaps to be more precise, the social-political determinants of health. In particular, I follow Navarro (1978, 1986, 2002, 2004, 2007) who emphasises that an understanding of the social context of health is best accompanied by an appreciation of the power relations at play, and the power context in which the social determinants shape peoples' health. This perception of the social determinants of health often struggles to make its voice heard in the medical mainstream, which tends to focus on biomedical investigations into disease (Humphery, 2006). The limitations of the biomedical approach can also be observed by the rising interest in other forms of medicine (Macdonald, 2005; Raphael, 2006).

The socio-political aspect of health is also related to health policy and the delivery and accessibility of health services. A look at the health infrastructures of a given society can be very revealing of the political nature and social issues of that society, as, in the words of Waitzkin, “the problems of the health system reflect the problems of our larger society and cannot be separated from those problems” (1978, p. 264). In the 1970s, an emerging global field developed, of Primary Health Care (PHC). This field continues to focus on those social determinants and search for ways to reflect an understanding of the social determinants in the organisational form of services. The PHC movement released the *Alma Ata Declaration* in 1978 (World Health Organisation). Article one of the declaration

defines *health* as “a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity” (World Health Organization, 1978). This definition was not new. In fact, it first appeared in the World Health Organisation’s (WHO) constitution of 1948. Yet the fact that this definition was reaffirmed (World Health Organisation, 1978) in Alma Ata is a good indication of the renewed interest in what is now termed as the social determinants of health.

The Alma Ata declaration recognises the role of social structures, political struggles, and economic relations on peoples’ health. Furthermore, the declaration emphasises that all parts of society should be actively engaged in shaping the health system itself. However, the implementation of the declaration in many places was problematic (Gilliam, 2008), and included variations such as *selective primary health care* (SPHC), which emptied the concept of PHC of any real content (Macdonald, 1992, Hall and Taylor, 2003).

However, even if the implementation was poor, the ideas of the Alma Ata declaration are still relevant today (Gilliam, 2008). One way in which these concepts are relevant is that they seem to resonate across a wide variety of changing contexts. A good example of this can be observed in the Australian Aboriginal context. Definitions of health that arise from Aboriginal experiences tend to correspond with the Alma Ata definition. An often quoted definition of health appears in the National Aboriginal Health Strategy (1989) (more about the politics of the report is explored in chapter 7.6). According to that definition, health is:

Not just the physical well being of an individual but is the social, emotional and cultural well being of the whole community in which each individual is able to achieve their full potential thereby bringing about the total well being of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life. (National Aboriginal Health Strategy Working Party, 1989, p. x)

Recently, an important book called the *Social Determinants of Indigenous Health* was released, which includes chapters written by various prominent researchers, each exploring a different social determinant of Indigenous peoples’ health in Australia. Issues in focus include housing, racism, policy process, class, education, and employment (Carson et al, 2007). This book shows that, in the Australian context, as well as in the wider global context, our understanding of health must overcome the false division between biomedical

and social health as inseparable aspects of one whole.

Health: between the social and the biomedical

Even if unnoticed, or ignored, the social elements in health always exist. According to Eckermann and others, “[d]uring the evolution of the biomedical model, power and control were specifically linked to technological developments such as the discovery of the microscope” (Eckermann et al, 2006. p. 150). It can be viewed as a case of not seeing the forest for the microbes: “In discovering that microbes could be identified and controlled, scientists lost sight of the whole person, not to mention the various environments surrounding each person” (Eckermann et al, 2006. p. 150). Macdonald (1992) sums up this concept elegantly by suggesting that, in a health enquiry, one needs to use some times a microscope, and other times a ‘macroscope’ (p. 66).

Eckermann and others further argue that the biomedical model by itself “is not a sensible approach to disease control” (Eckermann et al, 2006. p. 152) due to the lack of attention to the social determinants. The domination of the biomedical perception is furthermore tied to the domination of the capitalist system (Waitzkin, 1978; Navarro, 1986; Yeates, 2002) and, in the last thirty years, neoliberalism, a distinct stage of capitalism (Navarro, 2007). The evolution of health systems under capitalism is driven by profit, which inevitably clashes with the egalitarian ideal of health distribution. The biomedical model sustains an approach that focuses on individualism, rather than the social aspect in which people exist. Individualism is a key concept in the overarching ideological perception of capitalism as a whole (Machan, 1990), and is especially dominant in neoliberalism (Barnett, 2011).

The manifestation of the individual-focused/context-neutral approach to health issues leads then to a focus on individual, rather than social, approaches towards solutions, which then fits with the hegemonic neoliberal agenda. While a biomedical focus often demands individuals to change their *lifestyle* in order to better their health, social determinants of health researchers remind us that “[e]xhortations to people to adopt healthy lifestyles are easy and often of dubious efficacy. Frequently their focus on the individual can deflect attention from structural issues underlying problems” (Macdonald, 2005, p. 24).

Criticisms of the biomedical model from indigenous perspectives often echo similar sentiment to that of Macdonald's. Howard (2006) makes a revealing comment on the connection between these differing approaches to health and the question of health services: "Western and Aboriginal cultural frameworks differ, and western health services, based on 'item by item' approaches to various 'body parts', appeals more to notions associated with individual or 'self-responsibility' than those associated with collective responsibility" (Howard, 2006, p. 118).

Another aspect of capitalism that has a deep influence over both health and health care is the profit-driven economy itself. There is an inevitable clash between health services and profit, a tension that dominates the politics of health services around the world (Yuill, 2005). The potential contradictions between health and profits increased in the last thirty years, due to the rising power of medical corporations such as pharmaceuticals, insurance companies, and private service providers (Navarro, 2007). This reality of health infrastructures provides an access to *super-profits* by corporations, as, according to Waitzkin, "the exploitation of illness for private profit is a primary feature of the health systems in advanced capitalist societies" (1978, p. 267).

Social health and the Primary Health Care movement

Once we acknowledge the role of the social determinants of health, a harder question must follow – what can we do about it? In other words, how can we implement this understanding of health, in the present-time context of capitalism and the profit-driven medical system? According to Griew and Thomas, a major problem in addressing this has been a tokenistic approach to the issue:

...all too often the reaction is to acknowledge the importance of these 'upstream' factors [social determinants] that so powerfully influence health, but then consign them to the background, as issues that are too hard to address and outside the responsibility of the health system. (2008, p. 22)

Ever since the rise of the biomedical/individualist perception of health, some practitioners

have decided to join social/political movements that relate to those social determinants, or ‘upstream factors’. These include some of the leading theoreticians of the social determinants of health field, such as Navarro (1986; 2002; 2004) and Waitzkin (1983; 2001). The lack of sufficient attention to social determinants of health in mainstream medical structures makes such doctors with a critical understanding of social relations and social determinants of health likely supporters and collaborators with a political movement, which sets to target such issues.

Other practitioners, in different political situations, became involved and even led revolutionary movements (Mendelson, 2003). One such doctor, Argentinean-born revolutionary Ernesto *Che* Guevara, remains today a symbol of both class and anticolonial struggles. Another such doctor, Salvador Allende, ended his life as president of Chile in 1973 during a fascist coup. Long before becoming president, Allende was considered a leader in the field of social medicine in Chile (Waitzkin et al, 2001). Elsewhere, describing Allende’s contributions, Waitzkin asserts that “[a]lthough Allende’s political endeavours remain better known than his medical career, his writings and efforts to reform medicine and public health made him one of several important influences on the course of social medicine in Latin America” (Waitzkin, 2001, p. 56).

This concept of *social health* was developed through the Latin American public health discourse, which remains largely hidden from the English-speaking field. According to Waitzkin et al, “[b]oth historically and currently, leaders in Latin America have distinguished social medicine from traditional public health”, and social medicine “defines problems and seeks solutions with social rather than individual units of analysis” (2001, p. 1594). The Latin American social health movement developed as a part of a global movement that centred on different perceptions of the social determinants of health, the Primary Health Care (PHC) movement. This movement has gathered proponents for the focus on the social determinants of health to politically organise into both local and global movements from the 1960s, focusing on the implementation of the social determinants approach to health services and infrastructures. As mentioned, a key movement that focused on the social determinants is the Primary Health Care (PHC) movement, which culminated in the Alma Ata declaration of 1978 (Macdonald, 1992).

The strong emphasis that the global PHC movement offers on the social determinants of

health placed concepts of local community participation (to varying degrees) as central to the concept of PHC. Macdonald (1992) identifies three main pillars of PHC: participation, intersectoral collaboration (between health infrastructures and health-related ones), and equity. To these, Liamputtong, Gardner, and McGartland (2003) add an active emphasis on high risk / vulnerable groups, which naturally connects to questions of equity and inequality. According to the authors:

The rediscovery of the importance of the social environment in determining health and illness in the new public health has led to the recognition of community interventions by the primary health care movement in an attempt to improve the health of community groups. (Liamputtong Gardner and McGartland, 2003, p. 7)

Eckermann and others concisely assert that “[i]n a ‘nutshell’ PHC is health for the people, by the people” (Eckermann et al, 2006. p. 156). In other words, PHC can be understood as a bid to democratise the health-care system. It is derived from the simple but radical idea that people *do* know what is good for them: “We believe that PHC, as a strategy, in its true Alma Ata form, can diffuse the *power* and *control* within the biomedical model of health care” (Eckermann et al, 2006. p. 157, emphasis in source).

After the culmination of the PHC movement in the Alma Ata declaration (1978), in many places around the world, PHC was implemented selectively, as governments “advocated providing only PHC interventions that contributed most to reducing child mortality in developing countries” (Hall and Taylor, 2003). The revised approach to primary health was dubbed *Selective Primary Health Care* (SPHC). The selective implementation of PHC is commonly criticised for removing the main concept behind PHC: the need to broaden, not limit, the different factors that are taken into consideration in the health process (Macdonald, 1992, Hall and Taylor, 2003). According to Hall and Taylor, “in effect, SPHC took the decision-making power and control central to PHC away from the communities and delivered it to foreign consultants with technical expertise in these specific areas” (2003). Macdonald observed that SPHC “can be seen as an attempt to alleviate some of the worst consequences of the failing to provide a comprehensive health care system” (Macdonald, 1992, p. 82). In Australia, many such SPHC programs were established, including in Aboriginal communities (Anderson, 2006), often with particular focuses such as diabetes, substance abuse, and obesity (Eckermann et al, 2006). Such programs,

according to Eckermann and others, “target a particular health problem and retain the power and control of established health hierarchies” (2006. p. 157), and importantly, do not look at the cause of the causes.

It is important to emphasise that the struggle for the social determinants of health to raise some of the attention being given to the biomedical model does not take away from the many important contributions of the biomedical model to health and medicine. Rather, it is about putting these achievements in the social context in which they exist. For example, what is the value of such advancements in medicine if they are only accessible to small parts of the population? PHC services do not wish to throw the biomedical science out the window, but rather to implement it properly within the wider social and political context. The issue of poor health, therefore, is often not simply a medical one, but also a social and a political one (Macdonald, 1992): it involves social causes and determinants, as well as political struggles that shape these social determinants, including the health services and infrastructures.

Hall and Taylor (2003) suggest that PHC must break free from “political and economic ideology” in order to work. In my opinion, the conclusion must be the opposite – we should always be aware of both the social and the political structures behind health inequalities, health services, control, and participation. This reflects perhaps the most famous statement of Rudolph Virchow, the father of social epidemiology, who stated that “Medicine is a social science, and politics nothing but medicine at a larger scale” (Virchow, 1848; quoted in: Mackenbach, 2009).

2.2 Aboriginal health in context

This section explores some of the context of the case study. It introduces some of the many layers of the ever-important context. It starts with a discussion of health as a concept in pre-colonial societies, and continues to explore relevant contexts of the case study in a broadly chronological manner. The section includes discussions of health in the contexts of

colonialism and the destruction of traditional economies; the changing of the natural environment; the introduction of capitalism; racism; accessibility to health services; and the civil rights and land rights movements. The section ends with a discussion of the definition of community, and current related debates.

Health and Aboriginal societies before colonialism

It is estimated that people (now referred to as ‘Aboriginal’ and ‘Indigenous’) have lived in Australia for about 60,000 years or more (Lawlor, 1991). By the time of European invasion in 1788, it is estimated that the continent’s population was at least 750,000 inhabitants (Saggers and Gray, 1991a), with a plethora of different cultures and traditions. It is estimated that, in 1788, some 270 languages, with some 600 distinct dialects, were spoken throughout the continent. Some 60% of the languages have become extinct, and only 20 languages are still in regular use (Amery and Bourke, 1994). The social and cultural heterogeneity of pre-invasion Australia is often forgotten by non-Aboriginal people today, with an assumption that ‘Aboriginal’ is a social/cultural group in and of itself. What forced people from these different pre-invasion societies into what is sometimes misleadingly recognised today as a homogeneous group, was (and is) the shared experience of colonisation itself. Therefore, Aboriginality itself is a social construct, a bi-product of the colonial process.

One of the main shared experiences of pre-invasion Australian societies is the reliance on a hunter-gatherer economy, which influenced all other social and cultural aspects of those societies, including health. Saggers and Gray observe that “[t]he economic and social foundations of the hunter-gatherer life-style maintained a generally healthy population, whose greatest threat to life and wellbeing was probably infant mortality and accidents and trauma” (1991a, p. 168). It has been estimated that the health of Aboriginal people prior to colonisation was generally positive (Saggers and Gray, 1991a; Burden, 1994). According to Burden, “[r]eports from early European explorers and settlers often stated that, when first encountered, Aboriginal people appeared to be in good health and free from disease” (Burden, 1994, p. 190). Anderson adds that, “[w]hilst it would be naive to create an impression of perfect health, continuous survival on this continent would not have been

possible if Aboriginal society had not developed mechanisms for minimising the morbidity and mortality problems” (Anderson, 1988, p. 9). Due to the different developments and needs of that context:

...concepts of health and illness in traditional Koorie² society were bound up in an entire philosophy in which social interactions, the keeping of social regulations and spiritual matters were important to maintenance of health. There were many components of traditional Koorie life which contributed positively to health: such as a rich social fabric with many inbuilt social supports; reasonably equitable distribution of resources; and a varied, nutritionally sound diet and lifestyle. (Anderson, 1988, p. 12)

Similarly, Howard observed that Aboriginal societies are “based on complex networks of social connections and obligations and many rules govern social contact” (Howard, 2006, p. 119). Among the main different perceptions that made the process of colonisation even more destructive are perceptions of control and ownership. As Middleton (1977) shows, traditional Aboriginal ownership of the land is a fundamentally different concept to capitalist private ownership, which is based on alienation and commodification of the land (capitalism and alienation will be discussed in more details further in the chapter). According to Middleton, “Aboriginal ownership of the land was collective and inalienable; land was held by a group which was a unit continuing over time from the eternal past through generations into an infinite future” (p. 14). Furthermore:

A particular group owned an area of land, lived upon it, used it for they were economically dependent upon it and the natural resources in it, and their rights were recognised by members of other groups and were acknowledged when strangers made some form of payment if they needed to hunt or live on or sometimes even to cross it. (Middleton, 1977, p. 14)

This clash between different perceptions of ownership and control is not unlike the clash between the social determinants/PHC advocates and that of mainstream/biomedical-focused perceptions. This clash is illustrated even more clearly when we examine the way in which the social and political structures, which resulted in the disintegration of

² ‘Koorie’ often refers to an Aboriginal person from southeast Australia (Bangerang Cultural Centre, nd).

Aboriginal society and health, were constructed.

Massacres, smallpox, missions, and cane toads: Colonialism and its influence on people's health

The following paragraph, taken from a *Picturesque Atlas of Australia* (Garran, 1974/1886), tells of an expedition, led by explorer Frederick Walker, in Queensland. This one long paragraph captures some of the prevailing attitude of settlers and explorers towards Aboriginal people at the time: a combination of strong paternalism, ridicule, and a basic disregard for peoples' lives, often presented with a thin coat of hypocrisy:

His party started on September 7th, 1861, from Bauhinia Downs on the Dawson River, and proceeded north-westerly, via the head waters of the Alice and the Thomson. Walker's party, of course, comprised some of his friends – the New South Wales natives – and as the open downs stretched out on every hand, day after day, a Murrumbidgee black remarked that there was “no t'other side to this country.” It is painful to record that Mr. Walker, so remarkable for his friendly relations with the blacks, was, during this expedition, peculiarly unfortunate among explorers in being compelled to defend his party. On October 30th he was brought into collision with the natives, and had the grief of killing twelve, besides wounding a great number. Just a week later he had again to fight, but the numbers of the slain are not recorded. This occurred on a river which Walker named Norman. On November 25th he arrived at its junction with the Flinders, and came upon tracks made by Burke. The Norman does not join the Flinders, but allowance must be made for imperfections and confusions in geographical nomenclature which was only in course of creation. On December 1st he had again a conflict with the blacks on the Leichhardt River, and just three months and twelve days after his departure from the Dawson he arrived at Captain Norman's depôt on the Albert River. (pp. 340-341)

According to Saggars and Gray, from the settlers' perspective, “Aborigines were believed to be truly nomadic without significant attachments to place” (1991a, p. 65). Such

simplistic concepts of *nomadity* (Nichols, 2004) served as a main ideological justification for *terra nullius*, an empirical English legal term that expressed the view of Australia as unoccupied. Similar misuse of these two concepts, nomadity and *terra nullius*, appear in other settler-state contexts, such as the labelling of Bedouin in Israel/Palestine (Yiftachel, 2006).

Massacres were a significant part of European expeditions through Australia in the first years of invasion (Sykes, 1989; Siggers and Gray, 1991a; Reynolds, 1998). Siggers and Gray note that the “egalitarian social organisation” of Aboriginal societies “was a disadvantage when it came to the marshalling of military forces” (1991a, p. 65). Rape of Aboriginal women, which was recently recognised as a war crime under such circumstances, was also practised (Siggers and Gray, 1991a). Sykes details some of the context of the killings: “Many whites slaughtered Blacks to drive them off their traditional land. Blacks were also killed in retaliation for spearing cattle or otherwise attempting to ‘share’ in the white food, and for ‘trespassing’ on their traditional food gathering area” (Sykes, 1989, p. 188). Other practices of the colonialists included poisoning waterholes (Sykes, 1989) and even giving poisoned bags of flour (Middleton, 1977, Sykes, 1989).

Yet massacres and direct confrontations were not the only, and perhaps not even the main, direct contributors to deaths among Aboriginal people following invasion. A *British Parliamentary Select Committee on Aboriginal Tribes* (1837) report includes many insights into the effect of contact and colonisation over Aboriginal people and includes some concepts and themes that are still relevant today. It is asserted that “[i]n the formation of these settlements it does not appear that the territorial rights of the natives were considered”. The report mentions ‘demoralization’ of Aboriginal people (p. 10), and acknowledges that “many natives have perished by the various military parties sent against them” (p. 10), though “it is not to violence only that their decrease is ascribed” (p. 10). The report includes a quote from the testimony of Bishop William Grant Broughton, the single serving Bishop of Australia of the Church of England:

They do not so much retire as decay; wherever Europeans meet with them they appear to wear out; and gradually to decay: they diminish in numbers; they appear actually to vanish from the face of the earth. I am led to apprehend that within a very limited period, a few years... those who are most in contact with Europeans

will be utterly extinct – I will not say exterminated - but they will be extinct... Those in the vicinity of Sydney are so completely changed, they scarcely have the same pursuits now; they go about the streets begging their bread, and begging for clothing and rum. From the diseases introduced among them, the tribes in immediate connexion with those large towns almost became extinct. (Bishop Broughton, quoted in: Aborigines Protection Society, 1837, pp. 10-11)

The detrimental effects of the colonisation of Australia resonate strongly from those words. The quote also reveals that even in the early days of colonisation there was a realisation that the effects on Aboriginal peoples were devastating, and far exceed those of a military defeat in a battle over territories. Introduced diseases spread quickly and killed many. The myriad of introduced species of flora and fauna, many of which were brought in order to change Australia to a more European environment (Sykes, 1989), proved detrimental to local ecosystems, which were integral to Aboriginal economies and health. The first recorded smallpox epidemic among Aboriginal people occurred in 1789, which, according to Saggars and Gray, is “estimated to have resulted in the death of some 50 per cent of Aborigines” in areas around Sydney (1991b, p. 384). Yet, according to Anderson, “[t]here is some argument as to the type of health problems which existed in the pre-contact era” (Anderson, 1988, p. 9). With this, Anderson notes, “[u]ndoubtedly infectious diseases such as smallpox, measles, influenza and whooping cough were unknown at this time, since these epidemic illnesses killed massive numbers of Aboriginal people in the early years of colonization” (Anderson, 1988, p. 9).

A key reason for the destruction of much of the hunter-gatherer economic possibilities is the development of the pastoral industry, which became a leading industry for the colonies (Reynolds, 1987b). The pastoral industry was dependant to a large degree on the exploitation of Aboriginal peoples’ labour (Taylor, 1997; Saggars and Gray, 1991a). The actual use of sheep grazing in Australia also proved detrimental. The sheep competed with native animals for pasture areas, and sheep owners tried to exterminate native animals for that reason (Middleton, 1977). Native animals, such as the Woolly Kangaroo, were important sources of meat for the hunter-gatherer societies, and when they tried to hunt sheep instead, sheep owners often retaliated by killing people from local Aboriginal groups (Middleton, 1977). Apart from sheep, the growing of wheat also required vast tracts of land, from which local populations were driven out. As a part of this process, large systems

of fences were constructed. The cumulative effects of such measures on the hunter-gatherer economy were devastating (Saggers and Gray, 1991a).

As Sykes demonstrates, these experiences carry their effects on peoples' conditions and health even today: "The remnants of Aboriginal tribes³ were herded together on Reserves, decimated by introduced European diseases, and under the supervision of white Reserve Managers and Government, *the Aborigines were educated to eat the poorest possible European diet*" (Sykes, 1989, p. 188, emphasis in source). The reserves were even described as "concentration camps" (Gilbert, 1988/1981, p. 23).

During the nineteenth century, with the rapid ethnic cleansing of large parts of Australia in mostly the fertile south-east, policies of the colonies towards Aboriginal people were characterised as 'smoothing a dying pillow' (Middleton, 1977, p. 65), as most of the Aboriginal population had indeed perished within the first few decades of colonialism, and a complete extinction was seen as inevitable (Anderson, 2007). Missions were erected by churches near reserves, which indoctrinated survivors into Christianity. For many, the consequences included the loss of both country (original area) and culture (with both the economic basis and cultural determinants such as language, mythologies, and social structures):

Mission and government settlement superintendents were granted magisterial and other powers and administered laws controlling employment, Aboriginal marriages, miscegenation, maintenance of children, care of minors, education, compulsory action in case of leprosy, venereal and some other diseases, the supply and consumption of alcohol, possession of firearms, the removal of Aboriginal "camps" near towns, the enforced transfer of people to and from reserves, control of property, and the suppression of so called "injurious customs" (with missionaries quite free to decide which traditional religious and social customs fitted into this category) (Middleton, 1977, p. 66).

One of the practices of missions, which today is perhaps considered as their most notorious, is the practice of child removal, which led to generations of children raised

³ Regarding the use of the term 'tribes', according to Middleton (1977), "this division into tribes is a European imposition using labels or terms that were taken from other contexts – for example, from the North American Indians who had a more advanced economic and social structure" (p. 31).

outside of their original families and cultural context (also known as *the stolen generation*). It began in a systematic way in about 1883 in NSW (Read, 1981), and across Australia similar policies lasted at least as late as 1970 (National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children From Their Families, 1997). These policies correspond, both in attributes and in chronology, with policies of child removal in other settler-state contexts, such as Canada. In Canada, Aboriginal children were sent to “government-sponsored residential schools” run by various churches between 1892 and 1969 (Archibald, 2006, p. iii).

The introduction of the Capitalist mode of production, the metabolic rift, alienation, and health

The violent introduction of capitalist economics in colonised countries destroyed indigenous economic systems, and forever changed the economical basis of indigenous cultures (Bedford and Irving, 2001). This process, which was briefly overviewed in the previous chapter, includes many different intertwined aspects. Two of these aspects are the metabolic rift and, consequently, alienation.

According to Saggars and Gray, “[f]rom all accounts, Aborigines were not particularly attracted to the capitalist mode of production” (1991a, p. 60), and only minimally integrated into it. Consequently, the idea of ‘proletarianising’ Aboriginal people in the early period of colonisation did not gain much support, as Pastoralists focused on land acquisition, and the convicts supplied sufficient cheap labour (Middleton, 1977). When convict labour stopped arriving from Europe in 1868, “slave labour in the form of Pacific Islander kidnapping from their homes provided the necessary labour for the sugar cane industry in Queensland” (Saggars and Gray, 1991a, p. 61). When Aboriginal people started to slowly join the pastoral industry, they were often exploited, and issues of stolen wages (Taylor, 1997) remain unresolved today.

The trauma of enforcing a capitalist economy in Australia should not just be remembered as an event of the past, but as an event that started in the past and is not yet resolved. Many Indigenous people still try to exist in the margins of the Australian society, while being

largely alienated from it. The alienation of Aboriginal people from Australian society is such that some suggest that Aboriginal people suffer from a separate type of poverty in Australia today, which differs even from the poorest layers of the working class (Walter and Saggars, 2007).

Colonialism and the introduction of capitalism in Australia, with all the social and environmental changes which it entails, has also brought what Foster (1999; 2000) has termed the *metabolic rift* – the alienation of human society from their natural environment, a necessary outcome of the capitalist mode of production. This alienation creates an actual rift in the earth's metabolism, as resources are being exploited in a way which cannot be fully reproduced (Foster, 1999). The colonisers had left Europe in the midst of the industrial revolution, after an inherent process of alienation from nature. People in Australia, however, did not go through the process of industrialisation, but were suddenly forced into the outskirts of an industrialised society. It is within this context that, as Saggars and Gray observe:

Many of the changes to the health profile of Aborigines during this period mirrored those of large sections of the European peasantry who in the eighteenth and nineteenth centuries had been transformed by capitalism into a surplus population enduring both malnutrition and stress-related diseases. (1991b, p. 384)

The alienation from nature is but one of several types of alienation in modern society, yet one that is critical in the Aboriginal context. The indigenous communities in settler-states suffer from the same sort of alienation as other working-class people, yet colonialism adds a more profound element of alienation. The metabolic rift did not exist in the hunter-gatherer economies of pre-colonial Australia, and the sudden introduction of an industrialised economy in which the alienation from nature (as well as between people) is advanced is a highly destructive experience. Thus, Aboriginal people often experienced multiple types of alienation: from country, from culture, and in the missions, often from family, language, and religion: “Aboriginal religion is fundamentally a union of people, land and spirit... Alienation from traditional territory and the sacred sites within that territory frustrated attempts by Aborigines to maintain [that union]” (Saggars and Gray, 1991a, p. 68).

This concept of metabolic rift and some of its effects may appear under different names and descriptions among different writers about the Aboriginal experience. Trudgen, for example, observed that “[t]he root cause of these ‘diseases of development’ can be summed up in the words *loss of control*” (Trudgen, 2000, p. 8; emphasis in source).

For most people, health and medical services are some of the spheres in which alienation may be felt at its strongest (Macdonald, 2005; Yuill, 2005; Crinson and Yuill, 2008). In an Aboriginal context, this alienation corresponds with several other sources of alienation. This is a significant part of the Aboriginal experience. These alienations can be observed in the way in which the history of colonialism affects Aboriginal health today.

Colonial legacies, racism, class, and health

It is in this context of a colonial process in which local, state, and later federal Australian apparatus developed. This power relationship between Aboriginal peoples and the settler society can be observed in the context of race, class, and the legal system. All of these processes affect people’s health in a myriad of direct and indirect ways. I will now explore some of the ways in which these colonial legacies influence people’s health today. The process of the destruction of the hunter-gatherer economies drove survivors into the outskirts of a new Australian capitalist economy. Racist concepts, coupled with deep poverty, assigned Aboriginal people to a role which can be described as being that of ‘Australia’s untouchables’ (Gilbert, 1973, p. 15).

The notion of racism in the Australian context is not unrelated to the notion of racism in other former-colony states. An interesting insight into the use (and misuse) of racial concepts in the public discourse is offered by Fields, writing in the context of the African-American experience in the United States (1990). According to Fields, racism did not enable slavery, but was rather a result of slavery. It is the particular historical conditions that enabled slavery, and racism was born out of this historical context. Furthermore, according to Fields, race as a concept exists today because it is actively practised, even by people of ‘good intentions’, who may use discourses of ‘difference’ and ‘diversity’ (Fields, 1990, p. 118). In other words, we must be mindful of what is *behind* racial differentiation,

and not see racism as a phenomenon that exists separately of a material context. In Fields' own words:

Nothing handed down from the past could keep race alive if we did not constantly reinvent and re-ritualize it to fit our own terrain. If race lives on today, it can do so only because we continue to create and re-create it in our social life. (Fields, 1990, p. 118)

While Fields wrote from the African-American context, this concept is pertinent to the Aboriginal experiences in Australia. The experience of 'race' changes from one generation to another, in ways that correspond with the socio-economical conditions of Aboriginal people. So profound is the influence of racism, that Larson and others (2007) show that experiencing 'interpersonal racism' is a significant determinant of health (p. 326).

As a result of the totality of the colonial experience, traditional healing practices, which were developed by pre-colonial hunter-gatherer societies, were often unable to address the new challenges. While until the 1960s very little attention was given to Aboriginal people's health as a distinct issue, access often remained either very hard or impossible. According to Siggers and Gray, "[b]y the early 1970s many health professionals had begun to recognise what Aborigines themselves had known for a long time – that mainstream health services had failed Aboriginal people" (1991a, p. 144). Even when general health-care services slowly became more accessible, the medical system often lacks the needed consciousness of the deep connection between the individual and her/his community, nature and country (the importance of context in health was explored in chapter 2.1).

This legacy and history of colonialism, with its complex race and class relationships as well as the different relationships with the natural environment (the metabolic rift), have affected the shaping of Aboriginal perceptions of health, in a way which differs from the mainstream biomedical approach. Anderson (1988) has compared what he identifies as the 'Koorie approach' to health, which developed through both pre-colonial societies and colonial experience, with the biomedical model. By countering the two, Anderson hints that what he calls the 'Koorie approach' to health is strongly tied to the social determinants and PHC approaches. In fact, if we look at a variety of cultural perceptions of health, the western approach, which relies mostly on the biomedical model, differs significantly from

a variety of other cultural approaches.

In his book about Aboriginal health-workers, Genat describes how these different perceptions of health are reflected in the experience of Aboriginal health-workers (the development of the role of Aboriginal health-workers in community-controlled services is explored in chapter 5.3):

Healthworkers find that the oppressive social context experienced by Aboriginal people over generations continues to overwhelm clients and their families. Legacies of exclusion and oppression are a major challenge to their effectiveness, and one consequence is a pervasive mistrust of doctors, nurses and health institutions.
(2006, p. 51)

Table 1: the ‘Koorie approach’ vs. the ‘Biomedical approach’ to health

	Koorie Approach	Biomedical Approach
Causation	Serious disease is a result of what is often labelled as magic-supernatural influences or breaking of food and social taboos.	The body is seen as a machine which may malfunction. Reductionist approach, in which microbes and risk factors are central to understanding disease processes.
Context of the sick individual	Always public, the individual is seen in the context of their social and spiritual world.	Diagnosis and therapy centre on the individual. Role of social/physical environment seen to be outside the practitioner’s sphere.
Therapy	Bush medicines used unless illness is serious or chronic which then involves intervention of a social or spiritual nature.	Mechanical intervention (either surgical or medical) continually refined with technological advances.
Context of Beliefs	A part of a wider set of ideas from which it is very difficult to separate.	Medicine is a branch of western knowledge with its own language and culture
Control	Minimal degree of special knowledge, hence it was accessible to all. One or two individuals in a community have special understanding of spiritual/social factors of illness.	- Doctor centred and controlled. - Professional hierarchies with refined knowledge and power at higher levels.

(Anderson, 1988, p. 10)

In the next section, I will review some of the resulting historical issues with health services for Aboriginal people in Australia.

Throughout the experiences of survivors in missions and reserves, the health services were an integral part of the colonial process. These were based strictly on western medical perceptions, and had continuing accessibility issues for Aboriginal people.

During the early 1920s, a few 'Aboriginal hospitals' were established, although these were reported to be far from sufficient. Saggars and Gray (1991a) provide a description of these facilities:

the term 'hospital' is probably rather elevated for what were often little more than tin sheds in which Aborigines received the most rudimentary of treatment. Sometimes they were luckier, and inherited obsolete European hospitals as new buildings were established. Until about the 1930s Aborigines had no access to other than Aboriginal hospitals in many parts of Australia. (p. 123)

Although accessibility was supposed to improve over the next four decades, the establishment of services often proved insufficient in improving the health status. Kamien (1978) observed during his work at Bourke in the early 1970s that:

Although there were ample health services theoretically available to the Aboriginal people, they were mainly being used only when an illness reached such a stage of severity that hospitalisation was indicated... The major reasons for the ineffectiveness of health care for this Aboriginal population were, first, the cultural chasm between the providers and the potential consumers of health care, and secondly, the inefficiency of the health delivery services themselves. (Kamien, 1978, p. 196)

These observations by Kamien resonate in Anderson's (1988) observation of what he refers to as the 'sociocultural determinants' which affect access by Aboriginal people to health services:

- *The conflict between the dominant western philosophy of the service provider and the cultural background of the patient*
- *The failure to utilize (even undermine) the strong kinship networks which are an important part of Aboriginal culture*
- *The authoritarian nature of the Doctor-patient relationship, which when compounded by previous bad experiences with other non-Aboriginal professionals, serves to intimidate Aboriginal people*
- *The alienation which an Aboriginal person feels in an environment largely made up of people who have had little contact with Aboriginal people accentuates the helplessness normally felt by sick people.*

(Anderson, 1988, pp. 108-109)

Another key contributor to alienation in the Aboriginal context is the question of language. Language affects the entire range of contact between the colonisers and the colonised. Health services are but one of many institutions in which the issue of language is very significant.

For some, such as the Yolŋu people in Arnhem Land, English may be a fifth or even sixth language, which, according to Trudgen, “leaves them severely intellectually marginalised in the dominant culture’s world” (2000, p. 8). One of the various implications of this is that “some Yolŋu wait years to understand what is making them sick. Many never find out” (p. 8).

While for some, not knowing English can create serious problems in Anglo-centred Australia, for others, knowing *only* English is a serious hardship. In the major cities of the east coast, many Aboriginal people were completely alienated from their cultural and linguistic background. As many are a part of the *stolen generations*, many cannot speak their own native languages. Without language, the complex political and legal systems of different peoples were destroyed.

These issues have been exacerbated by the fact that, for many Aboriginal people, the mainstream health services remained inaccessible at the time, physically and/or culturally. Even when Aboriginal people did go into a hospital, they were often subject to demands for cash in advance (Foley, 1991) and made to wait in segregated waiting areas (Saggers and Grey, 1991a). Issues of accessibility to health services were described even in the

1980s as based on “severe Aboriginal alienation from the basic medical system” (Thomson, 1984, p. 944). Swan describes this institutional alienation, and ties it with issues of interest to the social determinants of health:

For Aboriginal people, contact with European culture has been characterised by the denial of access to public facilities, to adequate housing, to education (even exclusion from schools), to economic power or resources needed to play a meaningful role in the new culture. (Swan, 1988, p. 13)

A key element of this alienation was the way in which the medical system regarded the role of Aboriginal people in the health delivery process. As Kamien observed from his experiences in Bourke in the early 1970s:

Perhaps the greatest lack of direction was due to the lack of consultation with Aborigines about their felt needs and their opinions about the sort of health care that they might want and therefore be prepared to help organise. At all levels Aborigines were regarded both directly and by implication as passive objects who were expected to accept the results of any planning decision which was thought would be of benefit to their health status. (Kamien, 1978, p. 202)

This alienation from health services meant that, as was written in a 1973 report about the state of Aboriginal people in Sydney: “It is clear that many Aboriginals do not use existing health facilities. While these may well be generally adequate for the population as a whole, they are not serving the real needs of many Aboriginal families” (Scott, 1973, vol B sec 8-3. for a more detailed discussion of the report, see chapter 4.4). This remains a key obstacle to improving Aboriginal people’s health even today, and was a focus of the Aboriginal health movement. In fact, it was such stories of underutilising medical services that instigated the construction of the first Aboriginal community-controlled health service (ACCHS), in Redfern in 1971, as will be mainly discussed in chapter 4.3.

In the introduction to his seminal book *A White Man'll Never Do It*, Kevin Gilbert writes:

Ever since the invasion of our country by English soldiers and then colonists in the late eighteenth century, Aborigines have endured a history of land theft, attempted racial extermination, oppression, denial of basic human rights, actual and de facto slavery, ridicule, denigration, inequality and paternalism. Concurrently, we suffered the destruction of our entire way of life – spiritual, emotional, social and economic. The result is the Aboriginal of twentieth century Australia – a man without hope or happiness, without a land, without an identity, a culture or a future. (1973, p. 2)

The creation of Australian federalism in 1901 enshrined the role of the States in managing Aboriginal people. Under these arrangements, most Aboriginal people did not gain full citizenship status, until changes occurred in the 1950s to the 1970s. These changes were made separately and under different circumstances in each state – some by direct legislation, some by bureaucracies and policies (Chesterman, 2005). However, the main issues that most Aboriginal people faced in their everyday lives were far deeper. According to Attwood and Markus, “[d]uring this time, Aboriginal communities were oppressed by Protectors and Protection Boards that variously tried either to push Aborigines into supervised reserves or to disperse them into the white Australian society, thereby threatening their land holdings and families” (1999, p. 58). Around the 1930s, a few Aboriginal people started to organise together with white supporters, mainly seeking civil rights and equality. A key event in the construction of this new movement was the *Historic Day of Mourning and Protest* on January 26, 1938, Australia’s national day (marking 150 years since the start of colonisation in 1788), in *Australia Hall* at the centre of Sydney. The conference was organised by one of the leading Aboriginal rights groups at the time, the *Aborigines Progressive Association* (Attwood and Markus, 1999).

In a statement released on the day, two of the leaders of the movement, Jack Patten and William Ferguson, attempted to explain the situation that Aboriginal people were facing at the time. One paragraph in the statement focuses on the national aspect of the situation, and is revealing, both of some of the demands of the movement and for the way the arguments for these demands were framed, seeking support from the wider Australian

community:

If ever there was a national question, it is this. Conditions are even worse in Queensland, Northern Territory and Western Australia than they are in New South Wales; but we ask New South Wales, the Mother State, to give a lead in emancipating the Aborigines. Do not be guided any longer by religious and scientific persons, no matter how well meaning or philanthropic they may seem. Fellow-Australians, we appeal to you to be guided by your own common sense and ideas of fair play and justice! Let the Aborigines themselves tell you what they want. Give them a chance, on the same level as yourselves, in the community. You had not race prejudice against us when you accepted half-castes and full-bloods for enlistment in the A.I.F. We were good enough to fight as Anzacs. We earned equality then. Why do you deny it to us now? (Patten and Ferguson, 1999/1938, pp. 84-85)

It took more than twenty years after this before fundamental changes in Aboriginal civil rights started to emerge in the different states. The main legislative changes that paved the way for formal equality started in the mid 1950s, when the WA government allowed freedom of movement to Aboriginal people in 1954, followed by Victoria in 1957, which in the same year was the first state to allow Aboriginal people to purchase alcohol outside reserves (Chesterman, 2005). Of the states and territories that banned Aboriginal people from voting by law, Western Australia, the Australian Capital Territory, and the Northern Territory scrapped the bans in 1962, while Queensland scrapped it in 1965. Despite this, in Queensland some rights such as the freedom of movement and the right to control personal property were only gained in 1971 and 1975, respectively (Chesterman, 2005). Throughout his book, Chesterman shows how these achievements were gained by continuous political actions, and were not handed down by governments (2005).

It is in this context that, in 1967, a referendum was called, and passed, on the amendment of two articles in the Australian constitution, which effectively kept Aboriginal-related policies in the hands of state/territories. Thus, the 1967 referendum, in the words of Taffe, “created a community expectation that the welfare of Indigenous Australians was, morally as well as fiscally, a responsibility of the Commonwealth” (2005, p. 122). The expectations often exceeded the scope of the actual changes to the constitution on which the referendum was based (as shown by Chesterman, 2005, and Rowse, 2000, among others). According to

Anderson, the referendum shaped the nature of the political process around Aboriginal issues since:

one direct consequence of the 1967 referendum result was that it was now possible for Aboriginal political processes to address claims to the Commonwealth level of government. Eventually, this would lead to a consolidation of national political processes in Aboriginal affairs, and the development of specific national indigenous institutional structures to advocate or manage these processes. (2003, p. 229)

The 1967 referendum created much hope for a change in conditions for many Aboriginal people (Sykes, 1989). The Commonwealth was expected to take a more direct responsibility for the condition of Aboriginal people, which until that time was under an almost complete discretion of the States. After gaining freedom of movement during the previous decade in most states, the prospect of leaving the missions in hope of better opportunities in the major urban centres together with the rural recession at the time (Briscoe, 1974) and major relocation schemes (Peters-Little, 2000) encouraged many to migrate to large cities. According to Foley (1991), “the Koori population of inner city Sydney went from approximately 4000 in 1966 to about 35 000 by 1968” (p. 5). While the source of the figures is not clear, another assessment, though much more conservative in terms of actual numbers, also shows a large migration to inner-city suburbs of Sydney at the time: a survey conducted in 1972 estimated at least 9,000 Aboriginal people resided in inner-city suburbs at the time, out of which 60% moved to the city within the ten years leading to the survey (Scott, 1973). Similar patterns occurred in other major urban centres at the time, including Melbourne, Adelaide, Brisbane (Gray, 1989), and Perth (Howard, 1977).

The cautious hope for significant social change and improved conditions following the referendum was quickly replaced with disillusionment. The same period saw a sudden rise in political movements around the world, including Australia, many catalysed by the Vietnam War (Clark, 2008). The upsurge of urban population in Australia created a platform for mass action. Particularly, Redfern became a scene of political awareness for many, “the Black heart” of “an intellectual revolution” (quoted in: Hulsker, 2002, p. 91). The civil rights movement evolved into the land rights movement, which emphasised the

demand for land rights and economic independence as the basis for self-determination⁴.

Other core issues and demands of the land rights movement were redefined in the context of self-determination as a basic condition for progress. The emerging Aboriginal land rights movement saw an upsurge in the early 1970s, “culminating in the legendary Aboriginal Embassy protest” (Foley, 1991, p. 9) of 1972. Moreover, one of the main issues that Aboriginal activism focused on was health, as awareness was starting to develop nationally about the extremely poor health of many Aboriginal people (Bartlett and Boffa, 2005).

One of the outcomes of the referendum and the reaction from social movements saw the creation of the Commonwealth Office of Aboriginal Affairs by the McMahon government in 1971. It was not until the election of the Whitlam government in 1972 that the office was expanded to a full Department of Aboriginal Affairs (DAA), which, according to Siggers and Gray, was “charged with implementing the government’s policy of self-determination for Aborigines” (Siggers and Gray, 1991b, p. 390).

A key element of the emerging land rights movement at the time was the concept of self-determination, and the forging of an *Aboriginal* identity. For many non-Aboriginal people, the term *Aboriginal identity* might bring to mind the remnants of pre-colonial cultures and narratives. Yet, as discussed previously, these cultures were only grouped together during the shared experience of being forced into an *Aboriginal* construct within the new settler-state structures. Therefore, the (pan) Aboriginal identity is itself defined by the traumatic common experience of colonialism. This logic of self-emancipation was well articulated by Gilbert:

To whom do we turn to justice? The heads of white society? Do we humbly beg the thief to act as judge? Do we ask the grazier, who fattens his cattle, his family, on land that was robbed from us in the most dastardly manner, for the return of our rightful property or at least a viable land base and reputation throughout Australia? No. It is not logical to expect a tyrant, a thief, to relinquish his unlawful gains. (Kevin Gilbert, 1988/1981, p. 24)

⁴ It is important to note that the demand for land rights has been a fundamental demand that is as old as the dispossession of land itself. In this thesis, the term 'land rights movement' mostly refers to the rise in activism around land rights in the 1960s-1970s.

One of the demands of the land rights movement was that the Australian state ‘pays the rent’, and compensates Aboriginal people for invasion and occupation (McGuinness and the Victorian Aboriginal Health Service, 1988). Similarly, a common argument from the movement was that “[l]and Rights is partial compensation for the Apartheid-like practices of Australia’s colonising governments” (Dodson, 1988/1985, p. 285). Funding of Aboriginal organisations was perceived by the movement as one way to start compensating Aboriginal people, or ‘paying the rent’.

Health, then, was at the heart of the land rights movement, and was even considered a key part of it. According to Siggers and Gray, “[w]ith the possible exception of land rights, health has been the issue that has most galvanised Aboriginal communities to action” (1991b, p. 403). Land rights themselves have even been recently identified as a health determinant (Watson, 2007). The case study for this thesis, the ACCHSs movement, developed out of this exact struggle, the struggle for health in the context of self-determination and land rights, as manifested in the early 1970s.

Aboriginal communities today: definitions and debates

Just as the concept of Aboriginality itself is a western construct, a ‘community’ is also a western construct, a social formation into which Aboriginal people were often forced. Yet ever since the establishment of such communities, much of the self-determination struggle was centred on them and the communities themselves became an integral part of the Aboriginal identities. As influential writer Mudrooroo describes:

‘Community’, with its derivation from ‘common’, implies a single social entity, thinking and acting along the same lines through some mysterious process of consensus. The word is too often applied to a supposed unity of individuals or groups, without taking due account of differences of class, race, or sex. In particular, when we examine the Indigenous community we find that instead of forming a bland amorphous and anonymous mass, it is as diverse and complex and fractious as any other. (Mudrooroo, 1995, pp. 76-77)

Similar critical sentiment was expressed by Liamputtong and others (2003), who asserted that the term community “can serve to conceal differences between people and hence obscure minority interests” (Liamputtong et al, 2003, p. 10).

The concept of community in its essence revolves around personal connection, participation, and a sense of camaraderie. According to Liamputtong and others, the term community “reflects a view of the world that is constructed by the people themselves; they feel part of a collective. In this sense it cannot be imposed bureaucratically” (Liamputtong et al, 2003, p. 10).

Cummings adds an important perspective to the definition of community, as she emphasises the role of family ties, which add a transient aspect to the complexities of a definition of an Aboriginal community. According to Cummings:

Aboriginal community is about relationships. This is so important. Aboriginal people connect through the kinship system. It's not only a blood line, it is also about those particular levels of responsibility. Family relationship gives you a particular place within the extended kinship, but it also gives you your totem, and then who your totem is also gives you that responsibility. And your totem tells you the responsibility you have to country. (Cummings, quoted in: Taylor, Wilkinson and Cheers, 2008, p. 46)

A critical analysis of the use of the term community was presented in 2000 by Peters-Little. Peters-Little traces the development of what she describes as ‘the community game’, or the abuse of the term community in the mainstream political sphere, developed during the Whitlam government:

The term was used to enable the government to distribute funds for welfare programs and the delivery of services to Aboriginal people. It was seen as the medium which would automatically be culturally appropriate, democratic, and at the same time politically and socially acceptable to the majority of Australians. Since that time Aboriginal people across Australia have become so good at playing the ‘community game’ that many have begun to believe it. (Peters-Little, 2000, pp.

13-14).

It should be remembered that, however artificial the creation of a social structure such as a community may be, the struggles which were forged around these communities poured a real identity content into the concept of community for many of the participants. In fact, this is precisely the way in which national identities are often formed – through a joint experience of oppression, which unites the participants in forming a new joint identity. In the Australian context, as Ian Anderson defines it, “[t]he basis of community is created by this perception of commonality, as well as a sense of being different or distinctive from other groups of people in Australian society” (1988, p. 25). Yet it should also be remembered that, in the words of Peters-Little, “romantic view of ‘community’ is what some have described as the type of romanticism that one can afford to have when they don’t have to live in the community” (Peters-Little, 2000, p. 18).

2.3 Community control

The concept of community control stands at the heart of this thesis. The term itself though may be interpreted quite differently by different people and groups. The specific contexts of different struggles for community control will inevitably affect the perception and definition of the term. This section starts with an exploration of some existing definitions of the term. It then explores the economic issues, which are inevitably at the heart of real-world attempts at establishing community-controlled spaces.

The section will then discuss the concept of community control in two other key contexts that are relevant to the case study of this research: community control in a health context, and issues in national groupings of community-controlled organisations. The chapter will then finish with an overview of some other experiences around the world with community control in a health context.

Defining community control

Defining a term such as *community control* is not an easy task. While local self-emancipation is a fundamental part of progressive, liberation and/or revolutionary movements around the world (as discussed in the health context further in the chapter), the difference of the local contexts are too significant to give a true global definition of the term. Another implication of the local complexities is that the very terminology is likely to vary – meaning that the phenomenon of *community control* might be termed in different ways as a result of local contexts of struggles. Similarly, the term *community control* itself may have different meanings in different contexts. In fact, even in Australia some of these different contexts might mean that community control, as understood in Aboriginal communities in urban centres, might be irrelevant to remote communities for example (Trudgen, 2000). This may create very different experiences under the same label of *community control*. Here, I discuss several definitions of community control, articulated from both the Aboriginal Australian context and other international contexts. In the discussion chapter (and specifically 8.1), I will revisit the question of definition of community control, in light of the findings presented in chapters 4-7.

The concept of community control, in the Indigenous Australian context, developed from the self-determination movement discussed above. According to Fagan, “[c]ommunity control was a popular political sentiment of the left worldwide in the 1970s. It was a term often loosely used but tending to refer to community action not initiated by Government and not run by professional bureaucracies” (1990, p. 27). Boughton commented that the development of community-controlled social services by Indigenous communities in Australia fundamentally shifted local struggles. According to Boughton, community-controlled organisations “moved the conflict over power and resources to a different level, beyond campaigns around workers’ rights or even land rights, to the whole question of self-determination and governance” (2000, p, 22).

An organisation’s commitment to *community control*, however the organisation defines it, adds another layer of complexity to both its operation and its scope. Nassi (1978a, 1978b) addresses such services that do make this commitment. Nassi offers an ideal-type model,

which breaks down the different dimensions of community-control. Despite the different context of time and place, Nassi's work remains highly relevant to the case study.

Nassi, who wrote in the context of a case study into community-controlled mental health services in New York, focuses her analysis on the single-unit community-controlled health service. She distinguishes *community control* from other models of community's input into social services, *community involvement* and *community participation*. While the last two models are dictated 'from above' by the service provider (the state or otherwise) and differ by the level of community input or participation, *community control* programs are defined as having "control and power – the real social power that comes from choice of programs and from control of money and jobs" (Nassi, 1978a, p. 4).

Nassi's definition of the term *community control* relies on a growing body of work from the preceding decade about the concepts of public participation. One of the most influential works on this was presented by Arnstein, who offers a typology of different types of citizens' power, presented in a *ladder of citizen participation* (1969). The ladder includes eight levels, grouped into three types of power, in ascending order: *Non-participation* (manipulation, therapy), *tokenism* (informing, consultation, placating), and *citizen power* (partnership, delegated power, citizen control). *Citizen control* is presented at the top of the participation ladder. According to Arnstein:

Demands for community controlled schools, black control, and neighborhood control are on the increase. Though no one in the nation has absolute control, it is very important that the rhetoric not be confused with intent. People are simply demanding that degree of power (or control) which guarantees that participants or residents can govern a program or an institution, be in full charge of policy and managerial aspects, and be able to negotiate the conditions under which "outsiders" may change them. (1969, p. 248)

Nassi's ideal-type model of a community-controlled health service emphasises the crucial importance of meaningful self-determination through full control over all aspects of running such service by an incorporated, democratically elected community governing board. Its services should remain free and open to all members of the community (Nassi, 1978a). The relevance of Nassi's model is seen when compared to the working definition

of *community control* used by the case study's current national organisation, NACCHO. Table 2 presents Nassi's ideal-type model together with NACCHO's working definition of a *community-controlled health service*.

Despite the very different contexts, there are similarities between the two definitions. Both suggest an incorporated board, both reject the direct involvement of government, and both must declare reliance on support and recognition of the community. The NACCHO definition relies on identity, which does not appear in Nassi's definition, due to the different contexts of the definitions.

Table 2: Models of community-controlled health: two definitions

Nassi's ideal-type of community-controlled health service	NACCHO's working definition of a community-controlled health service
<ul style="list-style-type: none"> • "Total self-determination in health-care planning ... through an incorporated community staff governing board • Removal of all outside appointed administrators and staff • Immediate cessation of health care facility construction – pending review by a community-appointed board • Publicly supported health care – eliminating all fee-for-service remuneration • Health education programs for all members of the community • Total control of budget allocations, overall policy, hiring, firing, salaries, construction, and health code enforcement by the community worker board • Total support from community and extracommunity organizations <p>(Nassi, 1978a, p. 6)</p>	<p>"An Aboriginal Community Controlled Health Service is:</p> <ul style="list-style-type: none"> • An incorporated Aboriginal organisation • Initiated by a local Aboriginal community • Based in a local Aboriginal community • Governed by an Aboriginal body which is elected by the local Aboriginal community • Delivering a holistic a culturally appropriate health service to the Community which controls it." <p>(National Aboriginal Community Controlled Health Organisation, 1993, p. 3)</p> <p>Later additions: community-controlled services:</p> <ul style="list-style-type: none"> • Must not be controlled by Government "to any extent" • Must provide "holistic comprehensive primary health care services" <p>(National Aboriginal Community Controlled Health Organisation, 2008b)</p>

Source: Nassi (1978a), NACCHO (1993, 2008b)

The dialectics of funding

Community control was described by Nassi as a potential double-edged sword, with both progressive and conservative possibilities. Nassi regarded community control as "dialectical in the sense that it embraces both conservative and radical possibilities"

(1978a, p. 11):

As a conservative force, community control could become preoccupied with local issues, encourage local factionalism, become an exercise in “sociotherapy”, become co-opted and bankrupt of its original intentions... With an eye toward radical social change, community control challenges federal intervention in the formulation of local policy, invites health care reform by demanding consumer accountability and upsetting professional equilibrium, provides a mechanism for self-determination, and suggests an alternative model of government and social decision making. (1978a, p. 14)

When communities decide to establish their own services, the question of funding becomes central to the question of community control. Except for a situation of open hostility by the state or even warfare, the state (on either local or national levels) is often the only possible source of such large-scale grants. Yet relying on state funds may put the very basic concepts of self-determination and community control in jeopardy, as the funder is unlikely to stay clear of the decision-making process. The question arises: if the state provides the funds, and inevitably intervenes to some degree in the decision making process, does it still constitute community control? At what point can we recognise the process as co-optive rather than liberating? Collmann offers a definition of co-option (or ‘cooptation’) from an Australian Aboriginal context:

Cooptation is part of the process whereby bureaucrats attempt to confine particular historical conflicts to within their own fields of activity and to contain the secondary conflicts generated thereby. From this perspective, cooptation may be a critical aspect of the general concentration of the means of conflict administration in the hands of particular bureaucratic agencies, leading to the demise of some agencies and the transformation of others. (1981, p. 52)

In my view, the question of community control or co-option should not be viewed as a dichotomous, either/or definition. Arnstein’s ladder of participation offers some sense of different stages of community-control/co-option (1969). Through the process of state funding, community-controlled organisations enter a dialectical relationship with the state. This relationship can rarely be appropriately described as a ‘clean’ form of either, but

rather as a community-control/co-option whole. The two competing concepts create the whole in all its intricacies. A dialectical perception of community-control/co-option is the first step we need to take in order to have a fuller understanding of the processes, which unfolded in the case of Aboriginal people in Australia, as I will explore in chapters 4-7.

Community control in a health context

In the health context, community control over health services may represent the flowing of self-determination concepts from an existing social movement into new areas of struggle, specifically, health services. According to Waldram, Herring, and Young, the “issue of control is within the realm of the political”, and in the Australian context, “represents the legitimate aspirations of Aboriginal peoples to have control over the delivery of health services within their communities, and control over the research that informs health policy” (2006, p. 288). The use of directly political tools in the context of social services represents to some extent the failure of the welfare state in addressing these issues.

The welfare state is then further tested when groups who seek community control over service delivery ask for funds. As previously explained, the state is often the only source that can provide long-term funds for such projects. This relationship, between a movement seeking to maximise their independence from the state through community-controlled services, and the state, which is the only available source of long-term funding, is the main contradiction at the heart of the community-controlled services experiences in a capitalist/welfare context.

This contradictory relationship of funding affects all aspects of the struggle. One way to theorise this relationship is as a dialectical community-control/co-option (following Nassi, 1978a) between the movement and the state: community control and co-option are both sides of the whole experience of the movement, and cannot be simply understood as either/or.

Another aspect of community control, which is especially pertinent to the health context, is alienation, which was discussed in further details earlier in the chapter. Health services are

alienating institutions for most people, and marginalised groups often suffer greater alienation from mainstream health services, as they often amplify already existing alienation from the colonial experience (Crimson and Yuill, 2008; Yuill, 2005; Scambler, 2007). Community control, in theory, may address the cause of alienation, as people take power directly and emancipate themselves from the existing systems.

Community control over health services, as it is a political act, may also help to reveal the social and power structures that affect health in a given context, such as class dominance (Waitzkin, 1978) or the postcolonial power struggle. This is true of community controlled services more than mainstream services, which are more likely to be tied with the institutional/structural problems that people may face.

As a result of this, the concept of community control ties in directly with the ‘battle of ideas’ in the health field between the biomedical and social health focus. As the PHC movement put an emphasis on community participation (Macdonald, 1992), some see community control as the ultimate manifestation of community participation, and thus a key PHC phenomenon (Eckermann et al, 2006). The Alma Ata declaration of 1978, which championed the social determinants of health approach, stated in article 4 that: “The people have the right and duty to participate individually and collectively in the planning and implementation of their health care” (WHO, 1978). According to Eckermann and others, “[t]he participation referred to is not just the involvement of or consultation with the community but a true taking part to the extent of ownership and control (Eckermann et al, 2006. p. 158).

However, Nassi, who as mentioned previously defined community control as a distinct phenomenon separate from community participation and consultation, also points out that community control is inherently different from reformist politics, however progressive (1978b). In other words, according to Nassi, the difference between community participation and community control is more than just a scale of community engagement, but rather describes an inherently different process. Eckermann and others seem to agree with Nassi, but attribute this concept of community control more broadly to the PHC movement: “It is essential that this be real control, not just involvement. If the people are not responsible for the planning, implementation and evaluation of health care then it is not PHC” (Eckermann et al, 2006. p. 156).

The concept of community-control became of some interest to consumer participation groups, as these were growing. Some argue that “[i]n theory this model [of community control] represents consumer participation at its strongest” (Department of Public Health, Flinders University and South Australian Community Health Research Unit, 2000, p. 100). Yet Liamputtong and others emphasise the difference between the concepts: “[c]ommunity participation is sometimes confused with consumer participation, which has a more individual focus” (Liamputtong et al, 2003, p. 9).

Nassi further defined some of the potential benefits of community-controlled health services in a health context:

(a) a direct challenge to the prerogative centralized bureaucracy to establish local policy; (b) a dramatic transformation and improvement in the health care service delivery system through accountability to the consumer and a transformation of traditional political power relationships; (c) a mechanism for self-determination and the acquisition of greater competence, skills, and resources; and (d) an alternative model for government and social decision making, which rejects the efficacy of representative but distal institutions to reflect popular aspirations in a given locale. (1978a, p. 12)

A key element in the concept of ACCHSs is democracy. ACCHSs, according to Eckermann and others, “are designed to be run by the people, for the people, according to their needs, and in harmony with their holistic view of health. Consequently, the decision-making base is shifted from the medical professions to community-elected boards of directors” (2006, p. 180).

National organisation and community control

Community control, understood as an initiative that is conceived and run by local community members, requires joint political awareness by enough community members to be viable. A discussion of an organisational form of a movement has to acknowledge the

uniqueness of the context in each case. This is why both the concept of community control and the examination of the case study need to be understood in the context of the state of social movements (Zald and Ash, 1966). Social movements are characterised by a mass rise of consciousness around a specific issue, which lends to a creation (and recreation) of ‘cultural innovations’ (Rao Morrill and Zald, 2000, p. 239). A part of this process, according to Rao, Morrill, and Zald, is the creation of new organisational forms. Furthermore, according to the authors, social movements act as “core mechanisms of organizational change, rather than a phenomenon relegated either theoretically or empirically to the margins” (p. 278). The question of the organisational form of social movements is crucial, and especially so in the context of community controlled services.

According to Nassi, one of the dangers which community controlled organisations may face is over-occupation with organisational questions: “[c]ommunity control may become preoccupied with decentralization and neglect the issue of national power, which continues to determine the significant decisions on funds, resources, and basic policy” (1978a, p. 11). The question of national organising is a key question, as the issues that the political act of establishing community controlled services cannot be fully addressed at the local level.

Minkoff (2001) discusses what she terms national *hybrid organisations*: such organisations of social movements combine ‘identity-based’ advocacy and service delivery. Although Minkoff does not differentiate between community-controlled (or similarly defined) organisations and others, the definition of such *hybrid organisations* implies some level of affiliation to at least some demands of the broader social/political movements of such identity groups, combined with some level of open democratic structures which allow input from communities which use the services.

According to Minkoff, hybrid organisations have three features. These organisations are:

1. Identity-based
2. Service providers
3. Advocating for social change in issues relating to the respected group

(2001, p. 381).

It is not the features themselves but the combination of all three that makes these a unique organisational form.

Minkoff's research looks at groups organising in the United States. According to Minkoff's findings, prior to the 1960s, organisations were established for service provision and had some gains, yet these organisations rarely challenged political structures and advocated for wider social change (2000). Organisations of marginalised groups in Australia went through a similar process, yet the demand for wider change is evident from earlier on (as discussed in Nathan, 1980; Briscoe, 1981; among others). The experience of such organisations has set the scene for the rise of hybrid political/service delivery organisations, with the change of political tides.

The form of hybrid organisations fits quite well with indigenous struggles, as the very need to combine service delivery and advocacy flows from disillusionment with the promises of the welfare state as it simply failed to deliver to many marginalised groups. The common experience of marginalisation creates both a common identity and disillusionment with existing power structures. In this way, the disillusionment indicates very high marginalisation of communities, which turn to hybrid forms of organising, and, in the case study at hand, form their own community-controlled welfare services.

The entrenchment of neoliberalism proved fatal to many social movements (Touraine, 2001). Minkoff's study of hybrid organisations points to a rapid growth in numbers after 1970 (which also corresponds with the rise of the ACCHSs movement), and an overall stagnation by the 1980s. The ACCHSs movement has seen a continuing rise of health services throughout the 1970s and 1980s, yet the movement worked within the context of the time – and was also affected by the entrenchment of neoliberalism and the subsequent withdrawal of social movements. The findings chapters explore the development of such a shift in the case study, in the context of the changing political scenery (especially chapter 7). A discussion of the shift itself is presented in chapter 8.3.

Minkoff's work serves to remind us that the role of such national organisations is a very complex one, as they need to cohere the diverse politics of the movement, from a variety of different local contexts, into coherent national demands. The existence of such national organisations is tied to the existence of broader social movements. A main issue, which such national organisation may face, and which will be discussed further in the thesis in the context of the case study, is how changes in an erratic phenomenon such as social

movements are reflected in the national organisational forms of such movements?

Overview of some international experiences of community-control health care services around the world

In terms of international experiences in self-determination in health, a survey is not a simple matter. The narratives used in regards to the subject vary greatly, and examination of actual power relations behind health movements and health services in each context is outside of the scope of this thesis. This section presents several examples of grassroots health movements, mostly in a colonial/postcolonial context.

The overview here is by no means a definitive one. It is meant to provide some context of similar struggles in different, yet not unrelated, contexts.

The situation of Aboriginal people in Australia is often examined in comparison to that of indigenous people in other post-British settler-states, mainly New Zealand, the United States of America (USA), and Canada. There are of course many differences in the context of the struggle in each of these states. One such difference is the level to which traditional economies were destroyed. In Australia, the destruction of the hunter-gatherer economy was one of the most profound. Another main difference, which separates the Australian case from the rest of these examples, is that fact that in Australia, treaties were not signed between the colonisers and the indigenous peoples (Brennan et al, 2005). However, in New Zealand, Canada, and the United States, “legislation, court decisions and government action have whittled away the position that Indigenous peoples originally secured by agreement with the colonising power” (Brennan et al, 2005, p. 82).

Griew and Thomas (2008) draw similarities in the development of indigenous people’s health in these contexts along similar lines during the last few decades. This hints at the role of social movements, including global ones, in the developments of these struggles, as discussed previously. In the words of Griew and Thomas:

Broadly speaking, New Zealand, the United States and Canada saw major health improvements for Indigenous populations up to around the 1980s, leading to an appreciable narrowing of the gap in life expectancy between Indigenous and

mainstream populations. However, between the 1980s and the end of the century, a slowing or stalling of Indigenous health improvements measured by life expectancy meant that the gap failed to close significantly (Canada) or even widened (New Zealand and the United States). (p. 6)

Griew and Thomas then comment on the Australian context of the findings, noting that also in Australia attempts to improve health outcomes of Indigenous peoples have stalled.

Another context in which Aboriginal Australian health struggles are sometimes placed is the Pacific postcolonial context. Anderson and others (2006) offer a comparative analysis of indigenous health in Australia, New Zealand, Hawaii and Micronesia. The authors argue that indigenous health policy is connected to international trends of policy towards indigenous populations: the authors tie the rise of indigenous movements worldwide in the 1960s to the increasing public discussion of indigenous rights and indigenous people's health. Similarly to Griew and Thomas, Anderson and others also show how in the 1980s all of their study cases had a national indigenous health strategy (in Australia it was the National Aboriginal Health Strategy, or NAHS, of 1989, which is discussed in chapter 7.6), although they often did not get enough continuing support from the governments to achieve their aims. Anderson and others also show that in recent years the tendency is to eradicate the concept of self-determination in regards to policy-making (2006).

A main aspect of self-determination in Canada is the existence of treaties, and the signing of land claim agreements. Such treaties and agreements sometimes provide a space for community social services to be recognised and funded. One effect of the existence of different treaties in Canada is that Aboriginal self-determination struggles tend to be more localised, around the specific conditions of different nations, and the role of national organisations is not as prominent.

One example of this is the struggle of the Cree and Inuit people of James Bay and Northern Quebec, who were “the first groups to sign a comprehensive land claim agreement in Canada” in 1975 (Waldram Herring and Young, 2006, p. 263). These agreements allowed for some community-controlled infrastructures, such as the establishment of a Cree Board of Health and Social Services in 1978 (p. 263). According to Robinson (1988), this experience offered the Cree people “a measure of control over health and social services”

(1988, p. 1611). This avenue for recognition of community structures is usually a very challenging process. According to Waldram, Herring, and Young, “[f]or the Cree, the battle to gain control was a difficult one, fraught with tense negotiations with the Quebec government in particular, and accusations that sufficient funding as called for under the agreement had not been made available” (Waldram Herring and Young, 2006, p. 264).

Following these developments in the 1970s, the Canadian federal government announced the *Indian Health Policy* of 1979 (Young, 1991), which was said to have “sparked the process of self-determination in Aboriginal health care” (Waldram Herring and Young, 2006, p. 264). The policy was prompted by both a rise in grassroots activism and the Alma Ata declaration, which was endorsed by the Canadian government in the same year. The policy offered pathways for communities who choose so to take some measures of control over their health services via a board. This policy is still at the basis of Aboriginal health policy in Canada today (Waldram Herring and Young, 2006). The process started with the Indian Health Policy eventually led to the *Community Health Demonstration Program* (1982) and the *Health Transfer Policy* (announced 1986, enacted 1988), in which control over existing services was given to community boards.

However, this process was criticised for being focused on self-administration rather than self-determination. The difference is with the political/economic context in which the project is perceived, and is related to the discourse of degrees of public involvement, as discussed in further details earlier in this chapter. According to Waldram Herring and Young (2006), One of the issues raised in terms of funding Aboriginal health services in Canada is that funding was often allocated in advance for a limited amount of time, such as two years. Such uncertainty can be demoralising and harmful. The authors further noted on the consultation process: “Aboriginal organizations, while consulted, were not made aware that only communities funded under the Demonstration Program would be allowed to transfer health services to local control” (p. 267).

A national indigenous health policy developed in Canada at the end of the 1970s offers some interesting insight into the Canadian context. Canada’s 1979 *Indian Health Policy* offered particular focus on some Aboriginal groups rather than others. This approach prevented the formation of a unified Canadian Aboriginal movement. According to Waldram, Herring, and Young (2006), “this approach to self-determination, stressing

community-level initiatives and the transfer of some federal powers, was part of the broader federal approach, one that continues to be much criticized by some Aboriginal groups” (2006, p. 267). It should be noted that, as progressive as rhetoric may sound, there are fundamental limits to the level of self-determination groups can achieve under the wing of the state. Other transfer programs that have been implemented since include a new *Indian Health Transfer Policy* from 1986 and the *Integrated Community-Based Health Services* from 1994. A national umbrella organisation, the National Aboriginal Health Organisation, was finally formed in 2000 (Waldram Herring and Young, 2006).

Such advances in progressive health services were by no means strictly an indigenous issue. Writing about the history of Community Health Centres in the US, Lefkowitz comments that the centres “had a commonsense, holistic philosophy that came from understanding that good health is close to impossible if you have to choose among food, rent, and medicine” (2007, p. vii). Such centres, according to Lefkowitz, “were governed by the people who used them, and brought power where none seemed to exist” (p. viii). In 2007, over 900 Community Health Centres operated in the United States (Lefkowitz, 2007). In the early days of this movement, people involved “saw health centres as a model to link health services to jobs, nutrition, and economic development. Grassroots groups heard about the model and adapted it as their own” (Lefkowitz, p. 13). In other words, the US context also shows us the importance of community-controlled health services in raising the social and political determinants of health, in a way that is very difficult to do appropriately in mainstream services.

An influence of large political movements on health and health delivery can also be observed in states that are going through fundamental political and economic transitions. A main difference in this context is the role of the state in supporting and even initiating local community empowerment. In Venezuela, the rise of the social movements, which were able to access state power with the election of Hugo Chavez in 1998, had significant effects on public health. In Venezuela, there also exists a strong indigenous political context, although very different from the Australian one. Chavez, himself from a partly indigenous heritage, is supported by many of Venezuela’s indigenous nations (Gott, 2005).

According to McIlroy and Wynter, “[o]ne of the most successful aspects of Venezuela’s Bolivarian revolution has been the “social missions” – social programs funded by

Venezuela's oil wealth that aim to solve the most pressing problems of the nation's poor majority" (2008, p. 99). Such missions, funded with money from Venezuela's oil reserves (through Venezuela's nationalised oil company, PDVSA), aim to provide essential services, such as health and education, mainly in poor urban areas (the *barrios*). One major problem has been the refusal of many doctors in Venezuela to work in such areas. This led to exchanges with Cuba, which supplies doctors to work in the social missions, mainly in exchange for oil (McIlroy and Wynter, 2008). In 2008, there were 2500 'popular clinics' across Venezuela, half of the official goal of 5000 (p. 99). Another community process, which is related to the construction of the social missions with regained public resources, is the construction of community councils. Throughout Venezuela, councils of 50-200 families are given resources directly through the government for a more direct local control, in a bid to bypass often-hostile local bureaucracies (McIlroy and Wynter, 2008). These communal councils are fighting to practice a meaningful level of local community control, and in this context, the local accessibility of health and other social services is an empowering process.

In El Salvador, the role of health care in the revolutionary movement has been documented in the book *The People's Remedy: the Struggle for Health Care in El Salvador's War of Liberation* by Francisco Metz (1988). Questions of ownership and power over services were central in El Salvador as well, where in the 1980s an important part of the revolutionary effort was centred in rural communities, some of which were engulfed in the armed struggle. These communities also had poor access to medical facilities, and the act of self-organising health and other social services by communities was an important part of the revolutionary effort.

In conclusion, the concept of community control in a health context is a recurring concept in liberation struggles in a large variety of contexts. The scope of the struggle and the social movements from which a community-control movement arises plays a key role in shaping the size and scope of such movements.

This chapter has presented an overview of some of the key themes and concepts that are discussed in this thesis: health, community control, and the Australian context. The next chapter will examine the chosen methodology, a single case study research, and will lead into the presentation of the findings and the discussion.

Chapter three: methodology

This chapter consists of two main parts. The first, 3.1, examines the chosen methodology, a single-case study research, and its application in this thesis. The second part, 3.2, discusses some of the different types of resources used. The main resources used are primary sources, which were produced by the movement in real time. The main such source is the Aboriginal Medical Service Newsletter, which was produced by the Redfern Aboriginal Medical Service from 1973 to 1991. Other primary sources explored are policy reports, some of which have never been officially released. Another primary source used was interviews. This chapter includes a discussion about the use of these sources in the context of this research. Such resources are typical resources for a case study research (Yin, 2003).

3.1 Choosing the methodology

As discussed in the introduction, the initial idea for this research project was to focus on the issue of health services as an arena for confrontation between a settler state and indigenous peoples. It is my experience of working in a similar field in the Israel/Palestine context that led me to examine this subject in the Australian context. Yet the same experience also taught me that the uniqueness of each case is significant, and I decided to focus on a single case study rather than using a methodology that is based on comparisons of several case studies. Such a model would not have allowed me to explore the specific case study in the same resolution and depth, and I believe that the complexities of the case are better served with a single focus. One of the common justifications of using a single case study is to explore a unique case (Yin, 2003, p. 40). Furthermore, according to Yin, “[c]ase studies are the preferred strategy when “how” or “why” questions are being posed, when the investigator has little control over events, and when the focus is on a contemporary phenomenon within some real-life context” (2003, p. 1). Similarly, according to Stake, “[c]ase study is the study of the particularity and complexity of a single case, coming to understand its activity within important circumstances” (1995, p. xi). In

other words, a case study research offers a way to approach the observed phenomena in a way that is aware of the different levels of complexities (in the given limitations).

For these reasons, the case study has long been a preferable methodology in the study of social movements (Snow and Trom, 2002). As early as 1955, Messinger used a case study of the Townsend Mission Movement in the United States to study the organisational dynamics of a declining movement. Specifically, in his research, Messinger studied the 'organisational transformation' of the movement (1955, p. 3). More recently, Lefkowitz explored a case study of the Community Health Centres movement in the United States (2007).

Another influential use of a case study in social movement research is Freeman's *The Politics of Women's Liberation: a Case Study of an Emerging Social Movement and Its Relation to the Policy Process* (1975). Freeman set to explore the history and the development of the women's liberation movement in the United States, while examining several types of organisations, including both local groups and a national one (*The National Organization for Women*). Furthermore, Freeman examined the role of grassroots organising in the development of the policy process. Similar themes are explored in this thesis, and the case study methodology is a common one in describing such processes.

A case study of social movements may be used to examine a specific aspect of a social movement. For example, Shanley, Da-Silva, and Macdonald's recent use of a case study of a social movement organisation in the Amazonia region of Brazil focuses on the development of the role of women in the movement (2011). Barchiesi focuses his social movement case study research on a specific campaign – that of the South African Municipal Workers' Union against the privatisation of municipal services in Johannesburg (2007). A case study approach provides Barchiesi with a suitable methodology to Barchiesi's research, which emphasises the uniqueness of the case study. In this case, the case study is a campaign that started before the collapse of South Africa's Apartheid regime and continued after the transformation of the country in 1994. This research therefore continues a long tradition of using a case study methodology in an exploration of a social movement.

As detailed in chapter 1.2, the topic of this research is health services as an arena for a

political struggle between an indigenous social movement and the settler state, and the case study focuses on the national organisation of Aboriginal community-controlled health services in Australia. This research, to paraphrase Creswell's definition of a case study, is exploring a 'bounded system' over a period of time (2007, p. 73). In order to do so, and given the constraints on my research (as detailed in chapter 1.5), I decided to use a variety of sources which include interviews and exploration of documents including organisational documents, activist literature, newsletters, and policy reports. All of these tools are commonly identified as key tools in a case-study research (Creswell, 2007; Yin, 2003).

In addition, my research includes some limited aspects of phenomenological research. Creswell (2007) defines phenomenology as an examination of "the meaning for several individuals of their lived experiences of a concept or a phenomenon" (2007, p. 57). In the case study, the phenomenon is the community control over health services, and some observations and discussion of the phenomenon do arise from the case study (as discussed in chapter 8.1). Yet I recognise that the discussion of community control as a phenomenon should directly flow from the discussion of the particularities of its politics and organisation. I prefer to do this type of investigation, allowing me to present the evidence that I came across in the data collection process more clearly (as presented and explored in chapters 4 -7). The discussion of community control as a phenomenon is then presented as my interpretation of some of the findings, and is discussed in chapter 8. In a way, phenomenology is an integral part of the discussion and analysis of the findings from a qualitative case study. For example, as the data collection of this research yielded the most results from activist documents, the discussion and analysis of them is not dissimilar to Van Manen's concept of *Hermeneutic phenomenology* (1997). According to Van Manen, "Phenomenology describes how one orients to lived experience, hermeneutics describes how one interprets the 'texts' of life" (Van Manen, 1997, p. 4), an appropriate approach for this specific case study and type of materials gathered in the data collection.

One methodology that I did not find particularly fitting for this research is ethnography. I do not see the focus of this research as a specific cultural group. This is for several reasons. First, the issues that stand at the heart of this case study are political in nature, and not specifically cultural. Of course, there are cultural contexts, which inevitably affect, and are in return are shaped by the political processes. However, the cultural element, of either the colonisers or the colonised, is not itself the focus. Furthermore, Indigenous people of

Australia are divided into many different cultural groups. Australia, as mentioned, included over 200 different language groups with over 600 spoken dialects at the start of European invasion in 1788 (Amery and Burke, 1994). What unites this variety of groups is the experience of invasion and construction of a foreign society hostile to their economic activity, the loss of land and cultures which follows, and the struggle for survival, which has continued since. The construct of Aboriginality as its own unifying culture can only be defined then by one factor: the shared experience of colonialism (the construct of Aboriginality is further explored in the literature review, in chapter 2.2). By rejecting an ethnographic approach to the case study, I do not wish to argue that a cultural element does not exist in this case. On the contrary, I believe that the cultural element is highly complex, and is often tangled with the political process. Nevertheless, I do reject an existing tendency in the social sciences to accentuate the cultural element rather than the political when approaching political struggles that exist away from the mainstream (Bowman, 2007).

Applications of a single-case study methodology and the question of generalisability

The construction of the specific case study approach for this research was not an especially difficult task. Observing a single organisation over a defined period of time is a common example of a case study research (Gerring, 2007). According to Yin, “the case study is used in many situations to contribute to our knowledge of individual, group, organizational, social, political, and related phenomena” (2003, p. 1).

The question of generalisability is one of the main problems of a single-case study research. Can conclusions of a wider scope than the specific case study be made from a single case, despite the deep role of specific context and circumstances? Some see generalisability as not only possible in a single case study, but even as a main purpose of such methodology. Gerring, for example, defines case study as “the intensive study of a single case where the purpose of that study is – at least in part – to shed light on a larger class of cases (a population)” (2007, p. 20). Gerring then offers a distinct type of case study that focuses on a single case for its own purpose. Gerring defines this as a *single-outcome study*, in which generalisability may or may not be possible (2007, p. 187).

In a way, my research is a single-outcome study, as it seeks to understand the history of the ACCHSs movement in its own unique context. On the one hand, the research and its conclusions may be relevant to a larger number of cases, which may relate to community organisations, local/national grassroots health initiatives, and/or organisations. Yet I have a deep appreciation of the different contexts in which different cases may operate, which may give this research some aspects of a single-outcome study. I believe that some aspects of the research are more generalisable than others, and while some conclusions will be of relevance to other cases, other conclusions will be more focused on the particular study of this case, mainly the tracing of historical processes in the development of the national organisation of the ACCHSs movement (the conclusions are presented in chapter 8).

Stake (1995) offers another categorisation of case studies that is helpful for the discussion of the generalisability of this research. Stake differentiates between the *intrinsic* and the *instrumental* case study (p. 4). An intrinsic case study is a case study for its own sake, without necessarily leading to generalisable conclusions applicable to other cases. An instrumental case study, according to Stake, is designed for the purpose of generalising towards comparison with other cases. Following Stake, I identify this case study as an intrinsic one. I believe that, first of all, there is great value in studying this case study for its own sake, reconstructing events in the development of an important social movement with a strong emphasis on voices from within the movement itself. The use of documentation such as activist literature that was written during the time period in question provides unobtrusive, precise evidence (Yin, 2003, p. 80), which I find especially helpful in the construction of an intrinsic case study.

Yet an intrinsic case study does not mean that generalisations cannot, or should not, be made. I believe that acknowledging the uniqueness of the case, especially when discussing complex social subjects such as social movement organisations, is a basic condition for an informed discussion, which may lead to observe some commonalities with other cases. Furthermore, my first interest in the case study stemmed directly from my previous work and activism (as explored in chapter 1.4). The basic similarities between the Indigenous Australian context and the Palestinian/Bedouin contexts are strong. Both are indigenous populations whose society has been devastated by a process of colonialism. Much like my work in the past, the topic of this thesis involves the political aspects of health in a context of an indigenous struggle. There are vast differences between the situation of the

Palestinian Bedouin people and that of the Australian Indigenous people, but there are also some basic similarities. In other words, my first interest in the case study was to some degree created, intentionally or not, by a thought process of generalisation. Therefore, the more detailed the case study is, the larger the possibility that readers will find similarities to cases which they are more familiar with. By not forcing detailed comparisons in the limited scope of a thesis to case studies that occur in different contexts, I leave an open space in the argument for readers to compare this with cases and contexts more familiar to them. I follow Stake (1995), who wrote:

The real business of case study is particularization, not generalization. We take a particular case and come to know it well, not primarily as to how it is different from others but what it is, what it does. There is emphasis on uniqueness, and that implies knowledge of others that the case is different from, but the first emphasis is on understanding the case itself. (p. 8)

A similar approach is suggested by Donmoyer (2000), who argues that criticisms of the generalisability of a single-case study research rely on traditional perceptions of social science, a paradigm that has since been challenged. According to Donmoyer, “social scientists’ traditional, restricted conception of generalizability is consistent with traditional views of applied social science but inconsistent with more contemporary views” (p. 46). This traditional perception is also said to be “out of sync with contemporary epistemology” (p. 46). The tension between traditional perceptions and alternative paradigms is not dissimilar to that which occurs in the health sciences (as explored in chapter 2.1).

The roles of the case study researcher

As an undergraduate geography student, I learned that all maps of the world as we know it are inherently inaccurate, as they attempt to project a three-dimensional world onto a two-dimensional image. In a way, a qualitative thesis involves a similar limitation, as qualitative research attempts to project a complex, multi-layered phenomenon onto a single document. This is why qualitative research acknowledges rather than ignores the human element in the researcher, or the *human instrument* (Maykut and Morehouse, 1994, p. 26)

of the research process.

According to Stake, the case study researcher plays different roles, which “may include teacher, participant observer, interviewer, reader, storyteller, advocate, artist, counsellor, evaluator, consultant, and other” (1995, p. 91). Of course, not all of these parameters are always relevant, certainly not in this particular case study research. The relevance of different roles depends of course on the particular research and researcher. Yet I do identify with some different roles. For example, Stake defines teaching as “not just lecturing, not just delivering information; more, it is the arrangement of opportunities for learners to follow a natural human inclination to become educated” (1995, p. 92). As mentioned previously, it is a similar thought process, which Stake identifies as an inclination, which initially drew me to the case study.

Another one of Stake’s roles, which I strongly identify with, is that of an advocate. I fully agree with Stake who argues that “[r]esearch is not helped by making it appear value free. It is better to give the reader a good look at the researcher. Often, it is better to leave on the wrappings of advocacy that remind the reader: Beware” (1995, p. 95).

As discussed in more detail in chapter 1.4, the road to this specific case study research goes directly through my political activism in the struggle against the oppressions of Palestinians in my homeland. Through this involvement my interest in politics developed, as well as my world view. As a researcher and an advocate, it is my duty to be fully honest about my own subjectivity. My tendency is always to support struggles that revolve around creating a just, equitable society. This phrase can mean many different things, and I have some thoughts about my preferred interpretation of those terms. Nevertheless, I do not believe that there is always only a single way forward, and I have deep appreciation and curiosity about particular movements that have found new ways of advocating and creating social change. I need to be as honest as possible about my approach to the case study, because as discussed, without my subjective positioning in support of the basic goals of such struggles, I would have never approached such a topic and a case study.

This way, the role of an advocate is firmly connected to another role, that of the interpreter. Interpretation is the process of analysing a case study through the prisms of previous knowledge, “[f]inding new connections” (Stake, 1995, p. 97). The way I interpret the data

that is involved in this case study is inevitably influenced to some degree by my own positioning and advocacy.

These different roles of a case study researcher, of teacher, reader, interpreter, and advocate, were all parts of this research process. It is through these different roles that I fulfil my duty in this research process, which is to preserve the information about the history of this important movement, and make it more widely available.

3.2 The use of primary sources

According to Yin (2003), there are six main sources of evidence used in case studies: documentation, archival records, interviews, direct observations, participant-observation, and physical artefacts. This research has utilised most of these types of resources, with varying degrees of success, in terms of the suitability of the collected information to the specific inquiry. Here I wish to focus on some types of resources that I found particularly useful and rich in data through the course of my research: activist literature, mainly newsletters of the Redfern AMS, and various policy reports by state and federal bodies, some of which have never been officially released. I also conducted several interviews for this research, which added important insight to the process.

When I first approached this research, I was amazed at how little available literature exists on the political history and the development of the political/organisational aspects of the movement. A big part of the research process, which took place throughout the process and not only in the early stages, was a constant search for pieces of information and references to the movement, in books, articles, theses, and any other sort of documented information. This search consisted of many visits to libraries, second hand bookshops, and personal collections, across Australia. Some of these existing texts will be overviewed further in this chapter.

It is through these searches that I also came across much of the activist literature that

became a focal point in the data collection, mainly in newsletters, as well as a variety of policy reports, some of which remain officially unreleased. These sources, which are sometimes referred to as 'grey literature' (Luzi, 2000), turned out to hold very precious data and analysis, and became the sources of some of the main findings of this research. The main types of documents that I found, together with data arising from several interviews I held, will be overviewed in the rest of this chapter. An examination of the case study, as portrayed by the collected data, will take place in chapters 4-7.

Activist literature and alternative media

The most substantial evidence I found through the course of this research was literature and media resources written and produced by the activists of the ACCHSs movement themselves, offering an almost real-time commentary and discussion of their movement.

The search for documents included searches through a variety of libraries and archives, personal collections, and access to the library of the National Aboriginal Community Controlled Health Organisation (NACCHO). NACCHO is an organisation that was established to replace the main organisation in the centre of my case study, the National Aboriginal and Islander Health Organisation (NAIHO) (the relationship between NACCHO and NAIHO is explored in chapter 7.7). The access to NACCHO's documents was made possible thanks to the involvement of Dr Mick Adams, then chair of the organisation, in the supervisory panel.

While there were surprisingly few documents from NAIHO available at the NACCHO library, one of them in particular is worth a mention as an example of a particular piece of activist literature, which provides a unique source of information for a research such as this. The document depicts the evolving NAIHO Congress. The document is not dated, but appears to have its origins in the mid 1980s, with perhaps some revisions and late additions. The undated document, *Evolving the NAIHO Congress*, includes a detailed overview of NAIHO's philosophy, organisational concepts, commentary on specific events in the evolution of community controlled health services, and even a drawing representing the then-evolving NAIHO Congress (this document will be further explored in the

appropriate context, in chapter 7.1).

Yet the most substantial piece of evidence I came across is the *Aboriginal Medical Service Newsletter*, a publication that was issued by the Redfern Aboriginal Medical Service (AMS). In my data collection, I was able to gather 54 issues of the Newsletter, from 1973 until 1991. The Newsletter was edited (and probably largely written) by prominent and influential figures not only in the community-controlled health services, but also in the land rights movement and the broader Australian society (although the identity of the editor is not always mentioned). Editors of the Newsletter included notable academic and activist Roberta Sykes (editor in 1973-1974, 1977-1978), who stopped editing the Newsletter when she left for her PhD studies at Harvard; activist and historian Gary Foley (1975-1976, 1979-1983), who remains today a highly influential voice of the movement; and John Newfong (1981), a prominent journalist who was also an editor of *Dawn* magazine.

The issues I found were mostly located in the collections of three libraries, the Australian National Library, the New South Wales State Library, and the library at the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS). When I found a copy of the first AMS Newsletter at the National Library in Canberra, the Newsletter was stuffed with other Newsletters in a dusty file. The page of the first edition itself, which was the only edition printed on a single page, was not in a good condition, and the page was starting to decay. At the bottom, the decay of the paper almost reached the written text, near Sykes's signature. It is crucial for such unique documents to be preserved.

The AMS Newsletter, though under the name of the Redfern AMS, gave platform to NAIHO's politics and national-level issues of relevance to the ACCHSs and the land rights movement as a whole. An indication of the national rather than local scope of the Newsletter is that for some years, the Newsletter was written and edited by Gary Foley, who had already moved to Melbourne by the mid 1970s.

These Newsletters provide a unique source of information. They include commentary and analysis by activists writing in real time from within the movement itself. The Newsletters, in both their style and their role, are not dissimilar from utilisation of more current mass communication technologies, such as blogs. The Newsletters were then also a form of

independent/alternative media. The sheer volume of information that I accumulated from the Newsletters, much of it including references and reproduction of relevant documents and mainstream newspaper articles, meant that these Newsletters became a main source of information in the case study. Much of the information presented in the Newsletters is not available elsewhere. Moreover, the Newsletters themselves have been almost untouched by either health policy or Aboriginal history researchers until now. It is also an indication that resources that are based in social movements and not in academic or professional bodies are often considered inferior. For this reason, it is worth examining the definition of the terms alternative media and activist media, and examine it as a potential resource for valuable information.

The term 'alternative media' does not have a clear definition, and there are differences of opinion regarding the definition of 'alternative' in this context. Waltz offers a simple and broad definition of the term alternative media:

media that are alternative to, or in opposition to, something else... in situations where a variety of mass-media products is available, those media that provide a different point of view from that usually expressed, that cater to communities not well served by the mass media, or that expressly advocate social change would meet this very basic definition. (2005, p. 2)

Activist media, according to Waltz, is likely to correspond to the definition of alternative, but it also sets out to “encourage readers to get actively involved in social change” (2005, p. 3). Furthermore, according to Waltz, “[s]ocially marginalised or dissenting groups, subcultures, ethnic minorities, and others who inhabit liminal spaces in mainstream cultures may be most likely to seek out alternative media, and to create their own if it is not found” (2005, pp. 7-8). In other words, it can be said that activist media as a term offers a particular perspective into the way alternative media is perceived by those activists who produce it (Coyer Dowmunt and Fountain, 2007).

From this perspective, the establishment of alternative media is not dissimilar to the main act of the case study – creating much needed services (critical media, health services) where no sufficient ones are found. This makes such media a key resource in understanding the social movement from which they emerge.

The production of alternative media then is a conscious, 'grassroots' (Waltz, 2005, p. 1) political act. According to Coyer, Dowmont and Fountain, "[t]he political nature of alternative media is often present irrespective of content, located in the mere act of producing" (2007, p. 4). This is why many alternative media sources, including the AMS Newsletter, are/were open about their political tendencies. It can be argued that all types of media, by definition of their use of knowledge, hence power, are political. Alternative media then tends to be more honest about its own political stand in comparison to the mainstream media, both public and corporate. These often hide their politics under the guise of a supposedly objective, de-politicised, mainstream consensus.

In the context of the AMS Newsletter, its political role included both internal and external elements. The Newsletter served a function of keeping ACCHSs and their supporters around Australia informed about various issues, as well as a call for donations (see chapter 4.6 for a detailed discussion of the role of the Newsletter). The experience of slowly reading through the collection and learning the unfolding history of the movement from the pages of the Newsletters was a riveting experience, which offered information and points of view I could not have received elsewhere. The advantages of using documents, as detailed by Yin, became apparent: the stability of documents, their unobtrusive nature, preciseness, and scope (2003, p. 86). Furthermore, I agree with Stake, who writes: "Quite often, documents serve as substitutes for records of activity that the researcher could not observe directly. Sometimes, of course, the recorder is a more expert observer than the researcher" (1995, p. 68). I wish to reiterate, that this is the case with my research. Authors of documents such as the AMS Newsletter, and some of the policy reports which I accessed, are greater 'experts' than me. And how can they not be? Authors of these documents lived and created the reality that I, several decades later, am trying to retrace. In fact, I had no previous knowledge of the movement before moving to Australia in 2007 (as discussed in chapter 1.4-5).

A heavy reliance on activist literature does not come without dangers. The issue most often brought up against activist literature is its non-objective positioning towards a topic. There is no doubt that this is the case – and in fact, activist literature would rarely try to hide the predisposition of its writers. Availability of resources may cause a selective bias, and a reporting bias of the authors of the documents (Yin, 2003, p. 86). The question of bias is ultimately linked to epistemological questions about the nature of truth and validity of

experience. As this research features activist literature, this question is especially pertinent. This is why I emphasise my personal positioning (in chapter 1.4), offer a detailed account of the development of this research (1.5), and discuss the application and limitation of my data set (in this current chapter).

The main weakness of activist literature then can also be seen as its most important strength: its unique positioning offering an account of a series of events from a unique perspective. Any unique perspective is inherently biased, and this bias should be remembered. Although this bias is in itself very important to document – the unique perspective on a series of events as documented by the participants. How can someone so invested in a topic not be biased in her or his approach? Such open approach to bias is often associated with a hermeneutic approach to texts, which seek to shed light on the process of interpretation as a key part in understanding the text itself (Van Manen, 1997). A hermeneutic approach to a text demands the same level of attention and examination to familiar and unfamiliar parts of a text (Patton, 2002). A hermeneutic approach to texts then “reminds us of the interpretive core of qualitative inquiry, the importance of context and the dynamic whole-part interrelations of a holistic perspective” (Patton, 2002, p. 498).

An important introspection was expressed by Foley, who wrote: “As a participant in most of the events discussed, I have both the advantage of first-hand knowledge and the disadvantage of the constraints imposed by the inherent subjectivity of such a position...” (Foley, 2001). My own bias and subjectivity is therefore presented in chapter 1.4. By being open about my own positioning and bias then, I wish to negate the effect of the inevitable bias.

The activist literature used in this research is very open about its own positioning and subjectivity. In fact, the specific point of view of the activists in the early days of the movement was a significant part of the development of a shared consciousness, on which the movement was based.

Together with the openly biased positioning, the Newsletters did in many cases show evidence to support their arguments, including references to and reproductions of media items, policy reports, communications, and other documents.

Policy reports

Of the different types of documents gathered in the course of this research, after activist literature, policy reports were the second most prominent group. I came across a variety of policy reports, often from reading references in the activist literature. Policy reports were and remain a key part of the process of policy making, and as such often draw public attention and may be used in a variety of ways by both policy makers and the general public. Some reports can present very important information regarding a specific social issue or phenomenon, but often policy reports are either not adopted, or implemented with such deep changes that may not reflect the original intent of the authors.

In the context of the case study, there has been wide disillusionment regarding policy reports. As Ring and Brown neatly argue, “[i]f policies and strategies and frameworks made people healthy then Aboriginal people would possibly be the healthiest people in the world” (2008, p. 2)

The variety of policy reports I came across include both released and unreleased documents, commissioned on both state and federal levels. One of the interesting unreleased reports which I came across was a Program Effectiveness Review (PER), written by a committee appointed in late 1979 by the then PM Malcolm Fraser, in order to re-evaluate funding agreements to be allocated for Aboriginal health. The report of the findings and recommendations of this committee was eventually suppressed and was never officially released. Through the activist literature, I learned about the existence of the PER, but also about the role which the PER played in the development and changes which the ACCHSs movement went through in the 1980s. A presentation of the findings regarding the PER is detailed in chapter 6.

The PER report is but one of many different types of reports into various aspects of the health of Aboriginal people. Such reports have become main features of Aboriginal health politics in Australia. Commissioning a report is often a popular move, which may in effect allow politicians and bureaucracies to stall on more direct action (Rochon and Mazmanian, 1993). Many reports are conducted by committed people and offer invaluable insight into the specific social and economic conditions of the time. Many reports are not implemented,

or even released, despite their intellectual value. Often, by the time a report is issued, a whole new set of items are on the political agenda, perhaps after a change of Minister or whole Government, and many remain only selectively implemented, if at all.

A more recent controversial selective implementation of a report is the Northern Territory Emergency Response (NTER), which followed the June 2007 release of the *Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse*, also known as the *Little Children Are Sacred* report (Wild and Anderson 2007).

The NTER includes far-reaching measures, many of which revolve around forced external governance in Aboriginal communities throughout the Northern Territory (Australian Indigenous Doctors' Association and Centre for Health Equity Training Research and Evaluation UNSW, 2010). The NTER has been criticised since its inception by many in the Aboriginal health field from the early stages of implementation, including by the writers of the report (Adam and Concerned Australians, 2010). Despite this, both the Coalition and the Labor Party supported the NTER, and the policy largely remains in place today.

Many reports are commissioned as a response to a rise in activism around a certain issue, such as the 1991 *Royal Commission into Aboriginal Deaths In Custody*, which was a result of a sustained campaign by Aboriginal groups and organisations (including the Aboriginal Legal Service), families of people who died while in custody, and supporters (Royal Commission into Aboriginal Deaths In Custody, 1992; Cunneen, 2008). Despite the publicity, most of these recommendations remain not fully acted upon, and the main issues remain unresolved (Cunneen, 2008).

The politics of reports on Aboriginal people's health and well-being (and consequently policy) is almost as old as colonisation itself. In 1837, the *Aborigines Protection Society* printed a report by a British *Parliament Select Committee on Aboriginal Tribes*. The report examines the states of Indigenous peoples throughout the British colonies, and included chapters on *New Holland* (mainland Australia) and *Van Diemen's Land* (Tasmania).

The report includes many insights into the effect of contact and colonisation on Aboriginal people as appeared in the 1830s. The report acknowledges that "[i]n the formation of these settlements it does not appear that the territorial rights of the natives were considered" (p.

10). The report further acknowledges that “many natives have perished by the various military parties sent against them” (p. 10), yet there was already an established understanding that “it is not to violence only that their decrease is ascribed” (p. 10), but to the actual contact with colonisers and the destruction of social structures.

The report recommended, among other things, that “every inhabitant of that vast island is [to be] under the defence of British law as often as his life or property may be attacked” (p. 126), and that Aboriginal people should be held “to the same responsibility, and to the same penalties, as if the sufferers were white persons” (p. 126). Such issues of legal and social inequalities, which are an important part of the context of policy formation, remain contested today.

Reports on the poor social and health conditions in Aboriginal communities gained more public attention, thanks to publications such as the trilogy of books by C.D. Rowley in the early 1970s (1970a, 1970b, 1971). Yet some important research remained unpublished at the time. A suppressed report from 1972-1973 provides a good indication of the immediate impact of the Redfern AMS on the growing Aboriginal population in Sydney. The report, *Problems and Needs of the Aboriginals of Sydney*, was presented to the Minister for Youth and Community Services in NSW in March 1973. The report was commissioned by the Minister and was conducted by *W. D. Scott And Company*, a private management consultant firm. Despite its suppression, copies of it circulated and now exist in some libraries. The report focuses on Redfern and additional suburbs, and is based on 778 interviews with ‘Aboriginal households’ (1973). Among other things, the report offers a good indication to early effectiveness of the Redfern AMS. The relevant findings of the report are discussed in detail in the findings section, in chapter 4.4.

Interviews

At the start of the research project, it was projected that interviews would become a main source of information. For a number of reasons, the interviews conducted, although very informative and helpful, became an additional resource, rather than the main one. The first reason is that some of the key players were unavailable to be interviewed, for a variety of reasons. Some were reluctant to discuss the events of the case study. Others unfortunately have passed away. As previously explained, the limited scope and funds of a PhD research project, together with the strict limitation on the duration of the research due to visa constraints (as discussed in chapter 1.5) were further limitations on the number of interviews held. Eventually, five interviews were conducted, as well as several other informal conversations with people who wished not to be named or quoted directly. The conduction of interviews was approved by *The University of Western Sydney Human Research Committee*, and interviews occurred after the approval of the application, from July 2009 to July 2010.

The information gathered in those interviews offers some unique perspectives and fills some important gaps in the development of the story of the case study. However, the information gathered in the interviews was not in itself substantial enough to base this research on. As I realised that interviews were not necessarily be the main source of information for this thesis, I discovered a wealth of detailed information in documents, including activist literature and policy reports, as detailed earlier in the chapter.

The interviews which were held included: Mick Adams, former chair of NACCHO who was also a member of the supervisory panel in the early stages of this research (interview in March 2009, and several other discussions throughout the research process), Gary Foley (July 2009), Sally Goold, the first nurse to work in the Redfern AMS (April 2010), and Joan Maero, who was involved with a variety of community organisations in Adelaide in the early 1970s (July 2010). One more interviewee, a leading figure in the field, asked not to be identified. In addition to these in-depth interviews, I held several informal and informative conversations with a variety of people who are, or were, involved with the movement.

As discussed earlier in the chapter, the research process was planned in a cyclical way, which allowed me to re-evaluate the sources of information and research plan at several points throughout the process. This process allowed me to remain flexible with my use of resources, utilising the data as it emerged from the data collection, even if it did not fit the initial plan, which had projected a bigger reliance on the interviews rather than documents

The following four chapters discuss the development of the Aboriginal community-controlled health services (ACCHSs) movement, using the data that has emerged from the data collection process (as discussed in chapter 3.2). As previously explained, the focus of the thesis is on the national level of the movement, and in particular, its umbrella organisation, the National Aboriginal and Islander Health Organisation. Yet for an in-depth understanding of the national level of the movement, I feel that it is important to dedicate the first chapter of the findings to the development of the first ACCHS, the Redfern Aboriginal Medical Service (AMS).

The four findings chapters present a chronological and thematic investigation of the data I collected in my research. Keeping a chronological framework was an important way to sort through the data and establish some of the processes in the development of the ACCHSs movement and NAIHO. However, some deviations from the chronological flow are inevitable in order to explain the findings in an appropriate context. The themes that are presented stem from my interpretation of the findings, and correspond with the themes discussed in chapter two: the politics of health and health-care, the concept of community control, and the particular context of the Aboriginal struggle in Australia.

Chapter four discusses the development of the Redfern AMS, the first ACCHS. The chapter presents findings in regards to some major themes which I identify from the findings, and includes a discussion about the actual process of development in the context of Redfern in the early 1970s. The chapter then looks at the issue of funding, which emerged as a main theme throughout the research. The chapter also includes a discussion of Redfern AMS's relations with the Department of Aboriginal Affairs (DAA), the federal government, and also international relations.

It is important to emphasise that each ACCHS is unique, and each can be a topic of research in its own right⁵. The particular focus on the Redfern AMS is needed due to the Redfern's influence on the national development of the movement. It paved a way to the services that followed, and assisted other communities in developing their own services. In addition, the Redfern AMS played a leading role in the formation and the politics of NAIHO.

The final part of the chapter examines the development of other ACCHSs that followed Redfern in the early 1970s. This provides a link to chapter five, which focuses on NAIHO's development in the mid-to-late 1970s. Chapter five explores some similar themes in NAIHO as are explored in the context of the Redfern AMS: the issue of funding, relations with mainstream political structures as well as other social movements. The chapter also includes sections that discuss specific themes to the findings of NAIHO: a discussion of NAIHO's philosophy, the development of the role of Aboriginal health-workers, and NAIHO's involvement with the National Trachoma and Eye Health Program.

Chapter six focuses on one of the main themes that emerges from the findings, a Program Effectiveness Review (PER) on Aboriginal Health that was commissioned by the Fraser government in late 1979. The politics around the process of the review and the confrontation between NAIHO and the federal government following the suppression of the report are in particular focus. The end of the chapter discusses some breakthrough, which was achieved through the Victorian and NSW governments.

The discussion of the developments in the state level provides the link to chapter seven, which discusses the demise of NAIHO as emerges from the findings through the mid-to-late 1980s, and eventually the formation of the National Aboriginal Community Controlled Health Organisation (NACCHO) in 1991. Some of the main themes of previous chapters continue, with discussions of NAIHO's relationships with the DAA, the federal and State governments, and international relations in that period, as well as a discussion of changes within NAIHO's internal structures. Some of the themes that are particular to this period

⁵ Too little research has been done on the history of particular ACCHSs. There have been studies of the history of some of the early services, such as Nathan's (1980) study of the Victorian Aboriginal Health Service; Best's (2003) thesis about the Brisbane Aboriginal and Islander Community Health Service; and a study exploring the first decade in the development of the Central Australian Aboriginal Congress (Rosewarne et al, 2007). The Katherine West Health Board released a booklet detailing its own history (2003), which provides an interesting perspective into a formation of a later service.

include NAIHO's involvement with the Brisbane Commonwealth Games of 1982, and the politics around the development of the National Aboriginal Health Strategy in 1989. The chapter finishes with a discussion of some more recent findings regarding NACCHO and its relationship with the federal government.

In order to emphasise my own role as a presenter and interpreter of the findings, I often chose to present lengthy quotations. By doing this I wish to offer the reader a more direct presentation of the findings, in a way that also preserves much of the context and complexity of processes discussed.

Some sections of documents that are of particular relevance and insight are presented in text boxes, and some images from the findings are also presented.

Chapter four: the development of the Aboriginal Medical Service in Redfern

This chapter is the first of four chapters that overview the findings of the research. The chapter explores the development of the first Aboriginal community-controlled health service (ACCHS), the Redfern Aboriginal Medical Service (AMS). In order to situate the development of the Redfern AMS in an appropriate context, the chapter starts with a background of some of the ideological influences on the movement, and the development of the Aboriginal Legal Service in Redfern, which played a big role in the establishment of the AMS. The chapter ends with an overview of the early national spread of the movement, which then links to the next chapter and the discussion of the formation of the National Aboriginal and Islander Health Organisation (NAIHO).

4.1 Background: ‘Black Power’ in Australia

The period shortly after the 1967 referendum may be described as a ‘changing of the guard’ in the Aboriginal political movement. The generation that fought for equal civil rights and acceptance of Aboriginal people into the wider Australian society saw the rise of a new generation of young activists, influenced by and connected to global anti-colonial movements of the time. This new generation of the movement was influenced, among other things, by the African-American struggle for political and economic independence, also known as the Black Power movement, with the *Black Panther Party* as one of its leading political organisations (Hilliard, 2007).

The influence of the Black Power movement even brought an establishment of a *Black Panthers of Australia party* in December of 1971 by Dennis Walker (Foley, 2001; Lothian, 2005), who was also later involved with the ACCHSs movement and NAIHO. Although

the ‘made-for-media’ party (Foley, 2001) did not develop into a major political platform as such, it received some public attention, and some of its activists were involved in other organs of the land rights movement, as well as the ACCHSs. In their platform, the *Black Panthers of Australia* concentrated on demands such as housing, stopping police brutality, and equality in treatment by the legal system (Black Panthers of Australia, 1999/1970). Its first point simply states: “We want freedom. We want power to determine the destiny of our Black Community. We believe that Black people will not be free until we are able to determine our destiny” (Black Panthers of Australia, 1999/1970, p. 252). According to Lothian (2005), while the actual *Black Panthers of Australia Party* was not very significant itself, the influence of the US Black Panthers is far wider, and its main influence was the actual empowerment that contributed to the galvanisation of a national land rights movement. That movement used some of the methods pursued in the United States, such as the concept of community-controlled (or community survival), overtly political service delivery organisations.

Kevin Gilbert, in his seminal book *Because A White Man’ll Never Do It* (1973), draws on the influence of the Black Power movement from the United States. According to Gilbert, it is the disillusionment that followed the 1967 referendum that provided the main drive behind the influence of the Black Panthers movement in Australia:

The disillusionment after 1967 hit hard. It is little wonder that younger, more literate blacks began to search for their values in the literature of the Black Panther movement of the United States. They read somewhere about how some white fat cat reckoned that Australia was a ‘lucky country’ and said ‘Yea, for the gubbahs⁶’.
(Gilbert, 1973, p. 101)

Another activist who emerged as one of the leaders of the movement from this period onwards is Gary Foley. Of the Black Power movement in Australia, Foley wrote that “the Australian version of Black Power, like its American counterpart, was essentially about the necessity for Black people to define the world in their own terms, and to seek self-determination without white interference” (Foley, 2001).

⁶ A definition of Gubbah (sonetimes spelled Gubba) was offered by Dr Bill Robert in the December 1985 edition of the AMS Newsletter: “Gubba – originally derived from the term “gubbermen man”, because initial contacts with white men were those bringing orders from the government of the day, and so all white men came to be called “gubba”, which is essentially seen as a term for those who oppress” (p. 31).

From the early stages of the post-referendum land rights movement in the late 1960s, there seems to be ongoing positive connection of solidarity and support with other Indigenous struggles, perhaps mainly with Indigenous peoples in wealthy English-speaking countries, mainly New Zealand, Canada, and the United States. Yet the influence of the African-American Black Power movement seems to be more profound. A possible explanation is that the African-American struggle for civil rights had a more direct political relevance to the Aboriginal civil rights movement in Australia. During these days of the late 1960s, the African-American struggle was at its peak, with leaders such as Malcolm X making a big ideological impact worldwide, including among Aboriginal Australians. The Native American movement was at a very different stage however at the 1960s, and the tide of the Indigenous movement in the United States was not nearly as high as that of the African-American movement.

Roberta Sykes distinguishes the Australian manifestation of Black Power from the American one. In the United States of America, Sykes identifies two main opposing types of Black Power: 'Blood and Guts', and 'Black Capitalism', the first being the sensationalised presentation of Black Power activists, and the second being of the emerging layer of "blacks struggling to join the ranks of the oppressors" (in: Turner, 1975, p. 9). The Australian Aboriginal manifestation of Black Power differs from both, according to Sykes, and constitutes a stream of 'Black Action' that is defined as "action in all possible forms to solve [our] problems" (in: Turner, p. 10). Gary Foley wrote of the way in which the concept of Black Power came into use by Aboriginal people in Australia:

The term was catapulted into the Australian imagination when the Victorian Aborigines Advancement League (AAL) under the leadership of Bruce McGuinness and Bob Maza who, galvanized by the same notions as Malcolm and Stokely, [in] 1968 invited a Caribbean activist and academic, Dr. Roosevelt Brown, to give a talk on 'Black Power' in Melbourne. The initial result was frenzied media overreaction that was closely observed by younger activists in Brisbane and Sydney, thus the term came into use by a frustrated and impatient new indigenous political generation. (Foley, 2001)

The more radical wing of the land rights movement emerged mainly in the large urban

centres, such as Melbourne and Sydney. The increased move into the cities (the background of which is discussed in 2.2) had several results. An interesting observation and analysis of such changes was made in the Scott report, which was conducted in 1972, handed to a NSW minister in 1973, and was never officially released. One section in the report observed several results of the increased urban Aboriginal population in Sydney, and is presented in Box 1.

Box 1: Social trends in Redfern identified in a 1972 survey

- More political and social awareness.
- A modification of former allegiances based largely on family networks, in favour of broader based identification with other Aboriginals.
- A growth of a black intelligentsia who may be able to offer leadership to other Aboriginals.
- An increase in economic and social mobility, particularly through education.
- On the one hand, more Aboriginals moving into white society; on
- the other many Aboriginals forging stronger links with their Aboriginal past.
- More conflict and jealousy within the community as differential opportunities appear
- More discontent and frustration as the level of Aboriginal expectation rises.

(Scott, 1973, p. 5)

These observations provide some of the context from which the Redfern AMS developed. It is this context of increased political awareness and organisation in light of increased frustrations and disillusionment from existing structures in which important community organisations developed into nation-wide movements.

4.2 The Aboriginal Legal Service

In this context drawn by the Scott report, Redfern at around the turn of the decade was one of the main suburbs in which Aboriginal people settled and joined the local community. In Redfern of 1970 (and for many years to come), police harassment of Aboriginal people was commonplace (Fagan, 1990). In this context, community activists including Paul Coe and Gary Williams (Foley, 1991) organised with support and advice of sympathetic non-Aboriginal legal experts (among them, Professor Wooten, then Dean of the Law School of the University of New South Wales, according to Eggleston, 1977, p. 353), to establish a

legal service for the local Aboriginal community. The Aboriginal Legal Service (ALS) opened its shop-front service in Redfern in 1970, pioneering the concept of community control (Eggleston, 1977, p. 353), and staffed with volunteer lawyers (Foley, 1991).

The ALS was not necessarily the earliest attempt at an Aboriginal community-controlled institution: community controlled adult education in Aboriginal communities can be traced back as early as 1958, with the establishment of the Tranby College in Glebe, another inner-western suburb of Sydney (Durnan and Boughton, 1999). The establishment of community-controlled educational facilities happened in the context of the civil rights movement, a decade before the Black Power movement enabled the establishment of the ALS, and later the AMS.

A major changing point for the ALS movement came with the election of the Labor government in 1972. A part of the ticket on which Labor contested the 1972 elections was the inaction of the previous Liberal government in trying to implement its new perceived federal responsibility for the Aboriginal people, as a result of the referendum and the growing Aboriginal self-determination movement. According to Eggleston, this election result:

completely transformed the scene. The Labor Party's pre-election speeches included the promise that any Aboriginal appearing in court would be supplied with legal representation. The new government honoured its commitment by including in the budget for the period ending 30 June 1973 the sum of \$850,000 for Aboriginal legal services. (Eggleston, 1977, pp. 354-355)

One major change, which Whitlam enacted, was the construction of the Department of Aboriginal Affairs (DAA), which was to replace the previous government's smaller scaled Office of Aboriginal Affairs. The DAA was to be the main channel for funding Aboriginal-related projects. Collmann further commented that, "[a]s general advocates and active practioners (sic) of self-determination, the ALS personnel regarded themselves as the vanguard of the DAA's program and were often dedicated, highly committed activists" (1981, p. 50).

The ALSs experienced substantial growth within the first five years of the establishment of

the first service in Redfern in 1970. The Redfern ALS inspired the establishment of similar legal services in Adelaide in November 1971 and Melbourne in June 1972 (Eggleston, 1977, p. 355). By the time of the first national conference in Canberra (on September 4 1973), similar services had opened in Townsville and Perth, and by 1974, services were established in all states as well as the Northern Territory (p. 355).

The concept of the ALS, in which a community board is in charge of the service and the relationship with non-Aboriginal (legal) experts due to the lack of Aboriginal qualified lawyers at the time, was not that of clear hierarchy between the professionals and the community. The influence of this concept was deep. According to Collmann, “[t]he Aboriginal Legal Service program was perhaps the major showpiece of the self-determination policy” (Collmann, 1981, p. 49), or at least a breakthrough tactic.

The breakthrough tactic of the new ALSs generated an unexpected response from the federal government. According to Eggleston, an unexpectedly large financial contribution from the federal government had some strong negative effects on the ALS movement:

The finance which has been provided by the federal government was beyond the wildest dreams of those who participated in setting up the original services. But money does not solve all problems. It may be that the sudden accession of wealth has fundamentally changed the nature of Aboriginal legal services and rendered them less capable of achieving some of their basic aims. (Eggleston, 1977, p. 355)

The flow of funding changed dramatically from the 1980s, for a variety of reasons, which are not unrelated to the changes that the ACCHSs movement went through, as will be explored further in chapters 6-7. The ALSs established a national organisation, the National Aboriginal and Islander Legal Services Secretariat (NAILSS), which, much like NAIHO, is very poorly documented. Unlike the ACCHSs movement, the ALS movement largely did not survive. The first ALS in Redfern closed in 1996. According to Hulsker (2002), the reasons for the ALS closure in 1996 included its firm political stands. Among those, an unsuccessful legal challenge to *terra nullius* (ten years before the historic ruling in the Mabo case in 1992) and a challenge to the NSW Land Council over the existing structure of land rights, and arguing for control of the actual traditional owners rather than the Land Council, which is funded by the state (Hulsker, 2002). Other reasons for the

closure of the Redfern ALS observed by Hulsker were a dwindling community support base and changes of policy of the Howard Coalition federal government (elected in 1996). The ALS was replaced by the Sydney Regional Aboriginal Corporation Legal Service, in which most clients have to pay to meet private solicitors (Hulsker, 2002). The change of conditions in the 1980s, which eventually led to the decline of the ALS movement and to changes in the ACCHSs movement, will be explored in the latter movement's context in chapters 6-7.

Back in Redfern in 1971, a year after the establishment of the ALS, its activists had faced the grim everyday reality that many in the Redfern community share. One of the ALS activists, Gordon Briscoe, wrote of how the experiences of the ALS led to the establishment of the Aboriginal Medical Service:

In June 1971 Mrs. Shirley Smith, another Aborigine, and I went to a house in Redfern on some business related to the Aboriginal Legal Service. When I arrived the person whom I went to see was very ill; so ill, in fact, that he was unable to speak to me. I asked his family if they had called a doctor and the answer was that they could not afford it. I left the house appalled and disillusioned in two ways: firstly, because I was working for the improvement of my people, who have no hope; and secondly, because through white prejudice and racist attitudes, Aboriginal people have been and are being denied the right to receive benefits, and have been suppressed and alienated. (Briscoe, 1974. p. 167)

This particular encounter gives a strong sense of the urgency in setting up grassroots health services at the time. Following this encounter, the Redfern AMS was conceived.

4.3 Establishing the Aboriginal Medical Service

Following the description of the encounter with a dying ALS patient, Briscoe initiated an open meeting to discuss ideas to directly address the urgent health needs in the community.

Briscoe recalls the meeting:

[I]n July 1971⁷, I called together a group of interested Aborigines and white people so that we could pool our ideas. The meeting took place in Redfern at the South Sydney Community Aid and it was attended by about six Aborigines and about the same number of interested whites. At the meeting, the Aborigines put forward general thoughts on health problems that we had advocated previously based on research findings. Emphasis was given to the high concentration of Aborigines in Redfern and the fact that this group was becoming or had become a self-perpetuating 'sub culture of poverty' which, if not checked, would become increasingly difficult to overcome. (Briscoe, 1974. pp. 167-168)

Foley recalls the attendees of the first meeting, which included “Paul Coe, Shirley Smith, Gordon Briscoe, Dulcie Flowers, Professor Fred Hollows, Ross McKenna, John Russell of South Sydney Community Aid, and Eddie Neumann of the A L S” (Foley, 1991. p. 5). Some of these early meetings, which decided to establish the Redfern AMS, were hosted by the Foundation for Aboriginal Affairs (AMS Newsletter, 8-11/1981, p. 17).

In his autobiography, Professor Fred Hollows recounts his involvement with the early days of the Redfern AMS. Following the establishment, Hollows played an important role in supporting and working with both the Redfern AMS and the ACCHSs movement that soon followed. Hollows attended the first meeting, which was initiated by Gordon Briscoe, after being approached by Ross McKenna (Hollows and Corris, 1991). Hollows was not fully aware of what the meeting was about, except of it being related to the ALS.

It was a small group – two or three whites, three or four Aborigines – and to my surprise they were talking about medical matters. There were no doctors or nurses in the group, I was the only medico present and it was impossible not to be interested in what they were saying in general and in particular. In general, the legal service was getting swamped by people with a whole range of social and medical problems. In particular, they were talking about a case in which a sick Aborigine had died in the back of Gordon Briscoe's car. Gordon Briscoe was a field officer with the legal service... Briscoe was at the meeting along with Shirley Smith,

⁷ Both Foley (1975, 1991) and Hollows and Corris (1991) date the first meeting in late June.

'Mumshirl', who's done a lot for Aborigines over more than thirty years, and Gary Foley, and they asked me if I could help them set up a medical service for blacks. I said that whatever lawyers could do doctors could do, and I agreed to talk to a few people. (Hollows and Corris, 1991, pp. 99-100)

At the following meeting a week later, forty people attended, approximately half of which were members of the local Aboriginal community (Briscoe, 1974). In the second meeting, some of the important practical ground work for the setting up of the AMS was discussed. Hollows describes the second meeting in his autobiography:

Next Friday there was another meeting, better attended. The Aborigines started to outline the case for a medical service and they were utterly convincing: blacks weren't welcome in doctors' surgeries, they got pushed to the back of the line in Casualty wards and public hospital clinics and so on. Paul Beaumont stood up and he said, 'You only need six things to start a medical service. Doctors, Fred and I can get the doctors; premises, Len Russell can organise that; Aboriginal receptionists and managers, Shirley Smith can find them; publicity in the pubs and shops, Ross McKenna can do that; and transport, Eddie Newman can handle that' ... Everyone there saw that he was right and they got very excited. Someone said, 'When can we start?'. Someone else said, 'Monday night.' I said, 'Whoa, it might take a bit longer than that.' But in fact we opened just ten days later. (Hollows and Corris, 1991, p. 100)

According to Briscoe, the meeting reached the following decisions:

- *To set up a clinic to be staffed by voluntary doctors*
- *To locate and employ a full-time Aboriginal nurse*
- *To encourage the use of a voluntary Aboriginal field officer and also a roster of secretaries and receptionists*
- *To establish a roster of interested people with vehicles to act as drivers.*

(Briscoe, 1974. p. 168)

Hollows describes some of the logistics in the first days of operation, with high need and no funds: "So we went ahead. We plundered the Prince of Wales Hospital for equipment –

stethoscopes, thermometers, scales, all the accoutrements of a medical practice, we shamelessly stole” (Hollows and Corris, 1991, p. 101). Hollows quickly realised another problem: even if people in Redfern were now to have better access to a doctor, they still could not afford to buy medicine. Sykes observed that “Doctors were expected to bring their own instruments and equipment and also supplies of drug samples that came into their hands” (Sykes, 1989, p. 190). Hollows recalled:

We backed a truck up to the pharmacy at the hospital and loaded it half full – tens of thousands of dollars worth of pharmaceuticals. It wasn't always a matter of clandestine raids, there were some sympathetic people around. Pretty soon we had more doctors, GPs, specialists, professors of this and that, volunteering their services than we could handle. (Hollows and Corris, 1991, p. 101)

The Redfern AMS first opened its doors on July 20, 1971 (“Aboriginal Medical Service”, 1971, p. 6), “in a small shop front at 171 Regent Street, Redfern. The staff of the first clinic included one doctor, one Aboriginal sister, one Aboriginal field officer and one Aboriginal receptionist” (Foley, 1975, p. 38). The first doctor to be employed full time in the Redfern AMS was Dr Ross Macleod (out of ten applicants), and the second was John Mackay (“Expanding the medical service”, 1973, p. 3).

Sister Sally Goold was the first nurse to work in the Redfern AMS. She was a young Aboriginal nurse at the time that had moved to Sydney, and was then approached by Fred Hollows and Dulcie Flowers (interview with author, 2010). Goold tells that work in those days was “particularly difficult, because we had no equipment, we had no stock, we rented the downstairs area of a shopfront of a building in Redfern... and we had nothing, nothing. The doctors used to come in their own time after finishing their day’s work”. Her own salary was paid by the ALS, which is a further indication of the deep connection between the two organisations, especially in those formative years.

The Redfern AMS addressed the issue of the state’s responsibility for social services and the role of the AMS in relations to the state, in the first issues of its Newsletter (the role of the AMS Newsletter is discussed in chapter 4.6): “We are often told that it is the duty of the Government to do something about ‘us’. Well, we waited two hundred years, we couldn’t wait any longer. Now, we are doing something about us” (AMS Newsletter, 1, 1973).

The rise of the Aboriginal Medical Service in Redfern then, was enabled by several elements that have been examined, and are summarised below:

- Sudden change in socio-geographic conditions, mainly caused by mass migration from missions to urban centres following the 1967 referendum and related political changes.
- High need for social services
- Inaccessible and inappropriate existing services
- Support by other grassroots community initiatives, which combined activism with service provision, the Aboriginal Legal Service.

Briscoe discussed some of the main difficulties of organising in this context:

To organize any voluntary action programme is an exceedingly difficult task. But to organize a voluntary action programme amongst a 'sub culture of poverty' is an even greater task. Because this level society is an alienated group whose authority and leadership structure has been destroyed, there is very little incentive to be committed to any organization, and there is a noticeable lack of community motivation or goal orientation. (1974. p. 168)

It is in this context in which both the AMS and the ALS, according to Saggars and Gray, “saw their charter as encompassing political activism, and both attempted to foster Aboriginal modes of operation – their structure and management reflected this desire” (1991a, p. 178). The development of community organisations can perhaps be seen as an application of traditional social structures in a modern political context. As shown previously in the chapter (see Box 1), the Scott report (1973) identified both an increase in political awareness and reaffirmation of traditional social structures as formative social trends in Redfern at the time.

4.4 The first two years

One of the many issues that had to be addressed in the early years of the AMS was the question of premises. According to Sykes, the first premises of the Redfern AMS:

consisted of a tiny waiting room, a room used for consulting with an examination table curtained off under a staircase, and beyond this room were toilet facilities, small kitchen and storage space. Patients needing to use the toilet had to pass through the consulting room to get to it. As well, up the staircase there was an apartment - which was rented out to someone else, un-connected to the AMS. The entrance to this apartment, however, was located right in the doctor's consulting room, and persons using the stairway were able to see directly into the curtained examination table alcove (1989, p. 191)

The first location of the AMS was always meant to be temporary, and the early organising meetings seem to have had a clear vision for the Redfern AMS, which, in large parts, did eventuate. For example, as early as November 1971, the assessment appeared in *New Dawn* (p. 8) that the dental services, which were already planned, would not be possible until the AMS could move from the Regent St location to larger premises, which should be located and acquired. The process of finding new premises was a long and arduous one, as even when a twenty year lease on an unused school facility was secured in 1973 (*AMS Newsletter*, 1976, p. 3), the South Sydney Council tried to block the approval and delayed the move (Hollows and Corris, 1991, p. 101).

An important part of the initial effect of the AMS was the use of programs that addressed some of the social determinants of health, which are so crucial in this context. A significant determinant of health recognised by the Redfern AMS as a high priority from the beginning was poor nutrition. The issue of nutrition became central after the AMS staff, during early operations, encountered people who reportedly had not eaten in days and families without income who could not afford proper food. Some of the children encountered were “even displaying signs of obvious brain damage through lack of nutrition” (*AMS Newsletter* 2, p. 3). Two significant projects were maintained to address

this situation:

- Shirley Smith (Mum Shirl) organised a weekly fruit and vegetable run, which was allocated a budget from the AMS (AMS Newsletter no. 2). The program expanded through the years to a more comprehensive community nutrition program (Foley, 1991), which also included nutrition classes (AMS Newsletter, n. 14, 11/1974).
- *Breakfast for Kids* program, which later became an independent organisation called the Murawina Aboriginal Women and Children's Centre (Foley, 1991).

The nutritional project was recognised as a very important one and continued to develop and grow. It received some support from the Freedom from Hunger campaign (AMS Newsletter, 7, 10/1973), although the program was occasionally suspended due to lack of funds (AMS Newsletter, 16, 6/1975), and once due to a fire in the premises (AMS Newsletter, 3-4/1978). In 1973, an article in *New Dawn* assessed that:

Shirley Smith's weekly vegetable run is but the beginning of a long-term and more fundamental attack on the problems of malnutrition, a move towards prevention as well as cure. Already there is talk of the establishment of medical and nutrition centres, initially using a white nutritionist in conjunction with trainee Aboriginal nutritionist. The programme would of course be directed towards mothers and grandmothers. The impact of what Dr Macleod calls "a white authority figure" speaking to Aborigines is much less effective than of another Aborigine. (New Dawn, 3:8, 1973, p. 2)

Within a few years, the nutrition project developed towards educational and preventative programs (AMS Newsletter, 5/1977) and was used as a model in other ACCHSs. A national nutrition seminar that was described as "the first national black nutrition seminar" (AMS Newsletter, 17, 08/1975, p. 2) took place in 1975, with 80 people in attendance. The resolutions of the conference linked the poor nutrition to the land rights struggle:

the expropriation of our land was one of the major causes of the destruction of our traditional society and hence the rapid deterioration of our once healthy diets. The return of our land is the first requirement towards establishing fruit orchards and market gardens, so that firstly, nutritious food can be made accessible to our people and secondly so that we can have direct control of this accessibility. Especially in

the rural areas as fruit and vegetables are too expensive and often non-existent (sic). (p. 2)

Other major projects that started to develop early included dental services, infant health service, health education, family planning consultations, and alcoholism programs (Aboriginal Medical Services Workshop, 1974). An urgent issue that the Redfern AMS had to address was the poor dental health of many Aboriginal people, both in Sydney and in rural NSW. According to Sykes, when the AMS presented a plan for a ‘dental van’ for primary dental treatment and preventative education, “[t]here was a concern raised that the AMS dental van would take business away from local doctors” (1989, p. 195). The NSW Health Department “felt it could do a better job. It obtained funds from DAA to build a van and put it on the road” (p. 196). This was one of the first open accusations of ACCHSs for allegedly doubling existing services, an accusation that was occasionally raised by state health bodies, especially in the first decade of the development and organisation of the ACCHSs movement (such claims are examined in chapter 8.1). The way in which the dental van case developed is somewhat indicative to the nature of some of these accusations. According to Sykes, the NSW Health Department “was unable to attract dentists to work on the van, and eventually was forced to hand its operation over to the AMS” (1989, p. 196). Sykes attributes the success in this case of the AMS to the fact that “the AMS could directly employ doctors and dentists to work in the field” (p. 196). Furthermore, according to Sykes:

the AMS got better value for each dollar spent on staff because its staff members were attracted by the ideology and challenge of the service... The AMS was therefore able to harness what altruism and personal generosity the white community extended, and to put that into the service to improve the level of care available to the Black community. (1989, p. 196)

Community response in Redfern to the AMS appears to have been very positive, and there is indication that the impact of the AMS was quick and widespread. This was mainly due to the nature of the service: “free, accessible, available on their [people in the Aboriginal community] terms and in a place they could call their own” (Fagan, 1990, p. 26). Foley indicated in an early article (1975) that “[i]t was immediately apparent that the demand far exceeded the supply, so to speak”, but a “remarkable response from the general public”

allowed the service to operate “almost entirely upon donations up until December, 1972” (p. 38). The *Sydney Morning Herald* reported in March 21 1972 that more than 2,000 people had used the AMS in the first nine months of operation.

A good indication of the immediate impact of the Redfern AMS can be found in the report *Problems and Needs of the Aboriginals of Sydney*, presented to the Minister for Youth and Community Services in NSW in March 1973. The report was commissioned by the Minister and was conducted by *W. D. Scott and Company*, a private management consultant firm. The report was “suppressed” (AMS Newsletter no. 11, 02/1974, p. 1), yet copies of it (marked *Confidential*) circulated and now exist in several libraries. The report focused on Redfern and additional suburbs, and conducted 778 interviews with Aboriginal households.

The Scott report found that over 40% Aboriginal people who lived in the inner city area had used the Aboriginal Medical Service, which made the AMS the health institution most used by Aboriginal people in Sydney (vol B, section 8 p. 6). Considering that the fieldwork was reportedly undertaken between July and September of 1972, a year after the formation of the AMS, this figure reveals a hint of the deep impact that the AMS has had within the first year of operation. According to the AMS Newsletter, the Redfern AMS saw approximately 7000 people, plus some 3000 home visits, during 1973 (no. 9, 12/1973).

The Scott report also examined the reasons why mainstream health services are inadequate. The first reason noted was economic hardship (1973 vol B, section 8 p. 4) that limits the use of services to crisis situations, as many in the Aboriginal community were not qualified for subsidised medical schemes and could not afford private health insurance. The second reason according to Scott was psychological, “where Aboriginals have delayed essential and important treatment for reasons of anxiety and diffidence” (Scott, 1973 vol B, section 8 p. 4). The third reason was lack of knowledge about their options in terms of available health services for their medical needs. Furthermore, even those who did use existing mainstream services often were not treated in a way that addressed *real needs*. Those needs are a product of a “complex interrelating pattern, not only connected directly with health, but indirectly, through lack of knowledge, poor housing, social problems, economic problems, personal habits and life styles which act against good health” (Scott, 1973 vol B, section 8 p. 4).

The Scott report recommended that the Redfern AMS or similar organisations may be “the key to success in the area of Aboriginal health”, and that “[a]ny proposals from the Aboriginal community, therefore, to extend or duplicate the present Service, or to start new Aboriginal Medical Services, should be treated with favour” (1973 vol B, section 8 p. 8). The report further concluded from its findings that “[s]ince the Medical Service is an Aboriginal service, run by Aboriginals for Aboriginals, people feel that they are able to go there without fear or embarrassment” (1973 vol B, section 8 p. 4).

An article in *New Dawn* featuring the AMS pointed out that many in the Aboriginal community, because of poor socio-economic state, gave the AMS a positive assessment within months after its opening. It mentioned that Aboriginal people in Sydney:

tend not to see a doctor until their illness is at an extreme stage, especially as very few of them belong to the normal medical and hospital benefit schemes. Also, a man with six children earning say \$59 a week, earns just a few dollars too much to get free health insurance under the Commonwealth's subsidized medical scheme. Yet he may be in serious trouble when faced by big medical bills. A free service is a partial answer to these problems. (New Dawn, 1971, p. 6)

Another early aspect of the Redfern AMS, which later became a focus of the national ACCHSs movement, is educating mainstream health providers about specific issues and health needs of Aboriginal people and communities. This has been an important feature of the ACCHSs movement since its early beginning in Redfern. According to Sykes:

As well as providing some access to medical care for residents, Aboriginal Medical Services set about trying to make white medical institutions less racist in their practices and more responsive to Black needs. We did this in a variety of ways - by public education, by venturing into medical training institutions to put our views directly to their students, and by confronting and conciliating with individuals and institutions about incidents of racism or racist misunderstanding when they occurred. (1989, p. 192)

4.5 Early years funding: grants and donations

Initially, the idea was for the Redfern AMS to exist solely on donations, as the dangers of entering into funding agreements with government seemed apparent. Yet the overwhelming need forced regular grants applications soon after, in addition to continual independent fund-raising (Foley, 1991). According to Foley, the first submission for a grant from the Office of Aboriginal Affairs for a sum of \$13,000 was approved almost in full, yet all subsequent requests from the Office, and later the Department, met with walls of bureaucracy and, in most cases, only small parts of the amounts requested were approved, in processes that often took months without a clear reason (1975). Elsewhere, Foley describes the early grant application processes as “battling inept and insensitive bureaucrats and politicians for resources”, which then became a key occupation for the AMS (and other ACCHSs) for many years (Foley, 1991, p. 6). One particular request that was met with bureaucratic hardships was for a grant to fund moving the AMS to a new premise. According to Foley, this early interaction influenced the tone of negotiations with the DAA for years to come:

This was one of the first instances where we detected a degree of double standards in the attitude of the D.A.A. On one hand the D.A.A. (a purely administrative body) could occupy very luxurious offices in Canberra, but the A.M.S. (a body directly working with blacks) could not even get money to make its 100 year old premises inhabitable. (1975, p. 38)

Relations with the NSW DAA were also tense, with accusations from the DAA of poor record keeping, which were strongly rejected by the AMS (AMS Newsletter, 8-9/1978, p. 3). The question of funding, and the dangers of co-option, seemed apparent to the AMS staff and activists from these early days. A key strategy in that regard, which was developed in Redfern from the first years of the AMS, was constant attempts to secure funds from a variety of sources, donations and public agencies, thus limiting the reliance on a single source of funding:

We cannot jeopardize [our lives] by entertaining structural changes in either ideals

or policy in the A.M.S., and in order to remain 'free', we have to aspire to financial independence to some degree. We entreat the general public, and particularly those people who have shown support for us in the past, to help us fund our operation outside of total Government domination. (AMS Newsletter, no. 6, 09/1973, p. 2)

This strategy was a way to partially reconcile the necessary acceptance of government funds and autonomy. The AMS received some support from non-Aboriginal people in Sydney, as various groups and individuals answered the donations pledge. Shows of support included a charity race organised by Sydney University students (“Uni race for charity”, 1972). Another student group, the NSW Film Group, raised funds for the AMS (and other mainly charity/health organisations) (“Foundation Day film festival”, 1973). In 1977, it was reported that children from the Shell Harbour School sent donations and letters of support following a call for donations (AMS Newsletter, 10/1977, p. 4). An early donation was achieved from the Australian Freedom from Hunger Campaign, which granted the Redfern AMS more than \$100,000 for the nutrition program (“Aborigines get \$100,000 grant”, 1972). A note at the beginning of issue 13 of the AMS Newsletter (1974) thanks those who donated to the AMS for a number of programs, “which the Government would not finance” (p. 1). These included the fruit and vegetable run, sending medical supplies and vitamin C to Palm Island and Townsville area communities, food supplies to the Gurindji people in Wattie Creek, and clothes for families in NSW and NT (AMS Newsletter no. 13, 1974).

The Newsletter was a key asset in fund-raising, and a donations appeal appeared usually at the beginning or the end of each issue (the Newsletter will be further explored in the next section). A list of donors, which appeared in the AMS Newsletter no. 5 (8/1973), reveals a particularly high response for donations to the AMS. Among the long list of donating bodies are pharmaceutical corporations (such as Roche, Pfizer), other major corporations (Ford Motor Company, Ampol Petroleum), religious groups (Bass Hill Methodist Group, Religious Society of Friends), and community groups (Woolloomooloo Residents Action Group).

The Redfern AMS was incorporated as a co-operative in 1975. The stated reasons for the incorporation were to facilitate asset ownership and applying for funds (Aboriginal Medical Service Newsletter, no. 15, 1/1975). “We are now in the process of becoming

incorporated” (Aboriginal Medical Service News, AMS Newsletter no. 13, p. 4). The registration was as a co-operative, rather than as a company. It was a necessity for registering property ownership, and seems like it was a necessary step to secure ongoing funds. The incorporation of the AMS constitutes an important stage in the development of the dialectical community-control/co-option relationship with the state.

Parallel to this process, as mentioned, the constant seeking of grants continued, in order to try to not fully rely on a single funding source. As Fred Hollows noted, “you never left a session at the [AMS] with any money in your pocket” (Hollows and Corris, 1991, p. 102).

4.6 The role of the AMS Newsletter

In the methodology chapter (3.2), I wrote of the way in which finding the AMS Newsletter was a significant find in my research. Its 54 issues that I was able to trace follow the first two decades of the development of the ACCHSs movement. Before being confined to forgotten library files, the AMS Newsletters constituted an important method of the AMS to raise funds and politically engage people in Redfern and the wider community around issues relating to the Redfern AMS, the larger ACCHSs movement, as well as other Aboriginal rights and land rights issues. The Newsletter was printed from early 1973 until 1991.

The first edition of the AMS Newsletter is undated, but seems to have been released in the second half of March 1973, as the first dated issue is no. 4 (June, 1973), and the first issue includes a reference to a story in *The Australian* dated 15/3/1973. It was printed with the help of the Foundation for Aboriginal Affairs, which moved to different premises shortly after. The second issue was printed with the help of the Builders Labourers Federation (BLF), which could not print the third edition as they were on strike at the time (AMS Newsletter, no. 3). The first printing machine that the AMS was able to secure to print its own newsletters was loaned by Gestetner (no. 5, 8/1973). The first issue of the newsletter had a circulation of about 200, which grew to approximately 700 readers by issue 4 (no. 4, 6/1973).

There was an early decision to keep the newsletter free, and not to set a subscription fee. “[W]e hope to be able to keep it ‘our way’. We will send it to whoever is interested enough to let us know, until we run out of money and can’t continue” (AMS Newsletter, 2, p. 2). This meant sometimes irregularity in the appearance of the newsletter: “we are not in the Newspaper business, we are in the business of trying to save lives” (AMS Newsletter, 2., p. 2). The general idea was expressed elsewhere as: “Send us what you can, when you can, and we’ll send you our Newsletter for as long as we can” (no. 4, 6/1973, p. 2). This policy continued throughout the publishing of the Newsletter (1991).

The AMS Newsletter remains a precious resource, containing sharp analysis that points at the deep connections between the poor state of Aboriginal health and the social and political oppression. The Newsletters included analysis of a variety of national political issues and their effect or possible effects on Aboriginal people, community issues such as police harassments and community initiatives, and matters regarding the AMS, including programs, updates on recent developments, and new emerging information regarding health and wellbeing. Some editions included reprints of articles of interest from other newspapers, reprints of documents of interest, poems, caricatures, and even recommended book listings, which included radical classics from Australia and overseas struggles. In addition, on top of all, the newsletters always remained focused on fund-raising, reminding readers in each edition the pressing need for donations, including listing of projects that donations cover (and that the DAA would not cover).

Most of the issues opened with a donations appeal, including a list of projects to which the donations assisted. One of the items on the list details communities to which the Redfern service assisted with the organisation of their own health services.

A good indication for the role and importance that the AMS placed on the Newsletter is hinted in a report by Duckett and Ellen (1979), who studied the work of the Redfern AMS staff, including the division of their time:

Activities concerning community organisation and development occupied 8% of total staff time. Nearly one-third of this was spend (sic) on researching, writing and printing the AMS Newsletter. A further 28% of time involved liason (sic) with other community groups, particularly agencies such as the Aboriginal Legal Service, the

Aboriginal Housing Company, and the Department of Youth and Community Services. The same proportion of time again (26%) concerned developing an understanding of community influence in decision making and allocating of resources, and an understanding of community determinants of health and well-being. This mostly occurred in lecture and discussion situation. (Duckett and Ellen, 1979, pp. 16-17)

The role of the Newspaper may have also been another indication of the influence of the Black Power movement from the US, as discussed in 4.1. The Black Panthers' *Intercommunal News Service* was a key tactic of political organising within the communities (Hilliard, 2007).

4.7 Relationship with the Department of Aboriginal Affairs

As previously discussed, the Department of Aboriginal Affairs (DAA) was established after the 1972 federal elections, which brought Whitlam's Labor government into power. The DAA was to facilitate public funding for projects regarding Aboriginal people and communities. Its establishment was enabled due to the 1967 referendum, which underlined a public recognition that the federal government has a responsibility for Aboriginal and Torres Strait Islander people, a responsibility that is not solely the states'. The department replaced the Office of Aboriginal Affairs, which was established under the McMahon Liberal government (Gilbert, 1973).

The DAA was heavily criticised for creating large and expensive bureaucratic bodies, which leave little actual money for community-initiated projects (AMS Newsletter no. 13, p. 1). In a strong article published in *Identity*, Gary Foley provides an early, detailed account of what he describes as *bureaucratic obstructions* practiced by the DAA at the time: "it would seem that the success of the A.M.S. has been in spite of, rather than with the help of, the D.A.A." (Foley, 1975, p. 38). Elsewhere, Foley points out that the DAA employed in its bureaucracies "staff of the old hated Aborigines' Protection Boards of the

various states” (Foley, 1991, p. 9). Some of the main complaints presented by Foley were detailed accounts of lateness and stalling by the DAA of delivering grant monies, which often put the DAA in large overdrafts (Foley, 1975), which “almost forced the closure of the A.M.S. on many occasions” (AMS Newsletter no. 18 11/1975. p. 1).

Naomi Mayers of the Redfern AMS wrote a letter to Barry Powell from the DAA regarding this situation on January 14, 1974 (Foley, 1975). In the letter, a number of issues were raised:

- AMS projects that the DAA refuses to contribute any funds towards, such as the fruit and vegetable run, and supplying clothing and blanket donations to rural communities in emergencies.
- The DAA’s refusal to contribute funds towards rent and renovation of new premises
- Recommendations of the Scott report which the DAA have not adopted.

(Foley, 1975)

The DAA reportedly responded with an approval of a further grant of over \$30,000 (Foley, 1975).

By the 1973-1974 financial year, the budget of the Redfern AMS was \$93,425, out of which some \$20,000 was raised through fund-raising activities, and the rest came from government grants (Foley, 1975).

The growth of the AMS and concurrently the growth of government grants did not deter AMS activists from their role in the land rights movement at the time. In the winter of 1974, against the background of a government review into Aboriginal peoples’ sentiment towards the DAA, protests in Canberra grew stronger, and even included an occupation of the DAA offices in Woden by Aboriginal protesters. “The AMS was one of many organisations which sent representatives to Canberra to seek change, if possible, in the monolithic bureaucracy of the D.A.A.” (Foley, 1975, p. 39). However, it is interesting to note that at least one of the founders of the Redfern AMS, who was still taking an active interest in the ACCHSs movement, was recruited to work in the DAA. Gordon Briscoe joined the DAA in 1973, and moved to the Department of Health in 1974, where he worked as a senior project officer (Grace, 1979).

The question of co-option by the state agencies such as the DAA, which as discussed (2.3) is an integral part of the community-control experience. The potential danger of co-option seems to have been clear to activists in the movement even in the early years of operation. In the sixth edition of the Redfern AMS Newsletter (09/1973), an interesting analysis acknowledges the possible complications of the relations between community-control and co-option (or 'take-over'), as a result of accepting government funds. It resonates with similar processes that the ALS went through (as discussed in 4.2):

With the increased Budget has come the increased fear from those connected with the A.M.S., Staff and Council, that the Service is now in real danger of being 'taken over' by the Federal Government, and that we, the employees, instead of being answerable to our own community, to the people whom we treat, will become answerable to the Federal Govt. No matter how nicely 'Government take-over' can be made to look, community control is the driving force behind the success of the A.M.S. (no. 6, 09/1973, p. 1)

From this point on, a new theme developed in the AMS's demands, which will resurface both in the Redfern AMS and in NAIHO in several instances in the future (as explored in the following chapters). The Redfern AMS attempted to disassociate from the DAA, and seek funding from the Health Department as an alternative.

Interestingly, the AMS activists were perhaps unaware at the time that, in 1973, the Whitlam government prepared a Ten Year Plan for Aboriginal health, although it was apparently not publicly announced (Saggers and Gray, 1991a). According to Saggers and Gray, the plan "proposed that the Australian government, through the Department of Health, be responsible for a national campaign to raise the standard of Aboriginal health ... however, the plan was more like a statement of intention to develop a plan" (Saggers and Gray, 1991b, p. 390). The Program Effectiveness Review (1980), which was also not publicly released (as discussed in great detail in 5.4) examines the failure of the plan, and shows, among other things, that the states were reluctant to take responsibility, and there was general disagreement and a lack of clarity regarding the roles of the states and the Commonwealth (Anderson, 2003).

The Redfern AMS made its first bid for a move to be funded by the Health Department

during the first introduction of Medibank in the latter days of the Whitlam government. The editorial of the AMS Newsletter of August 1975 announced to the readers that

The Aboriginal Medical Service has divorced itself from the bureaucracy, that is of course, the Department of Aboriginal Affairs, and has gone over to Medibank. This means that we have set a great precedent in discarding these shackles, one we hope will be followed eventually by all community controlled Aboriginal organisations. It is a step taken in spirit of and in the direction of self-determination. (Editorial, AMS Newsletter no. 17 08/1975, p. 1)

Yet the Medibank scheme did not last beyond the next year. The March 1976 issue of the newsletter reported that the Redfern AMS returned to DAA financial assistance. However, the AMS (and at this stage, the ACCHSs movement) continued to try to find ways to switch to the Health Department for funding:

Gary Foley, Naomi Mayers, Dr David Smith and Professor Fred Hollows, of the A.M.S. recently met with the officials of the D.A.A. and the Federal Health Department, to discuss future government assistance for the A.M.S. The two major officials met were Mr Laurie Malone of the D.A.A. and Dr Langford of the Health Department. The A.M.S. was forced into seeking government assistance again, because of the failure of Medibank to provide us with sufficient funds to maintain our many and varied programs ... Ultimately, however, it seems that the Federal Department of Health is going to assume the responsibility for funding the A.M.S. and that move will be greatly welcomed by all of us who detest the D.A.A. (A.M.S. Returns to Government Assistance, AMS Newsletter no. 20 3/1976, p. 2)

The issue of the division of funding responsibilities between the DAA and the Department of Health continues to be central to the relationship between the ACCHSs movement and the federal government. It will be further explored in chapter 6, in the context of the Program Effectiveness Review (1980), which flagged the sorting of funding responsibilities between the departments as a main issue.

4.8 Relationship with the Whitlam government and the opposition

As part of the openly political nature of the AMS and the Newsletter, federal elections were treated with serious analysis. The Newsletter focused on the meaning of elections and possible outcomes for Aboriginal people, while generally being critical of both major parties (AMS Newsletter n. 12, 3-4/1974). The analysis of the different elections gives a good insight into the politics of the ACCHSs movement, and to the way in which the movement related to different federal governments at the time of writing.

Relations between the McMahon Federal Liberal/Country Party Government and the land rights movement as a whole were cold. As mentioned, the Redfern AMS was able to secure small grants even before the Whitlam Government was elected after sustained political pressure (Foley, 1991):

most Aboriginal organisations grew out of the upsurge of Black militant activity in the 60's and 70's. These evolved as a direct expression of self-determination and the complete rejection of oppression, the relegation of our people to second-class citizenship. The Labor Party saw the signifance (sic) of our movement and quickly took up our demands as its platform, especially because we potentially provided a catalyst to the heightened workers' movement of which we were becoming a small but significant part, (AMS Newsletter no, 17 08/1975, p. 1)

Quoted below is an analysis of the political atmosphere in Australia prior to the 1972 federal elections. It was presented in the editorial comment of the AMS Newsletter no. 12 of March-April 1974, in the context of the then upcoming 1974 federal elections, which brought Gough Whitlam into power.

the public were involved in one issue or another, whether it was opposition to the war in Vietnam, opposition to the conscription, opposition to Australia playing host to racist South Africa sporting tours; others were involved on a more personal level, when Federal law and hypocritical morals denied the need to easier access to divorce, and when the Pill carried a luxury tax; Liberal paranoia had poured

millions into the coffers of ASIO, and many people were finding their phones tapped and their persons harrassed (sic), their offices and homes searched and their privacy invaded, foreign ownership of Australia was almost inevitable; and suppression of information was wide-spread. The Black community was virtually un-heard, and the fate of the Aboriginal protest which culminated in the creation of the Aboriginal Embassy is well-known; Land Rights was regarded as some sort of joke by the national leaders, and a forced assimilation program was in practice if not in policy. (AMS Newsletter no. 12, 3-4/1974, p. 1)

The expectations on the part of the AMS of the Labor government were clear:

When the Labor government implements in reality, not just the words, its recognition of our inalienable right to self-determination, organisations such as ours will be able to solve the urgent problems of our communities which the "normal channels" have proved incapable of doing. (AMS Newsletter no. 17 08/1975, p. 1)

Largely due to the experienced 'bureaucratic obstructionism' of the DAA (Foley, 1975), the approach of the AMS Newsletter towards the Whitlam government was mostly critical. One criticism regarded the government's use of 'self determination' language as shallow (editorial of the AMS Newsletter no. 5, 11/1973), which is mostly used as lip service (no. 8, 11/1973, p. 1). The AMS Newsletter even encouraged supporters to contact the PM. In issue no. 13, readers were urged to send telegrams to PM Gough Whitlam and the Ministers for Health and for Aboriginal Affairs, and demand that the full budget submission made by the Redfern AMS would be received (AMS Newsletter no. 13. p. 2).

Yet despite the criticisms, the AMS called in its newsletter to vote for Labor in the 1974 Federal elections (AMS Newsletter no. 11, 02/1974, p. 1), and then again in 1975 (AMS Newsletter no. 19 12/1975, p. 3):

1975 will be yet another year of uncertainty for Aboriginal people. Disillusionment with the Labour (sic) Government is high in Aboriginal communities. Furthermore, the general communities (sic) anti-Labour (sic) feeling is causing concern for Blacks because a Liberal Party win at an early election would spell disaster for

many Black projects throughout the country. Add to this the worsening economic situation generally and the future looks particularly bleak for Blacks, most of whom are already living close to the poverty line. (Editorial Comment, AMS Newsletter no. 15, 1/1975, p. 1)

A special edition of the AMS Newsletter dedicated to the 1975 federal election (no. 19, 12/1975) offered commentary on the 1975 Constitutional Crisis⁸

we, as people who never really beleived (sic) democracy anyhow, were hardly surprised by the Governor General's action. The myth that Australia is a democratic country where the people have the final say has been exploded for all time. The recent events in Canberra have highlighted something that most Aborigines have known for years, and that is that MONEY is POWER! Anyone who can secure the support of big business and newspaper barons is in a position where he can rewrite the rules and gain power. (AMS Newsletter no. 19 12/1975, p. 1, emphasis in source)

The Newsletter assessed that the three most urgent issues in Aboriginal Affairs as assessed prior to the 1975 federal elections were: “(1) Land Rights and Compensation, (2) Abolition of the Queensland Act and (3) Black control of Black Affairs” (AMS Newsletter no. 19 12/1975, p. 2).

In the lead up to the 1975 federal elections, the Liberal and Country Party Coalition contacted the Redfern AMS directly to assure that funding would continue if the Coalition wins the elections. Bob Elliott, Coalition Spokesperson for Aboriginal Affairs, sent a telegram to Naomi Mayers of the Redfern AMS prior to the elections, announcing that under a Coalition Government “there would be no cuts in Aboriginal Affairs budget or in Aboriginal Affairs programs” (the telegram was reprinted in: AMS Newsletter no. 20 3/1976, p. 1). In particular, the telegram noted that a Coalition government “will support Aboriginal organisations such as the Aboriginal Medical and Legal Services” (p. 1). Despite these assurances, the Newsletter reported that six months later, the new Coalition government has cut \$80 million from funding of Aboriginal organisations (p. 2).

⁸ The 1975 Constitutional Crisis refers to the dismissal of the Whitlam Government in 1975 by the Governor-General, representative of the Queen of England and officially the head of state of Australia.

4.9 International relations

The Redfern AMS established international connections from a very early stage. The fifth newsletter (August 1973) carries a report by Bobby Sykes on her upcoming trip to attend a conference in Geneva “and also speaking and fund-raising in a few other countries” (no. 5, 8/1973, p. 3). It is emphasised that the trip was not funded by the Redfern AMS. It is later reported that the meeting (perhaps of the World Health Organisation) raised a lot of interest, especially by delegates from ‘third world countries’, into the structure and policies of the AMS (no. 6, 09/1973, p. 3). These early aspirations for strong international ties have proven crucial for the community-controlled health movement as a whole in difficult times further on.

Delegations of Aboriginal activists visited different parts of the world from at least 1970, to network with other postcolonial/liberation movements around the world. These delegations usually did not represent a single organisation, but included activists from a variety of groups, or alternatively activists who would try to represent a broader face of the movement, and not solely a specific organisation.

An early delegation of Aboriginal community activists toured the United States in 1970. The tour included meetings with leaders of the civil rights movement, including leaders of the Black Panthers movement. The delegation included, among other people, Bruce McGuiness, who later became one of the founders of the Victorian Aboriginal Medical Service, and was involved with the community-controlled health movement for decades to come, and Bob Maza, who recalled this from a speech he gave in front of 80,000 people at a rally in Atlanta during the tour: “someone asked, ‘What did they call Australia before the white man came?’ I was completely rattled and all I could say was ‘home’” (quoted in: Gilbert, 1973, p. 115).

AMS activists also visited China as part of Aboriginal delegations. China had then only recently opened up to visitors for the first time since the 1949 revolution. A concept in Chinese public health, the Barefoot Doctors, inspired the early conceptualisations of the role of the Aboriginal health-worker (AMS Newsletter, 1-5/1983) (as will be discussed in

chapter 5.3). Chicka Dixon wrote about one of the delegations that “[i]n China we were treated, for the first time, as human beings” (quoted in: Gilbert, 1973, p. 114).

The AMS Newsletter no. 11, 02/1974, tells of a conference in Guyana, which was attended by the then-chair of the AMS, Gary Williams. The conference was hosted by the National Indian Brotherhood and included participants from different indigenous struggles (AMS Newsletter no. 11, 02/1974).

On another occasion, Gary Foley (AMS Publicity Officer at the time) travelled to New Zealand for a week and formed connections with Maori organisations. “He also had an opportunity whilst there to offer Australian blacks’ support for the Maori Land March and Maori “Embassy”, which has been set up on the lawns of Parliament House in Wellington” (AMS Newsletter no. 18 11/1975 p. 3).

NAIHO, the national body of the ACCHSs movement (that will be further discussed from chapter 5 onwards) started to send on occasion representatives on overseas trips on its behalf. While NAIHO representatives Bruce McGuinness and Gary Foley toured Europe in 1980, they met with different funding agencies, potential donors, and even the World Health Organisation (AMS Newsletter, 5-6/1980; Identity, 1979). The trip was related to the setting up of Aboriginal Information centres in London and other main (western) European cities. According to Identity magazine, the cities toured include London, Paris, Bonn, Munich, Amsterdam, Copenhagen and Geneva (“Going international”, 1979).

The ACCHSs also received visits from overseas activists involved with other indigenous struggles. The newsletter reported that, throughout 1980:

Aboriginal Medical Services were visited by numerous overseas groups including Canadian Indians, North and South American Indians, and representatives from numerous African and third world countries. The irony is that these numerous overseas people recognise the worth and effectiveness of community health programs developed by the Aborigines themselves, but our very own Australian government continues to try and subvert their work. (AMS Newsletter, 11-12/1980, p. 4)

The international relations forged between the Redfern AMS (and later the ACCHSs movement) and overseas activists and movements is an indication of the international wave of social movements in the context of which the ACCHSs movement developed. The movement's ongoing international relations in the 1980s are further explored in chapter 7.5, while some examples of the movement's relations with other Australian social movements are explored in chapter 5.5.

4.10 The national spread of the movement

Another good indication of the effect of the Redfern AMS was the number of other community-controlled health services that had sprung up across Australia in the three years after its formation (Sykes, 1989). The AMS played a key role in providing example and organisational advice to other communities seeking to organise their own services, as well as help recruiting doctors and at times even material assistance to other communities. Assistance was given to the Melbourne Aboriginal community (AMS Newsletter, no. 4, 6/1973) and the Victorian Aboriginal Health Service opened in 1973 (Nathan, 1980). Also that year, services opened in Townsville, Gippsland (AMS Newsletter no. 8, 11/1973), Brisbane (Samisoni, 1977; Best, 2003), and Alice Springs (Rosewarne et al, 2007). By 1974, community-controlled health services were also opened in Perth (House of Representatives Standing Committee on Aboriginal Affairs, 1975), Adelaide (Aboriginal Medical Services Workshop, 1974), and Wilcannia (AMS Newsletter no. 14, 11/1974). Regarding the influence of the Redfern AMS as an example, an article in *New Dawn* in January 1973 assessed that:

Given the connection between the social conditions faced by Aborigines and their health problems, the Aboriginal Medical Service itself provides the model for what could be an effective attack on the underlying causes of the ailments that disproportionately afflict Aboriginal people. (New Dawn, January 1973, p. 1)

It was also later observed by Anderson that other ACCHSs “were modelled on the original service prototype in which health services were managed within a cooperative structure

that was governed by a board of management elected from the local Aboriginal community by the local Aboriginal community” (Anderson, 2003, p. 230).

Due to the chronic underfunding of the movement and the leading role the Redfern AMS played in helping other communities to establish their own services, it was quite common for the AMS Newsletter to feature an appeal for donations. In the appeal on the January/February 1981 edition of the newsletter, it is explained that:

the Redfern A.M.S. is often called on to support Aboriginal groups, particularly in remote areas, who desire to control the delivery of health care to their own communities. N.A.I.H.O. believes that the initial financial and organisational support which such communities receive, is a key factor in whether an embryonic Aboriginal Medical Service will survive or not. This is a major reason why the two major services in the NAIHO network (Redfern and Melbourne) respond quickly and positively to requests for assistance from communities who have set up a committee to establish their own health service. (AMS Newsletter, 01-02/1981, p. 2)

Assistance from the Redfern AMS to emerging services often included visits from AMS activists to early organising meetings. Such trips often included deliveries of donations of drugs and medical supplies (an example of such a visit to Port Augusta is detailed in: AMS Newsletter, n. 22 11/1976, p. 2). In other cases, Redfern’s help also included financial assistance. The 1-2/1981 Newsletter continues with an example of financial assistance made for young AMS’s: Port Augusta is reported to have received:

almost \$25,000 in its first year of operation, the Kempsey (NSW) and Broome (WA) A.M.S.’s which both received approx. \$18,000 each in their first two years of operations, and Wilcannia and Purfleet (Taree) A.M.S.’s which both received in the region of \$12,000 for the early stages of establishing their services. (p. 2)

In Fitzroy, which was home for the largest Aboriginal community in Melbourne at the time, activists started the long process of organising soon after the example of the Redfern AMS.

The conditions in Redfern that resulted in the construction of the AMS were not entirely unique to Sydney, but reflected, and to a limited extent led, a national outcry. The VAHS based in Fitzroy, a suburb of Melbourne, was established in a process that started at 1973 and saw the launching of the service in 1974, according to Nathan, “by some concerned members of the Aboriginal community” (1980, p. 1).

In 1979, Pam Nathan undertook a major study of the Victorian Aboriginal Health Service (VAHS), which included 239 interviews. The report of the study was later published as a book, *A Home Away From Home* (1980). According to Nathan, the study was developed as “there has been some uncertainty regarding the value of Aboriginal health centres” (p. 1) in the context of the ongoing struggle for funds. Nathan reveals that “although this was not the original intention of this research, health has been treated as a political matter” (p. 2). Echoing similar conditions experienced in Sydney as well as other contexts around Australia (Briscoe, 1974, as quoted in chapter 4.2), Nathan noted that “[t]he majority of the Aborigines interviewed claimed they only used mainstream services in cases of emergency, referral or after hours” (Nathan, 1980, p. 116).

The development of the VAHS included weekly community meetings, which after months of organising, were able to rent a property in Fitzroy. The building was painted and prepared by community volunteers. “The initiative sprang from the community at a grass roots level, and not from a government initiative” (Nathan, 1980, p. 22). The VAHS received its first DAA grant, in the sum of \$57,000, 11 months after opening, and after treating nearly 1,000 patients (Nathan, 1980).

According to Nathan (1980), VAHS became somewhat of a community centre, as some:

activities encourage a club-like atmosphere. For instance, films are shown, birthdays and other events are celebrated, trips are made to the zoo, the river, a park, the pool or for a barbeque lunch. Speakers are invited to give informal lectures on various aspects of health care. Fifteen to thirty mothers with their children attend the Clinic and the numbers in attendance are increasing. It appears that whilst the health education that occurs is very informal, it is most effective in this form and the relaxed atmosphere encourages mothers to attend, allowing the regular monitoring of the health and nutritional status of the children. (Nathan,

1980, p. 24)

A major part of Nathan's work included a detailed comparative analysis of the VAHS with the Special Services Health Section (SSHS), an Aboriginal health service provided by the state. Nathan notes that the SSHS has an underlying approach to health as an "individual problem" (Nathan, 1980, p. 77). This is being expressed, among other things, by an overwhelming emphasise on helping people to "feel good about themselves" (p. 77). Nathan observed, regarding the SSHS approach, that:

[n]o linkage is made between key personal troubles and the reality of Australia's social structure. It presupposes that Aborigines have the capacity to control their lives and if they have not, it's because of the weak 'constitution of the individual'. In doing so, SSHS advocates the notion of 'self-actualisation', making the object the fulfillment (sic) of self and in the process ignoring the factors necessary for fulfillment (sic). A better approach to the problem and its solution might be to consider the social structure of society and not merely the personal situation of individuals. The situation is one in which Aborigines' needs must be stated in a much wider context than just the personal and the discrimination which Aborigines face must be seen in relation to society as a whole (Nathan, 1980, p. 79).

A most revealing observation by Nathan about the animosity of the SSHS towards the VAHS is that "[t]he overwhelming response of the white employees of the SSHS was to describe the VAHS as a 'militant black power' group whose main preoccupation was 'to extend its power base throughout Victoria'" (Nathan, 1980, p. 99).

In Perth, the development of the AMS occurred in a very different context than in Sydney. According to Howard (1981):

[t]he Aboriginal Medical Service and the Aboriginal Legal Service, were begun by Whites as subcommittees of the New Era Aboriginal Fellowship. At New Era's annual general meeting, early in 1973, Aborigines took over the health committee with the help of a couple of Whites ... The committee's minimal services were greatly expanded when in late 1973 the Aboriginal committee members were successful in an application to the federal government for \$100 000 to establish an

Another influential early ACCHS was the Central Australian Aboriginal Congress (commonly referred to simply as Congress). “Established in 1973 as a political voice of Aboriginal people in central Australia” (Rosewarne et al, 2007, p. 114), Congress combined the medical services with other important organisational aspects. Its concept of membership was very broad within the defined identity base: according to Nathan and Japanangka, “[a]ny Aboriginal person who identifies with the Aboriginal community in Central Australia is a member of Congress” (1983, p. 37). Congress was initiated in June 1973, in a meeting of some 100 people from Alice Springs and remote communities in the area (Scrimgeour, 1997). Japanangka and Nathan observed that “Congress is first, a political organisation which seeks to safeguard and further the diverse interests of its people, and second an organisation which offers a medical, welfare and dental services in a community context” (1983, p. xii). Furthermore, they observed that:

In the very early days, Congress staff, operating from an old blue Datsun car, were engaged in handing out tents and giving shots of penicillin to the homeless Aborigines stranded in the heavy rain in the winter of 1973. Congress has now grown into a large organisation, housed in town premises, which has successfully met many, even if not all, of the emergency needs of its clients. (Japanangka and Nathan, 1983, p. xii)

The development of the Congress ACCHS in Alice Springs was recently documented by Rosewarne and others (2007), and is a testament to the diverse local conditions and contexts from which very different ACCHSs emerged, with both similarities and differences to one another, and not duplicates or ‘branches’ of the Redfern AMS, or any other.

The next chapter continues the discussion on the establishment of these early ACCHSs, and follows the establishment of a national ACCHSs movement.

Chapter five: the National Aboriginal and Islander Health Organisation (NAIHO)

The idea of community-controlled health travelled from Redfern across Australia. As different communities struggled to establish their own services, it became apparent that the needs and problems confronting ACCHSs were often similar, despite the different contexts. Such issues include funding and dealing with state and federal bureaucracies. As explored in chapter four, the Redfern AMS played a key role in supporting other services, yet as the movement grew the task of supporting the national growth of such a movement became much too big for a single service to handle, especially given Redfern's own difficulties. In this sense, the development of a national organisation seems almost natural. In this chapter, I will explore the development of NAIHO, as well as some of the main issues that the ACCHSs movement faced in the second half of the 1970s.

5.1 The establishment of NAIHO

The earliest written discussion of a future national organisation of the emerging ACCHSs movement that I located is expressed in a position paper of the Redfern AMS, submitted on April 17 1973 to the *Senate Standing Committee on Social Environment*. The submission was presented jointly by Naomi Mayers and D. R. Laing, a medical doctor advising the AMS at the time. In their submission, Mayers and Laing predict that the ACCHSs movement could become national, and advocate for an increase in grassroots services. An interesting passage in particular discusses a future national organisation. It is also interesting to note that as early as April 1973, when other ACCHSs just started to take Redfern's lead and to organise their own ACCHSs, the Redfern AMS already envisaged not only a national spread for the movement, but also started to discuss the nature of its future national organisation:

The A.M.S. certainly have the contacts, rapport, and enthusiasm to ensure the involvement of Blacks nationally, and should finance be available to employ the necessary expertise and to furnish the necessary equipment, A.M.S. could certainly become a viable, national, and successful organization. However, it is not envisaged that a national organisation of the A.M.S. should become another bureaucratic structure, but rather consist of a network of Services, with involvement of the local people at grass-roots level at every centre, and merely co-ordination of available medical expertise, and information dispensed from a national research centre to avoid unnecessary state-by-state duplication. (Mayers and Laing, 1973)

The potential issues alluded to in this paragraph, the question of a bureaucratic structure of a national organisation versus an autonomous network, will prove to be a key issue for the movement for years to come.

There are conflicting stories regarding the inception of NAIHO. Some, such as Littlewood (1982) and Foley (interview, 2009), attribute the formation to a meeting or meetings, between people from the Redfern and Fitzroy ACCHSs, with perhaps other representation of early services, from around 1973. A more formalised beginning, which was perhaps agreed upon in advance, happened in July 1974.

In July 1974, a Workshop on Aboriginal Medical Services was held in Albury, on the Victoria - New South Wales border, organised by the Federal Department for Health. Gordon Briscoe was also elected by the Aboriginal delegates to chair the workshop. It is of note that, while Briscoe was perhaps the initiator of the Redfern AMS (as discussed in 4.2-3) as an ALS activist at the time, by the time of this workshop Briscoe was working in the Department of Health (Grace, 1979).

The then Federal Minister, Dr D.N. Everingham, opened the seminar. The discussion included reports given by representatives of all existing services at the time, from Sydney, Melbourne, Brisbane, Perth, Adelaide, and East Gippsland in south-eastern Victoria, as well as representatives of other Aboriginal communities, which reported on their aspiration and action towards setting up their own services. Other guests and observers included

representatives from the National Aboriginal Consultative Committee (NACC), various members of Aboriginal and Health department bureaucracies (both federal and State level), and representatives of national and international organisations, such as the World Health Organisations, the Australian Medical Association, and the Royal Flying Doctors Service, as well as other doctors and health-workers. The July 1974 conference in Albury was planned for over a year by the Federal Minister for Health. Kevin Gilbert wrote in 1973 that, on April 12, “Federal Minister for Health announces a national conference ‘next year’ to discuss the health of Aborigines and their situation in each state” (Gilbert, 1973, p. 63). In his opening remarks, Minister Everingham stated that:

The idea for this Workshop arose from a meeting held in Canberra in August 1973 to discuss Aboriginal Medical Services. The delegates at that meeting made it clear that there were many deficiencies and problems facing the medical services and these needed to be resolved as soon as possible. (in: Workshop on Aboriginal Medical Services, 1974, p. 6)

It is of note that elsewhere, the AMS Newsletter was very critical of Everingham, who reportedly advocated for sterilization of Aboriginal men “as the answer to the Aboriginal ‘problem’” in 1969 (AMS Newsletter, 2/1978, p. 1). This workshop should also be contextualised in the attempts of both federal and State/territory agencies to define their share of the responsibility for policy related to Aboriginal and Torres Strait Islander people, in the wake of the 1967 referendum. The rise of the ACCHSs movement added further complexities to the issue of authority and control over Aboriginal issues. In this context, Everingham also stated in his opening remarks that:

Responsibility for the actual delivery of health care lies with the various State authorities, except in the Northern Territory and the A.C.T. where my Department [Federal Department of Health] is responsible. I believe we must be flexible in our planning, always ensuring that the Aboriginal communities are involved at every stage. (in: Workshop on Aboriginal Medical Services, 1974, p. 7).

The most notable outcome of this seminar was a unanimous agreement by the ACCHSs delegates on the formation of NAIHO. The motion, which was the first recommendation of the seminar, was moved by Dennis Walker, representative from the Queensland Aboriginal

and Islander Community Health Service (QAICHS), and Bruce McGuinness from the VAHS in Fitzroy, who was representing the NACC at the workshop⁹. The recommendation reads that the role of NAIHO would be:

as a concrete and positive step towards self-determination of Aboriginal and Islander people, to enable them to formulate and implement Medical and Health policies and priorities which are directly and indirectly related to the immediate needs and aspirations of the Aboriginal and Islander people. (Workshop on Aboriginal Medical Services, 1974, p. 32).

It was also decided that NAIHO's structure "would enable easy two way communication at all levels. It would also provide the ways and means to tackle the immediate and pressing Aboriginal health problems and the local Aboriginal community level" (Workshop on Aboriginal Medical Services, 1974, p. 32). NAIHO was to be composed of "one elected member from the State and Territorial assemblies as well as one from Torres Strait Islands" (p. 32). The outline of the desired development of national community-controlled health infrastructures was put forward as the first proposal of the workshop, and is presented in Box 2.

The regional boundaries at this stage, it should be noted, were to be designated by NACC electorate boundaries, and not state/territory boundaries. The question of regionalism is interesting, and reflects at this stage the commitment to pre-colonial geographies. When NACCHO was established to replace NAIHO in the early 1990s, the regional division followed modern geography, with a state/territory division. These changes are later explored in chapter 7.

⁹ Gordon Briscoe and Bruce McGuinness are good examples of the way in which, many of the players in this complicated scene, were often active in a few different organisations, and may even have worked for governmental departments, as was the case with Briscoe. This should help us to keep in mind that, while organisations may strictly define their own boundaries, these different agencies are connected by several levels, such as funding relationships and even an exchange of people themselves.

Box 2: the proposal for the establishment of NAIHO from the Workshop on Aboriginal Medical Services, 1974

Local Community Groups

1. define the problems and needs in each specific area.
2. disseminate information to local indigenous people on all health matters

Regional assemblies

- collate, identify and program priorities.

State and Territorial Assemblies

- communicate with relevant State and local government and other non-government organisation including all indigenous groups
- formulate state budgetary policies.
- allocate financial grants.

National Aboriginal and Islander Health Organisation (N.A.I.H.O.)

- formulate national policies for the permanent and rapid improvement of the health status of all indigenous people.
- provide a direct link with Federal Government Ministries, Australian Government departments and other instrumentalities concerned with Aboriginal health.
- receive and allocate all forms of financial assistance for Aboriginal and Islander health programs.

(Workshop on Aboriginal Medical Services, 1974, p. 32)

Back to the 1974 Albury workshop, a comment was written in the health department's report from the workshop on the discussion in the workshop about the prospects for NAIHO:

There was lengthy discussion on this recommendation. It was argued that the establishment of such a national organisation would give the Aboriginal and Islander people more effective control over their own health problem. However, the view was expressed that it was a big decision to take and should therefore be given further consideration; that the autonomy of the Aboriginal Medical Service could be adversely affected; and that such a move could signal yet another attempt to impose on the Aboriginal people the establishment of a black bureaucracy. It was also pointed out that the proposal should be referred to local Aboriginal community groups in the first instance for ratification. The proposal was said to be consistent with the N.A.C.C. manifesto. It was agreed that the recommendation be forwarded to the National Aboriginal Consultative Committee for consideration, and that the proposal be referred to local Aboriginal community groups for comment before submission to the Minister for Aboriginal Affairs and Health for consideration by the Australian Government. (Workshop on Aboriginal Medical Services, 1974, p. 33)

This comment sheds a lot of light on some of the politics behind this recommendation. Some of the issues raised are still active arguments within the movement.

It should be noted that NAIHO seemed to only start organising actively and independently later in the decade. The Redfern AMS hosted a meeting of ACCHSs representatives from across Australia at Sydney University in 1976 is when NAIHO started to organise more actively and regularly (NACCHO, 2006a, p. 14).

5.2 NAIHO's philosophy

NAIHO produced a few documents that shed some light on its guiding leading political philosophy. NAIHO, as any other organisation, was comprised of people with various, often conflicting, world views.

An interesting indication of some of the ideas from which the movement drew inspiration is to be found in the recommended reading lists, which appeared in a few AMS Newsletters from 1974-1976. Some of the readings included classics from overseas struggles, such as: Franz Fanon's 1961 classic work on resistance to colonialism, *The Wretched of the Earth* (recommended in: AMS Newsletter n. 10, 1/1974), written in the context of the Algerian anticolonial struggle; Dee Brown's (1971) *Bury My Heart at Wounded Knee*, which documents the displacement and massacres of native Americans in today's western regions of the USA, from 1860-1890 (AMS Newsletter n. 10, 1/1974, no. 19a, 1/1976); and *The Autobiography of Malcolm X* (Malcolm X and Haley, 1965, recommended in: AMS Newsletter n. 18, 11/1975, no. 19a, 1/1976).

Recommended Australian books included some literary classics and up to date social science books. These included: Thomas Keneally's (1972) *The Chant of Jimmy Blacksmith* (AMS Newsletter n. 18, 11/1975, no. 19a, 1/1976); Mudrooroo's (1965) *Wild Cat Falling* (AMS Newsletter n. 19a, 1/1976); C.D. Rowley's trilogy of books about the current state of Aboriginal people in Australia (1970, 1971, 1972, recommended in: AMS Newsletter n.

10, 1/1974); Geoffrey Blaney's (1975) *Triumph of the Nomads* (AMS Newsletter n. 18, 11/1975, no. 19a, 1/1976); and Kevin Gilbert's (1973) *Because a White Man'll Never Do It* (AMS Newsletter n. 10, 1/1974, no. 18, 11/1975, no. 19a, 1/1976).

The development of NAIHO during the second half of the 1970s went through some very different stages. In its early days, it started as a coalition of the early ACCHSs, and was led mainly by the Redfern AMS and VAHS.

Regarding formal structures, the data I collected suggests that NAIHO did have some formal structures. Throughout the 1970s, as more ACCHSs emerged, the need for a unified national approach demanded the formalisation of structures. These appeared in the early 1980s, and are further explored in chapter 7.1.

In a 1984 NAIHO meeting at Minto, NAIHO adopted a document titled *Community Initiative, Participation and Control*. The document reveals much of NAIHO's basic ideals, and is perhaps the best document to detail NAIHO's philosophy. The document is presented in full in box 3.

Box 3: *Community Initiative, Participation and Control*, NAIHO document from 1984.

The concepts within this document have formed the basis of our operations from the beginning, and we see it as the most valuable reference point for judging the quality of community activities and decision-making.

We believe it most closely reflects traditional methods of community, and is a most appropriate vehicle to carry our communities forward in the regeneration process, and in their progress towards full health.

COMMUNITY CONTROL is basic to the philosophy of Aboriginal health care delivery as exemplified by Aboriginal community initiated, community based health services throughout Australia. This philosophy of Community Control of necessity is reflected in the structure and workings of the national support organization of Aboriginal Health Services, which is known as the National Aboriginal and Islander Health Organization.

COMMUNITY CONTROL means that each independent and autonomous health service is controlled by the community it serves, in order to provide that community with health care delivery to meet its health needs as defined by that community. The solution to each community's health is in the hands of each particular community.

To ensure the highest level of community control, there must be participation by the community as a whole in the decision making process. This process, for practical reasons, varies from urban to rural to traditional communities but participation remains a key element.

PARTICIPATION is a process in which a community or group of communities exercise initiative in taking action, stimulated by their own thinking and decision making, and over which they exercise specific control.

PARTICIPATION has been described as the collective effort by the people concerned in an organized framework to pool their efforts and whatever other resources they decide, in order to attain objectives set for themselves.

It is through action generated by community thinking and initiatives that men and women give expression to their creative faculties and develop them and thereby develop further the personalities of

those community members, who participate. It is for this reason that participation is a basic human need.

(It is important to note that it is a basic human need still being denied to our peoples today by Federal, State and Territory Departments, even by some Aboriginal bureaucrats)

Membership of the Service should be open to all Aboriginal and/or Islander people in the community, so that they may contribute to the selection/election of the office bearers of a Board/Committee/Council of the Health Service. The selection/election process should take place at regular intervals as determined by the community.

To guarantee ongoing community control, this selected/elected group of people must be accessible to community opinion, and should ensure that Health Service staff respond to community health needs and that the administrative staff in particular, convey to the Office Bearers their assessment of the evolving health needs of the community.

COMMUNITY CONTROL means the community's control of the health care delivery service, NOT the control of the community by the Service or its Office Bearers.

These principles must be reflected at the national, regional and local levels.

In order to ensure that a national organization reflects community control of Aboriginal Health affairs across Australia, PARTICIPATION must be maximal, the community checks and balances must be in place at all times. This demands that the National Organization must not interfere in the decisions of the communities but rather be ready to respond to community requests for support and development. That is COMMUNITY CONTROL. This means that there must be a constant free flow of information to and from all levels.

This builds trust, builds community and will ensure protection against the forces in Australia, which are opposed to Aboriginal real community development and Aboriginal real community self-determination.

The talents and abilities of each individual in a community in a community must be encouraged, so that every individual can develop their full potential. With community support, this is possible and, in turn, those talents and abilities can be applied to help the community develop and to meet its needs.

Individual decision-making breaks down community, and so breaks down the support system for individual development. An individual in isolation cannot understand the total needs of his/her community, and therefore both the desire and the ability to meet those needs are lacking. This does not mean that the talents of each individual are not valued, but rather that they are valued as part of the sum total of talents within the community. They are of most value to each person, when they are devoted to the development of community initiatives, in co-operation and consensus with the total community.

The essence or essential element of community control that distinguishes the process of community control from all other methods of control, rule or governance is the coming together of the minds of the community – the use of all the talents within the community – to come to consensus. Consensus meaning agreement, concord reached after feeling together, perceiving together, and thinking together, best described as the sum of pooling together of the individual talents.

COMMUNITY CONTROL is like a living, developing, evolving tree, which is the sum total of the individual elements of the seed, the soil, the sun and the rain.

Community Control means that we have control in the face of Governments and institution, which continue to seek to oppress us, to make us dependants, to satisfy us with 'hand-outs', to perpetuate a welfare mentality – a mentality which is a total contradiction of:-

ABORIGINAL COMMUNITY INITIATIVE, PARTICIPATION AND CONTROL OF ABORIGINAL BUSINESS

(NAIHO, 1984, reproduced in: NAIHO, nd, emphasis in source)

This document is very revealing as to some of the concepts of community control and participation, which NAIHO developed from its experience and was guided by. It includes definitions of participation and community control that were developed directly out of the living experience of the authors, who signed on the document as one group. This document remains today a good summary of the philosophical approach behind *community control* as a concept.

Other documents reveal other approaches by NAIHO to different aspects of Aboriginal health, society, and politics. The question of political organising was also addressed elsewhere. Here in a quote from the AMS Newsletter, it is asserted that:

It is pertinent for members of the press to understand that, as a people who found it more appropriate to be governed by consensus in small social units, we have never had the hierarchical values of Western society. We tend to be suspicious of hierarchical government administration and we tend to view the society and the media with extreme distaste. As a result, we have never had the chieftains, warlords, monarchs, or papier mache presidents one sees in Western administrations throughout the world and we do not particularly want them now. (8-11/1981, p. 18)

Other documents reveal that the struggle for land rights was deeply held as the basic concepts that the ACCHSs movement is a part of, and aspires to. According to a document titled *Land Rights, Sovereignty and Health*, signed by Bruce McGuinness and The Victorian health service (VAHS), it was stated that:

Land rights and sovereignty are basic to the full restoration of Aboriginal health. This is a challenging statement. Yet the individual is doomed to failure who seeks to establish a strategy for lasting positive change in the health status of Aboriginal people but ignores their relation to land and their struggle to maintain and restore this relationship. To place this statement in context, we must examine the reality of history and the reality of today. (McGuinness and VAHS, 1988)

5.3 The Aboriginal Health-Workers: development, education, and philosophy

As the ACCHSs challenged some of the traditional concepts of health services, a new role was developed in the ACCHSs experiences: that of the Aboriginal health-workers. Aboriginal health-workers were employed locally by State health departments from the late 1960s, but under ACCHSs, the role of the Aboriginal health-worker and the practice itself became a much more central role in the services. According to Bill Genat, who recently published a book entitled *The Aboriginal Healthworkers: Primary Health Care at the margins*, “[t]he unique situation of healthworkers, with their dual status as community members and health service providers, and their painful familiarity with the contextual complexities facing clients, prompted the development of a distinct professional practice” (Genat, 2006, p. 174). One of the important developments of Aboriginal health-workers education came on the local level in the VAHS, in Fitzroy, which sought funds for a training program for ‘community health resource people’, another term for Aboriginal health-workers. The idea behind the development of this role was directly inspired by the Barefoot Doctor, a development of public health in China that saw the training of health-workers within communities:

The role of such community health resource people was envisaged as monitors of the general health of the community; to be able to deal with a wide range of minor health problems; to act as intermediaries between the community and outside professional medical personnel; and also the important role as agents of social, political and economic change (through community development projects, negotiations with local, state and federal government agencies, etc.). In short, the VAHS believed that the Aboriginal community should train their own equivalent of China’s “Barefoot Doctors”. (AMS Newsletter, 1-5/1983, p. 18)

The actual development of local “Barefoot doctors” can be seen as the development of the role of the Aboriginal health-worker. The role of the Aboriginal health-worker became central to the ACCHSs experience. Years later, when NACCHO was established in the early 1990s to replace NAIHO, it released its new manifesto, which included some discussion of various aspects of the ACCHSs movement. In the document, the role of

Aboriginal health-workers was emphasised:

Since their inception, Aboriginal community controlled health services have viewed Aboriginal Health Workers as the most important link between the community and the health care system. In fact, Aboriginal community controlled health services conceived of and were the first organisations in colonial Australia to employ Aboriginal Health Workers including the need to equip them with primary health care skills. (NACCHO, 1993, p. 21)

Due to the specific context in which Aboriginal health-workers were employed in the ACCHSs, the development of the role and education was a political act. As such, the development of these programs was occasionally on the political front line of the eternal struggle by ACCHSs to secure funds. In the early 1980s, local struggles of the Melbourne and Sydney ACCHSs (VAHS and the Redfern AMS) saw the establishment and development of Aboriginal health-workers education programs by these services.

The VAHS health-workers education program started to develop in the early days of the service. "By 1975 the VAHS had prepared a detailed submission for the funding of Aboriginal Health Worker Education Programme", which was sent to "various government funding agencies, both state and federal" (AMS Newsletter, 1-5/1983, p. 19), at first in vain. This is how the reaction of the Victorian Health Commission, the state's health department, was described in the AMS Newsletter:

However, the Victorian Health Commission had an even more novel response. They were sent a copy of the submission and, whilst in public responding negatively to the idea, secretly and hurriedly prepared an almost identical submission rushed it to D.A.A. in Canberra and immediately received funding to set up a health worker education programme under the auspices of the Health Commission! (And people wonder why we distrust the bastards!!) (AMS Newsletter, 1-5/1983, p. 19)

The Newsletter further reported that "[w]hile this happened and the Victorian Health Commission used the money to extend its existing and very inadequate internal departmental training programme, the VAHS was naturally outraged and re-submitted to DAA for an Aboriginal controlled programme" (AMS Newsletter, 1-5/1983, p. 19), which

was denied due to lack of available funds. VAHS then appealed for public donations for the plan for Aboriginal health-worker training. It was reported that:

VAHS was able to make contact with a private trust fund whose trustees were most impressed with the idea of an Aboriginal inspired, conceived and administered “self-help” project and they subsequently provided sufficient funds to enable the course to run for its first year. (AMS Newsletter, 1-5/1983, p. 20)

While there was no detail about who donated these funds, this is another good example of how the use of the tactic of multiple funding sources, as discussed in chapter 8.2, has the potential to allow ACCHSs more actual control in the context of funding relationships with the state and the question of co-option.

The education program, now relying on donations, had its first class in 1982, and was described in the Redfern AMS Newsletter as “Australia’s only community controlled Aboriginal Health Worker Education Programme” (AMS Newsletter, 1-5/1983, p. 18). The process of recruiting students is worth noting. As the AMS Newsletter describes, recruiting students:

was conducted in a uniquely Aboriginal manner and in that individual applications were not necessarily sought, but rather Aboriginal communities were invited to nominate students chosen by them on the basis that these communities should have the say who would ultimately be their “health resource person”. Furthermore, if the communities selected their own students it would give them a very real and positive sense of involvement and provide strong psychological support for the individual student and thus circumvent potential personal problems that may otherwise force the student to “drop out”. Despite the fact that this was a “new” idea, Aboriginal communities responded positively with the result that almost all areas in Victoria were represented in the final group of twenty-six students chosen to do the course. The students ranged in age from 17 to 42 and came from a variety of backgrounds and employment situations, most being unemployed prior to starting the course. (AMS Newsletter, 1-5/1983, pp. 20-21)

The curriculum was drawn up by members of the VAHS, including one of the employed

physicians, together with other NAIHO members (AMS Newsletter, 1-5/1983). The list of subjects taught reflects on the philosophy of the ACCHSs and some of its leading themes. Mainly, the emphasis was given to both the social and the political determinants of health, although, the critique of health politics, including of health under capitalism, goes hand in hand with a serious study of some of the key biomedical terms and aspects of medical care, which are also being integrated with traditional health concepts. The subjects, as presented in the AMS Newsletter, are quoted in box 4.

The Newsletter notes that 20 out of the 26 students who started the course graduated after nine intensive months, “and were presented with their graduation certificates at a ceremony attended by a significant proportion of the Melbourne Aboriginal community” (AMS Newsletter, 1-5/1983, p. 23).

In Redfern, a program based on the VAHS’s model was launched in April 1984, and was funded by CEP and DAA grants (AMS Newsletter, 3/1985, p. 4). The program was run along similar lines to the VAHS program, and put similar emphasis on the social and political determinants of health. According to the December 1985 issues of the AMS Newsletter, “with responsibilities for promotional, preventive and curative health of the community, the Aboriginal Health Worker is a powerful weapon against oppression” (p. 34). One of the subjects presented, *Politics of Health*, “deals with the demystification of medicine, the reason for Aboriginal community controlled health services, the study of “Western” medical institutions and the structure of societies and their relationship to community health and medicine” (AMS Newsletter, 12/1985, p. 34). This is an example of the importance of community-controlled health services, in ‘demystifying’, or overcoming the false gap between the medicalised ‘health’ sphere and the social/political structures of society.

Another subject in the education program is titled *Community Organisation*: “here the trainees are being armed with the necessary skills to be able to organise in their communities, research resources, submission writing and meeting procedures” (AMS Newsletter, 12/1985, p. 34). About 40 percents of the course focuses on medical and dental subjects. By 1988, the Redfern AMS Health Worker Education Program has been running for four years, with some 37 graduates (AMS Newsletter, 09/1988 p. 9).

Box 4: curriculum for the first class of Aboriginal health-work students, VAHS 1982

Community Organisation: This subject was done one half day per week and included such topics as Administration, Organisations, Comparative Culture, Research, Decision Making, Law and Society, Meeting Procedures, Oral History, etc.

Communications: This subject dealt with the following topics: Personal Communication, Interviewing Techniques, Public Speaking, Media Studies, Newspaper Production and a radio programme which was produced by the students each week on Melbourne radio station 3CR.

Politics of Health: In this subject students examined the development of both Western and Traditional Aboriginal medical concepts and how today the two can be integrated, and also how powerful lobbies on behalf of medical practitioners and pharmaceutical interests can and do subvert and prevent community aspirations of community control of health care. The profit motive in health care delivery and all its implications for disadvantaged groups would also be dealt with.

Medicine: This was to be one of the most important components of the course and would occupy half the working week for students. The idea would be to give students a basic understanding of as many aspects of medicine as possible. This segment of the course would be divided into two main parts:-

Theoretical Studies: Subjects included Anatomy, Physiology, Microbiology, Audiometry, Embryology, Gastro-intestinal pathology, Parasitology, Sexuality, Neurology, Cardiovascular pathology, Preventative Dentistry, Otolaryngology and the Cardiovascular, Respiratory and Uro-genital systems, as well as Obstetrics, Gynaecology Ophthalmology and Paediatrics. These subjects were to be taught by Dr Galak, VAHS doctors and a team of over twenty Doctor/Specialist volunteers.

Practical Experience: Throughout the course, students were to be given many opportunities to be involved in practical experience situations. Thanks to the co-operation of Melbourne health institutions, students would be given placements in St. Vincents Hospital, St. Andrews Hospital, Royal Childrens Hospital and the Fairfield Infectious Diseases Hospital. Field work placements were also offered by many community health centres, infant welfare centres and when the course began it was conducted in the Eric McGuinness Study Centre and, apart from the medical studies segment, was taught exclusively by Aboriginal lecturers and tutors, particularly Bruce McGuinness. Later in the year a major field trip to central Australia was undertaken. This trip was intended to broadene[n] the students understanding of the different situations confronting Aboriginal communities throughout Australia. The students travelled by bus through Victoria, South Australia and the Northern Territory, visiting many Aboriginal health centres and communities. Most students agreed that this was the highlight of the course and that it really accentuated the relevance of the theoretical studies back in Melbourne.

(AMS Newsletter, 1-5/1983, pp. 21-22)

Through NAIHO's network, the developments in the role of Aboriginal health-workers and the education process became available to other ACCHSs, as indeed is the case. This development is another example of a significant change in the entire practice of health service delivery in Aboriginal communities, and to the significance of a national network of community-controlled services.

5.4 Funding of services and relationship with the state 1974-1979

In the second half of the 1970s, more ACCHSs were organised by local communities, and the early services continued to evolve and develop more programs. By 1976, most ACCHSs were incorporated under the Aboriginal Councils and Association Act of 1976 and DAA by-laws (Eckermann et al, 2006). Securing ongoing funds was (and still is) essential for an ongoing operation and development of services, and a substantial part of the workload of ACCHSs had to be dedicated to secure funding (as shown in the case of the Redfern AMS in chapter 4.5). It was estimated that by 1976 ACCHSs had received over \$1 million in DAA grants (Hay, 1976), yet uncertainties and funding issues continued, as the different players – State and federal DAAs, Health Departments, and the ACCHSs – continued to struggle to find an ongoing formula that was acceptable to all sides and could allow for an expansion of the movement. The question of funding emerging services was becoming a major problem, which revolved around the question of control. In 1976, the DAA released a *Review of delivery of services financed by the Department of Aboriginal Affairs*. In the assessment of the ACCHSs, the report reveals some of these tensions:

Assessed against the high priority they accord to curative services, Aboriginal Medical Services appear to have performed effectively, although they have not responded readily to Departmental attempts to control their rates of expansion. However, in relation to the stated Objectives of the health program which give priority to health care over clinical treatment, this judgement has to be qualified, unless it is the statement of objectives which needs amendment. (Hay, 1976, p. 13)

In a further comment that reveals the tension about the growth of the movement and the implication of a subsequent need for growth in funding, the report stated that “[n]o evidence has been seen of other options being considered when most of the Services were established and expanded. They just grew” (Hay, 1976, p. 14).

This issue is a recurring theme in the question of control, or rather, the community-control/co-option relationship, which is created through funding agreements. This relationship can be further observed in some of the report’s recommendations: the report

recommended that ACCHSs “receive only limited finance to cover prescription fee charges. They should consider instituting a fee where appropriate or meeting this expenditure in other ways” (Hay, 1976, p. 90). Also, the report recommended that the DAA and Health Department “make a condition of all grants the right to inspect and take extracts from all the books of account of organisations receiving health grants to verify that the Commonwealth grants have been properly spent” (Hay, 1976, p. 90). The reserved approach of the report can be summed up in the following quote:

There is little doubt that Aboriginal Medical Services are effective in doing what they set out to do, i. e. provide a clinical service for Aboriginals with maximum use of Aboriginal staff. It is less clear whether the Services should continue to receive grants. The clinical service which they provide does not appear to accord with the stated purpose of the health program, in which the emphasis is more on health care.
(Hay, 1976, p. 87)

Emerging services were not the only ones to struggle for funds, as the earlier services continued to face financial insecurities. The Redfern AMS, for example, faced another threat of closure due to lack of funds in July of 1977. Graham Williams (1977a) reported in the *Sydney Morning Herald* that the recent threat came in a context of reports by the AMS nutritional project and AMS employee Dr Archie Kalekorinos that about 25% of the Aboriginal children in Sydney can be described as ‘Biafran babies’¹⁰. As part of the crisis, 23 staff members of the Redfern AMS were asked to agree to have their salaries cut in half (Williams, 1977b). The staff agreed, even though it meant that most were then waged less than they would be on unemployment benefit (‘the dole’) (Williams, 1977c). The public exposure, which was partly ignited by reports of hunger and malnutrition in Aboriginal communities at the time, succeeded in ensuring more federal funds for the operations of the AMS within days (“More cash for Aboriginal centre”, 1977). It should also be noted that Vilner, DAA Minister at the time, argued in a letter to the *Sydney Morning Herald* that no actual cuts were made (Vilner, 1977), a claim that was rejected in a letter of reply from Naomi Mayers, Redfern AMS administrator (Mayers, 1977).

¹⁰ The Nigerian civil war (1967-1970), which claimed the lives of up to two million people, included a siege on Biafra, a secessionist region in east Nigeria that declared independence in 1967 (Uzokwe, 2003). The siege caused mass starvation, which created an epidemic of Kwashiorkor among children, a condition caused by severe malnutrition (Ifekwunigwe, 1971). Images of children displaying physical signs of the condition, including a bloated stomach, appeared in western media at the time, and came to symbolise the plight of people suffering from starvation.

Two weeks later, on August 24, Williams further reported in the Sydney Morning Herald that the DAA refused to help fund a nutritional education project by the AMS in Redfern (Williams, 1977d), despite a governmental report that strongly backed the suggested nutritional project (Williams, 1977e). Months later, funds for the projects were raised through the *Freedom From Hunger Campaign*, which pledged \$132,000 (Williams, 1977f), the exact sum that the DAA refused to add to the then existing biannual budget of \$60,000 to nutritional projects. Less than two years later, in July 1979, Dr Kalekorinos announced that the Biafran baby syndrome has been eradicated from Sydney (Williams, 1979).

Tensions between the movement and State and Commonwealth health agencies were also evident in the objection of ACCHSs to a joint Commonwealth/States conference on Aboriginal health, which was held on 12-13 December 1978 (AMS Newsletter, 10-12/1978, p. 5). Some of the main concerns regarded an agenda item for the conference to discuss changes to ACCHSs funding arrangements, which would see the move from federal DAA grants to State health agencies. Despite the strong criticisms of the federal DAA (as discussed in chapter 4.7), State health departments were seen as worse. State health bodies were seen as responsible in large part for Aboriginal people's health before the construction of federal bodies (Office of Aboriginal Affairs, then DAA) to meet the new public perception of federal responsibility to the state of Indigenous Australians after the 1967 referendum (as discussed in chapter 2.2). The conference was to discuss these funding arrangements without the ACCHSs themselves, and by 1978, the ACCHSs movement's scope and influence was significant enough to raise strong public objections to such conferences to discuss them in their absence.

In 1979, parallel to the study of the VAHS by Pam Nathan (that resulted in the book *A Home Away From Home*, 1980), a study of the Redfern AMS was conducted by S.J. Duckett and J.M. Ellen from the University of New South Wales. The writers noted that:

the AMS has been under constant threat of funding cutbacks – not for any reason related to the need for the service provided by the AMS, but possibly because of what is perceived as a change in the philosophy of the funding agency and the Federal Government. Any information provided may be used as evidence to justify cuts in funds, and so, not unreasonably, the AMS is loath to supply such information

Five years after the 1974 Albury workshop (as presented in 5.1), NAIHO made some of its first national headlines, around the first such attempt to participate not just in the service level, but also in larger picture policy formation. One of the needs for such intervention was the uncertainties that arose regarding the expansion and development of the movement, as explored above.

In early 1979, NAIHO suggested a new policy plan for the Fraser government. The document that proposed these changes, *a National Black Health Program*, was considered a consolidation of the views of NAIHO at the time (Department of the Prime Minister and Cabinet, 1980, p. 36). The plan would have seen funding for the establishment of thirty-five new ACCHSs, in all National Aboriginal Council (NAC) electorates. These were to be based in communities in the process of setting up a board, and NAIHO suggested that, over three years, it would work with these communities “to implement the necessary administrative techniques” (Ester, 1979, p. 468). NAIHO calculated a proposed budget for the development of these services, which amounted to some \$24.2M, about \$5.8M less than the budget allocated to the State governments for Aboriginal health, which would be superseded, thus saving the Commonwealth the difference. “But Fraser is not interested, and Finance Minister Eric Robinson is understood to have told the NAIHO bluntly that the plan would interfere with State rights” (Ester, 1979, p. 468). Furthermore, it was reported that “[t]he Minister for Aboriginal Affairs has advised NAIHO that he will not respond to the organisation’s proposals until the PER has reported. NAIHO argued strongly for the National Black Health Program in its discussion with the PER” (Department of the Prime Minister and Cabinet, 1980, p. 36) (a detailed discussion of the PER is found in chapter 6).

In some cases, when new services were not able to raise enough funds for their operation, the Redfern AMS supplied some financial assistance. In the September-October 1980 issue of the Redfern AMS Newsletter, it is reported that Redfern AMS provided close to \$30,000 in assistance to such communities in the twelve months prior, including Wilcannia, Broome, Geraldton, the Pitjantjatjara Homeland Health Service and Purfleet/Taree (AMS Newsletter, September-October 1980). In some areas, such as Wilcannia, the AMS was also serving local non-Aboriginal patients, due to a dire lack of health services in the

remote areas (AMS Newsletter, July-August 1980).¹¹

The development of these five services provide a good example of the importance of an organised movement. All five services were initiated by local communities following the lead of Redfern and other early ACCHSs. The existing movement provided example, advice, and even some of the material needs. The new services also enjoyed some of the hard-gained changes achieved by the movement. For example, these new services could bring in a doctor that was funded by Medibank, when it existed (AMS Newsletter, 1976), and later Medicare, thanks to earlier and ongoing efforts of previous ACCHSs.

Concurrently, NAIHO and the ACCHSs continued to actively seek donations and other funding opportunities. Some donations were received from international sources. For example, the Wilcannia service received a donation from United States-based computing company IBM for the sum of US\$22,000 (AMS Newsletter, 8-9-1979, p. 3). One fundraising source that caused some controversy at the time was the Council of Churches. In 1980, some key figures in the land rights movement agreed to join an Aboriginal Advisory Committee (ACC) set up by the Council of Churches, “to advise the Council on matters relating to Aboriginal affairs, and also to dispense grants to Aboriginal groups from a special fund which was established by the A.C.C.” (AMS Newsletter, 01-02/1981 p.13). The committee was chaired by Gary Foley and included Bob Bellar, Paul Coe (founder of the Redfern Aboriginal Legal Service), and then-priest Pat Dodson. In December of 1980, the AAC gave NAIHO a grant of \$5,000. In February of 1981, Geraldton and Purfleet/Taree ACCHSs, which the DAA was still refusing to fund, were granted \$2,000 each. According to the AMS Newsletter:

The Committee has three conditions which have to be met before any group is eligible to receive grants. They are: 1. That the applicant group be Aboriginal controlled. 2. That the group is in no way associated with the State or Federal Government. 3. That the group has no possibility of receiving funds from any other source. (AMS Newsletter, 01-02/1981 p.13).

¹¹ Apart from the financial assistance, the Wilcannia service is one of the earliest remote services that the Redfern AMS was able to assist organisationally. It has its roots in a meeting organised by the “Organization for Aboriginal Unity” (AMS Newsletter, no. 14, November 1974, p. 4). The meeting was held on 25/5/1974 and was attended by Naomi Mayers of the Redfern AMS. The meeting “advocated strongly that this organization do something concrete about this situation as the Government Organizations apparently wouldn’t or couldn’t do anything” (p. 4).

A year later, the activity of the Council of Churches research team on the state of Aboriginal people was accused of being a 'Communist operation' by the International Council of Christian Churches (AMS Newsletter, 4-9/1982 p. 13).

5.5 Relationship with other movements, 1974-1979

As explored so far in the thesis, the ACCHSs movement arose out of a broader Aboriginal struggle, in an environment of a tide of progressive movements, and constitutes a part of the land rights movement. The first ACCHS, in Redfern, was a result of the formation of the legal service a year earlier, another community-controlled initiative and a part of a rising tide of activism. The ACCHSs movement maintained connections with different parts of the movement, and took part in some of the key events in the land rights struggle.

In this section, I will explore two examples of the connection of the ACCHSs movements with other movements. The first example is of its relations with another progressive movement, the feminist movement, and the other example looks at the connection of the ACCHSs movement with the more reformist wing of the land rights movement. A third example, which looks at the relationship between NAIHO and the National Aboriginal Congress (NAC), will be presented separately in 6.7 in the context of the 1980 Program Effectiveness Review (chapter 6).

The connection between the ACCHSs movement and broader movements in the context of which it operates was and remains dynamic. Reflecting on the Aboriginal tent embassy 10 years later, an article in the AMS Newsletter reported that the Aboriginal Embassy:

remains to this day, the biggest and most successful mass protest ever undertaken by Black Australia. Without the 1972 Embassy demonstrations it is unlikely that the Aboriginal movement today would be as well organised and successful as it is today. It is also unlikely that organisations such as the Aboriginal Medical Service

would exist today had it not be for the “Embassy” demos or the people that were involved with them (AMS Newsletter, 11/1981-4/1982, p. 23)

In 1975, a group of about fifty protesters interrupted a reception in Parliament House in Canberra of the Women and Politics Conference, which was attended by 700 delegates (*Sydney Morning Herald*, 1/9/1975). The reception was also attended by PM Whitlam and other ministers and parliamentarians, and was intended partially to welcome back the Australian delegation to the UN World Conference of Women in Mexico. One of the leaders of the protest was Naomi Mayers. The protest was about a lack of representation of Aboriginal women, and a lack of understanding of feminism within the context of Aboriginality and racism by the wider feminist movement. One sign of the protesters, as appeared in a photograph in the *Sydney Morning Herald* read, “Germaine cops all, we get nothing” (“Women’s talks begin in uproar”, 1975), referencing Germaine Greer as a symbol of the focus on white feminism and ignorance towards the situation that Aboriginal women were facing. This is how the event is described in the AMS Newsletter. The description of events in the AMS Newsletter is presented in Box 5.

Box 5: Description of events surrounding International Women’s Year, 1975 in the AMS Newsletter

On Sunday 31st of August Mr. Whitlam opened the reception of the Women and Politics Conference in Parliament House in Canberra. But the hallowed halls were reeked (sic) by a group of Aboriginal women singing “We shall overcome”. Naomi Mayers, our venerable secretary-organiser took the microphone from the Chairwoman and addressed the session to make known that black women had bypassed the official channels of International women’s Year, that representatives to the Mexico Conference had been undemocratically appointed and no attention had been [paid] to the fact that black women’s needs and aspirations were difference from those of the majority of the women at the conference, and in fact those who were struggling for women’s rights. We are firstly oppressed by racism and secondly by the sexism not significantly by our men but by the men in positions of power who are by definition white. The Secretariat after not inviting black women and immigrant women apologised (sic) and allocated two days to Aboriginal and Island women for a “Black Speak-out” where we spoke to a packed house. After our revelations on the effects of individual racism, the stifling effects of the bureaucracy, the Queensland Acts, our attitude to International Women’s Year, overseas speakers stated that Australia was more racist than South Africa.

(AMS Newsletter no. 17 08/1975, p. 2)

The events around International Women’s Year remind us that solidarity between social movements is not always guaranteed, as social movements may sometimes see each other as in competition. The two movements have some key joint goals – the creation of a more equal society being perhaps the most central one. There are also living connections between the movements (as famously explored in the US context by Deborah King, 1988)

yet disagreements between the movements are understandable in a context of constant competition for general support and identification.

Another interesting example of NAIHO's debates with other social movements exists within the context of the land rights movement. One of the key debates within Aboriginal communities revolves around the concepts of autonomy versus integration (or assimilation) into Australian society. This question is debated on both tactical and ideological levels. In the ACCHSs movement, the strongly autonomous approach focuses on health infrastructures. The ACCHSs movement developed from a distinct leaning towards autonomy, or community-control. Furthermore, in this context, the question of autonomy versus integration is manifested in the community-control/co-option relationship, which the movement and the mainstream infrastructures enter.

The question of autonomy versus integration can be further observed through the argument between the Autonomy-leaning elements of the land rights movement and those elements proposing integration within existing political structures, to try to influence the system from within. This debate is commonplace with progressive movements, or change-seeking movements in other contexts as well, often referred to as the question of 'reform versus revolution'.

Roberta Sykes, the Redfern AMS publicity officer and Newsletter editor at the time, polemicised with Senator Neville Bonner about the Black Power movement in Australia in a fascinating booklet titled *Black power in Australia: Neville Bonner versus Bobbi Sykes* (edited by Turner, 1975). Neville Bonner was the first Aboriginal senator in Australia, and represented Queensland for the Liberal Party between the years 1969-1983. He had a tumultuous relationship with the radical parts of the movement ever since he entered office. Kevin Gilbert wrote in 1973 that:

Far from being proud of Bonner as the first black member of parliament, many blacks have become alienated in the extreme by the statement that Bonner will keep making. Blacks suspect that he is a stooge being used by the Liberal Party to show Australia, tongue in cheek, its commitment to blacks. (1973, p. 130)

For the booklet, Bonner and Sykes wrote two essays each, the first presenting an opening

statement, and a second essay of rebuttal. While Bonner argues for working within the existing political system, Sykes advocates for communities to take power and self-organise. This booklet is a precious document as it features a debate between two key characters representing two competing political ideas in Aboriginal community: is it more effective to work within the system or to openly oppose it? Today this debate continues to create a deep divide in Aboriginal politics. In the introduction, Editor Ann Turner writes:

The difference between ms Sykes and Senator Bonner lies less in posing the problems than in seeking the solutions. Both believe that blacks are at present under-privileged and have legitimate claims to improve their position in society. They disagree on the ways of attaining this; on just how to make blacks first-class citizens. (in: Turner, 1975, p. 1)

Senator Bonner presents his own advancement in the ranks of the Liberal Party as proof that “if I can do this then a lot of others can too” (in: Turner, 1975, p. 43), and that “[m]y fellow Aborigines have got to learn the intrigues of politics they have to learn to be ambitious” (p. 46). Bonner also tries to emphasise improvements in Aboriginal policy over the 40 years leading up to the writing of this document. “What Aborigines can do is learn to use the political process to make sure this advance continues and is accelerated” (p. 43). In regards to the tactical question at hand, Bonner emphasised that “[a]s a minority, Aborigines must realise that their primary tactical goal is to win the support of the majority in achieving what the minority wants” (p. 52). Yet with all the criticism, Bonner concedes that “I have to admit that if I were thirty or so years younger, I probably would have been tempted to become a Black Power activist” (p. 46).

In her essays, Sykes mainly wrote about her definition and perception of the Black Power movement. According to Sykes, “Black Power is the power generated by people who seek to identify their own problems, and those of the community as a whole, and who strive to take action in all possible forms to solve those problems” (in: Turner, 1975, p. 66). The position that Sykes represented in this debate is indicative of both the tactical mindset and ideology of the movement at the time, especially the emerging national leadership of the ACCHSs movement. More on the concept of Black Power, including some of Sykes’ input, can be found in chapter 4.1.

5.6 NAIHO's involvement with the National Trachoma and Eye Health Program

The battle over control of the National Trachoma and Eye Health Program (NTEHP) offers another case study of the political power NAIHO had obtained by the early 1980s. Trachoma, an infectious eye disease that can lead to blindness if untreated, was a major epidemic among Aboriginal communities. One of the main people to publicise the need for tackling the issue of trachoma was Fred Hollows, who as discussed earlier (4.3) assisted in the establishment of the Redfern AMS, and had a supportive working relationship with the ACCHSs movement ever since. Hollows started to call for a national approach to trachoma from about 1974, together with Gordon Briscoe and Dr S.I. 'Pip' Iivil of the Department of Health (Hollows and Corris, 1991). They decided to organise a national campaign through the College of Ophthalmologists. The main mission of the program was to create teams that would eventually cover the entire mainland, set up field clinics to treat trachoma and other eye health issues. The teams were composed of about nine full-time members, of which at least half were Aboriginal people, including field officers that contacted and liaised with communities. "All up, we visited 465 Aboriginal settlements, performed a thousand operations, treated 27,000 people from trachoma and delivered 10,000 pairs of individually prescribed spectacles" (Hollows and Corris, p. 147).

Like other conflicts between the movement and the state, conflict over the NTEHP was essentially over the question of the means of control over the program. According to the AMS Newsletter, "conservative elements" in the Royal Australian College of Ophthalmologists (RACO) "seemed determined to hand control of the program over to the various state health departments" (AMS Newsletter, 11/1981-4/1982, p. 6). It is also reported that the same conservative elements are "determined to remove Professor Fred Hollows" from the program (p. 6). NAIHO "strongly opposed" the idea, and Naomi Mayers, who was appointed by RACO as an advisor, prepared a report that "called on the college to re-establish the [Trachoma] Program under the control of regional committees with a majority of Aborigines on each" (p. 6). RACO is reported to have "initially rejected the main findings of their Aboriginal Advisors report, but after a meeting with the N.A.I.H.O. executive, slightly modified their attitude" (p. 6). The Newsletter report concludes: "Nevertheless, the current situation at the time of writing, is that the major issue

of authentic Aboriginal control of the program remains unsolved, and this is an issue about which you will read more in the near future” (11/1981-4/1982, p. 6).

In early 1980, federal Health Minister MacKellar advised the NTEHP that their funding for field programs for the year would be cut (AMS Newsletter, 5-6/1980). The Minister informed, via letter, the NTEHP that it would no longer be funded by the Department of Health. The move to block funding for the program by MacKellar was heavily criticised by NAIHO, and gave Fraser a good opportunity to signal good intentions during the meeting with NAIHO as he overrode MacKellar’s decision and assured NAIHO that the program would continue (AMS Newsletter, 5-6/1980). The apparent tension between Fraser and MacKellar continued, after MacKellar reportedly tried to stop funding of a health survey in and around Alice Springs, which was organised by NAIHO and the Central Australian Aboriginal Congress (which operates a community-controlled health service, among other projects).

According to the AMS Newsletter, the refusal was made on the grounds that Dr Trevor Cutter, one of the two doctors who was to run the survey, was involved in publicising the Maralinga nuclear test and its effects on the health of Aboriginal people and communities in the area¹² (AMS Newsletter, 5-6/1980). Such involvement may have been seen as a tendency to identify with popular struggles. The Newsletter reports that this “obviously was a purely political motive for stopping the project, and MacKellar managed to blissfully ignore a series of telexes from NAIHO demanding that the project go ahead” (AMS Newsletter, 5-6/1980, p. 3). Eventually, Naomi Mayers of the Redfern AMS “sent MacKellar a telex stating that NAIHO was prepared to make an international issue of his political interference, by having our NAIHO representative who was attending a conference in Holland, expose his actions to the international media”. (5-6/1980, p. 5) Fraser’s direct intervention overrode MacKellar’s original decision, and the funding for the health survey was granted.

On March 13, 1981, Fred Hollows, joined by Gary Foley as the NAIHO representative, attended a meeting of the Western Australian Department of Health, which was to give the WA Government control over the Western Australian part of the NTEHP (AMS Newsletter,

¹² For more on the Maralinga nuclear test and aftermath, see: Parkinson, 2002.

1-2/1981, p.14). Despite the fact that the meeting decided on the control over the WA section of the program, Aboriginal people were not allowed into the meeting, a refusal that stood even when Hollows pointed out the absurdity of it, as Aboriginal groups were protesting outside the meeting. After the meeting, Hollows reported to a meeting of Aboriginal groups that took place simultaneously. Hollows reported “that the ‘old men with outdated ideas’ had virtually decided to go ahead with a state Trachoma programme without his involvement” (AMS Newsletter, 1-2/1981, p.15).

The tension between both NAIHO and the NTEHP and the federal government continued, which at this stage was also in the context of the Program Effectiveness Review, as will be explored in the next chapter (6). In 1981, Gary Foley invited Fred Hollows to attend a meeting at the Redfern AMS between representatives of various ACCHSs with federal DAA Minister, Peter Baume, to observe the way that the Minister regarded Aboriginal people (Hollow and Corris, 1991). Hollows’ recollections of the meeting are presented in Box 6.

Box 6: Fred Hollows describes meeting with DAA Minister Peter Baume and ACCHSs representatives, 1981

I went to the meeting and sat there for two hours. Every time an Aborigine made a point, Peter Baume would stand up and contradict him or her, completely disregarding the facts and circumstances. A woman from the Davenport Reserve stood up and told a story about their attempt to establish a medical service. They’d run it on a shoestring with a visiting doctor and the police had come and confiscated all their records and notes, kept them for three months and returned only photocopies, not the originals. Now I knew that Aborigines are very sensitive on those questions of privacy and confidentiality, as are doctors, so I thought, Here’s a chance for Peter [a Gastroenterologist] to show sympathy with these people. He stood up and lectured them on the duties of the police. I was incensed; here was a privileged, middle-class professional who had never had a copper’s hand on him, telling black people about the police who had been their natural enemies for generations. Bruce McGuinness, an Aborigine, was in the chair and he asked me if I had anything to say. It was another of those occasions when I was almost incoherent with anger. I couldn’t trust myself to speak - the result would have been too violent and obscene. I had some papers in my hand, notes I’d been taking. I walked up to the table where Baume was sitting and threw them down in front of him. ‘I will never work with this man again,’ I said, and I left the room.

(Hollows and Corris, 1991, pp. 155-156, emphasis in source)

In that meeting, NAIHO, for the first time in its existence, passed a vote of no confidence in the DAA Minister, “condemning Government policy and administration in so doing” (AMS Newsletter, 6-7/1981, p. 2). This event, on top of ongoing funding difficulties, caused Fred Hollows and Gordon Briscoe to resign from the NTEHP (Hollows and Corris, 1991). PM Fraser subsequently invited Hollows and Briscoe to a meeting (AMS Newsletter, 6-9/1981, Hollows and Corris, 1991). After their meeting, it is reported that

Hollows and Gordon Briscoe retracted their resignation and resumed their positions in the program. This move created some tensions between Fred Hollows and some of the NAIHO leadership, who believed that Hollows was “sweet-talked” by Prime Minister Fraser, and was promised vague new health arrangements (AMS Newsletter, 6-7/1981). The Newsletter then reported on a NAIHO conference that took place in mid 1981 in Redfern, where, in the aftermath of the latest incident over the program, representatives of ACCHSs from across the country discussed the latest developments in the talks with Government (this conference needs to be also understood in the context of the PER, as explored in chapter 6):

With Professor Hollows and Mr Gordon Briscoe’s return to the National Trachoma and Eye Health Programme, the Government undoubtedly felt it had effected a coup which might ‘defuse’ the situation. However, at the National Aboriginal and Islander Health Organization Conference at the A.M.S. in Redfern several weeks later, debate on ‘The New Health Arrangements’, the Programme Effectiveness Review, and the three other reports before Parliament, indicated even more resentment and discontent at the Fraser Government’s attitude towards Aboriginal health. More than one hundred representatives of community-controlled Aboriginal Medical Services throughout the country denounced the Government’s ineptitude and lack of action over the four Aboriginal health reports and described ‘The New Health Arrangements’ as reactionary. Great concern was expressed for those Aboriginal people who do not have access to a community-controlled Aboriginal Medical Services and whose ‘disadvantage’, under the New Arrangements, would be means-tested. (AMS Newsletter, 6-7/1981, p. 8)

The battle over the NTEHP bears similarities to other main conflicts between the ACCHSs movement and the state. Most of these revolve around the question of control and authority, and include both a practical and a theoretical debate about the state’s role in funding community-governed projects. The next chapter will look at perhaps the main clash between the ACCHSs movement and the state during the first two decades of the movement, a clash that revolved around the Fraser government’s *Program Effectiveness Review* of 1980, and its subsequent suppression.

Chapter Six: The Program Effectiveness Review (PER) and its suppression¹³

This section will trace the crucial period of 1980-1983, a period of intensified political struggle over health services and control between the ACCHS movement and State/federal agencies. This period is bookended by two significant developments: the *Program Effectiveness Review on Aboriginal Health* (1980), which was commissioned and subsequently suppressed by Prime Minister Malcolm Fraser, and the New South Wales Task Force on Aboriginal Health (1983). This dramatic period has shaped the present-day topography of Aboriginal health infrastructures, yet it remains almost untouched by health policy researchers. Studying this period is central in conceptualising the dialectics of co-option/community control in the Aboriginal Australian context. The Redfern Aboriginal Medical Service Newsletters from the period are used to gain unique real-time insight into the politics of that struggle, as was captured by health activists at the time.

Despite the importance of the “long-forgotten and actively suppressed” (Kunitz and Brady, 1995, p. 554) PER and its significance in the process of the development of policy around Aboriginal health, the report has raised very minor attention from health policy researchers, with some discussion (Bartlett, 1998; Kunitz and Brady, 1995; Nathan and Japanangka, 1983) and passing mentions (Brady, 2002; Anderson and Saunders, 1996) in accessible literature. Together with the historical significance and influence on policy in the area of Aboriginal health, the PER and the events that unfolded as a result of its suppression remain a good example of the way in which policy is formed in the points of contention between social movements and the state.

¹³ An earlier version of this chapter was published as a journal article (Gillor, 2011).

6.1 The commissioning of the PER

By the end of the 1970s, two major reports brought some more public attention to the unbearable state of Aboriginal health across Australia and the need to re-examine state funding in light of the emerging community-controlled health services movement: the Federal Parliamentary Committee on Aboriginal Affairs' *Report on Aboriginal Health* (House of Representatives Standing Committee on Aboriginal Affairs, 1979), and the Report of the *National Trachoma and Eye Health Program* (1980), which included an Australia-wide study of the prevalence of trachoma in Aboriginal communities and ways to tackle the disease. The latter report was conducted by Fred Hollows with collaboration of NAIHO and ACCHS around Australia.

In the wake of these two reports, Prime Minister Malcolm Fraser commissioned another committee to carry out a *Program Effectiveness Review on Aboriginal Health*, which was to re-examine the question of Aboriginal health funding (AMS Newsletter, 3-4/1980; Bartlett, 1998). The committee was first proposed by PM Malcolm Fraser on October 4, 1979, as he approached DAA Minister Fred Chaney and Health Minister Michael Mackellar, who agreed to the committee before the end of November (Department of the Prime Minister and Cabinet, 1980). The PER was to "take into account all existing reports on Aboriginal Health" and "would itself be the 'definitive' report on Aboriginal Health" (AMS Newsletter, January-February 1981, p. 5).

One of the main recommendations of the House of Representatives Standing Committee on Aboriginal Affairs Report (1979) was to establish "an independent evaluation team responsible to the Minister for Aboriginal Affairs... to evaluate the effectiveness of all Aboriginal health care services and programs in accordance with the World Health Organisation's definition of health and the principles of self-determination..." (House of Representatives Standing Committee on Aboriginal Affairs, 1979, p. 109). The PER, which was commissioned later that year, offered an evaluation of effectiveness of services, yet they did not refer to the WHO definitions as principal guidelines. Also, the PER was commissioned and was responsible to the Prime Minister's office, rather than the DAA Minister. The report further recommended that "Aboriginal communities be given the

opportunity to determine the type of health service that will best suit their needs and available resources and that a Task Force be established to place the full range of alternative health care services before them” (House of Representatives Standing Committee on Aboriginal Affairs, 1979, p. 117). Such Task Forces were eventually established in Victoria and NSW on the State level, after the suppression of the PER, as will be explored in the following sections.

The PER committee was chaired by an officer from the Department of the Prime Minister and Cabinet, and included officers from the Department of Aboriginal Affairs, the Department of Finance, the Department of Health, and the Social Welfare Policy Secretariat (Department of Prime Minister and Cabinet, 1980). During its research, the PER committee held a meeting with representatives from NAIHO member services at the time (AMS Newsletter, 1-2/1980), as well as meeting with representatives of Aboriginal organisations such as NAIHO and the NAC and visiting a ‘small number’ of Aboriginal communities (Department of the Prime Minister and Cabinet, 1980, p. 7). The meeting with the ACCHSs representatives took place on February 11 1980, and reportedly went on for about seven hours (AMS Newsletter, July-August 1980). In the meeting, community-controlled health services representatives complained that the existing funding system was giving about 80% of the existing Commonwealth budget allocated to Aboriginal health directly to the State Health Departments, leaving only 20% for the ACCHSs. The Newsletter reports that those who attended described the meeting as “very positive” (AMS Newsletter, July-August 1980, p. 4) as it allowed them to have their say to a committee that was directly appointed by the Prime Minister, and had the potential to bring about a progressive change in funding structures.

6.2 The PER: findings and themes

Despite the importance and significance of the PER, its report and conclusions were scrapped, and were never officially released, however, a few copies have leaked to the media (Anderson and Sanders, 1996; Kunitz and Brady, 1995). The report itself included

about 75 pages of findings (including ten pages of recommendations) and some further 75 pages of attachments and bibliography. I was able to locate the findings and the recommendations, but not the attachments, which include (according to the table of contents) overview of related reports, programs, and policies, as well as some statistics and a bibliography. The PER report noted that a “significant constraint” of the committee’s work was “the difficulty of establishing causal relationships even where changes in health status occur because changes result from the interaction of social, cultural, environmental and economic factors” (Department of the Prime Minister and Cabinet, 1980, p. 7). The committee also acknowledge its drawback of being all non-Aboriginal, and the lack of comprehensive statistical data (Department of the Prime Minister and Cabinet, 1980).

The PER included detailed analysis of the different types of health services that are available for Aboriginal people. One of the main themes explored in the report was the recurring issue of federal and state relations and division of responsibility, also in the context of the rise of the ACCHSs movement. The PER report noted the increased involvement of the Commonwealth in the provision of health services throughout the 1970s, which until then was mainly a function of the individual states. The PER made an interesting comment on the *Ten Year Plan for Aboriginal health*, announced in 1973, which aimed to raise Aboriginal people’s health status to “at least that of non-Aboriginals” (Department of the Prime Minister and Cabinet, 1980, p. 10) by 1983. The report emphasised that “the PER was unable to find any indication of formal state endorsement” of the plan (Department of the Prime Minister and Cabinet, 1980, p. 11).

A main issues that State authorities struggle to come to terms with, according to the report, was the rise of the ACCHSs movement:

It is not clear how far the State authorities subscribe to the principle of Aboriginal self-management. Insofar as the principle may apply to States Grants programs, the States are adamant that policy, planning and management of health care must be undertaken by properly qualified personnel, and this tends to exclude Aboriginals because of their lack of training and particularly of formal qualifications. (In relation to the delivery of health services the States also require appropriate qualifications, but are able to employ Aboriginals at lower levels). This conflicts with the Commonwealth’s view that self-management can be pursued concurrently

with the training of Aboriginals in health care. (Department of the Prime Minister and Cabinet, 1980, p. 14)

The PER noted that, because each state interprets its agreements with the Commonwealth in different ways, a consistent coordinated approach to policy was hard to achieve. Specifically, the PER identified “three main areas of policy difference existing between the Commonwealth and the States” (Department of the Prime Minister and Cabinet, 1980, p. 15):

1. *appropriate division of financial responsibility and the role of special supplementary funding;*
2. *co-ordination of policy and planning; and*
3. *the emphasis to be given to Aboriginal self-management and the level at which Aboriginals should be involved effectively.*

(Department of the Prime Minister and Cabinet, 1980, p. 15)

The PER also touched in its discussion on the recurring question, whether the DAA or the Health Department should fund Aboriginal health projects. The report mentions that the DAA “believes that financial responsibility should be transferred from DAA to CDH [Commonwealth Department of Health]”, as the “CDH holds consultations with State health authorities on all health matters and believes that such transfers of funds would enhance its position in these consultations for promoting Aboriginal health in both general and special Aboriginal health programs” (Department of the Prime Minister and Cabinet, 1980, p. 16). The PER also noted that there were differences between the CDH and the DAA regarding the policy of self-management. On this, the PER agreed that “it is not DAA’s responsibility to provide all health services in areas where Aboriginals are the great majority of the population” (Department of the Prime Minister and Cabinet, 1980, p. 50).

Regarding ACCHSs, some of the main findings were to the system of grants, which became the economical basis for most ACCHSs. The program, which is referred to in the PER as the *Grants-in-Aid* program, was recorded providing grants to 17 AMS in all states and territories, except Tasmania (Department of the Prime Minister and Cabinet, 1980). It was noted that “[d]uring 1979 AMSs extended access to an estimated 40% (72,500) of the Aboriginal population involving an estimated total of 120,000 patient contacts”

(Department of the Prime Minister and Cabinet, 1980, p. 35). These services relied on a total of under \$3m in DAA grants for the financial year 1979-1980, and a further estimated \$1m from Health department grants (Department of the Prime Minister and Cabinet, 1980). The PER noted NAIHO's plan of expansion, which was rejected by the government (as discussed in chapter 5.4): "There are other organisations seeking Commonwealth funding to operate as AMSs, and the Minister for Aboriginal Affairs has indicated that he is awaiting the PER Report before making a decision on these applications" (Department of the Prime Minister and Cabinet, 1980, pp. 34-35).

The PER noted that "the technical standard of the services provided by AMSs is comparable with that provided through other health services" (Department of the Prime Minister and Cabinet, 1980, p. 55), and was supportive of Aboriginal involvement in health care:

The PER supports the increased involvement of Aboriginals in health care delivery and emphasises the need for community participation and support, for an increasing number of male health workers and for a greater Aboriginal role in the development and modification of health care services as well as in actual delivery. (Department of the Prime Minister and Cabinet, 1980, p. 56)

Furthermore, the PER attributed a low level of involvement in the policy process as a key reason for failure of such programs:

The low level of effective Aboriginal involvement in the existing health care delivery system is, in the PER's judgement, a major reason why general programs have had little effect in improving Aboriginal health. Aboriginal involvement is greater for the Grants-in-Aid programs than for the States grants programs. It is clear that Aboriginals can and do take responsibility for their own health - and this is most important if their health status is to be significantly improved. (Department of the Prime Minister and Cabinet, 1980, pp. 60-61)

The criteria that the PER used to assess the different programs included four main parts: accessibility, quality of services, program organisation and delivery, and notable impact on health status (p. 42). "The fifth criterion (degree of Aboriginal involvement) is a special

criterion adopted for an evaluation of Aboriginal health programs” (Department of the Prime Minister and Cabinet, 1980, p. 42) in table 3.

In terms of its recommendations, the committee emphasised that “[t]he recommendations set out below are put as a package. The PER believes that if Ministers accept this package as a whole, then measurable progress in improving Aboriginal health status will become apparent within a 3 year period” (Department of the Prime Minister and Cabinet, 1980, p. 67). The PER presented 10 pages of recommendations on the various aspects of Aboriginal health policy. It is of note that the first recommendation was “that Aboriginal communities and organisations be involved in implementing any course of action that follows from Government consideration of the PER report” (Department of the Prime Minister and Cabinet, 1980, p. 68).

One recommendation of the PER was to establish a new national Aboriginal health body, “responsible to the Ministers for Health and Aboriginal Affairs, to be involved effectively in the planning, development, administration, evaluation and monitoring of Commonwealth programs affecting Aboriginal health” (Department of the Prime Minister and Cabinet, 1980, p. 68). The body was to consist of an all Aboriginal membership. The members would be nominated by Aboriginal bodies such as the NAC and NAIHO (Department of the Prime Minister and Cabinet, 1980).

Table 3: the PER on the different types of health services available to Aboriginal people.

Type of service	Access	Quality of care	Program organisation	Impact on health status	Aboriginal involvement
General medical and hospital services	“good for hospitals, moderate and variable for GPs and poor in relation to specialists. Lack of access to GPs increases use of hospital facilities. There are major socio-cultural and financial barriers to access (including lack of information and significant geographical variations...)” (p. 44)	“when received and at the levels available, is technically satisfactory, but there can be significant problems in relation to such factors as attitudes, and also socio-cultural differences and lack of income” (p. 44)	“is generally centralised and gives little opportunity for Aboriginal input, resulting in the fitting of Aboriginals to the general programs rather than vice versa” (p. 44)	“given the large volume of health resources available to be utilised by Aboriginals and the technical competence of health personnel, the results achieved are disappointing” (p. 44)	“negligible” (p. 44)

<p>State Grants Programs (largely concerned with preventive care)</p>	<p>“appears to be satisfactory, but social, cultural and financial barriers often impede access in practice. Uneven geographical coverage in most States. Variations between States and within them” (p. 45)</p>	<p>“good on a technical level, when available and at the levels provided. However, problems arise with the high turnover of staff which disrupts the continuity of services and the opportunities for staff to establish rapport with Aboriginal communities. Other factors such as attitudes to and relationships with Aboriginal communities and socio-cultural differences also hamper mutual understanding. Training and career structures require improvement, particularly for Aboriginals” (p. 45)</p>	<p>“centralised and gives little opportunity for Aboriginal input on major questions of policy or resource allocation. Limited professional advice from CDH to DAA, especially at local, area or regional levels. There is a maldistribution of these funds between and within States” (p. 45)</p>	<p>“hard to establish. Has contributed to improved infant and maternal health and communicable disease control: but less effect on other women, older children and men generally. [PG] Programs are not fully accepted by many Aboriginal communities. Major improvements in health status require improved living environment, which these programs generally cannot affect” (pp. 45-46)</p>	<p>“greater than for general medical and hospital services, which enhances effectiveness. Aboriginals employed have a significant role, but mainly at lower levels” (p. 46)</p>
<p>Grants-in-Aid Programs</p>	<p>“variable geographically and concentrated in major urban centres. Potential access to AMSs for some 40% of Aboriginal population involving some 120,000 patient contacts in 1979, successful in overcoming socio-cultural and financial barriers to access. Often a wide range of services is available e.g. dental, health education, etc.” (p. 46)</p>	<p>“quality of primary care service is good, both technically and in relation to cultural and socio-economic factors” (p. 46)</p>	<p>“decentralised and flexible with self-management, low turnover rates for staff, and links between employment and training” (p. 46)</p>	<p>“hard to establish, but appears favourable and may be substantial for AMSs” (p. 46)</p>	<p>“dominant in these self-managing services e.g. in determining priorities and program administration, in employing Aboriginal staff, and in deciding when to seek and take expert professional advice. The high proportion of Aboriginal staff minimises social and cultural barriers, staff recruitment is not a problem, turnover rates are low by comparison with Government programs, and the activities of AMSs are welcomed by Aboriginal communities” (p. 47)</p>

(Department of Prime Minister and Cabinet, 1980)

The PER called on the government to alter funding arrangements by transferring “administration of special Aboriginal health policies, programs and funds to CDH” (Department of the Prime Minister and Cabinet, 1980, p. 71) gradually over 3 years. With this, the PER reaffirmed the responsibility of the DAA in developing, administering, and co-ordinating national policies, in consultation with Aboriginal people (Department of the Prime Minister and Cabinet, 1980).

Regarding funding of Aboriginal health programs, the PER recommended that “the States to be advised that cost sharing arrangements on a 50:50 basis will be introduced from the 1983-84 year, on the basis that the health of Aboriginals is a shared Commonwealth/State responsibility” (Department of the Prime Minister and Cabinet, 1980, p. 72). The Commonwealth’s share, which by 1980 was about 20% of money designated for Aboriginal health, is mainly aimed at providing grants mainly to ACCHSs, so in effect, the PER recommended to redistribute Aboriginal health funds so about half go to mainstream State health infrastructures, and about half would go as grants to Aboriginal organisation, principally ACCHSs. It was further recommended that the CDH would provide funding to national health bodies, including both NAIHO the newly proposed national Aboriginal health body. With this, the PER emphasised that, concurrently, the CDH needed to examine existing health infrastructures and try to make these as accessible as possible to Aboriginal people. For example, in terms of hospitals, the PER recommended to increase Aboriginal representation on hospital boards, and provide accommodation when needed by families of Aboriginal patients. (Department of the Prime Minister and Cabinet, 1980)

Another recommendation of the PER was to widen the scope of what the government recognised as health programs, to include what the report referred to as “environmental factors” (Department of the Prime Minister and Cabinet, 1980, p. 73). These may include main infrastructures such as water, electricity, sanitation, and housing. The PER also emphasised the need for “greater employment and training of Aboriginal health personnel”, especially of Aboriginal health-workers, in mainstream health bodies (Department of the Prime Minister and Cabinet, 1980, p. 75).

In terms of implementation, the PER recommended that cabinet committee would oversee the implementation, which would be put in place by a Task Group of officers from relevant departments.

6.3 NAIHO meets Fraser

Through the PER experience, the Fraser government first met with representatives of NAIHO. Following Fraser's decision to suppress the findings of the PER, NAIHO kept pursuing the public release and implementations of its recommendations.

By May of 1980, there was increasing pressure on the Fraser government to change the existing funding structures to Aboriginal community-controlled health services. Two months after the completion of the PER report, PM Fraser invited for the first time a delegation from NAIHO for a meeting in Canberra On May 14. NAIHO was represented by Bruce McGuinness and Gary Foley (Melbourne), Naomi Mayers (Sydney), Christine George (Townsville), and Muriel Olsen (Port Augusta). The meeting also included the Minister for Aboriginal Affairs Fred Chaney and the Health Minister Michael MacKellar (AMS Newsletter, May-June 1980).

The meeting was reported in great detail in the May-June edition of the Newsletter, which provides a fascinating insight. PM Fraser and the Ministers, Fred Chaney and Michael MacKellar, for the first time made sure that the NAIHO delegation would be accepted in Canberra with respect and good conditions, which the NAIHO delegation did not expect. From Fraser's point of view, forging close relations with the NAIHO leadership was a priority, as an 'elite' of the movement that the government could negotiate with, rather than adapting to more complex structures of community-control. In other words, for Fraser, this meeting seems to have been a chance to co-opt the leadership of the movement.

In the meeting, the delegation was given general verbal assurances of an upcoming change in Commonwealth funding structures for Aboriginal health, but without a clear timetable. They were also asked by Fraser to keep the content of the discussion classified until the governments make a final decision about how to proceed with the recommendations in the PER report. Here is a detailed description of the trip to Canberra by the NAIHO delegation and its meeting with PM Fraser, as printed in the AMS Newsletter:

Most of the delegation are veterans of innumerable trips to Canberra over the past twelve years, but none ever recall being on the receiving end of such a con job. From the moment the delegation arrived in Canberra, it seemed that every time we turned around there was a chauffeur driven Commonwealth limosine (sic) ready to drive us anywhere we wanted to go. Upon arrival at the great white phallic Woden tower, which is D.A.A. [Department of Aboriginal Affairs] Head Quarters, we were immediately given exclusive use of the main D.A.A. boardroom on the 16th floor, for the whole day. A seemingly never ending stream of top D.A.A. brass then paraded through the room offering anything and everything. The delegation quickly discovered that those D.A.A. top nobs were willing to do anything to stay on the good side of us, so we took the opportunity to have some of the more negative and obstructionist D.A.A. beaurocrats (sic) hauled before us to be 'grilled' on specific problems some NAIHO member organisations were having ... this was the first time I had ever seen the D.A.A. allow a Koorie group to do this, and it was an interesting insight into many aspects of the D.A.A. mentality. Nevertheless, the VIP treatment continued with us being invited to have 'drinks' with D.A.A. head, Tony Ayres. Then it was a quick limosine (sic) ride to Parliament House where Aboriginal Affairs Minister Fred Chaney saw fit to give us an hour of his valuable time verbally sparing with us whilst we waited to see the P.M. (not to mention the chicken sandwiches delivered on the P.M.'s sterling silver trays) and after an hour and twenty minutes with the P.M., Chaney and 'Empty Head' MacKellar [referring to the Minister for Health, Michael MacKellar], it was on to more drinks, this time courtesy of the Minister for Aboriginal Affairs. (AMS Newsletter, May-June 1980, p. 3)

A further remark is interesting when evaluating the role of NAIHO in Aboriginal politics. Organisations that developed out of the Land Rights movement, such as NAIHO, often held deep disagreements over ways of engagement with mainstream Australian politics.

The only incident to mar an otherwise pleasant day was an encounter in the corridors of Parliament House with a very upset Aboriginal Senator, Neville Bonner, who was obviously distressed that he had not been included in our discussions with the P.M. (an understandable exclusion NAIHO felt). (AMS Newsletter, May-June 1980, p. 3)

Regarding the outcomes of the talks, the Newsletter reports that “[t]he proposed changes are still confidential at this date but the NAIHO hopes that the P.M. and Cabinet will accept the major recommendations of the P.E.R. in the near future” (AMS Newsletter, May-June 1980, p. 3). It was clear for the NAIHO delegation that the stakes were high. After nine years of inch-by-inch progress of the dialogue with the DAA and other government agencies, they hoped for a fundamental shift of funding structure, which, they had hoped, would allow greater development of community-controlled health services and some financial securities. The NAIHO delegation left the Canberra meeting with cautious optimism, a will to engage with Government yet enough experience and hard-gained political astuteness to know that nothing of the potential changes that Fraser mentioned were yet set in stone:

Overall, NAIHO representatives were impressed with the apparently genuine desire of the P.M. to improve Aboriginal health. At the same time they were realistic (cynical) enough to know that the P.M. obviously has ulterior (sic) motives (e.g. his desire to be an international statesman could be torpedoed by the Third World’s increasing awareness of Aborigines), but NAIHO nevertheless believes that if Fraser does implement the proposed changes, he will be the first Australian P.M. ever to adopt a realistic and positive approach to Aboriginal health (AMS Newsletter, May-June 1980, p. 2)

Despite the cautious optimism following the meeting, the PER itself was never released. A formal explanation for the shelving of the program’s recommendations was never given. According to Anderson, “[t]he Program Effectiveness Review was never to be officially released, apparently entangled by conflicting perspectives of the different interests, and its recommendations for the time being were put in abeyance” (Anderson, 2003, pp. 231-232).

6.4 The Townsville 1980 NAIHO Conference

Two months after the meeting between the NAIHO executive and Malcolm Fraser, the PER report and recommendations were yet to be made public. The government stalled its decision to follow the recommendations of the PER. In light of this, NAIHO was preparing a national conference to be held in Townsville in July 19-21.

On June 30, NAIHO made a request to the DAA for a grant in the sum of \$28,000 to assist with funding the conference and the transportation of delegates from the existing services to Townsville. NAIHO had held about three conferences a year since 1976 (AMS Newsletter, July-August 1980). These conferences provided a space for direct interaction between the existing services. Such interaction is crucial for a joint decision making process, especially in a vast land mass such as Australia. Despite the frequency and financial burden of the conferences, this was only the second time NAIHO sought a grant from the DAA to assist with its organisation (AMS Newsletter, July-August 1980).

On July 11, eight days before the conference was to begin, DAA Minister Fred Chaney sent a telex¹⁴ to NAIHO in which Chaney announced the refusal to fund the conference. Chaney argued that because it was taking the government “longer than we had hoped” to consider the PER recommendations, “it appears to me that you [NAIHO] would not be in a position to discuss the various ‘future developments’ referred to in your telex”, referencing one of the listed items on the agenda of the conference – a report on the state of negotiations with government (AMS Newsletter, July-August 1980, p. 20). Chaney therefore attempted to use the grant request to influence NAIHO’s inner political mechanisms, in an attempt to define/confine, and essentially co-opt NAIHO and override its internal political mechanisms.

Towards the end of his telex, Chaney reiterates that “I would be most interested to have comments from N.A.I.H.O. on the decisions when announced, possibly through a meeting with Government officials and would be prepared to consider sympathetically provision of funds for that purpose” (p. 20). Here, Chaney hints at the rules of the game: non-committal

¹⁴ A copy of the telex was reproduced in the Aboriginal Medical Service Newsletter of July-August 1980.

community consultation ('comments') – yes; a more meaningful community control and participation in policy development – no.

The denied financial assistance for the Townsville conference for the sum of \$28,000 needs to also be understood in the context of Redfern AMS's assistance to other communities in setting up their own community-controlled health services, which were estimated as close to \$30,000 at the time (AMS Newsletter, 9-10/1980; see also previous discussion in chapter 5.4). The refusal was seen by NAIHO as an attempt to intervene in its internal structures and process.

As a result of the cancellation of the Townsville conference, NAIHO decided to publish the content of their talks with the Prime Minister and Aboriginal Affairs Minister Chaney, using a "special national edition" of the Redfern AMS Newsletter copy of July-August 1980. The cover included a caricature of the Commonwealth Minister for Aboriginal Affairs, Fred Chaney, with the words "King Freddy of the Gubba Tribe", and the subhead "Chaney Vs NAIHO" (AMS Newsletter, July-August 1980) (see image 1).

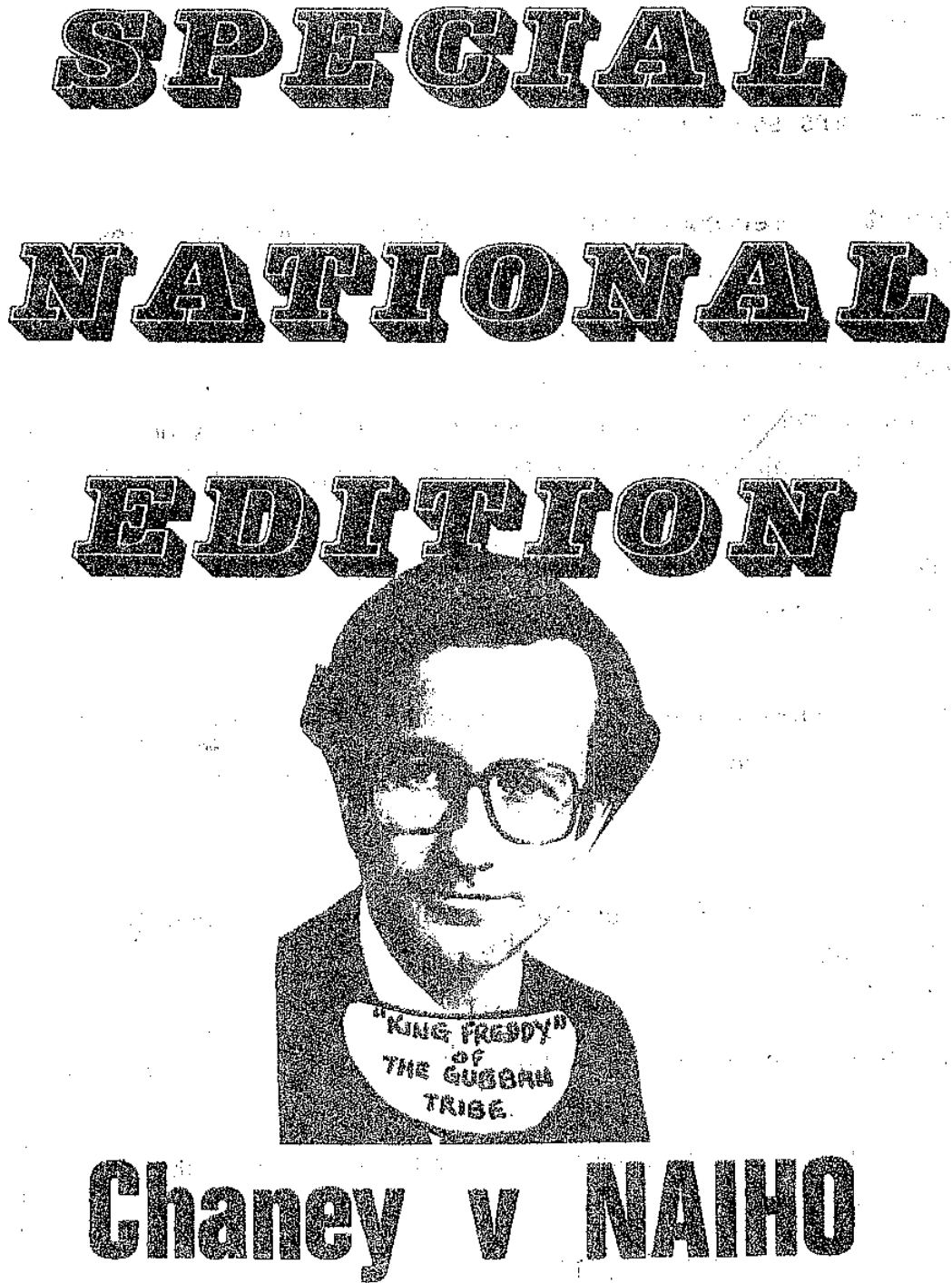
The Townsville NAIHO conference was finally held on September 4 and 5, despite the continued funding refusal. The Redfern AMS newsletter reports that "N.A.I.H.O. was able to secure alternative funding from an overseas source", p. 6)¹⁵.

The September-October 1980 edition of the AMS Newsletter reported in detail from the conference, including reports about the state of different ACCHSs. Thirteen services sent delegations to the conference: "Alice Springs, Melbourne, Mackay, Brisbane, Taree, Kempsey, Geraldton, Kalgoorlie, Perth, Port Augusta, Adelaide, Townsville, and Cairns" (AMS Newsletter, 9-10/1980, p. 6). Some services reported receiving only partially grants as submitted to the DAA. The Geraldton service reported an outright refusal of DAA to provide any funds due to the disapproval of the WA government of the health service, while the local Townsville delegation reported a refusal by the DAA to fund a dental clinic at the service (AMS Newsletter, 9-10/1980). Furthermore, the local Townsville delegates reported that the Queensland government continued to refuse the Townsville Aboriginal and Islander Health Service (TAIHS) to operate on Palm Island (AMS Newsletter, 9-

¹⁵ The specific source was not mentioned. NAIHO members travelled overseas in several occasions, mostly as knowledge exchange and fund-raising with various other indigenous organisations as well as international health groups, as detailed in 4.10 and 7.5.

10/80). One of the more significant advances reported from the conference is how newer health services were taking regional leading roles, helping other communities to establish health services. For example, the Durri (Kempsey) delegation reported assisting the regional community in Nambucca Heads, despite being in financial difficulties, as the DAA gave only partially the funds asked for by the AMS (9-10/80). The Geraldton delegation reported that the process of establishing and running the health service “brought the Aboriginal community closer together and had overcome identity crisis problems amongst many in the Aboriginal community” (AMS Newsletter, 9-10/80, p. 10). Among other things, these reports help to demonstrate the importance of such national conferences to the movement. The local reports allowed representatives of services across the country to identify systemic issues emerging from the cumulative local experiences, as well as advice and mutual support.

Image 1: From the cover of the July-August 1980 AMS Newsletter.



(AMS Newsletter, July-August 1980, front cover)

6.5 Further meetings and negotiations

After the Townsville conference, NAIHO called for another national conference at Hamilton Downs, outside Alice Springs, to be organised by the Central Australia Aboriginal Congress, between October 20 and 24, 1980. The theme of the conference was Health and the Community, and hosted guest delegates from Nigeria, Papua New Guinea, and Canadian Aboriginals. A funding request for this conference was also denied by the DAA, and the conference was cancelled due to insufficient funds (AMS Newsletter, 11-12/1980, Lippmann, 1981). The Newsletter reports that a delegation of Aboriginal Canadians who travelled to Australia to participate in the conference found out about the cancellation only when landing in Melbourne, as NAIHO was reportedly informed only three days before the conference was to commence (AMS Newsletter, 11-12/1980).

Shortly after the cancellation of the Alice Springs conference, following the 1980 re-election of the Fraser government, some cabinet changes were made, and a new DAA Minister was appointed, Peter Baume, who replaced Fred Chaney. The November-December 1980 edition of the AMS Newsletter reports on a meeting between NAIHO activists and the new Minister Baume. The meeting was held on December 11, 1980, and NAIHO was represented by then Chairperson Bruce McGuinness, Naomi Mayers, and Gary Foley. The meeting was originally to be held earlier, and was to be attended by NAIHO representatives from each state. According to the Newsletter, the meeting “was called off when the Minister refused to provide travel costs for interstate N.A.I.H.O. representatives. Because Aboriginal Medical Services are not allowed travel funds by D.A.A., that meeting had to be cancelled” (AMS Newsletter, 11-12/1980, p. 5). The negative impression of the new Minister was strongly captured on the cover page of the Newsletter (see image 2).

Image 2: Cover of the AMS Newsletter, November-December 1980.

**ABORIGINAL
MEDICAL SERVICE
NEWSLETTER**

NOV. — DEC. 1980



**meeting with new minister
reveals true face of govt.!!!**

(AMS Newsletter, 11-12/1980, front cover)

The NAIHO representatives especially looked for a commitment to the PER's conclusions, which PM Fraser and former DAA Minister Chaney did not pursue. Another issue was the continued refusal of the DAA, and governments in general, to fund the ACCHSs of Broome, Geraldton, Wilcannia, and Purfleet/Taree (AMS Newsletter, 11-12/1980). The three delegates expressed hope that the new minister would be sympathetic to their struggle, as he is a medical doctor:

Unfortunately, these illusions were shattered in the first 15 minutes of the talks. The new Minister proved himself to be a pompous, arrogant little man who attempts to hide his monumental ignorance with an officious attitude which seeks to browbeat Aboriginal groups into acceptance of Ministerial authority as the paramount force in Aboriginal affairs. (AMS Newsletter, 11-12/1980, p. 5)

The poor approach of Baume to ACCHSs was also described in some detail by Fred Hollows, in a passage that was quoted in 5.6, in the context of NAIHO's involvement in the NTEHP, which was led by Chaney. As described earlier, Baume's approach was the final stroke that drove Hollows to temporarily resign from the project.

Regarding the PER, Baume reportedly stated that "he had yet to prepare a submission for cabinet on the report, but that other reports (including: House of Representatives Standing Committee on Aboriginal Affairs, 1979; National Trachoma and Eye Health Program, 1980) had to also be taken into consideration" (AMS Newsletter, 11-12/1980, p. 5). The NAIHO members pointed out to the fact that the PER was supposed to consider and supersede all previous reports (AMS Newsletter, 11-12/1980):

Senator Baume's reaction to this was to launch into a stern lecture that he, as Minister, would make the final decision on any matters relating to health because after all he was the ultimate authority and that was that. After being asked whatever happened to the government policy of self determination and self management, the Minister pointed out that what the Government really meant is 'responsible' self management, ad infinitum, ad nauseum. (AMS Newsletter, 11-12/1980, p. 6)

The estimation of NAIHO's delegates after the two-hour meeting was that "it seems that

the government is determined to defuse the P.E.R. and thus avoid confrontation with the W.A., N.T. and Queensland governments” (AMS Newsletter, 11-12/1980, p. 6), mainly over the changing of funding rations between State health bodies and grants to ACCHSs. It was later reported in the Newsletter that Baume “told a journalist ‘off the record’ that the government would not release the P.E.R.” (AMS Newsletter, 1-2/1981, p. 5), but would act on the recommendations of the *House of Representatives Standing Committee on Aboriginal Affairs Report on Aboriginal Health (1979)*, one of a few previous reports that the PER was to take into account and effectively supersede. Recommendations of the 1979 report favoured self-determination in the health field and were well received by ACCHSs (AMS Newsletter, 4/1979, p. 1), yet stayed clear from detailed policy recommendations, which the PER did offer. One of its main recommendations was for ‘greater consultation’ between the DAA, health bodies, and ACCHSs (House of Representatives Standing Committee on Aboriginal Affairs, 1979, p. 134).

6.6 “Top Secret Govt P.E.R. Report Unveiled”

“Alas”, wrote Jack Waterford of *The Canberra Times*, “the report on reports has now assumed the status of just another report” (1981, p. 18). A year after the PER was submitted to the Cabinet, and the report remained unreleased and not implemented. Yet the findings and recommendations of the PER were too far reaching to be ignored. NAIHO and the ACCHSs simply could not allow the PER to vanish at this stage, and the mobilising around the demand for its release and implementation continued. The AMS Newsletter summed the feeling by the end of the year:

Generally 1980 saw N.A.I.H.O. consolidate its bargaining power and consequent government attempts to weaken the organisation. The Prime Minister continues to ignore his own personally commissioned P.E.R. report and we go into 1981 with our highest political priority being to force the government to implement the recommendations of the P.E.R. (AMS Newsletter, 11-12/1980, p. 3)

After the discouraging meeting with Baume, NAIHO felt it reached a dead end with the Fraser government, who, by the end of 1980, did not appear to have any intention of releasing or implementing the PER report. NAIHO then decided to publish the content of the PER as they knew it, especially the recommendations. These were released in a special edition of the AMS Newsletter, for January-February 1981. The cover of the Newsletter announced, in all capital letters: “In this edition: top secret govt P.E.R. report unveiled” (AMS Newsletter, 1-2/1981, p. 1, see image 3). It appears that copies of the PER had leaked to the mainstream press in early 1981 (“The States’ health policies lag”, 1981). Earlier, *The Age* reported that NAIHO is set to publish “secret talks” with Government (Mills, 1980). It appears that the AMS Newsletter (AMS Newsletter, 1-2/1981) was indeed the first public exposure of detailed content from the PER report.

Image 3: From the cover of the January-February 1981 AMS Newsletter.

IN THIS EDITION:

**TOP
SECRET**

GOVT P.E.R. REPORT

UNVEILED Page 5

(AMS Newsletter, 1-2/1981)

Regarding the decision to publicise their knowledge of the PER, it was stated in the Newsletter that:

Representatives of N.A.I.H.O. were briefed on the results of the P.E.R. in a meeting with the P.M. in May 1980, and N.A.I.H.O. officials at the time gave an undertaking to Mr. Fraser that what we were told about the P.E.R. would not be made public by us. We gave that promise as a result of certain undertakings given to N.A.I.H.O. by

Mr. Fraser, that the P.E.R. would be acted upon within a certain period of time. Unfortunately, the promises made to N.A.I.H.O. have been broken by the government and we therefore no longer feel bound by the promises N.A.I.H.O. made to the government. We now then are in a position to publicly reveal the major findings and recommendations of the P.E.R. (AMS Newsletter, 01-02/1981, p. 6)

The Newsletter names two PER recommendations that were mostly significant for ACCHSs. The first is an increase of the share of Commonwealth funding for Aboriginal health allocated to ACCHSs through grants. The Newsletter reports that “over a three year period the level of funding to C.B.A.H.’s [community-based Aboriginal health services] would increase from the 20% of existing funds, to reach a peak of 50% of available funds” (AMS Newsletter, July-August 1980, p. 4) by July 1, 1983 (AMS Newsletter, January-February 1981, p. 8).

The second significant PER recommendation reported in the Newsletter is that the funds would be channelled via the Community Health Branch of the Commonwealth Department of Health rather than through the DAA. The ACCHSs had expressed ongoing discontent with the DAA due to ongoing bureaucratic hardships that started in 1972 when the Redfern service first applied for a grant (Foley, 1975). The department was set up by the Whitlam administration and was supposed to support the interaction between Aboriginal communities and the Commonwealth. A main issue with this arrangement is that the DAA operated with an allocated sum to be distributed as grants for Aboriginal organisations. NAIHO argued that, as health services are essential services, their funds should not be reached in competition with other community organisations. The PER accepted this position, and proposed a transfer of funding responsibility over a period of three years (Department of the Prime Minister and Cabinet, 1980).

A further major recommendation, of which NAIHO was much more critical, was the establishment of a new national consultative body on Aboriginal health, as discussed in 6.2. The AMS Newsletter provided NAIHO’s comment on the proposal: “NAIHO believes that usually Aboriginal advisory committees are a waste of time because of the fact that the Minister (or whoever the committee advises) is never required to take that advice” (AMS Newsletter, March-April 1980, p. 2).

6.7 United Front with the National Aboriginal Congress (NAC)

One of the interesting developments of this period of heightened tension over the suppression of the PER was some of the alliances forged by NAIHO with other organisations of the movement. On December 12, 1980, a NAIHO executive delegation of Gary Foley, Bruce McGuinness and Naomi Mayers met with the National Aboriginal Congress (NAC)¹⁶ and announced a “united front”:

in an effort to force the government to implement the recommendations of the P.E.R. Report, and to make other necessary alterations to government and bureaucracy policy in order to generally improve the delivery of primary and preventative health care to Aboriginal people. (AMS Newsletter, 11-12/1980, p. 6)

The NAC unanimously supported the united front, and passed a resolution that acknowledged NAIHO as the umbrella organisation of Aboriginal community controlled health services, reaffirmed its solidarity with NAIHO and community-controlled health in general. Furthermore, the resolution called for the Minister for Aboriginal Affairs “to make public all the recommendations contained in the P.E.R. report, and to fund the health services in Broome, Geraldton, Purfleet/Taree, Wilcannia and Central Western (WA) AMS” (11-12/1980, p. 6). As previously mentioned, the Broome, Geraldton, and Wilcannia services were finally approved for funding in the following year.

The employment of a united front was a significant political development, as NAIHO was openly critical of the NAC, including in past Newsletters (such as 07-08/1980). The united front then “represented a major policy change for N.A.I.H.O. who up till now had considered the N.A.C. to be a ‘paper tiger’” (AMS Newsletter, 11-12/1980, p. 6).

The Newsletter then provides three goals for the united front:

- *To fully brief N.A.C. Members on the latest developments in the area of*

¹⁶ The National Aboriginal Congress (NAC) has developed out of an earlier body called the National Aboriginal Consultative Committee (NACC), which was originally set up by the Whitlam government in 1973. Though initiated by the government, the NACC became a more politically independent body, and its members were elected by communities across Australia. In 1977, the NACC restructured and renamed the National Aboriginal Council (NAC) which were active until 1985 (Beresford, 2006).

Aboriginal Health (in particular the P.E.R. Report).

- *To seek solidarity and a unified approach to Government on Health issues*
- *To determine ways in which greater communication, co-operation, and sharing of resources between the two organisations could be achieved*

(AMS Newsletter, 11-12/1980, p. 7)

The NAC continued to endorse NAIHO until the last days of the NAC in 1985. This support mainly included favourable resolutions. The NAC executive passed a motion strongly supporting NAIHO's demands of government on their meeting in May 17-21, 1982, and a further motion in their meeting of June 15-17 (AMS Newsletter, 11/1981-4/1982). After the election of a Labor federal government in 1983, the NAC "passed unanimously a resolution" to endorse NAIHO's demands of the new DAA Minister (AMS Newsletter, 8-9/1983 p 9). It was further reported in that Newsletter that:

The NAC has, on every occasion asked, always been prepared to give NAIHO support in the strongest possible terms. NAIHO has been appreciative of that support and has, in turn, supported many of the philosophies and activities of the NAC. But our support is not without criticism where we feel it is due, and at the Canberra meeting NAIHO officials bluntly told the NAC that NAIHO was not always happy with either the NAC secretariat or executive. Specifically, the assembled NAC multitudes were told that NAIHO had been most upset at the fact that NAC Chairman, Roy Nichols, had taken over five weeks to pass on an urgent NAC Executive resolution regarding NAIHO, to the Minister, Mr Holding. Mr Nichols gave a public apology to NAIHO and said that he had "bearably notified" the Minister NAIHO officials felt that this was a lame excuse, but were prepared to forgive and forget. (AMS Newsletter, 8-9/1983 p. 9)

The same edition of the Newsletter contained a separate piece, criticising NAC delegates for accepting to fly on first class to a conference in Geneva, while other groups such as NAILSS (Legal services umbrella organisation) could not raise enough funds to go to the same conference (AMS Newsletter, 8-9/1983).

6.8 The Victorian Working Party on Aboriginal Health

The dead end in the relationship between the ACCHSs movement and the federal government opened room for states (Victoria and New South Wales) to improve their relations with the movement. The first sign of change came from Victoria (AMS Newsletter, 9-10/1980). Victorian Health Minister Bill Borthwick announced the establishment of a *Working Party on Aboriginal Health*, with representatives of various Aboriginal communities and community-controlled health services. The main responsibility for health delivery to Aboriginal people was transferred from Victoria Health Commission to the Working Party. According to the AMS Newsletter:

a state committee on Aboriginal health was established, comprising representatives from virtually every Aboriginal community in Victoria, the Vic. Health Commission, D.A.A., and the Federal Health Dept. That committee then fully consulted every Aboriginal community in Victoria, and asked the people what they perceived their health needs to be, and what they thought was the most practical, efficient and effective means of delivering health care to their own people. With the support of the most enlightened State Health Minister in Australia, the recommendations of that committee were then implemented in full. The result was that at least six new community controlled Aboriginal Medical Services are being established in Victoria. (AMS Newsletter, November 1981 – April 1982, p. 5, emphasis in source)

The AMS Newsletter comments that this move shows that “Aboriginal people had proven beyond all reasonable doubt that they could deliver health care to their own people in a far more efficient and cost-effective manner than could the monolithic bureaucracy of the Health Commission” (AMS Newsletter, 11/1981-4/1982, p. 15). Specifically in Victoria, evidence had recently emerged that evaluated very favourably the effectiveness (including financial effectiveness) of the Victorian Aboriginal Health Service (VAHS) in Fitzroy, Melbourne (Nathan, 1980). Furthermore, the Victorian changes were hailed by the Newsletter as “the greatest step forward in Aboriginal health for 200 years” (AMS Newsletter, 11/1981-4/1982, p. 17).

The significance of the working party was clear after its meeting on November 18th, as a decision was made to hold public meetings in every Aboriginal community in Victoria in order to get the most effective and direct feedback from the Aboriginal population itself. This is a significant change to usual States attitude towards Aboriginal involvement in policy formation. “This is a remarkably innovative approach to the delivery of health care to Aboriginal people, and the Victorian Government, in particular Mr Borthwick, are to be congratulated on the progressive steps that they have taken” (AMS Newsletter, 11-12/1980, p. 9). The Victorian Working Party cannot be properly understood outside the context of the previous ten years of ACCHSs grassroots activity.

This development from Victoria also provides an interesting development into the tension between States and the Commonwealth regarding the areas of responsibility, which was also one of the focal points of the PER. The DAA sent a “notorious D.A.A. ‘hatchet man; and former A.S.I.O. Operative, Mr George Brownbill” to attend meetings of the working party and to “examine the Victorian proposals” (AMS Newsletter, 11-12/1980, p. 9). His presence in the meetings “was the subject of strong objections from the Victorian Aboriginal Health Service which regarded his presence as an attempt by the Department of Aboriginal Affairs to sabotage the operations of the Working Party” (AMS Newsletter, 11-12/1980, p. 9). The Newsletter then asserts that:

The Federal Government’s concern appears to be that the restructuring of the Victorian system of Health Care delivery to Aboriginal people will set a major national precedent which will ultimately lead to calls for restructuring in other States. Whilst this is in line with N.A.I.H.O. policy, it is precisely what the Federal Government has been resisting for the past 5 years. The Fraser Government is extremely reluctant to involve itself in any major confrontation with the States (in particular W.A.) over the issue of Aboriginal Health. Consequently it would seem to be in their own interests to subvert the progressive action of the Victorian Government. (AMS Newsletter, 11-12/1980, p. 9)

It is also interesting to note that these changes in the Victorian health system took place under the Liberal state government and its Health Minister, Borthwick. When a Labor government was elected shortly after, its new Health Minister proved far less accessible to ACCHSs (*Melbourne Times* 24/11/1982, reprinted in AMS Newsletter 9-12/1982 p. 18).

6.9 The NSW Task Force on Aboriginal Health (1983)

NAIHO lauded the changes in Victoria as an example of an approach that could be adopted in NSW, and across Australia. As a result of the positive development in Victoria, NAIHO started to apply heavy pressure on the NSW government to follow suit with a similar plan. The NSW Parliamentary Committee on Aboriginal Affairs received submissions supporting a similar change to funding and delivery of health to Aboriginal communities from, among other submissions, Dr. Garvanic, former director of the Aboriginal Health Section of the NSW Health Commission, Fred Hollows, and NAIHO itself (AMS Newsletter, 11/1981-04/1982).

At the time when developments in Victoria were announced, the NSW government continued to resist such change. The premier at the time, Neville Wran, announced that a new strategy for Aboriginal health would be prepared by the existing NSW Health Commission, which the AMS Newsletter asserts, is “the government body which is historically to blame for the appalling state of Aboriginal health in NSW” (11/1981-04/1982, p. 16). It is important to remember that merely ten years prior, the discrimination and dehumanisation of Aboriginal people in the mainstream health services triggered the setting up of the Redfern AMS (Briscoe, 1974), followed by others.

The Redfern AMS “has completely rejected” the old-new plan (AMS Newsletter, November 1981 – April 1982, p. 17), and used the Victorian changes as an example and a concrete demand to the NSW government. Furthermore, the Newsletter even indicates that the Redfern AMS would not join any committee in which they would be a token minority among representatives of the various bureaucracies (AMS Newsletter, November 1981 – April 1982). Furthermore, it should be noted that the changes in Victoria occurred under a Liberal Party government, while NSW Premier Neville Wran, of the Australian Labor Party, was much more resistant to change. The AMS Newsletter at the time described the demand to establish a Victoria-styled force in NSW:

We believe that a state task force on Aboriginal health should be established along the lines of the Victorian Working Party on Aboriginal Health. The Victorian group

was comprised mainly of Aboriginal community reps from throughout the state, as well as one rep from each of, the Federal D.A.A., the Federal Health Dept and the Vic Health Commission. We call on all our supporters to urgently send letters, telegrams etc to Mr Wran and Health Minister Brereton, demanding that they adopt a more modern and progressive approach to Aboriginal health, and specifically that they make immediate moves toward giving Aboriginal people more control of the resources and facilities to provide health care to their own people. (AMS Newsletter, 11/1981-04/1982, p. 17)

The results of the pressure were immediately clear. At the end of the same Newsletter edition, a “stop-press” article appears with a report-back of a meeting between Naomi Mayers and Joe Mallie (representing the Redfern AMS), Gary Foley (representing NAIHO), and NSW Health Minister, Mr. Brereton. The meeting has reportedly been “productive and positive”, as the Minister “gave an undertaking to the group that he would consult many more organisations involved in Aboriginal health, before he made any final decision on the composition of the proposed new Aboriginal health consultative group” (AMS Newsletter, 11/1981-04/1982, p. 24).

The new optimism with the NSW government’s approach to change in funding structures to Aboriginal health services continues in the next edition, dated April-September 1982. It is reported that the proposed changes in NSW take the lead from changes in Victoria. The changes are specifically understood as changes in the democratic nature of health delivery: “If the NSW Government goes ahead with its plan to ‘democratise’ Aboriginal Health Care Delivery, it will represent a major victory for N.A.I.H.O. in its efforts to have Aboriginal people throughout Australia gain more extensive control over their own affairs” (AMS Newsletter, 4-9/1982, p. 3). NSW Health Minister Brereton, who receives ample criticism in previous editions, is now applauded for his “political courage” and his “willingness to allow the Aboriginal people of this State to have a meaningful say in their own Health Care Delivery” (AMS Newsletter, 4-9/1982, p. 3). Even at this embryonic stage of the Task Force there was some concern over “potentially serious problems looming”, such as “the NSW Health Commission is expected to strongly oppose the changes to the system”, because “the Task Force concept represents a threat to the power and empire building of the bureaucrats who currently control the system” (p. 4).

By the time of the next issue (October-December 1982), the new Task Force on Aboriginal Health had reportedly already held two meetings (AMS Newsletter, 10-12/1982, p. 6). The task force's main function was to examine "how Aboriginal health needs can best be met" (quoted in: AMS Newsletter, 10-12/1982, p.6), as well as "advise on the respective roles of the Health Commission and the Aboriginal Medical Services" (quoted in: AMS Newsletter, 10-12/1982, p. 6), and to recommend "on the general effectiveness of current health arrangements including the respective roles of the Commonwealth and the State" (quoted in: AMS Newsletter, 10-12/1982, p. 7).

The Task Force was made up of fifteen representatives: eight representatives of Aboriginal organisations, and seven representing State and federal bureaucracies. The Aboriginal representation included one representative from the five established community controlled health services in NSW at the time: Redfern, Kempsey, Taree, Wilcannia, and Nowra (note that the Campbelltown health service was in its early stages of organisation at the time), one representative from the Aboriginal Sobriety House in Moree (MASH), and two representatives from national organisations: NAIHO and NAC (AMS Newsletter, 10-12/1982). The inclusion of a NAIHO representative in addition to the various health services representatives is a good indication of the authority NAIHO had gained by 1982. As explored in 6.7, the relationship between NAIHO and NAC knew some turbulent times, yet by the time the Task Force was put in place, NAC and NAIHO were in a united front over the demand to release the PER report and recommendations. The rest of the Task Force included four representatives from New South Wales (all representing the NSW Health Commission) and three representing Commonwealth departments (two representing the Department of Aboriginal Affairs, and one representing the Commonwealth Health Department).

At the first meeting of the Task Force (November 26, 1982) the decision was made to hold a series of 25 public meetings to consult and hear from Aboriginal communities across the state¹⁷. This resolution was considered by ACCHSs representatives as an 'absolute minimum' and threatened to disassociate from the Task Force without a broad consultation with communities, despite the NSW Health Commission representatives warning that there might not be sufficient funds allocated the project (AMS Newsletter, 9-12/1982, p. 7).

¹⁷ The communities specified are: Broken Hill, Wilcannia, Ivanhoe, Bourke, Brewarrina, Walgett, Goodooga, Coonamble, Coonabarrabran, Cobar, Condobolin, Griffith, Deniliquin, Peak Hill, Orange, Grafton, McLean, Wollongong, Nowra, Wreck Bay, Sydney (including Western Suburbs and Campbelltown), Bega, Wagga Wagga, Moree, and Lismore (AMS Newsletter, 9-12/1982, p. 7).

Furthermore, the Newsletter reported that “one of the more interesting” resolutions of that meeting was to put a call for the NSW Minister for Health “to seek an official copy of the famous ‘P.E.R. Report on Aboriginal Health’” (p. 7). At the end of the article, the AMS invites readers to send submissions to the task force.

The Task Force continued to work during 1983 and published a report at the end of the year. As a result of one of its recommendations, the Aboriginal Health Research Co-op was set up in 1985, which is today known as the *Aboriginal Health and Medical Research Council* of NSW (AH&MRC). The AH&MRC today continues to play an immense role in Aboriginal health. At the time of writing (2010), it represents 60 community-controlled health and health-related services across NSW, as well as providing ethical reviews and guidelines on research into Aboriginal health issues (Aboriginal Health & Medical Research Council, nd). The AH&MRC is the NSW affiliate of NACCHO, the current national organisation of the ACCHSs movement.

The process and recommendations of the NSW Task Force received great support in the AMS Newsletter. Especially, the proposed new body (that became the AH&MRC) was perceived as a particular victory of the demand to channel Commonwealth funds through Aboriginal bodies. It was noted that, “[a]fter almost ten years, the struggle by NSW Aboriginal people to gain control of Federal Govt Aboriginal health monies in this state (\$2M. Annually) it now seems, WE HAVE WON!” (AMS Newsletter, 8-9/1983, p. 3, emphasis in source).

This declaration of victory came at the end of over three years of focused struggle around the PER and its suppression. It is interesting to note that the victory of the establishment of the AH&MRC, and later similar bodies in the different states, signified the end of this intensified period. Despite this victory, the PER itself remained untouched, and many of the issues that it presented remain key contentious issues today.

Chapter seven: NAIHO after the PER

The experience around the Program Effectiveness Review (PER), as detailed in the previous chapter, strongly affected NAIHO and the movement. Despite gaining much political recognition, NAIHO went into a series of changes and, somewhat mysteriously, had dissolved by the end of the decade. In this chapter, I will examine some main themes in NAIHO's development in the 1980s after the confrontation with the government over the PER. Towards the end of the chapter, I will discuss the last days of NAIHO and the formation of a new national organisation, the National Aboriginal Community Controlled Health Organisation (NACCHO), in the 1990s.

An appropriate place to start the description of the final years of NAIHO's existence is with the following quote from 1983, which reflects on the first decade of national organising of the ACCHSs movement:

[I]n the final analysis, the development over the past ten years of a national network of Aboriginal community controlled health services is, in itself a living testament to the genius of Aboriginal people and their ability to adapt to the most difficult and holistic circumstances, without necessarily compromising their basic cultural values and identity as Aboriginal people. The A.M.S. is proud to have played a vital role in those ten years of developments and we can assure you that we will be at the vanguard for another ten years. (AMS Newsletter, 1-5/1983, p. 12)

7.1 Changes in national structures

After working loosely as a coalition of ACCHSs through the 1970s, the early 1980s saw a restructuring of NAIHO. The NAIHO Congress was established as the main decision

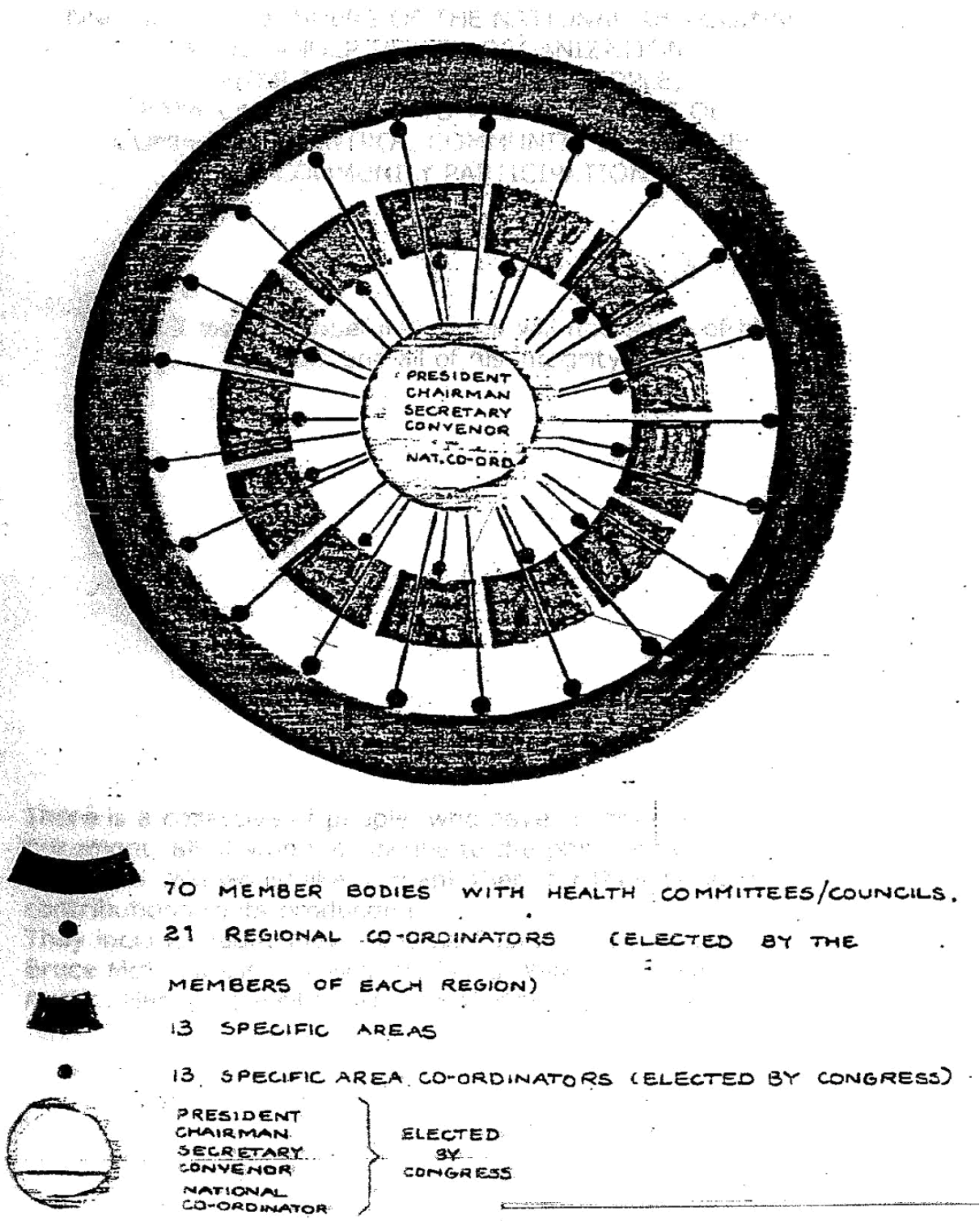
making body. Congress was formalised and organised in 1980-1981 (NAIHO, nd), and bodies such as the national secretariat and regional bodies emerged. The need to establish such structures seems to have been the growing number of ACCHSs, as well as a need for a “singular approach to Government” (NAIHO, nd). It is likely that national developments, such as the confrontation with the government over the PER, emphasised for the movement the need to establish more concrete structures. An undated document, written by “the NAIHO Collective” and entitled *The NAIHO Experience: Evolving To The NAIHO Congress*, details three fundamental working principles of NAIHO:

- *Each service remained completely autonomous.*
- *Each service or community seeking to establish a service had equal representation and equal voting rights.*
- *All resolutions were passed by consensus. If consensus was not achieved after negotiation, motion was shelved until next full meeting.*

(NAIHO, nd)

According to the document, the structures of the Congress were accepted in 1982 (NAIHO, nd). The congress was perceived to be a “decision-making, policy development and program-planning body. It is open to all Aboriginal community-controlled Health Services and Health Committees/Councils” (NAIHO, nd). Decisions were to be made by consensus decisions. A chart that depicts this structure is presented as Image 4. The chart is reproduced in the NAIHO Experience document (NAIHO nd), although it gives no indication of date or the artist’s identity.

Image 4: The NAIHO congress.



(NAIHO, nd)

While the document and the chart are not dated, these changes seem to correspond with national restructures that were discussed in the April-September 1982 Newsletter. The editorial explains restructures in NAIHO and their reasoning in a way that corresponds with the chart (see Image 4). It discusses the division into regions of work, and the integration of the pre-existing positions of national co-ordinators and secretary:

The basic idea of the NAIHO restructure is that Australia is administratively divided into seven regions and that responsibility for Aboriginal Health issues within these regions be entrusted to NAIHO regional Co-ordinators and member services in these regions. This will give AMS's in the different regions more control over NAIHO work in their own areas. The move is also designed to encourage more active involvement of Aboriginal people in health issues in their own areas. Each region will also be able to call on the NAIHO National Co-ordinators and Secretary for assistance in matters which may require certain negotiating or other skills which are not available in their own area. (AMS Newsletter, 4-9/1982, p. 5).

While the chart and the above quote indicate a clear internal structure, there is only scattered evidence in the data about NAIHO's internal structure, and it is not clear when exactly the first national structures emerged (the discussion about the early formation of NAIHO is presented in chapter 5.1). The quote discusses a 'move' and a 'restructure', which indicates that there was indeed an earlier structure. Some of the positions that are mentioned in the quote were mentioned in older editions of the Newsletter: the only NAIHO secretariat to which I found reference by name of its members is the secretariat during 1980, which included Chairperson Bruce McGuiness in 1980 (AMS Newsletter: 5-6/1980, 11-12/1980), National Secretary Gary Foley (11-12/1980), and National Convenor Naomi Mayers (11-12/1980). It is also indicated that, at least after the restructure, regional coordinators of the different regions also become a part of the executive, as well as coordinators of specific health areas (NAIHO, nd). The specific health areas included mental health, women's health, public/environmental health, preventative, health-worker education, dental health, justice, finance, sport and fitness, information, homelands, and trachoma (NAIHO, nd).

The circular shape of the NAIHO chart itself, it was noted, is appropriate as it allows for expansion of the wheel, when new members joined (NAIHO, nd). The last national

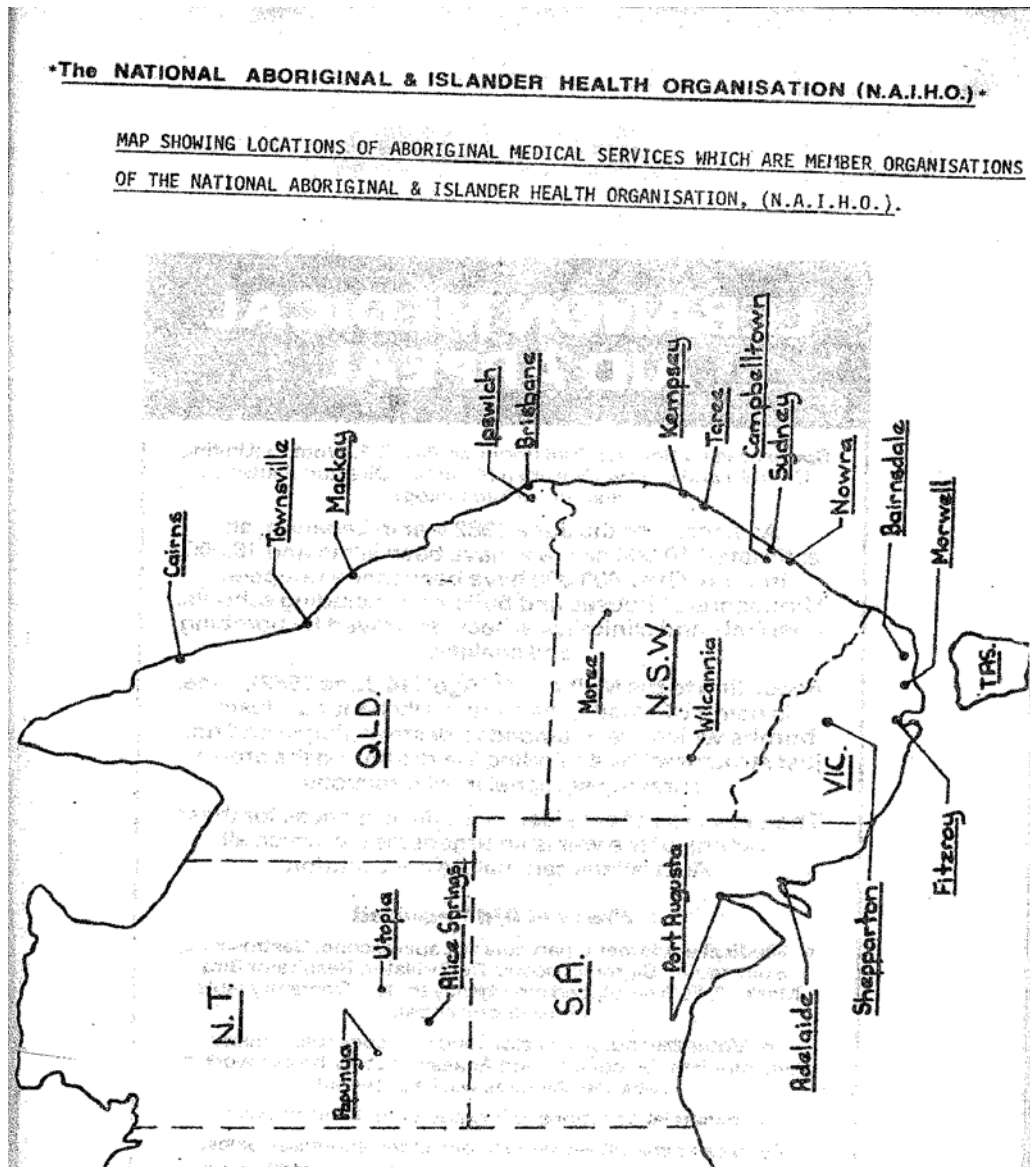
NAIHO position holder that I found a reference to in my data is Shane Houston, who was a National Co-ordinator at least during 1986 (6/1986). The relative unclarity surrounding the date of NAIHO's internal structures is of course not necessarily an indication that such structures were loose. It should be a reminder of the limitations in the data.

The regional division of ACCCHSs changed during the 1980s. As discussed in 6.9, in the fallout of the battle over the PER, new state health bodies started to emerge, which brought together ACCCHSs and state health bodies representatives, the first of which was Aboriginal Health & Medical Research Council of NSW (AH&MRC), which was discussed earlier (6.9). Although some of these bodies were only established in the 1990s (such as the Queensland Aboriginal and Islander Health Forum, 1990, and the Aboriginal Medical Services Alliance Northern Territory, 1994), today these are the official ACCCHSs peak regional bodies, which coalesce under NACCHO. It is also of note that the first division into traditional divisions corresponded with NAC electorates, and in 1985 NAC became defunct, which may have decreased the motivation to keep that division into traditional regions. Image 5 presents NAIHO member services in 1982.

7.2 Brisbane Commonwealth Games protests (1982)

During this period of the early 1980s, the influence of NAIHO seems to have been at its peak, because of the continued growth of the movement, as well as the public stand-off with the Government over the PER.

Image 5: Map of NAIHO members in 1982.



(AMS Newsletter, 4-9/1982, p. 21)

In 1982, the land rights movement organised major protest events during the Brisbane Commonwealth Games. This was seen as the first time the land rights movement united to such an extent nationally since the Aboriginal embassy, ten years prior (AMS Newsletter, 4-9/1982). In the months leading up to the games, as the land rights movement organised, so did the Queensland police. New laws against protests during the period of the games included outlawing most protests during the games, aroused much public debate and discussion, and seemed to have further galvanised the political motivation for the protests (AMS Newsletter, 11/1981-4/1982). The Newsletters tried to encourage people to join protest actions. Aside from the vast coverage of the lead up to and outcomes of the 1982 Commonwealth Games, the April-September 1982 edition featured a story on the “amazing young people” who are said to take to the streets in land rights rallies more than ever (AMS Newsletter, 4-9/1982 p. 9).

In the lead up to the Commonwealth games protests, the AMS Newsletter published a story regarding harassment and alleged frame-ups of Aboriginal activists, and activism as a whole, by ASIO, including a specific incident in which a fake document attributed to the fictional *Aboriginal Fighting Front* was circulated to mainstream media¹⁸.

The protests themselves drew thousands of participants from around Australia, and due to the far-reaching legislation before the games, hundreds of protesters were arrested during the games (Townsville Bulletin, 9/10/1982, in: Moody, 1988). Despite this, the mass mobilisation received some international attention and was the biggest Aboriginal protests in ten years. The next Newsletter issue (AMS Newsletter, 9-12/1982) reports on the success of the Commonwealth Games protests:

Brisbane was, without a doubt, the most successful attempt yet by the Black movement to take a case into the international political arena, and because such a move is a long term one, Australia has yet to realise the serious implications for this nation, unless Aborigines gain Land Rights and Economic independence.
(AMS Newsletter, 9-12/1982, p. 3)

¹⁸ The story is detailed in the AMS Newsletter of April-September 1982, in pages 14-15. The pamphlet itself was mentioned in the media at the time (“AAP reports blacks’ pamphlet”, 1982), but the story was never followed up. There appears to be no further mention of such Aboriginal Fighting Front outside of the single pamphlet, which is an indication that, regardless of who actually wrote the pamphlet, it was never a genuine organisation.

By the time of the Commonwealth games of 1982, NAIHO's leadership role in the land rights movement allowed it to play a part in the organisation of the protests. NAIHO activists did not seem to intervene specifically in the name of NAIHO, but they were among some of the leaders of the protest, and the AMS Newsletter presented many details, information, calls to action, and analysis of the protests. One of the stories presented in the Newsletter tells of a delegation of students from the Aboriginal Health Workers Education Program (AHWEP), conducted by the Victorian Aboriginal Health Service (VAHS) (and discussed in chapter 5.3). The students decided to travel to the protests in Brisbane. A description of the involvement of students appears in Box 7.

The political involvement of Aboriginal health-worker students seems like a natural outcome of the social/political approach to health, which the movement championed. The involvement of the ACCHSs movement in the protests also provides some good context to the next section, which discusses NAIHO's relations with the Commonwealth in the years following the confrontation over the PER.

Box 7: Account of the participation of Aboriginal health-work students in the 1982 Brisbane Commonwealth Games protests.

Towards the end of the course, approximately one-third of the students volunteered to travel to Brisbane for the Aboriginal demonstrations during the Commonwealth Games. They wanted to be on hand to act as medical personnel in case of expected police violence and consequent injuries. During those demonstrations, several students were arrested, despite clearly visible arm-bands identifying them as medical workers... But this did not prevent the Brisbane trip being a brilliant medical and political learning experience for those students who went. In fact, the AHWEP group at the Brisbane demonstrations proved to be superb ambassadors for the Victorian Aboriginal community and created a profound impression on other Blacks throughout Australia. Many Aboriginal people from other states were heard to remark how impressive they were with the self-discipline, pride and professionalism of the VAHS health workers. This in turn led to many interstate Blacks expressing interest in attending the course which had produced committed health workers as this!

(AMS Newsletter, 1-5/1983, p. 22)

7.3 Relations with the Commonwealth

The relationship between NAIHO and the second Fraser government reached a low point in the first half of 1981, in the context of the events surrounding the PER, and in particular, the appointment of Peter Baume to Aboriginal Affairs Minister. In a report of the board to the AGM of the Redfern AMS, the board reported on the increasing activity of NAIHO, and the increasing involvement of the AMS in these national processes: “1981 saw the A.M.S. involved in national issues to a greater extent than ever before. This increased national involvement was primarily caused by the A.M.S. increasingly important role in the continuing development of the National Aboriginal & Islander Health Organisation” (AMS Newsletter, 11/1981-4/1982, p. 5). Furthermore, according to the report, NAIHO:

continues to expand and give Aboriginal communities strong logistic support in their desires to control the delivery of health care to their own people. Unfortunately, as N.A.I.H.O. has become organisationally stronger, the Federal Government, particularly Aboriginal Affairs Minister Senator Baume and his Department Advisors, have become increasingly belligerent in their attitude toward the organisation. Senator Baume’s attitude appears to stem from the fact that N.A.I.H.O. seems to have become too effective in criticising out-dated government policy, and too effective in winning public support for our cause. The minister’s attitude is very childish given the very important position he is in. N.A.I.H.O. believes that rather than him using his position to politically attack us, he would be better off spending his energies trying to change the “irrational” government policies which at present contribute to, rather than alleviate, the massive Aboriginal Health problems throughout Australia. (p. 5)

In the long editorial of the June-July 1981 edition of the AMS Newsletter, editor John Newfong offered an analysis of the dangers that the movement was facing. Newfong identified three main areas that affect the ACCHSs movement: ‘federalism versus self-management’ (AMS Newsletter, 6-7/1981, p. 3), issues of funding (p. 4), and the withdrawal of the social movements, which is referred to as “[w]hen the ‘Winds of Change’ Blow Cold” (p. 5): Newfong raises the problem that, despite the enduring success

of the ACCHSs movement and the recognition it got in official reports, it gets very little recognition and general support for its struggle outside of the Aboriginal community:

[A] large section of the Australian press, politicians, and public servants still holds to the racist notion that community control by Aborigines is not really feasible because Aborigines do not know what is best for them and need to be told what is by distant figures who are unavailable, unaccountable, and unacquainted. (AMS Newsletter, 6-7/1981, p. 5)

The election of a Labor government in 1983 brought about a new Aboriginal Affairs Minister, Clyde Holding. This election led to new promises and new optimism from NAIHO. The Newsletter assessed that the election result “theoretically has created the climate whereby Aboriginal people could assume a greater degree of control over health care delivery systems in their own communities” (AMS Newsletter, 1-5/1983, p. 3). The new minister contacted NAIHO within the first week in office, which NAIHO saw as an ‘encouraging sign’ (p. 3). Yet there was still a strong understanding that, regardless of how well intentioned a minister may be, there needs to be a deep change in bureaucratic structures (possibly hinting at the suppressed Program Effectiveness Review):

there still remains the spectre of the monolithic D.A.A. Bureaucracy which has historically been the biggest stumbling block to such progressive change. Just how Holding manages to overcome D.A.A. Obstructionism remains to be seen, but Aboriginal people will be watching closely to see whether Holding is able to take control of the Department, rather than the Department taking control of him (which has been the case with all Federal Ministers to date). Holding does come into the job with the full confidence of Aboriginal people and theoretically this may make his task easier, but he must not waver or vacillate in his determination, or he will soon find Aboriginal groups losing patience very rapidly. We have seen too many spineless politicians wilt under pressure from the omnipotent D.A.A. and we would be appalled to see it happen again. (AMS Newsletter, 1-5/1983, p. 3)

The Newsletter points out four major ALP policies that they deemed progressive: (1) transfer of funds for community-controlled Aboriginal services; (2) funds for an expansion of ACCHSs; (3) support for NAIHO to have more regular input from it on national

Aboriginal health matters; and (4) changes to the Medicare scheme that would include abolishing individual 'health cards' and simplifying the process of bulk-billing by ACCHS (AMS Newsletter, 1-5/1983, pp. 9-10).

Two years later, it seems as if many of these hopes had been dashed. The December 1985 edition of the AMS Newsletter presents a detailed and pessimistic overview of Clyde Holding's term as Aboriginal Affairs Minister and assessments on the coming future. A main complaint that was detailed in the Newspaper was that PM Hawke decided at the end of 1984 that Aboriginal health funds should all be controlled by the DAA, instead of partly by the Department of Health. It was further asserted that:

The decision was taken against the advice of A.M.S.'s and Aboriginal communities. It means that wage increases and flow-ons will not come to A.M.S.'s automatically as they did with... when these monies were administered by the Commonwealth Department of Health. The strong centralist line being adopted by D.A.A. will no doubt mean more funding problems for community-controlled A.M.S.'s and organisations such as N.A.I.H.O. Funding is also much more likely to be affected by the whims of D.A.A. bureaucrats, already considered by many common public servants in that department to be racist and reactionary. (AMS Newsletter, 3/1985, p. 3)

In 1985, the DAA introduced new rules for grants, among them a clause that effectively enabled the DAA Minister to intervene in the appointments of individuals within organisations that receive DAA grants (Nettheim, 1986). According to Nettheim, NAIHO:

accepted an offer of funding for the balance of the 1985-86 financial year subject to a statement that it did not agree to [this condition]... and has since been told that funds will not be released until it agrees to the new Rules without exception. (p. 6)

Apart from specific issues with DAA policies, it seems that the big disappointment and the big worry of the AMS Newsletter had been of a decline in the activities of the land rights movements:

Gone are the days of the Aboriginal Tent Embassy's influence, which culminated in policy changes in all major parties in favour of land rights. All this, however, is indicative of greatly reduced support for the Aboriginal Movement from the public at large. This has been eroded because Aborigines, since 1972, have come to rely too much on the Federal Government to present their case to the general electorate. Much of the public debate on Aboriginal Affairs has therefore been governed by partisan, academic, or bureaucratic interests. It has also been largely uninformed but has been accepted as authoritative by the media. At the same time, the media has come to be dismissive of many Aboriginal Organisations, expecting from them only the "stunts" and "good copy" some Aboriginal people have been unfortunately only too ready to provide. All this has to be remedied very quickly by the Aboriginal movement if it is ever going to have the clout of widespread public support in confronting governments. (AMS Newsletter, 12/1985, p. 5)

Despite this, it is interesting to see the type of rhetoric that the DAA had developed by the mid 1980s. In a report titled *Achievements in Aboriginal Affairs* from 1986, the DAA reported an increase in "funding for Aboriginal health" (p. 7) from \$23.8m to \$37.9m in three years, yet the report does not specify how much of that went to community-controlled services. However, the report presents the DAA's relationship with one organisation in particular – NAIHO. According to the report, NAIHO "received support" (p. 8) in order to provide:

- *advice to the Government and the Department;*
- *health assistance to communities; and*
- *participation in national health programs.*

(DAA, 1986, p. 8).

The report does not specify how much NAIHO received in order to achieve these goals, nor is there any further comment on the working relationship between the DAA and NAIHO. In the following year's annual report, it is reported that funding to NAIHO was ceased due to an 'unsatisfactory audit report' (Department of Aboriginal Affairs, 1987, p. 60; Bartlett, 1998, p. 205), the details of which are not revealed. It is of note that this was not discussed or even mentioned in the AMS Newsletters at the time, which were being issued at highly irregular intervals at the time.

7.4 Relations with the States

In the 1980s, the relationships of the ACCHSs movement with the different States were affected by the local changes in Victoria and NSW (as explored in 6.8-9). These changes also emphasised the disparities in local approaches in different states. The often hostile attitude of the Queensland and Western Australian Governments made conditions for ACCHSs in these states different, but NAIHO's focus on the federal level tried to ensure that services were not dependent on State health mechanisms. Some states at the time still channelled funds that were designated to Aboriginal health only to improving existing services, despite their often insufficiencies and inappropriateness (AMS Newsletter, 6/1986).

Despite the changes, there were some notable clashes and incidents even in the more 'progressive' States. In Victoria, Bruce McGuinness, who was the Chairperson of both the VAHS and NAIHO during different times, was appointed as an adviser to the Victorian Aboriginal Affairs Minister on the 26th of February 1981, only to be dismissed on the 13th of March (AMS Newsletter, 1-2/1981). The newly elected minister, Jeff Kennett, later told the press the dismissal was due to a police record of Bruce McGuinness. It was later revealed that the person appointed instead of Bruce McGuinness also has a police record, which furthered the suspicion of many Aboriginal groups that the decision was political (AMS Newsletter, 1-2/1981).

The ACCHSs commented and took a stand on a variety of issues that arose in the 1980s. For example, here is some of the commentary that the AMS Newsletter offered on the 1985 NSW Doctors Dispute.

The NSW Doctors' Dispute of 1984-1985 saw approximately 1500 doctors around the state resign from public hospitals. The main issue in the dispute was the fear that "earning capacity within public hospitals would be reduced under Medicare" (Larkin, 1989, p. 69). Other issues revolved around "administrative arrangements and regulations governing the terms and conditions of employment of VMOs [visiting medical officers] in public hospitals, and certain practices relating to the classification of patients in public hospitals"

(Larkin, 1989, p. 69). Larkin (1989) suggests that “the dispute represents a continuation of the historic trend of resistance by sections of the medical profession to the contraction of the private market for medicine” (Larkin, 1989, p. 67). The AMS Newsletter presented an analysis of the dispute in the March 1985 edition of the Newsletter. The question of Medicare was very important to ACCHSs, as it was the source of funding for much of the medical personnel. According to the AMS Newsletter, “the people of Australia have elected the federal Labor Government on two occasions and thereby have given direct support to Medicare” (AMS Newsletter, 3/1985, p. 19), and that for 60% of Australians, Medicare was their sole health insurance. “The sheer size of our organisation provides additional testimony to the mass public support for Medicare and the determination of people to see it succeed” (AMS Newsletter, 3/1985, p. 19).

The Newsletter’s analysis focuses on the question of control, and is highly reflective of its positioning. The question is, should health services be controlled by doctors, as the ‘experts’, or the electorate, as the stake holders? This question is then tied to the issues of private services and the use of health services for profit making:

All doctors recruited to staff the public hospital system should be employed as salaried practitioners. Fee-for-service introduces an odious commercial background to the Doctor/Patient relationship allows discrimination on the grounds of health insurance cover, encourages over-servicing and fraud, discourages preventive health care and promotes the elitist position of Doctors within the health care hierarchy. Only by eliminating private practice from the public hospital system can we be sure that the sort of problems we now have will never recur. It is time that nurses and paramedical workers within the hospital system were given public acclaim for the enormous contribution they make towards patients welfare. It is time that doctors whose Labour is too expensive no longer remain at the top of the Hierarchy in the health care system. It is time that community, who after all fund the public hospital system, had a powerful voice in determining its priorities and structure. (AMS Newsletter, 3/1985, p. 21)

The relationship between NAIHO (and the ACCHSs movement in general) and the States at the time is a complex matter. The movement originated from a rejection of the State’s complete control over Aboriginal policy (health and otherwise), of a time when the federal

government tried to grasp its own responsibility for Indigenous Australians, following the 1967 referendum (as discussed in chapters 2.2 and 4.1). Yet the federal department that was erected to execute this policy, the DAA, was often seen as a ‘bureaucratic obstruction’ (Foley, 1975, p. 38). The conflict over the PER has led to new breakthroughs in the relationship between the movement and State health bodies, mostly through the construction of new joint bodies (as discussed in chapter 6.8-9). Positions taken on other health-related issues, such as the NSW doctors’ dispute, give a good indication of the movement’s basic approach towards the nature of health services, and is revealing of its approach to relations with State bodies. The relationship between the movement and different State and federal bodies is further discussed in chapter 8.2.

7.5 International relations

As a direct continuation of the Redfern AMS international links (as explored in 4.9), the ACCHSs movement and NAIHO continued to expand their connections with postcolonial and indigenous struggles in other parts of the world. These connections included both the travel of NAIHO activists overseas and hosting people from overseas struggles in Australia. Overseas travels, such as the trip of Naomi Mayers to a conference of Indigenous Peoples in Regina, Canada, were seen as very important aspects of internationalising the struggle (AMS Newsletter, 9-12/1982). Taking the Aboriginal issues to the international stage was seen as paramount to the success of the land rights movement as a whole. According to the AMS Newsletter:

[The movement’s] continuing strategy to take the Aboriginal People’s grievances into the international political arena where, we believe, our case will receive a more impartial analysis which in turn could result, ultimately, in international political and diplomatic pressure being brought to bear on Australia. This would, we believe, force the Australian Government to (under international scrutiny) justly resolve the Land Rights Claims of Aboriginal People. (AMS Newsletter, 9-12/1982, p. 10)

The protests against the Brisbane commonwealth games should also be understood as a part of these efforts to internationalise the struggle. NAIHO's involvement with the Brisbane commonwealth games is discussed in chapter 7.2.

NAIHO participated in the World Council of Indigenous Peoples conference on Canberra, April 27 to May 2, 1981 (AMS Newsletter, 1-2/1981). Such conferences were an important place to forge such connections, and the fact that this conference took place in Canberra made it all the more relevant for NAIHO to participate.

A further conference in Australia in which NAIHO intervened was the Commonwealth Heads of Governments meeting (CHOGM) in Melbourne in 1981. In the meeting, it was reported that Aboriginal issues were blocked early on by the Australian government (AMS Newsletter, 8-11/1981). According to the AMS Newsletter, “[a]nxious not to offend a newfound host in Prime Minister Fraser, African leaders agreed early in the conference to plead ignorance of the plight of Australian Aborigines and the Australian Government’s ineptitude in coming to terms with Aboriginal problems” (AMS Newsletter, 8-11/1981, p. 9). In contrast to this was the continuing positive contact by NAIHO members with the Vanuatu Prime Minister. In 1978, Gary Foley and Dennis Walker visited the newly independent Vanuatu, and met with then-PM Walter Lini, as both sides expressed the mutual solidarity between the land rights movement and Vanuatu’s independent government (AMS Newsletter, 7-8/1980). It is in this context that:

the Prime Minister of newly independent Vanuatu, who, prior to CHOGM had given public assurances that he would raise Aboriginal Affairs when he came to Australia, was told by Mr Fraser that, if one were to meet with representatives of the NAC, NAIHO, and the Federation of Land Councils, the disunity would be obvious. The Prime Minister of Vanuatu would seem not to have been convinced at this meeting that any such disunity did exist and followed up with further public statements of support for Aborigines and a visit to the Victorian Aboriginal Health Service. (AMS Newsletter, 8-11/1981, p. 10)

Some in the land rights movement, including NAIHO representatives, also confronted a number of African leaders who refused to openly support the Indigenous struggles in

Australia. One leader who was confronted was Robert Mugabe, then Prime Minister of Zimbabwe¹⁹, which won its independence from British colonial rule only months prior. The exchange is described in the 8-11/1981 issue of the AMS Newsletter:

Mr Gary Foley, Secretary of NAIHO, was extremely critical of the Zimbabwean Prime Minister, Robert Mugabe. Mr Foley, Mrs Naomi Mayers, National Convenor of NAIHO, Mr Bruce McGuinness, of VAHS and NAIHO, and representatives of the Lands Councils had spoken briefly to Mr Mugabe at a social function two days earlier. When they asked for his support at CHOGM for the Aboriginal people, Mr Mugabe reiterated that he could not embarrass the Australian Prime Minister. Mr Foley said he was astounded to find that Mr Mugabe could accept support for his struggle for Independence from a Movement here with such limited resources as the Aboriginal Movement and then turn his back on former allies. (p. 13)

Also in 1981, Prof J. Kibukamusoke, Ugandan High Commissioner to Australia, visited the Redfern AMS during his state visit to NSW (AMS Newsletter, 6-7/1981). In his speech, the High Commissioner referred to “the fraternal feelings that exist between yourselves and ourselves. Both our background and our future share a common destiny” (quoted in: AMS Newsletter, 6-7/1981, p. 15). Another high profile visit in 1981 was that of Dr Doug Sinclair, a former Chairman of the Maori Lands Council in Aotearoa/New Zealand, who worked with NAIHO for over six months, including working at the Redfern AMS, as well as Purfleet and Cairns ACCHSs. Another Maori Doctor, a final-year medical student from the University of Auckland, David Tipene, worked at the ACCHSs in Redfern, Melbourne, Wilcannia, Kempsey, and Purfleet that year (AMS Newsletter, 6-7/1981).

Such international relations are indicative of the context of social movements in which the ACCHSs movement developed. A good analysis of the international approach, or the internationalisation of the struggle, appears in the AMS Newsletter (9-12/1982), where six aspects of the internationalisation of the Aboriginal struggle were detailed:

1. *Established an “Aboriginal Information Centre” in London.*
2. *Set up support committees in France, Germany, Switzerland, Austria, Denmark,*

¹⁹ At the time of writing this thesis, Mugabe is still Zimbabwe’s head of state, currently as President. Mugabe’s regime has become increasingly autocratic. In recent years there have been increasing reports of grave human rights violations in attempts to suppress the country’s opposition (Howard-Hassmann, 2010).

Belgium, Holland, Italy and Greece.

3. *Briefed government officials of 6 African and 4 Pacific nations as to the situation of Black Australians.*
4. *Sent a high level delegation to Africa which managed to establish contact with many Heads of State, and subsequently overcome the past Aust. Govt. deliberate "misinformation" campaign about our situation.*
5. *Held demonstrations in many international capitals to make people more aware of our struggle.*
6. *Developed and continue to develop close links with other independence struggles throughout the world (including southern African, Palestinian, American Indian groups*

(AMS Newsletter, 9-12/1982 p. 10)

The international relations maintained by NAIHO and the ACCHSs movement then became an important strategic goal, and emphasise the importance of understanding one social movement in the overall context of other social movements at the time. In some cases, international relations allowed NAIHO more political freedom, such as the use of international donations to fund the Townsville conference after the DAA turned down a grant appeal (as discussed in chapter 6.4).

7.6 The National Aboriginal Health Strategy (1989)

At the end of the decade that started with the PER, a Nation Aboriginal Health Strategy (NAHS) was prepared and published by means of a radically different process. The NAHS Working Party was commissioned by an agreement of Commonwealth, State and Territory Aboriginal Affairs and Health ministers in a summit in December 1987, and Naomi Mayers, Director of the Redfern AMS, was appointed to chair the working party by Aboriginal Affairs Minister, Gerry Hand (National Aboriginal Health Strategy, 1989). The structure of the working party is very revealing. It was composed of nine Aboriginal community organisations representatives, eight State Government representatives, and two

Commonwealth government representatives. However, one of those two was the chair, Naomi Mayers, of the Redfern AMS. By appointing Mayers as chair of the working party, the nineteen-member committee had a potential majority for both Aboriginal organisations and mainstream organisations, as Mayers, a leading figure in the ACCHSs movement, officially participated as a representative of the DAA.

The process of the NAHS was made public by the commissioning of the Working Party, and the participation of ACCHSs, including the appointment of Naomi Mayers to chair the working party, created much optimism. The AMS Newsletter wrote about the process of the working party that:

After years of lobbying by Aboriginal health organisations, a national strategy is to be developed on Aboriginal health. The Commonwealth and State governments will spend \$500,000 over 12 months on a cost-sharing basis in the development of the National Strategy... A Working Party was established in early 1988 made up of representatives of State Ministers for Health, Commonwealth Minister for Health, Commonwealth Minister for Aboriginal Affairs and at least one Aboriginal community representative from each State. Mrs Naomi Mayers, administrator of the Aboriginal Medical Service in Redfern, was appointed by the Commonwealth Minister for Aboriginal Affairs to be the Chairperson of the Working Party. The Working Party will visit each State and hold consultation meetings in key locations with Aboriginal community representatives. (AMS Newsletter, 09/1988, p. 7)

Submissions to the Working Party were made by many hundreds of individuals and organisations, from Commonwealth/State/territory bodies, mainstream health infrastructures such as hospitals, and ACCHSs. In a statement to the National Aboriginal Health Strategy Working Party, Bruce McGuinness and VAHS emphasised some of the issues that the NAHS needed to address:

In the context of a national health strategy, sovereignty is a practical response to Aboriginal needs in the areas of housing, education, employment, health, legal and judicial systems, child care, and care of the elderly, In addition sovereignty is an appropriate response to the complex causative factors underlying Aboriginal deaths in custody. (McGuinness and VAHS, 1988)

The report produced by the NAHS was perhaps the most comprehensive document on Aboriginal health to date. The open public process of preparing the report offered the working party a wider scope of insight into the core issues that could simply not be accessed in an exclusive policy process.

The fact that this document was produced in a publicly open process means that its scope is more likely to offer a clearer evaluation of policies and adopt a workable strategy to improve people's health. Furthermore, unlike reports such as the PER, its content remains publicly accessible. However, as the developments that followed show, the fact that it was publicly open and transparent did not guarantee its implementation: In the preface of the NAHS it was acknowledged that "[t]he Working Party recognises that no matter how sound the strategy, or how broadly it is supported within the community, it will fail if there is a lack of political will and commitment on the part of governments" (National Aboriginal Health Strategy, 1989, p. xi).

The NAHS provided a list of recommendations, which spanned topics such as infrastructure, education, policy, research, and clinical assessments. In terms of policy, one of the main problems that the NAHS pointed out was a lack of communication between the different agencies:

In most areas where consultations were held there were no formal mechanisms for co-ordinating efforts between the States, health authorities, the community controlled health services, DAA, or the other relevant agencies. The provision of essential services was also affected by a lack of any formal mechanisms to co-ordinate State or regional efforts to provide such services. (National Aboriginal Health Strategy, 1989, p. 35)

The relatively progressive arrangements in Victoria and NSW were not followed by other States and territories until after the NAHS in 1989. The NAHS noted that

Generally the Working Party is critical of existing arrangements and expressed concern that formal Commonwealth/State co-ordination mechanisms in Aboriginal Affairs do not exist in most States and Territories, although the fact that the New South Wales and Victorian State Aboriginal consultative and advisory bodies do

include some Commonwealth representation was noted. (National Aboriginal Health Strategy, 1989, p. xxi).

The NAHS especially referred to problems in communication when a need to expand or establish new services arises. The NAHS identified over 90 potential ACCHSs to be established in communities around Australia with which the NAHS Working Party either consulted or received submissions (National Aboriginal Health Strategy, 1989). Furthermore, the NAHS recommended that “the Aboriginal health function remain within the portfolio responsibility of the Minister for Aboriginal Affairs” (National Aboriginal Health Strategy, 1989, p. xxi). The NAHS made a further interesting comment that was revealing in terms of the question of community-control and co-option through funding relationships. The NAHS noted that the DAA “has considerable influence over primary health care provision by virtue of its powers to determine the funding of some 64 Aboriginal community controlled health services” (National Aboriginal Health Strategy, 1989, p. 42).

Soon after the release of the NAHS in 1989, disagreements emerged between the ACCHSs representatives and the DAA over the implementation of the NAHS. The editorial of the June 1989 Newsletter, which expands on a number of criticisms regarding the planned implementation committee, is entitled *Farce Of The National Aboriginal Health Strategy* (p. 1). The main disagreement revolved around the method of implementation. The NAHS recommends the establishment of a ‘tripartite Council’ of State, Commonwealth, and community representatives (National Aboriginal Health Strategy Working Party, 1989, p. 231). However, in a joint State and Commonwealth Health Ministers meeting, it was agreed that implementations will be carried by a Development Group of thirteen department representatives and a single Aboriginal community representative (AMS Newsletter, 9/1989, p. 1). Box 8 includes a list of the main complaints regarding the decision.

Box 8: Objections raised in the AMS Newsletter to the establishment of a Development Group to implement NAHS recommendations.

The establishment of the Development Group is offensive to Aboriginal communities because:

- It is in stark contrast to the NAHS recommendations
- The Development Group is going over old ground that the NAHS Working Party spent 12 months working on.
- Not only do the Development Group members fail to understand the recommendations of the NAHS, they have completely ignored basic principles of Aboriginal cultural practices.
- The composition of the Development Group includes just one token Aboriginal community representative.
- The Development Group has only one Aboriginal community person representing all Aboriginal communities throughout Australia.
- Of the 14 members of the Development Group, only the Aboriginal community representative and one other person was on the NAHS Working Party. All the other members are new.
- The majority of members of the Development Group have no expertise working in Aboriginal health.

(AMS Newsletter, 06/1989, p. 1)

The frustration around the announcement of the Development Group, which seems to continue very familiar undesirable themes in the history of Aboriginal-related policy development, was particularly strong given the early optimism regarding the nature of the NAHS Working Party process. The announcement caused a split between the community representatives in the Working Party and the State/Commonwealth ones. This split impacted on the process of implementation of the Strategy from very early on.

Despite the split, some recommendations of the NAHS were carried to some extent, for example, encouraging the development of new ACCHSs. According to Burdon, “[i]n 1990-1991, following the recommendation of the National Aboriginal Health Strategy (1989), the Commonwealth Government allocated \$6.74 million to fund 67 additional health projects” (Burden, 1994, p. 211). Most of the NAHS recommendations though, were not implemented. According to Bartlett, the NAHS was not implemented due to two main reasons: first, “the lack of funds committed by governments to the implementation of the strategy”, and second, due to the continuing use of “practices which are based on historic continuities which are institutionalised, and often unknown to the individual” by non-Aboriginal institutions (1995, p. 207). Through the experience of the NAHS process, it is evident that articulating a policy strategy itself is only a first step towards change of policies, as institutional problems that caused the need for such strategy to begin with remain the same institutions that are to carry out the policy recommendations.

7.7 From NAIHO to NACCHO

Amazingly, there is no clear indication of the specific time and reason for the end of NAIHO. By the end of the 1980s, the AMS Newsletters became far less regular, and mentions of NAIHO stopped before the end of the decade. There have been a few different estimations as to when and why exactly NAIHO stopped functioning. One possible reason, which was told to me in informal conversations with people involved with NACCHO, was the will of Torres Strait Islanders to pursue a separate course for their self-determination struggle (also cited as the reason for the switch in NACCHO, 2006a, p. 14). Duncan and Bartlett suggest that “NAIHO collapsed due to lack of funding in the late 1980s” (Duncan and Bartlett, 2001, p. 19), while another assessment of the closure of NAIHO points more specifically to 1988 (Marz, 2003), although without mentioning a specific event to mark its end.

Another possible factor in the collapse of NAIHO may be its internal processes, and perhaps the frustration and withdrawal of some of its activists. Mudrooroo suggested that “[t]he cost of such [internal] democracy was enormous and perhaps this was one of the reasons why NAIHO ultimately faltered” (Mudrooroo, 1995, p. 137). In a short report about the history of ACCHSs, Scrimgeour suggested that internal factionalism was a main reason for NAIHO’s demise, particularly around mutual internal accusations of mismanagement of funds (Scrimgeour, 1997).

In his thesis, Bartlett mentions (but not expands on) developing ‘splits’ in NAIHO at the time (1998, p. 256). According to Bartlett, national meetings of ACCHSs that were held as a part of the development of the NAHS “were held as national meetings of Aboriginal community controlled health services rather than NAIHO” (1998, p. 256).

In this context, it is interesting to note that the earliest reference in the data to the term National Aboriginal Community Controlled Health Organisation is in fact found in the National Aboriginal Health Strategy (1989). Furthermore, it is of note that there is no reference to NAIHO itself in that context. One of the recommendations of the NAHS read:

That there is recognition of the need for the existence of a National Aboriginal Community Control Health Organisation:

- a) and that there be established a formal relationship between the National organisation to any bodies emanating from decision of the National Aboriginal Health Strategy Working Party;*
- b) such formal relationship shall include representation from community controlled organisations.*

(National Aboriginal Health Strategy, 1989, p. xxi)

Another potential contributor to the demise of NAIHO and its replacement with NACCHO is presented by Hetzel, who attributes the process to the creation of ATSIC in 1990:

A by-product of the creation of ATSIC has been the formation of NACCHO, the National Aboriginal Community Controlled Health Organization, which took over supervision of the Aboriginal community-controlled health services. This function was too complex to be handled by ATSIC in addition to its other responsibilities. There are now some 100 community-controlled health services represented by NACCHO, which maintains close contact with the Minister of Health through its chairman, Mr Puggy Hunter. (Hetzel, 2000, p. 159)

NACCHO as an organisation developed in the next few years. In 1991 (Bartlett, 1998, p. 256) and 1992 (Scrimgeour, 1997), meetings were held by representatives from a variety of ACCHSs, which started to develop the actual organisation's structures. In 1993, the constitution of NACCHO was approved by its member services as part of NACCHO's incorporation process, and it officially became the new umbrella organisation of ACCHSs (NACCHO, 1993). NACCHO established a national secretariat in Canberra (Spurr, 2005), which continues to operate today.

According to Scrimgeour, NACCHO failed to recreate the political effectiveness of NAIHO, for three main reasons: first, the lack of an activist context that initially sparked the movement; second, a process (inevitable, according to Scrimgeour) of institutionalisation and bureaucratisation that the early ACCHSs went through means that unity as a national social movement is less likely; and third, then-recent changes to political infrastructures around Aboriginal affairs (such as ATSIC) creates a stronger sense

of competition between Aboriginal organisations, “which led to an increase in the factionalisation of the Aboriginal movement as a whole” (Scrimgeour, 1997, p. 20).

7.8 1990s onwards

As mentioned in the previous section, a main development that shaped Indigenous-related politics in Australia in the 1990s was the establishment of the Aboriginal and Torres Strait Islander Commission (ATSIC) in 1990. ATSIC was to replace the DAA as the main federal body responsible for Indigenous-related matters, and was to be composed of community organisations representatives and some of the existing bureaucracies. The development of ATSIC was controversial. According to Anderson, “[t]he development of ATSIC, with its built-in consultative structure, has blurred the boundaries between community and bureaucracy” (Anderson, 1994, p. 35).

The creation of ATSIC was received with some criticism in an analysis by Bailey in the last edition of the AMS Newsletter, that of December 1991. Bailey emphasises that ATSIC is not a ‘community based initiative’ (p. 22). The criticism of the consultation process that preceded focuses on the placement of party politics ahead of communities’ needs:

During the round of whistle-stop visits which the government has called consultations the communities’ objections to the new structure were not heeded. The government’s basic object was to ‘sell’ the concept to the wider community in order for it to become legislation. The imperative for ATSIC to be acceptable to all political parties defeated the communities’ need to be heard and for the structure to be acceptable to the Aboriginal communities. Hence, the consultations amounted to nothing more than an utter farce. (Bailey, in: AMS Newsletter, 12/1991 p. 22)

Even in this very early stage of ATSIC, Bailey’s analysis in the AMS Newsletter was clear about its main drawbacks. One of his criticisms focused on ATSIC’s approach that Bailey connects to the basic questions of welfare versus community action, a tension that is

central to the ACCHSs movement:

ATSIC was a fait accompli, another imposition which fails to achieve anything more than an extension of the welfare system to which we have been subjected for two centuries. The simple fact that the new system was imposed reflects the paternalistic, “we know what’s best for you” welfare approach. So called welfare policies of the government have in the past also included the forced removal of children, the reserve system, relocation and resettlement programs in the name of protection, assimilation and integration, all designed to effect genocide on the Aboriginal populations of this country. (in: AMS Newsletter, 12/1991 p. 22).

In a further interesting comment, Bailey identifies a discrepancy between the use of the term ‘self determination’ in the promotion of ATSIC and its use in the actual Act in parliament that legally defines ATSIC and its roles:

In the preamble to the original ATSIC Bill the term ‘Self Determination’ appeared several times as it did in the propaganda which was circulated to communities to justify the structure in the first place. The term ‘self determination’ does not appear in the Act, anywhere. It would appear that it has been replaced with the term ‘self management’, a far cry from the meaning of self determination which involves a recognition of the Indigenous rights of Aboriginal people and the right to be self governing in every sense of the word. (in: AMS Newsletter, 12/1991 p. 23)

The Howard government announced the abolition of ATSIC in April 2004 (Brennan et al, 2005, p. 40). It can be argued that the end of ATSIC, by a government decision, is in itself a strong illustration of the lack of any real content of self-determination through ATSIC.

The abolition of ATSIC marked a new policy framework for the Howard government, with a “shift from a policy framework based on ‘self-determination’ to one based on ‘mutual obligation’, and the implementation of Shared Responsibility Agreements (SRAs)” (Anderson, 2006). The SRAs came as a replacement to the self-determination policy, which was, at least officially, a federal policy since the Whitlam government (Brennan et al, 2005, Anderson, 2006). In the two following years, over 100 such agreements were signed (Anderson, 2006). “The critique of SRAs has focused on linking a discretionary

benefit to basic civil rights; concerns about the capacity to evaluate them; the potential of SRAs to produce health outcomes and their underpinning ethics” (Anderson, 2006, p. 2). According to Anderson, “If locally agreed SRAs, which focus on health outcomes, are to be successful they need to articulate with established processes in Indigenous health strategy. Health gain in nearly all instances requires more than simple individual behavioural change” (Anderson, 2006, p. 8).

Another highly controversial policy decision of the Howard government was the Northern Territory Emergency Response (NTER), announced in June 2007 on the premise of tackling child abuse in the Northern Territory. Despite the public criticism of some of the far-reaching methods of the NTER, including compulsory land acquisition, welfare quarantine, and new alcohol laws, the measures were continued by successive Labor governments. According to the UN Special Rapporteur on the Situation of Human Rights and Fundamental Freedoms of Indigenous People, who visited Australia to evaluate the NTER:

Aspects of the Government’s initiatives to remedy situations of indigenous disadvantages, however, raise concerns. Of particular concern is the Northern Territory Emergency Response, which by the Government’s own account is an extraordinary measure, especially in its income management regime, imposition of compulsory leases, and community-wide bans on alcohol consumption and pornography. These measures overtly discriminate against aboriginal people, infringe their right of self-determination and stigmatize already stigmatized communities. (Anaya, 2009)

National Indigenous policies from 1990 onwards then were shaped by policy processes that were based on a questionable platform for community involvement (such as ATSIIC), or no community involvement at all (such as the NTER). In this regressive policy environment in terms of self-determination, NACCHO functions as the umbrella organisation of ACCHSs. One example of the effects of the changing political environment on NACCHO’s operations can be observed in a 2005 forced review process, which was carried by a private auditor, as discussed in the following section.

7.9 The KordaMentha Review (2005)

One controversial decision of the Howard government regarding NACCHO, which has been barely publicly discussed, was the commissioning of the KordaMentha Review. In 2005, the Office of Aboriginal and Torres Strait Islander Health (OATSIH) announced a compulsory review of NACCHO, to be undertaken by an external accounting firm, KordaMentha. This raised serious concern (Buckskin, 2005, p. 2) from NACCHO members and affiliates, especially as the government made acceptance of the review and its recommendations compulsory, which means that funding requests would depend on complying with the review. NACCHO's 2005-2006 annual report noted that:

Early in 2006 the Board met to discuss and plan 'ways forward' regarding the KordaMentha Final (NACCHO Review) Report recommendations which OATSIH stated needed addressing prior to DOHA funding NACCHO in 2006/07. Whilst the (eight) financial recommendations had already been implemented through the secretariat, an Extraordinary General Meeting was arranged to determine NACCHO members views on proposed constitutional changes and how to improve and maximise our relationships within the network. The March meeting took place and a summary of the changes to the NACCHO Constitution are outlined further in this report. (NACCHO, 2006b, p. 2)

A NSW General Meeting of ACCHSs "unanimously rejected the KordaMentha's Review recommendation to have the NACCHO Membership replaced by the Affiliates" (NACCHO, 2006b, p. 32). This was one of the most contentious recommendations of the review, as it demanded to change the national organisational structure so that only these peak bodies (such as those discussed in 6.9) would then affiliate to NACCHO. This recommendation was eventually carried, and today individual ACCHSs only affiliate to state/territory peak bodies, which are the only ones to affiliate directly to NACCHO.

NACCHO held an 'Extraordinary General Meeting' in March 2006, in which Constitutional Changes were voted upon, in order to pass the KordaMentha audit. The changes were summed in NACCHO's 2006 annual report:

These changes were:

- *Acted upon by the NACCHO Board and Secretariat immediately. This meant that some Board members resigned in May 2006 to effect this change (ie reduce the Board from 22 to 16 members):*
- *Articulated to OATSIH. NACCHO have sufficiently complied with the KordaMentha review report recommendations to enable OATSIH to make funding available to NACCHO for this financial year. In addition, the 60/40 split which has been very contentious for the sector over the past few years no longer applies; and*
- *Reflected in the revised Constitution. This document will be made available at the members meeting in Perth.*

(NACCHO, 2006b, p. 34)

The forced external review is a strong indication of the changing political landscape and its effects on community-based initiatives and organisations. At the time of writing these words, forty years after the establishment of the Redfern AMS, there are more ACCHSs than ever before (over 150), yet the movement perhaps play a different role than that of its earlier years. The next chapter includes a discussion of some of these main themes.

In the last four chapters I have presented some of the findings of my research, based mostly on ‘grey literature’ of newspapers and policy reports, and traced the development of the ACCHSs movement, while keeping a focus on the national organisation of the movement. Policy making was one of the key themes of this review, as they play a key role in shaping the political reality with which the ACCHSs movement needs to deal with. The chapter has finished with the recent KordaMentha review, which featured a regression to some of the ‘bad old ways’ of policy making, one that relies on arcane concepts of expertise, excludes community participation, and lacks openness for public knowledge and scrutiny. Such review mirrors other policy processes, such as the 1980 Program Effectiveness Review. Yet the existence of a process such as the KordaMentha review can only be understood in the wider context in which the ACCHSs movement exists, including the state of the other layers of the land rights movement. In the next chapter, I will discuss some of the main themes that arise from these findings, including the questions of community control, national organisation, and the policy process.

Chapter eight: discussion

This chapter will return to some of the main themes of the research, as described in chapter 2, in light of the emerging findings, as described in chapters 4-7. The chapter is divided into four main discussions: Primary health care (PHC) and community control; funding and policy formations; community control in theory and practice (praxis); and the struggle for self-determination in Australia today.

8.1 Primary Health Care and Community Control

An important context for the discussion in this thesis is that of the PHC movement, and its relations to the ACCHSs movement. The PHC movement has been discussed in greater detail in chapter 2. This chapter will return to such concepts in light of the findings. It starts with a discussion of the term community control.

The significance of community control

Out of the findings of this research, several observations can be made about the significance of community control in the context of the case study: the physical expansion of health delivery, the changes and influence on mainstream medical concepts and practices, and the contribution to a broader struggle for self-determination.

The first lesson that can be observed from the case study of the ACCHSs movement is that the first and most immediate significance of community control is the actual expansion of health delivery. It seems that such movements start to organise because of a concrete necessity, dire health conditions in particular communities that are not appropriately met.

In the case study, the actual expansion of available and appropriate health services and access is what the early organisers of the ACCHSs movement aspired to. The fact that there are now over 150 ACCHSs (NACCHO, 2011), which provide services to many areas that previously had none, is a highly significant achievement.

The action of self-organising also prompted the mainstream infrastructures to change. One major contribution is the holistic definition of health, which the movement has championed since its early days. This definition is also tied to the reality in which ACCHSs organise and the social and political determinants that have the deepest effects on Aboriginal health (as explored in Carson et al, 2007). The guiding ideas of the ACCHSs movement were validated on the international stage in 1978 with the Alma Ata declaration. The declaration (discussed in chapter 2.1) emphasised meaningful participation and a holistic approach that targets the social determinants of health as some of the key conditions for improvements in health.

Another significant contribution of community control is the development of new concepts in health delivery, which are harder to experiment with in mainstream services. In the case study, the role of the Aboriginal health-worker developed through the experience of services, as a crucial role that is often necessary to tackle some of the alienation that the medical system can create. Aboriginal health-workers, educated by programs that originate from the hard gained experience of the ACCHSs, now play a key role in other types of health services, which try to make their services more available and accessible. The Aboriginal health-workers, in a way, are the embodiment of some of the goals that the ACCHSs set to achieve: linking between possible health resources and a population that, directly and indirectly, was largely excluded from such resources. In 2006 there were close to 5,000 Aboriginal health-workers across Australia, although the definition of their role and responsibilities varies (Australian Indigenous HealthInfoNet, 2011).

The experience of the ACCHSs movement also carries a significant contribution to the experience of self-determination. Through the experience of this movement, concepts of self-determination were tested by hard experience against a backdrop of an ever-changing social and political context. The actual practice of community control, as it is still defined today by the movement's peak body (NACCHO, 2007), provides a template for one interpretation of community control in practical terms: the services are controlled by a

board of directors (rather than by doctors, as most other medical bodies), which is elected from within the community that established the service in an annual general meeting. This means that, as Ian Anderson observed, the context of the ACCHSs allows them to “closely tune into the dynamic, changing nature of Aboriginal society. Changes or programs instigated by [ACCHSs] can occur in harmony with the cultural and structural dimensions of the Aboriginal community” (Anderson, 1988, p. 114).

The urgent necessity should be remembered as the main reason that motivated the early development of this movement. However, this context of necessity and lack of access, and the experience of dealing with State and Commonwealth bureaucracies along the way, gave a meaning to community control that was both deeply practical and revolutionary in its implementation. The construction of community-controlled services was revolutionary, by virtue of their not only originality and ingenuity, but their attempt to construct a new system, and not simply trying to reform the existing one.

The question of reform or revolution is a basic tactical question for progressive movements (famously explored by Rosa Luxembour, 1973/1900). The establishment of the Redfern AMS was a significant break from the existing systems, as mainstream health infrastructures were clearly insufficient. The new system that emerged from this struggle now exists throughout Australia, although it can be argued that along the way and due to the changing political conditions, the movement became, to a degree, a reform movement integrating into the existing system, and working to better it from within. Some of the early and prominent activists of the movement see this as a mistake. According to Gary Foley, as the ACCHSs movement developed out of the land rights movement, the idea was to have a temporary solution, until real land rights would be achieved, which would allow the construction of entirely new social and political institutions and infrastructures (interview, 2009). As land rights were never fully granted, and with the change of the political terrain in the 1980s, the ACCHSs movement, and specifically NAIHO, its national organisation, had to change in order to survive. This process can be understood as a *movement/sector shift*. This concept will be explored in more detail later in this chapter.

Community control may be observed in different ways, out of specific contexts and experiences. As noted by Sagers and Gray, “[m]ethods of achieving community control differ according to the needs of the community” (1991a, p. 152). In this context, social movements work in interaction, and ACCHSs should be understood in the context of the broader social movements in which they operate.

In this case study, the grassroots health movement is a manifestation of popular ideologies, arising in the context of a broader social/political movement. The ACCHSs are an integral part of the land rights movement (Foley, 1982). As such, its national groupings were/are organisational manifestations of broader social movements. At least five layers of movements in which the ACCHSs movement operates can be identified:

- the local (and regional) community context in which a particular ACCHS emerges;
- the national movement of ACCHSs, which coalesce under a national organisation;
- the broader Australian Aboriginal land rights movement and other supportive progressive movements;
- the global Primary Health Care (PHC) movement; and
- a global, perhaps more loosely defined, movement of disenfranchised indigenous peoples in colonised countries.

Furthermore, as Fagan (1990) points out, the ACCHSs movement has preceded the Alma Ata declaration (1978) and constitutes an important part of the global Primary Health Care movement long after.

Both community and control are dynamic terms, at least in the sense that they will often not be agreed upon by all people involved. Understanding community control has to be done in context, because different elements of a community, the social forces, and the relations of control are ever changing. The terminology, and the meaning behind the terms, can often change in relation to the current environment in which the community controlled service is to function. However, it can be broadly assessed that there are two main aspects to community control: *political* (participation) and *economic* (funding).

At first glance, the need for participation in a community-controlled project seems

obvious: community control, by definition, relies on the active participation of community members. On the technical level, as the NACCHO definition clearly states (chapter 2, table 1), community control means a board that is elected from within the community where the service is located in an annual general meeting. Yet, much like the practice of democratic values elsewhere, the question remains: does a right to vote periodically really mean control? Some see model of a board as a step backwards. According to Best, for example, “the model of the elected board adds to the disparity between community control theory and practice” (2003, p. 189). Earlier in the thesis, I presented Nassi’s (1978) differentiation between the terms community control and community participation/involvement. Nassi emphasises the inherent difference between participation in projects “from above” (p. 5) and actual control. Furthermore, when considering issues of control, we need to distinguish between community controlled structures and selective structures. Terms often used, such as *Aboriginal control*, are not clear enough, as they may hide power relations behind an *Aboriginal* identity. An *Aboriginal controlled* organisation might have no actual accountability to the community.

Together with the political processes of community control, the community controlled health service strives for as much financial independence as possible, to exercise that control. However, as the case study shows, from its very early days, the need that the movement attempted to address was, and is, so vast, that applying for state and federal funding became inevitable. However, as discussed in chapters 4.6 and 5.4, attempts were made to limit the reliance on state funds, such as maximising donations from supporters, organisations, corporations, and overseas sources. For example, when NAIHO confronted the federal government over the PER recommendations, it was the diversity of funding sources that allowed NAIHO to proceed with its national conference in Townsville (as discussed in 6.4) despite being denied a DAA grant.

Another interesting lesson about community control that can be learned from the case study is about the ways in which it can nationally spread and operate. Despite the Redfern AMS’s early successes, it resisted suggestions to expand its service to other areas and communities, and instead decided to encourage and assist other communities to establish their own services. This position was made public as early as 1973, in a position paper by the AMS (Mayers and Laing, 1973). The endogenous nature of the expansion of services by the communities themselves rather than by health bureaucracies is a further attribute of

community control, in a national movement context.

Contribution of the Aboriginal community-controlled health movement to the philosophy of Primary Health Care

The practice of community control also had an effect on the practice of Primary Health Care (PHC). The Redfern AMS, established in 1971, preceded the Alma Ata declaration by seven years. Despite this, it has been claimed that the influence of the ACCHSs movement on the development of the PHC movement has been largely overlooked (Fagan, 1990; Rosewarne et al, 2007, p. 139). Many aspects of the philosophy of the ACCHSs were later echoed in the Alma Ata declaration. It was argued that the Alma Ata declaration came at the end, rather than at the peak, of the PHC movement, as the declaration was soon after diluted with concepts such as Selective Primary Health Care (Macdonald, 1992). This development should be understood as one of the many ramifications of the development of neoliberalism, which started to spread around that time (Navarro, 2002).

The global PHC movement offered a strong emphasis on the social determinants of health (Macdonald, 1992). Naturally, this is especially a central focus of the ACCHSs movement. Once a community has established its own health service, the struggle to improve health can be viewed much more clearly as a political struggle. Moreover, community-controlled health services are challenging a false dichotomy between health activism and political activism, illustrating clearly the role of social and political determinants of health and a course of action to address these directly. The autonomy of a community-controlled health service allows it to take up political actions that target directly the social determinants of Aboriginal (ill) health. This means that the question of autonomy, which encompasses the economic, organisational, political, tactical, and ideological aspects of the movement, is a key question in understanding the complexity of the praxis, the idea and the practice, of community control.

The PHC movement was a culmination of a more holistic approach towards health, which developed from an understanding that it is not enough to address the actual illness but rather the entire social and physical environment needs to be understood as an integral

dimension of the patient (Macdonald, 2005). In a similar way, we need to understand the health care system and policy itself in the context of its socio-political environment and societal power relations. We have to contextualise systems and policies and understand their underlying problems. This understanding was crucial in establishing community-controlled services, as evident for example in the establishment of the Redfern AMS (as discussed in chapter 4.3).

It remains unclear whether or not the definition of PHC as adopted by the Alma Ata conference drew a direct inspiration from the Aboriginal Australian experience and other experiences that preceded 1978. On several occasions during the 1970s members of NAIHO travelled to Europe, including to Geneva, home of WHO, to fund-raise, network, and raise awareness of the situation of Aboriginal Australians. But in hindsight, thirty years later, it is interesting to see how the Aboriginal Australian experience of PHC both preceded Alma Ata and has survived its demise, as it still exists, despite the many changes along the way.

Criticisms raised about the practice and theory of community control

In the history of the ACCHSs movement, some claims against the development of the movement were raised. Some of the most common issues that are raised include: duplication of existing service and creating competition; lack of sufficient professional knowledge; and internal conflicts within communities that may prevent actual community control.

Perhaps the most common claim that was made about ACCHSs was that they duplicate existing services, which are not currently utilised (AMS Newsletter, no. 20 March 1976, p. 1; Saggars and Gray, 1991a, p. 405). This perception largely ignores the real problems of both physical and cultural accessibility to health services (Saggars and Gray, 1991b). The context in which the Redfern AMS was established should be remembered: Aboriginal people who live close to the heart of Sydney, Australia's largest metropolis with ample health services, found mainstream services so inaccessible, that some would not go to a hospital even during emergencies. Fred Hollows tells in his autobiography of a contact he

had with a local physician in the Redfern area before the AMS was to open, to make sure that it really did not collide with existing services:

I went to see this doctor who said that he paid calls on Aborigines and collected the tiny fee the government paid GPs for services to 'indigent persons'. It was next to nothing. He admitted that he didn't see blacks in his surgery because if he did the whites wouldn't come and the practice would go broke. (Hollows and Corris, 1991, pp. 100-101)

This is another testimony of the inaccessibility of health services to Aboriginal people that prompted the establishment of the movement. The claim that the ACCHSs were somehow doubling available services is entirely false, if one considers health services as more than a purely medical institution. The ACCHSs were innovative, not just in the Australian context, but in an international context as well. The Program Effectiveness Review (1980) noted that “[s]ince AMSs are controlled by the Aboriginal community, in both policy and operation, it is not surprising that Aboriginal people are significantly more willing to attend them and appear to be more satisfied with the treatment they receive” (Department of the Prime Minister and Cabinet, 1980, p. 55).

Another claim made about ACCHSs was possible mismanagement of funds, yet such claims were not fully backed publicly. The House of Representatives Standing Committee on Aboriginal Affairs report (1979) indicated that “the Committee received evidence that the [DAA] funds provided [to ACCHSs] were often mismanaged” (1979, p. 88), yet no details were given of how and what sums.

Other noted criticisms regarding ACCHSs revolve around the question of community control in divided communities. In a case study of the Whyalla community, Champion, Frank, and Taylor examine issues that affect community participation in the local ACCHS, and suggest that internal separation between different kinship associations can be a major deterrent to participation (Champion Frank & Taylor, 2008). Peters-Little observed that:

Since Aboriginal people have historically survived over two centuries of oppression and division, it is unrealistic to expect long existing inequities and cultural and political divisions amongst Aboriginal people to disappear just because they now

have government funded organisations which determine their avenues of self-determination. It is particularly unrealistic to expect all loyalties to kin and tribe to disappear when the structure of 'community boards' is based on western notions of representativeness. (Peters-Little, 2000, p. 14)

Some critics of the movement focused on its connection to concepts that are deemed too 'radical'. Nathan (1980) shows that even after more than five years of successful operation, the Victoria Aboriginal Health Service was still being 'accused' of association with 'Black Power militancy' (p. 100). As explored in chapter 4.1, the concept of 'black power' played a significantly positive role in the development of the early ACCHSs. The concept of 'black power', which was seen as an expression of 'autonomy' and 'community control', and the US 'black power' movement itself, were highly influential and empowering to the young Aboriginal activists in the early 1970s. The term was used in mainstream public discussion well outside its social and political context, and was sensationalised in mainstream media. Nathan summed it well when she wrote:

It is a sad comment on mainstream white Australian society, that any ethnic minority or disadvantaged group is charged with militancy and hunger for power, as soon as the desire for assertion, identity and the free expression becomes conscious and paramount. (p. 101)

This also relates to the differences between the application of self-determination tactics/policies in urban versus rural and remote communities contexts. For example, Trudgen (2000) argues that applying "self-determination" policies on Yolŋu peoples in Arnhem Land was ironically forced upon the communities, and subsequent failure of services proved mentally destructive, as Yolŋu were made to believe that the failure of community services was directly their failure as Yolŋu. This result is the complete opposite of the idea and intent behind ACCHSs, and is a stark reminder of the importance of an endogenous approach – in which the initiative for a true community-controlled service must come from within the community itself.

It is also important to consider some of the criticisms of community control that were raised outside of the case study's context. One such issue is the openness of traditional communities to modern sciences. Flaming (1978), for example, in his comment on Nassi's

analysis of community control, asserted that “[s]pecialized professions such as medicine, psychiatry, social sciences, nuclear physics, and the biological sciences run counter to the values of the traditional community” (p. 22). In the ACCHSs movement, this is not evident. It was the lack of access to western services that sparked the establishment of the first services, and throughout the history of the movements, it made constant use of volunteer doctors, sympathetic to the cause. The ACCHSs can be seen as a bridge to enable access to western medicine, in a way that seeks to implement its great achievements in a holistic, socially conscious process.

However, what the ACCHSs did challenge is the hierarchy and the social and political structures that were imposed by the system surrounding the biomedical model, mainly the place of doctors in the hierarchy of control. As Liamputtong and others (2003) suggest, “[c]ommunity participation can be seen as a challenge to the power of professionals, organisations, and government” (2003, p. 11).

The developments of the ACCHSs movement did not go without criticisms from within the movement itself. Such conflicts often relate to the funding of ACCHSs, through State and federal grants. Applications for grants were made from the early days of the Redfern AMS, as the demand became much too high to be met, and demanded more secure funding than donations. Yet the reliance on such grants gives governments some level of control over the ACCHSs, which inevitably affects the bid for self-determination. The dependency on government grants was described by some as "mission mentality" (Peters-Little, 2000, p. 18). Sagers and Gray even suggest that “Aboriginal self-determination will remain an illusion in the absence of economic independence” (Sagers and Gray, 1991b, p. 392). The issue of funds, in effect, raises the question of co-option. According to Collmann (1981), the divisions within Aboriginal politics around the tactics of engagement with the state often revolve around different dimensions of co-option. Later in this chapter, the question of funding and control will be further explored.

8.2 Funding and policy formation

The issue of funding is at the core of the practice of community control. The break from mainstream health bureaucracies was one of the main initial goals of the movement, because of the failure of the system to deliver sufficient, holistic, and accessible services to Indigenous communities. And it was the overwhelming initial response to the early ACCHSs which forced reliance on state grants from an early stage. Funding, therefore, is at the core of the relationship between the ACCHSs movement and the state (both State and federal levels). There is no doubt that the need to rely on donations initially had a deep impact on the ACCHSs movement. Considering the overwhelming need, and the social and political environment in which it developed, there was simply no other choice for the movement but to apply for state funding.

The main issue regarding funding is the question of community control. Can such services claim to be controlled by the community, if the funding is effectively controlled by the state?

ACCHSs had to develop tactics that aimed at containing, or limiting, the effect that funding has on the power relationship between them and the state. One such tactic was (and still is) the constant appeal for donations from multiple sources. The appeal for donations allowed ACCHSs to fund some projects that the state would not. For example, the use of donations enabled the Redfern AMS to openly allocate some of its budget to political activism. The March 1977 edition of the AMS Newsletter details the AMS's expenditures of the previous three years. It details minor expenses on Land Rights badges (p. 3) and other unspecified 'political activity', and even 'political/medical activity' (p. 4). The explanation of the use of funds for political activity sums up the case study's approach to the relations of health and politics nicely (that echoes some of the discussion of the political nature of health in chapter 2.1):

Some of your money has been spent on politics. But then, we explained that to you at the time. There has never been any doubt, for instance, that the A.M.S. supports the struggle for Land Rights, supported the Aboriginal Embassy when it confronted

the Government in the little tent across the way, and supports those sister organizations which we know to be doing worthwhile work. As such, the A.M.S. has had cause to show its support in more than mere words, by actively campaigning on behalf of the organizations which we support, by assisting them with funds and by organizing political activity to ensure their continued success. The appearance, then, of debits for political activity on our ledger should be no surprise. Rather, what with our many words over the years on these subjects, it would be to our shame if we had not shared that which we had, in true Aboriginal manner, with those who had need of it. (AMS Newsletter, 3/1977, p. 3)

The openly political nature of ACCHSs is especially important to examine in the context of funding relations with the state. The contact itself between ACCHSs and the state via funding has been tremendously tense from its early beginnings, as explored throughout the findings chapters. It exposed a large array of existing problems, which made this relationship extremely rocky. It was claimed that the approach of State and federal bodies towards ACCHSs was often shaped by economic rationalism, combined with paternalism (Saggers and Gray, 1991a, p. 133). Yet funding agreements may have had deeper effects, not just on the relationship between communities and the states, but within Aboriginal communities themselves. Frances Peters-Little argues that the contradiction between the claim for self-determination and the reliance on government funding is creating tiers within Aboriginal communities, as it sets those who work in Aboriginal organisations in a position of authority over others in their own communities (Peters-Little, 2000, p. 14). The criticism made by Peters-Little raises serious questions regarding the relationship between Aboriginal organisations (especially those aspiring community control) and the state, and more specifically, regarding the political independence of the movement. Perhaps the core of the debate alluded to by Peters-Little is, does the reliance on state funding effectively mean that the movement was co-opted? I follow Nassi (1978a) who argued for a dialectical understanding of community-control/co-option as two interrelated parts of a single process, rather than a dichotomous view of these two terms (as explored in chapter 2.3).

The problematic approach by State and federal agencies is also marked by the nature of policy making. Somewhat inevitably, policy cycles revolve around mainstream political cycles of elections and changes of administrations. Such cycles provide a poor basis for long-term policy planning that requires stability of resources and actions. One of the main

themes of the findings of this thesis was a number of reports on Aboriginal health, none of which was acted upon in full. Such reports include the (1980) suppressed Program Effectiveness Review on Aboriginal Health (as discussed in chapter 6) and the (1989) National Aboriginal Health Strategy (as discussed in chapter 7.6).

The welfare state: ACCHSs and welfare

The history of the rise of the ACCHSs movement is also worth noting in the context of the Australian welfare state. On the one hand, the organisation of the movement was specifically due to the inadequacy of public health services, and the failure of the welfare state institutions in providing adequate services to Aboriginal people. In the period of the establishment of the movement, the early 1970s, social movements were on the rise, and demanded increasing government support and funding.

Yet on the other hand, the application of ACCHSs for state funds can also be seen as a plea for the public sector to play its role in the uphill battle for Aboriginal health, and agree to fund community controlled services, out of an understanding that community controlled services are truly public services. In their existence, ACCHSs often try to force governments into action, rather than be detached completely from them.

After the first decade of the movement, the funding process, now tied to the Australian welfare state, underwent a series of changes, which continue today. These changes, which took place in the context of the rise of neoliberal economic rationalism, are still mostly decided upon outside of community structures. Today, the Australian welfare state is described as a particular type of welfare state regime: a *Liberal/residual* type, which is characterised by minimal provision of welfare by the state, scrutinising means tests for welfare recipients, increasing intervention of the market, and increasing social gaps (Eikemo et al, 2008). These developments were of an opposite direction to that of the ACCHSs movement, which started in an attempt to address the existing gaping hole in the public health system. While the movement partially filled some of those gaps, the overall direction of the Australian welfare state was opposite, towards a *residual approach*, which stands in direct opposition to the universally-minded and holistic philosophy of the

ACCHSs. This change of winds found the ACCHSs trying to defend the ideas of public health and stop the erosion of the welfare state.

The residual approach that increasingly dominates Australian welfare policies means that not only do individual recipients need to constantly prove their claim according to ever-changing criteria, but so do organisations that rely on grants. The need to constantly apply for grants and the resources allocated to chase grants to ensure survival leads to conflicts in communities as community organisations are put in direct competition for grants. Such organisations often need to work together, and the tensions created by the constant race for funds make the already hard task of community organisations so much harder.

As described in chapter four, a major instigator of the development of the ACCHSs movement was a great deficiency of the Australian welfare state, coupled with a national and international rise of social movements, which often organised to address needs born out of similar deficiencies. Yet since the late 1970s, both social movements and the welfare state itself have somewhat eroded, and ACCHSs, which are now dependent on state funds, found themselves in a position of trying to defend the welfare state in the face of increasing cuts to the public sector and privatisations. While ACCHSs broke from the mainstream sector, the break was for the exact purpose of strengthening and redefining the concept of public ownership, outside of the official infrastructures.

Division of responsibility between Federal/State Health/Aboriginal Affairs departments

The often unclear question of responsibility between State and federal levels, and on each level between Health and Aboriginal Affairs departments, creates further complications for community controlled services. The 1967 referendum over two amendments of the constitution created an expectation that the federal government would share some of the responsibility of Indigenous-related policy-making, an area that was mainly a responsibility of the different states. The main problem was that the actual division of responsibility was never clearly drawn out and agreed upon by any of the parties. The lack of clarity over the divided role also applied to the different government departments, specifically Aboriginal Affairs and Health, both on the state and federal levels.

The question of the division of responsibility between the various state and federal agencies was addressed in a number of policy reports. In 1973 a Ten Year Plan for Aboriginal health, which sought to regulate the responsibility of the different agencies, was formulated. Yet the suppressed Program Effectiveness Review (1980) points out that none of the Ten Year Plan's recommendations was acted upon, as each state interpreted the plan, and its agreements with the federal government, differently (Department of the Prime Minister and Cabinet, 1980, pp. 10-11). The PER suggested that, on the federal level, responsibility for funding is transferred from the DAA to the Commonwealth Department of Health (CDH), among other things because of the close consultations between health departments on the state and federal levels. The formation of ATSIC in 1990 was hoped to resolve some of these matters, yet the development of ATSIC was heavily criticised from its early stages (as discussed in chapter 7.8) and ATSIC was eventually scrapped by the Howard government in 2004. The situation of the division of responsibilities between the different departments today has become so complex that, according to Brennan and others, "a single Aboriginal community-controlled health organisation... may have reporting obligations to 20 or 30 State and federal government agencies" (Brennan et al, 2005, p. 31).

The initial grant requests by the Redfern AMS were made to the NSW Aboriginal Directorate (Foley, 1975) and to the Office of Aboriginal Affairs (Foley, 1991), which was established by the McMahon government and later upgraded to a department during the Whitlam administration. The incorporation of the Redfern AMS in 1975, and subsequently other ACCHSs, was meant to help facilitate funding applications.

NAIHO seems to have taken some different positions in the late 1970s and 1980s, which tried to secure ongoing funding according to the changing political terrain. In 1979, as part of its National Black Health Program (AMS Newsletter, 10-12/1979, p. 2), NAIHO called on the federal government to fund the establishment of new ACCHSs directly instead of through funds from state agencies. One of the reasons for the rejection of the plan was possible interference with 'state rights' (Ester, 1979, p. 468). As discussed in chapter 6.8, in the early 1980s, after the collapse of the relationship between NAIHO and the federal government over the suppression of the PER, a change came from an unexpected direction – Victoria and NSW, which adopted more progressive positions and allowed for some

advancements in the process of funding ACCHSs. Those changes led to the creation of combined bodies on the state level, which include both ACCHSs representatives and state health and Aboriginal Affairs representatives.

The fact that the biggest advancements in the integration of ACCHSs were made on the state level is very significant. The establishment of the DAA in 1972 was driven, among other things, by the deep disillusionment of Indigenous people with State bureaucracies. Yet after ten years of rocky relationship with the DAA, the breakthrough of ACCHSs with the Victorian and NSW governments can be seen as a failure of the DAA. The DAA itself was replaced by ATSIC in 1990. The establishment of ATSIC in 1990 was criticised in the Redfern AMS Newsletter (Bailey, in: AMS Newsletter 12/1991, p. 22), who warned that ATSIC was using rhetoric of self-determination without a real basis. After the abolition of ATSIC in 2004, responsibilities were taken away from ATSIC's partially elective structures, yet a federal Department of Aboriginal Affairs was never re-established. Instead, the Office of Indigenous Policy Coordination was introduced, in the Department of Immigration and Multicultural and Indigenous Affairs. Following a reshuffling of responsibilities in 2006, the Office of Indigenous Policy Coordination is now under the Department of Families, Community Services and Indigenous Affairs.

Thirty two years after the Whitlam government upgraded the Office of Aboriginal Affairs (which had only existed for a year) to a Department of Aboriginal Affairs, the Australian federal government's responsibility to Indigenous Australians is once again diminished into a single office, not even deemed worthy of a full federal department. It is in this context that recent regressive policy approaches need to be understood (such as the process accompanying the NTER).

The Policy Process: declaratory policy and treaty-like policy

The policy process is a key issue that affects the relationship between Aboriginal communities and organisations and the Australian state (in its different layers). Yet the policy process seems to be inherently flawed, as evidenced by the fact that the list of generated reports that were not fully acted upon seems to keep growing. During the

findings section of this thesis, different policy reports were examined, including the Scott report in 1973 in NSW, the 1980 PER, and the 1989 NAHS. The different reports have very different circumstances of course, and it is worth considering the ways in which reports are generated and used.

Worse than just ineffectual, failed policy processes such as unimplemented reports can have strongly negative effects on the potential beneficiaries, especially when those are invested in the policy process. As summed up in a later edition of the AMS Newsletter, “Many government programs for our benefit have failed in the past. We then bear the brunt of public criticism about failed programs” (9/1988, p. 1).

Based on the experience of the reports examined in the case study, I wish to argue that policy formation on Aboriginal issues occurs in two major ways: a *declaratory* way and a *treaty-like* way. In a declaratory way, policy formation is controlled by an appointed body and remains a closed process. Community representatives, organisations and individuals may be asked to testify or make contributions during the process, and consultations may take place, but the power relations are such that there are no guarantees that any requests or suggestions recorded in such consultation will be incorporated into the policy report/suggestions. I refer to such processes of policy formation as declaratory, due to the nature of the power relations that such processes help preserve: the policy making process is rigid and inaccessible, and the end result – the policy – is being ‘declared’ to the people who will be most affected by the policies.

A treaty-like policy formation process, on the other hand, is a process in which all sides take real part in the process, and the power is structured in a way that guarantees active input and ownership of community members and community organisations in the process. Such a process is much longer and more time-consuming than the declaratory policy process, yet as larger sections of the community has more stake in the process itself, the resulting policy may become more widely accepted and adopted.

In the context of the case study, treaty can be defined as a “political agreement involving Indigenous peoples and governments that have a binding legal effect” (Brennan et al, 2005, p. 3). Brennan and others also identify three key elements in a treaty:

“A starting point of acknowledgement;

A process of negotiation; and

Outcomes in the form of rights, obligations and opportunities” (Brennan et al, 2005, p. 3).

The significance of ‘treaty-like’ policy making processes are especially important in the context of a lack of treaty between indigenous Australia and the colonisers. A good example for a declaratory policy process may be the PER, except for the fact that the report and its recommendations were suppressed, thus never declared. The policy process of the NSW Task Force, as it was prepared by both Aboriginal community-controlled organisations and State and federal bureaucracies and included wide and open consultations in communities around NSW, was lauded as an achievement by both Aboriginal communities and state bureaucracies. The NSW Task Force process included treaty-like characteristics between the movement and the state. Such a process of policy making, while longer, can be much more effective than any report written by external ‘experts’, which despite good intentions may preserve paternalistic policy approaches.

Yet the question is, is a treaty-like policy process nothing more than a glorified form of co-optation of sections of the land rights movements by the state? I find the NSW Task Force in particular to be a key point of integration of ACCHSs and mainstream bodies. The first point of major agreement between the forefront of the ACCH movement and the state had a tremendous affect on the movement. The NSW Task Force on Aboriginal Health was seen as great victory to a movement that set its sight on the seemingly impossible. More than anything, the NSW Task Force recommendations can be perceived as a first signed treaty between the ACCH movement and the state. It was the first such contract between the movement and the state that had enough open participation of both communities and state bureaucracies to be accepted by and hailed by both.

The feeling of victory in response to the report of the Task Force, as expressed in the AMS Newsletter, may have had a deactivating effect to some degree. As long as an agreement such as this was not struck, the political awareness, which was at the heart of ACCHSs, was high. The acceptance of the task force recommendations by both the movement and the state meant an immediate expansion of services, following the first recommendation of the task force (1983, p. 5). As detailed in chapter 6.9, the AMS Newsletter at the time declared the Task Force report as a great victory for the movement (8-9/1983, p. 3). Yet it

also appears to have been the last edition edited by Gary Foley. In fact, after this very edition the Newsletters became highly irregular. There appears to have been no Newsletter released at all in 1984; two editions were released in 1985, and then one edition each in 1986, 1988, 1989, and 1991.

It is also important to note that a treaty-like policy process is not at all a guarantee for implementation. A clear example of this would be the 1989 National Aboriginal Health Strategy, which was prepared by a committee that included representatives of both ACCHSs and state bureaucracies. Despite the significant report that the committee produced, not much was done by way of implementation. Shortly after the release of the report, splits in the committee led to the establishment of two competing implementation committees, and most of the recommendations of the report remained unimplemented.

Another example of the limitations of such process may be seen in the rise and fall of ATSIC, which in itself could have been seen as one possible example of an implementation of a treaty-like policy structure. The ‘declaratory’ disposing of local and state level structures by the federal government proved yet another strong reminder that even a ‘treaty-like’ process that uses all the ‘right’ language can never replace a genuine mass social movement and real community control.

8.3 The experience of national organising

One particular feature of the case study that is worth exploring is that NAIHO was a national organisation, which set out to unite different communities that often deal with particular and changing local contexts. This discussion can be framed as a discussion of the *praxis* of national organising, or, the combined theory and practice, as two inseparable sides of the experience. In particular, the concept of praxis is often used in describing the experiences of social movements (see, for example, Conway, 2006; Fox and Frye, 2010; Peterson and Thörn, 1994). A unique project such as the community controlled health services movement should be understood in such a way, which includes both the theory

and ideas behind the movement and the experience of its practice. In this section I will examine various aspects of the praxis of national organising of community controlled services. I will start by examining the differentiation and potential complexities of the different levels of the praxis of community control – the micro (single community) and the macro (national organising) levels of the movement. Next, another layer of complexity will be explored, and it is the state of the broader social movements and their relevance to the practice of community control. The context of the decline of social movements in the 1980s sets the stage to my exploration of the shift that, I would argue, the ACCHSs movement experienced during the decade.

Community control on the micro and macro levels

The ACCHSs movement provides one of the best examples of community action driven by a deep understanding of the social and political determinants of health. Addressing the sources of inequalities is a necessity in order to have a dramatic, long-lasting effect on a sustainable health status for a given population. As a result of this deep understanding of the social determinants of health, the roots of ACCHSs are embedded in the social movements that flourished at the time. The movement emerged in the early 1970s, in a time when progressive movements organised around issues such as the Vietnam War, and connected to international postcolonial struggles. ACCHSs then made gains by contesting the issue of health as one of the many faces of the struggle for Aboriginal self determination.

Beyond the local examples of the development of ACCHSs in specific communities, the ACCHSs movement developed a national movement organisation, first NAIHO and later NACCHO, as umbrella organisations. Given the heterogeneity of the ACCHSs, which are derived from the specific conditions in different communities, the umbrella organisation developed into an entity on its own. The independent existence of a national organisation may create a gap between the micro and the macro levels of the movement: on the one hand, the local establishments of ACCHSs are vital for local struggles for self-determination on the micro level, as they fulfil urgent needs that cannot simply wait for the bigger-picture problems to be solved. But on the other hand, how can work on the micro

level have any effect on broader macro-level issues, which as we know have the deepest impact on people's lives? Surely, the existence of an ACCHS cannot turn back the wheels of colonialism, bring back sovereignty and assert people's rights for their land, can it? By looking at the ACCHSs it is important to be aware of their *transitional* nature. In other words, local gains (such as the ability to gain community control over health care services) are seen not as stand-alone projects, but ones that are built towards further development of – or, a transition to – a desired structural change. In the case study, for example, the struggle for community-control over health care services correlates with the struggle for land rights, which would bring about the issue of sovereignty, and so forth. But this, of course, is a two-way street. Having community control is potentially transitional, but can also be co-opted and used by the state as a way to avoid dealing with the real issues: for example, the state may fund these projects, but then will create a false sense that its obligations are now fulfilled. A good example of that is the *shared responsibility* approach that was established by the Howard government (Anderson, 2006).

The leading role that the Redfern AMS played as the breakthrough ACCHS meant that it had a big influence on the national organising level from the beginning of the movement. As early as 1973, the Redfern AMS made it clear that, despite some expectations that it might open services in other communities, it preferred to help local communities establish their own services. NAIHO itself was dominated by the early, urban ACCHSs, mainly Redfern and Fitzroy. Most of the material gathered in this research originated from the Redfern AMS, which also covered development of other ACCHSs. It is likely that the position and analysis presented in the Newsletters was not fully shared by other ACCHSs. However, it appears that this commitment by Redfern to advise and assist local communities in establishing their own services rather than forming 'branches' helped unite the movement and to stand under NAIHO's umbrella (as discussed in chapters 4.10 and 5.1, in particular in Mayers and Laing's submission to the Senate Standing Committee on Social Environment, 1973).

In the second decade of the movement, some deep changes, including the mentioned construction of joint state-level bodies, followed the struggle over the suppressed PER, inevitably changed the relationship between the micro and macro levels of the movement. From the mid 1970s, regional coalitions of ACCHSs emerged, and from the mid 1980s, state bodies emerged that combined ACCHS and state health bodies' representatives,

starting in NSW and Victoria, and eventually became the model in the other states and territories. The question of self-determination then can be interpreted in different ways between communities, which also affects the national perception of the struggle. Negotiating these different perceptions into a unified national voice is one of the most central challenges of the national organisation.

Community-control and the retraction of social movements: survival tactics

When approaching the changes that NAIHO and the ACCHSs movement went through in the 1980s, it is important to be mindful of the context. The basis of my argument rests on an understanding that the grassroots health movement is a manifestation of popular ideologies, arising in the context of a broader social/political movement. In the Australian case-study, the Aboriginal community-controlled health services are an integral part of the land rights movement (Foley, 1982). As such, its national groupings are one of the organisational manifestations of broader social movements (as discussed earlier in the chapter): the local community, the national ACCHSs movement, the land rights movement, and global movements such as the PHC movement and an international Indigenous peoples' movement. Thus, in order to understand a movement (health-centred or otherwise), it is important to understand the broader context of social movements in which it operates.

But what happens to such movement organisations once those broader social movements go through a period of stagnation? In particular, global movements were affected by the rise of neoliberalism (Touraine, 2001). The case study offers an insight into the shift that such organisations may go through in order to protect some of their hard-won achievements, while adapting to a new political context. This is a complex and controversial process. Furthermore, I wish to argue that this process is shaped by the relationship between community-control and co-option by the state, a dialectical relationship (as suggested by Nassi, 1978a) that the communities and the state enter via issues of funding.

The development of bureaucratic/professional organisations is one important method of surviving through a period of stagnation or retreat of social movements (as explored in an

early work by Zald and Ash, 1966). In the case study, it allowed the ACCHSs to survive the turn to neoliberalism and to exist until today across Australia – a unique achievement of the highest value. Yet organisations that survived had to change in order to do so. In the case study, preserving such mechanisms was achieved by transforming the perceived framework, from a *movement-oriented* organisation to a *sector-oriented* one. Some of those movements/sectors still play a critical role, both in service provision and in constant challenges to the prescribed dichotomies of their respective fields. Specifically in health services, such a movement mounts a serious challenge to western medical conceptions and the artificial separation of health policy and broader politics, which hides inherent inequalities of the system. In a similar manner, organisationally, such organisations combine traditional organisational forms with new emerging ones (Minkoff, 2001). I will now focus on the question of re-orientation of those national organisations, while drawing from my research into the case-study of the Australian Aboriginal community-controlled health movement.

An important way of studying these dynamics and the effect of the decline of a broad social movement is to analyse these national organisations of movements, and the changes in the organisations over time. The tasks of the national organisation include, but are not limited to:

- Consolidating the efforts of the different health services into a coherent movement;
- Unifying the movement in its demands from the state, particularly on the question of funding and its strings;
- Offering a platform for a shared development of a radical political discourse, the ideological infrastructures of the grassroots health movement;
- Development of political strategy, tactics, and demands of the movement;
- Offering mutual help and support to the different health services by sharing the experiences of communities;
- Expanding the praxis of community-controlled health to other communities; and
- Maintaining the connection with the broader political movement.

One of the main challenges of the national organisation is to provide these while maintaining the autonomy of the member ACCHSs, in the ever-dynamic political environment, and under constant pressure from the state, mainly through funding. Once structurally defined, the organisation can maintain its actions even in times of retreat of the

broader political movements that were initially a catalyst to the particular movement the organisation represents.

It is this difficulty that grassroots health movements had to face, with the decline of social movements especially in 'rich' countries around the world after the Vietnam War and with the emergence of neoliberalism. These difficulties include, but are not limited to: a decline in the voluntary activist base that maintains the structure of the national organisation, a decline in the radical discourse adopted and developed by the grassroots health movement, and increasing pressures by the state for great levels of co-option via funding agreements.

The defining struggles of NAIHO in the early 1980s, such as over the PER, took place in such a context of stagnation of broader social movements. Yet the achievements of the ACCHSs were far too important for communities, and had to be maintained. The movement survived, and still exists today. But in order for it to survive in such an environment, it has had to undergo some fundamental changes.

The movement/sector shift

Because grassroots health movements are deeply rooted in broader social/political movements, the decline of the broader movements change the grassroots health movement significantly. The national organisation, then, needs to change in order to adapt to the new political terrain. The dwindling human resource of volunteer activists is often replaced by the construction of new bureaucracies in order to maintain a level of activity. Moreover, with the decline of the broader movements, there is a stark shift in discourse. The new emerging discourse maintains, to a limited extent, those demands of the movement that were entrenched deep enough into public discourse (such as the demand for self-determination), yet drops – at least publicly – much of the radical discourse and ideological infrastructures.

Such changes in social change organisations are common, and to an extent, unavoidable, given the ever changing social and political landscape. It has long been observed that “the organized arms of value-oriented movements may remain intact long after the movements

themselves have lost general impetus” (Messinger, 1955, p. 3). According to Rubin and Rubin:

Social change organizations are live and dynamic and change over time - some accomplishing their goals, others being co-opted, while some, either lacking resources or failing in their missions, die. More often organizations evolve to mesh with a changing mission; in advocacy organizations volunteers are replaced by paid policy professionals, while in general organizations take on bureaucratic forms... (2008, p. 104)

And thus, the *movement* becomes a *sector*. At the core of this shift is the specific transformation of the national hybrid (as per Minkoff, 2002) organisation, from a movement-oriented community-controlled health organisation to a sector-oriented community-controlled health organisation. While this analysis is being framed around the experience of national hybrid community-controlled organisations, I believe it is of relevance to other similar organisations that experience such a shift. It should be noted that this development from a “movement” to a “sector” framework is not predetermined. There is no evidence to suggest an inherent tendency of such movement-oriented organisations to transform into sector-oriented ones. This transformation is explained by (1) the changing dynamics of the larger social movements out of which the health movement (especially those who identify as community-controlled) emerged, and consequently (2) the changing dynamics of the relationship between the community-controlled health movement and the state through funding. This is an indication of the inherent connection to the broader social movements.

The transformation into a sector framework is evident in nearly all aspects of the organisation: table 4 analyses different aspects of the movement/sector shift and draws out the main features of both types of national organisation. This table should not be read as a comparison between two altogether different organisations, but between two different stages in a single organisation under the context that I have explored and demonstrated. In the case study, the sector-oriented organisation started as a movement-oriented one, and its main contradiction is a result of the contrast between the radical political context of its birth and the pragmatism that enabled its survival.

The basic contradiction between a 'sector' framework and 'community-control' arises from the confinement of the community-control theory and practice into a specific sector. A main part of the ideology of community-control was the challenge to the dichotomised understanding of health and power. Consequently, ACCHSs venture outside of the health 'sector' by challenging the state on the social and political conditions of those communities. Therefore, a shift from a movement approach to a sector approach may stand in contrast to the ideological background from which the ACCHSs movement has emerged.

Each of the attributes of the shift, as shown in table 4, can be observed when looking at the Australian ACCHSs case study, as explored in this thesis.

Consolidating a coherent movement organisation is of course a key task of the national organisation. The state of the Aboriginal struggle was, and still is, diverse around Australia. The condition of the struggle that enabled the establishment of the first ACCHS in Redfern allowed the development of the Redfern Aboriginal Medical Service in that period, and it is that ACCHS that triggered other communities around Australia to similar action, in urban, rural, and remote communities alike. The types of support the Redfern service, and later NAIHO offered to other communities included, but were not limited to, recruiting doctors and health-workers, consulting on appropriate structures, sending medical supplies, and even funding in cases where the service was not yet recognised by the state. After the organisational shift towards a sector-oriented organisation, the whole process of mutual support continued to be a focus, yet the way the organisation relates to the different health services became professionalised, even corporatised.

This shift reflects the construction of bureaucracies to replace activist networks that dwindled in numbers as the land rights movement, as well as other social movements globally, went into decline in the 1980s. This is a major issue for movement organisations that base themselves on a constant influx of activists. The replacement of some activist roles with professionalised bureaucracies might have unavoidable effects on the ongoing development of political strategy and demands of the movement. This is an example of how the construction of bureaucracies can have a direct effect on the political nature of the movement, as less people take part in the ongoing decision-making process. This means that more decisions are being carried out by a smaller, professionalised group.

Table 4: the movement-oriented and the sector-oriented community-controlled health organisation: features and shifts.

	Movement-oriented community-controlled health organisation	Sector-oriented community-controlled health organisation
Purpose	Consolidate the efforts of the different health services into a coherent movement organisation	Maintaining the existence of such health services in the changing political landscape
People	Run and maintained by activists	Fewer people are getting involved. Bureaucracies are constructed to fill this gap and maintain the organisation
Strategy	Developing political strategy and demands of the movement	Still a key element, yet it involves less people and is going through a process of “professionalisation”
Organisation	Unifying the movement’s demands from the state, particularly on the question of funding and “strings”	Maintaining the ongoing relationship with the state
Central function	Providing mutual help and support to the different health services by creating a network for sharing experiences of different communities	Continues to be a focus, although in a different, bureaucratised and professionalised way
Praxis	Expanding the praxis (theory/practice) of community-controlled health to other communities	Continues to be a focus, although in a different, bureaucratised and professionalised way
Politics	Shared development of a radical political discourse, the ideological infrastructures of the community-controlled health movement	The radical discourse changes dramatically, yet the particular aspects of the radical discourse that relate to the particularities of the movement are maintained, such as self-determination and community-control
Discourse	Political analysis of the determinants of (ill) health that is mainly aimed as an appeal for mass action	Political analysis of the determinants of (ill) health that is mainly aimed as an appeal to the state
Context	Maintaining the connection with the broader social/political movement; assuming a leadership role	With a decline in the broader movements, the “sector” organisation relocates itself from the core to the outskirts of the movement, in order to decrease its dependence on the broader movement
Networks	Large overlap of activists: leading activists in the organisation are leading activists in the broader movement	Smaller overlap of activists: only few of those involved in the sector-oriented organisation are also active in providing leadership in the broader movement
Funding/resources	National organisation funded primarily from the member health services that it represents, and donations	National organisation partially funded by the state

The political process as a whole is affected by the bureaucratisation. Some (Thorpe, quoted in: Maddison, 2009, p. 33) attribute this process to the incorporation of community-controlled health services. Yet this approach is too simplistic. The Redfern AMS was incorporated as a cooperative as early as 1975, and other ACCHSs followed. This was mainly a technical move, a necessity in order to increase chances of regular funding, as explored in chapter 4.5. The sorts of strings that are attached to state funding are at the heart of the question of community control in the long-term. Yet the more fundamental changes, which I identify largely as the movement/sector shift, happened a decade later.

The ACCHSs faced no other choice if they were to keep getting funded. Giving up the irreplaceable health services, after years of struggle, was simply not an option. Furthermore, the peak of political power and influence of the NAIHO, the movement-oriented organisation in our case study, came *after* the incorporation. The peak of the political influence of NAIHO seems to have been in the years 1980 to 1983. This period was book-ended by two major developments, the 1980 Program Effectiveness Review (Anderson and Sanders, 1996; Bartlett, 1998; Gillor, 2011) that was commissioned by then-Prime Minister Malcolm Fraser, and the New South Wales Task Force on Aboriginal Health (1983), which was compiled by a committee of both activists of the ACCHS and commonwealth and state bureaucrats from departments of health as well as Aboriginal affairs. The Task Force (as well as a similar task force in Victoria in 1982) was a significant part in the process of the shift, and might be considered as a much more significant act of incorporation into the mainstream health system.

The shift from a movement-oriented organisation to a sector-oriented one, therefore, was a development in the movement in the face of overarching changes to the conditions, and therefore the methods, of grassroots political struggles in the 1980s. This shift enabled to the maintenance of some of the important aspects of movement-oriented organisation, such as some basic structures of community control, a political analysis of the determinants of (ill) health, and expansion of the praxis of community-controlled health to other communities. Yet with the lack of a politicised mass movement, the orientation of many of these actions and appeals are to the state rather than to the land rights movement.

This of course led to epistemological changes in the radical political discourse of the

movement, or in other words, the ideological infrastructures of the ACCHS movement. The discourse shifts dramatically, yet the particular aspect of that discourse that relates to self-determination and community-control is maintained. The ideological particularities then remain, yet the overarching political discourse is changed. Documents by NAIHO often emphasise that “the overall solution to ALL [sic] of our people’s problems, rests in the concept of economic, social, political and cultural independence. And those goals can only ever be achieved through LAND RIGHTS! [sic]” (Foley, 1983, p. 5). With the decline of the land rights movement, the context of the land rights demands was somewhat removed from the politics of the ACCHS movement.

Howard (1981) suggests that the fact that ACCHSs have a clear goal helped them survive changes in the community and in the field: “Organizations with the least ambiguous role have been best able to weather recent changes” (p. 153). This is another important element of the movement/sector shift, which enabled the survival of the services despite the changes. Today, the use of the term ‘sector’ is most common within the movement (Councillor, 2004; NACCHO, 2008).

The movement/sector shift was studied here in the context of the case study, the ACCHSs movement in Australia, yet I believe it may be of relevance to other community organisations that need to adapt in order to survive. Community organisations develop from a very specific context of need and political awareness. These factors are ever dynamic and subject to change. These changes, as demonstrated, are tied to both structural changes in the specific political context, and the state of social movements at their different layers (local, national, and international).

A shift towards a sector-oriented approach also has the danger of alienating parts of the movement, which see their commitment as mainly ideological. This commitment is in turn tied to the organisational form of the movement. The ACCHSs case study is no exception, with some prominent activists, such as Gary Foley, distancing themselves from the movement after the disintegration of NAIHO and the formation of NACCHO. Yet the necessity of the shift to assure survival seems to have been an inevitable result of the existing situation, in its specific context.

8.4 The movement today

Forty years after the establishment of the Redfern AMS, over 150 ACCHSs operate throughout Australia, in urban, rural, and remote communities. ACCHSs play a crucial role in the delivery of health services to Indigenous Australians, with some 61.5% having access to a local ACCHS (Australian Bureau of Statistics, 2010). Beyond the physical services that provide access to many who otherwise would have had limited, inappropriate, or even no access to health services, the ACCHSs movement changed the practice of health delivery to Indigenous communities by mainstream health services as well. These changes have been somewhat forced on mainstream services with the proliferation of ACCHSs. The movement got mainstream health systems to acknowledge concepts such as the holistic approach to health and the importance of cultural appropriateness in health delivery.

The effects on Aboriginal society can be understood in different terms: first of all, directly, community-controlled services have generated a network across Australia of health services designed and controlled by local communities, and not by external bodies. Second, through this process, ACCHSs and other community-controlled organisations have educated mainstream systems on some of the physical and cultural needs of Aboriginal people, thus significantly improving the experiences of Aboriginal people even when they go to white-run hospitals and health services. Such institutions were a significant part of the ideological apparatus of Australian racism. Furthermore, such racist attitudes were a significant reason that the first ACCHS was established not in a remote area with little access to mainstream services, but in Redfern, at the heart of Sydney, despite its supposed high level of access to mainstream health services. It was noted (Briscoe, 1974; as discussed in detail in chapter 4.2-3) that the establishment of the Redfern AMS was sparked by the fact that people in the Aboriginal community in Redfern sometimes preferred to die and not be subjected to the racist treatment of the mainstream health institutions.

Yet the role of the national organisation of the movement changed significantly following its initiation in the early 1970s. As explored in the discussion of the movement/sector shift, there are some significant differences between NAIHO and the subsequent national

organisation, NACCHO. One change is in the micro/macro dynamics: as a result of the KordaMentha review in 2003, the individual ACCHSs no longer affiliate directly to NACCHO, but to state bodies that were established after the struggle over the suppressed PER. These bodies then affiliate to NACCHO, which effectively became a coalition of these state-level bodies rather than the actual ACCHSs.

These new arrangements and new role that NACCHO plays in comparison to NAIHO also means that NACCHO often refrains from taking a strong stand on political issues that are outside of its specific 'sector'. A striking example of this is the fact that NACCHO did not adopt an official position on the Northern Territory intervention. Some ACCHSs, in particular those in the Northern Territory, did speak out against it. The Sunrise Health Service, for example, participated in protests against the intervention (National Aboriginal Community Controlled Health Organisation, 2009).

Despite the positive influence and achievements of the ACCHSs movement, health outcomes of Indigenous communities did not improve as much as health indicators of other Indigenous communities in settler-states such as New Zealand, Canada, and the United States, gains that "are attributed to primary health care" (Griew and Thomas, 2008, p. 78). Griew and Thomas attribute this directly to the lack of sufficient funding to primary health care, including ACCHSs; As a result of this, "Aboriginal and Torres Strait Islander people are yet to fully benefit from what primary health care can deliver" (Griew and Thomas, 2008, p. 78).

The demand for land rights today

Since the start of the battle for land rights, some achievements have been made. Most notable of which include the partial granting of land rights in the Northern Territory, the establishment of land councils that continue to wage legal battles to recognise original ownership in various locations, and some historical legal decisions, most notably the 1992 Mabo case (Rowse, 1993; Attwood, 1996).

Yet these achievements were only very partial compared to the demands that unified the

movement in its height, when movements such as the ACCHSs emerged and iconic protests such as those of the tent embassy in Canberra in 1972 redefined the Aboriginal struggle. The different conditions around Australia, as well as the problem of distance, meant that the movement has sometimes lacked cohesion on the national level. The weakening of social movements from the 1980s further affected the land rights movement, and the ACCHSs, as discussed earlier in the chapter.

Today it would be hard to argue that a cohesive land rights movement, as such, exists. There are various political organisations, as well as a large variety of Aboriginal organisations that operate on different levels and with different perceptions of community control, yet the political situation is a far cry from a coherent national movement with clear demands. Perhaps one of the most devastating blows to Aboriginal self-determination was the story of ATSIC. Its establishment was surrounded by controversy and criticisms within Aboriginal communities and organisations, as it was perceived to be a body that was aimed at replacing the demand for actual self-determination (Bailey, in: AMS Newsletter, 12/1991 p. 22). The way in which ATSIC was abolished by the Howard administration proved just that. Yet, as bad as ATSIC was, its abolishment and the lack of other national infrastructures are a testament to the poor state of the land rights movement today.

Government policies today

Today, funding relations between ACCHSs and State and federal agencies are a complex web of various types of agreements that were made with different governments under different policies. The type of funding agreements usually correlates with the ruling policies at the time. For examples, some services that were established during the Howard administration operate under *shared responsibility agreements* (Anderson, 2006). Even forty years after the establishment of the Redfern AMS, much of the work of ACCHSs is spent on fund-raising and grant applications. The advancement of neoliberalism and its influence on policy making means that, in the last 30 years, the approach to social services has become more particular rather than universally oriented. This means much more scrutiny for grants applications, and essentially, more strings attached to funding. A good example of this is the KordaMentha review and reforms that were forced on NACCHO in

2003 (as discussed in chapter 7.9).

Funding policy today can be understood in the broader context of federal policies towards Aboriginal communities. The far reaching aspects of ‘top-down’ initiatives are a testament to the regression that has been made in Aboriginal policy, as a result of 30 years of neoliberalism and subsequent withdrawal and stagnation of the social movements. Policies such as the Northern Territory Intervention, which was initiated by the Howard Liberal government but maintained by two subsequent Labor governments, are a testament to the poor state of the struggle for Aboriginal control and self-determination today. The NT intervention is a brutal example of the tendency today towards a declaratory policy process rather than treaty-like policy processes. The stagnation of the movement that calls on the Australian government to finally sign a treaty with Indigenous Australians is not an unrelated occurrence.

The fact that the ACCHSs continue to operate under these conditions, which was enabled partly by the movement/sector shift, emphasises the true vitality of the movement, but also hints at the deep changes that ACCHSs had to go through in order to survive.

Chapter Nine: conclusions

As I write the final words of my thesis, three and a half years after starting the research, the world is witnessing a new rise in activity of social movements. From the United States to the Middle East, people are taking to the streets, in some cases for the first mass protests in decades, against repressive regimes. Though the struggles are all different, the demands are often similar: lower the burden of the rising costs of living, after the deep privatisation of public institutions; make services such as health and education equally available and free; and construct a new political system that would increase the democratic space, by involving the people in issues of control over society.

This global upsurge in protests should also remind us of the deep connection and interrelatedness of social movements on the local, regional, national, and international levels. In 8.1, I discussed the different layers that the ACCHSs movement operates under, and located different social movements in all of these different spheres. Social movements cannot exist in a vacuum, they rely on one another. As I discussed earlier, the establishment of the Redfern AMS, and subsequent ACCHSs, occurred in the context of the rise of social movements internationally during the early 1970s. We are now also seeing a global wave of social movements, reminding us how important those connections are, which often transcend national lines. Much like any other social movement, there are never guarantees of effectiveness. There are many things that can go wrong, but unlike times when the wave of social movements is dormant, there is hope – a hope that a genuine change to the structures of society is possible. And this is the hope that fuels social change.

In this thesis, I set out to examine social movements in the context of health and health services. I decided to focus on a case study of the ACCHSs movement in Australia, looking at the development of the national organisation (NAIHO). Through this thesis, I presented the development of the movement during its first two decades, focusing on NAIHO and on the Redfern AMS. The case study of NAIHO touches on many organisational issues. The organisational question, which is not usually the main element that sparks the passion of social change activists, may be a real determinant of success and failure of the movement. This thesis examined the role that NAIHO played, and looked at the changes it went

through when the premise in which it was active changed. Specifically, the withdrawal of social movements in the 1980s forced the movement to change in order to survive. In the discussion chapter, I classified these changes as the movement/sector shift: a shift in the way the role of the organisation is perceived – as a movement, or as a sector. These two different positions imply different roles and orientation towards the issues involved. This shift is further explored in 8.3.

Another important aspect that accompanied this thesis was the way policy is being done, and more specifically, the use and implementation of reports. Some of the main findings of this research regarded reports that have either been suppressed (Scott, 1973; Department of the Prime Minister and Cabinet, 1980) or very partially adopted (National Aboriginal Health Strategy, 1989). With that, this thesis also discusses different methods and approaches to the question of policy and policy making. This issue is presented and further discussed in chapter 8.2.

A term that has been at the heart of this thesis is *community control*. As many other terms in the social/political world, community control can mean a large variety of things, both in theory and in practice. In this thesis, I examined some of the different ways in which community control is perceived. I did not intend to offer a sweeping definition of the term. One conclusion that arises from this thesis is that the meaning of such a term cannot be seriously discussed outside of a specific context. It is the context that gives such definitions their meaning.

Yet it is important to find the commonality in the different definitions of the term. At the end of the day, the use of the term ‘community control’ comes to remind us that the political question, the question of power relations in society, is at the heart of any issue of social significance. In the context of this thesis, this means that health must be perceived in its social context in order to have a basic understanding of it. This perception of health is championed by a section of health studies that focuses on those social determinants of health. In particular, the PHC movement emphasises the role of political matters (such as control and participation) in the health process.

While this thesis has focused on the past, its ideas are firmly planted in the present. As we see the start of another wave of social movements around the world that try to secure more

democratic spaces, learning from past experiences is crucial. This is what I hope that this thesis may offer, an example of the experiences of this particular movement in a particular focus (on the national level). It is my hope that this field of studying and preserving the knowledge of social movements will continue, and that in particular, that other researchers will find interest in the ACCHSs movement and will contribute to its study and the expansion of available knowledge.

In terms of the primary sources used in this thesis, this case study may offer an example of the importance and value of activist literature. The use of media in social movements developed since the early days of the ACCHSs movement, with the spread of personal computers and the creation of the World Wide Web. Newsletters, such as the AMS Newsletter, appear online, significantly reducing the costs involved in production, while also being instantaneously available around the world. Today's 'activist newsletters' range from large-scope alternative news websites to individual blogs. It is my hope that, in the study of social movements, more emphasis is given to the unique insight and information that such resources may offer. These resources, written in real-time by activists, still offer a unique and precious perspective to the mind of social movements, and should be preserved for future prosperity.

It is my hope that future scholarship could continue to tell the story of NAIHO in greater detail. In particular, NAIHO's internal processes and structures are worth further exploration. The thesis offers some different existing explanation to NAIHO's demise and NACCHO's rise (as discussed in chapter 7.7), and I hope that future research could shed more light on this fascinating period. Also, the nature of the primary sources employed in this thesis focused on the role of some of the major ACCHSs (in particular the Redfern AMS), and while these played leading political and organisational role in NAIHO, the history of other ACCHSs and the role they played in NAIHO deserves further investigation. While this thesis explores the organisation of the Redfern AMS in particular (due to it being the first ACCHS and a leading political influence in NAIHO), a full thesis could have been written on the history of each of the hundreds of ACCHSs established since. It is my hope that future research would preserve these fascinating stories.

Despite the particularities of context, which shape each social movement separately, there are some strong parallels that bond different movements around the world. Social

movements are often similar in their demands and aspirations, and connected by their experience and practice. For example, in a profound way, movements such as land rights movement in Australia, the Palestinian movement, the Maori movement, the movement of working people from around the world to secure basic living conditions, are all manifestations of one movement: a global movement of liberation and emancipation. And, in the same breath, all of these movements are different: each one exists in a unique context, and each has to be understood on its own terms. Because of their difference and uniqueness, it is very hard to draw direct lessons from one movement to another – what works in one context might be devastating in another. This complexity must be acknowledged for a full understanding of the nature of social movements.

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