Remoteness, Indigeneity and Community Health Engagement Processes: A Discursive Approach

Abstract

Using a discursive approach, this paper examines the impact of remoteness and indigeneity on community health engagement processes in rural Australia. The paper asserts that effective community engagement processes are limited by the discordant notion of community in the discursive practices of the government, the indigenous and non-indigenous health workers in rural areas. The analysis, using machine learned textual analysis, thematic analysis and critical discourse techniques, comprises focus group interviews at five hospitals with community health workers and community members. The outcome of this analysis is that the elaborate managerial structure is frequently averted or subverted in order to get on with the job. The analysis also identifies political and cultural assumptions that underlie the positive connotation of 'community', and reveals tensions based on power, gender, and race that need to be addressed.

Key words: Indigeneity, community health, Critical Discourse analysis, Leximancer, thematic analysis, government policy

INTRODUCTION

Community involvement is important and beneficial in government responses to public issues because it: contributes to decision makers' competence in generating better decisions; provides legitimacy to those decisions through greater accountability (by decision makers); and constitutes part of the proper conduct of a democratic society (Benhabib, 1996; Bessette, 1994; Bohman, 1996;Carnevale & Wechsler, 1992; Gutmann & Thompson, 1996; Ivie, 1998; Priest, 2001; Schudson, 1998; Trend, 1996). Consequently, various governments are adopting community-based health strategies.

This study evaluates the implementation of a new health strategy initiated by Queensland Government [QG] of Australia. The QG incorporates its community health policy within an economistic framework claiming that a healthy population is critical for an economic and socially vibrant state. In 2002, under its political slogan the *Smart State,* QG launched the *Smart State: Health 2020* direction statement, which maps the health direction for the state for the next two decades. Two important principles motivated the strategic statement. Firstly, Queensland has the fastest growing population in Australia, about 2.3%/year[i]. Although Queensland is a vast state—1,730,648 square kilometers (695,408 square miles; 2.5 times Texas)—it has a relatively small population of about 3.7 million, 66% of whom live in the South East corner of the state within a 100 kilometer radius of the capital (representing about 5% of the area). Despite this population growth, it faces the challenge of an aging population with the proportion of aged persons increasing from 11.3% in 1998 to 11.9% in 2003, and an increasing median age (35.5 years in 2003), which is in line with the increased national median age, which has increased by 5.8 years from June 1985 to 36.6 years at 30 June 2005. The second impetus was that the current 'high quality health system and world class health workforce' cannot be sustained unless Queensland Health (the arm of QG that is given the responsibility of administering the state's health programs) plans, develops, and manages the organization to meet both current and future demands of the population (Queensland Government, 2004).

A third unstated motivation might lie in the reduced level of government expenditure, placing pressure on Queensland's free-hospital system. Set up in 1944 by a socialist Labor Government, this system has been maintained even under ultra-conservative governments when Labor lost office. Ironically, recent Labor governments, operating within the fiscal constraints of hegemonic neo-liberal economics, have had considerable difficulty maintaining Queensland's commitment to this system. A recent symptom of this crisis in staffing was the 'Doctor Death' scandal (http://www.abc.net.au/7.30/content/2005/s1520308.htm), in which a US-trained Indian doctor's criminal incompetence in a rural hospital (Bundaberg) led to at least 13 deaths. It was clear that his appointment was possible because of the difficulty in obtaining doctors to work in remote regions. The state department responsible for administering hospitals, Queensland Health [QH], adopted the *Smart State: Health 2020* statement. It outlines three strategic directions: involving Queensland communities in better health and heath care; taking a wider perspective on health; and providing integrated people-focused health services. Essentially, the blueprint sought to ensure that effective decision making processes would incorporate a variety of perspectives from the different segments of the remote but culturally diverse communities in Queensland. The strategic directions were to be operated using a 'whole-of-government approach' aimed at 'safer and more supportive communities', 'community engagement', and 'a better quality of life' (Queensland Government, 2003). In addition, QH adopted the Balanced Scorecard [BS] (Kaplan & Norton, 1998) as an operational and evaluation tool to gauge the effectiveness of these new strategic directions.

PURPOSE

This research examines the discursive relationship between the government community-based health initiative and subjects in a remote rural health district who are expected to implement the initiative. These subjects are QH nursing staff, a doctor, ancillary health staff, indigenous district health officers and community members of hospital boards.

THEORY

From a critical Foucauldian perspective, discourse emerges from configurations of spatio-temporal locations and macrostructures to provide people with a range of utterance possibilities. It allows human beings to share sets of understandings about a particular aspect of the world within certain time and space configurations. Thus, discursive subjects are limited by the macrostructurally determined boundary constructions of knowledge, values, and subjectivities contained in any particular discourse. Macrostruture here means the larger and more powerful discursive formations that 'frame' societies at particular times. For example, the discursive macrostructural elements that contextually frame the discourse of this health region would include Western medical concepts into which doctors and nurses are inducted; the neo-liberal philosophy (popularly called 'economic rationalism') underpinning government fiscal policy within which public hospitals must conform; and 'new management' processes that inform hospital administrative procedures. Thus discourse becomes an 'unconscious structure of conscious thought as the *a priori* organising principle' of what people think and say, and so constrains the expression of thought to operate within certain limits (Bannet, 1989, p. 164). This limits the epistemic bases of the discursive formation, which are then manifested in the range of possible statements in a given discourse (Foucault, 1972, p. 191). According to Bannet (1989), discourse makes 'objects perceptible in certain ways' and provides textual coherence (p. 161). Similarly, for Fairclough (1995), discourse is a way 'of signifying areas of experience from a particular perspective' (p. 134). A critical discourse perspective allows the researcher to study 'real, and often extended, instances of social interaction which take (partially) linguistic form,' and so provides an insight into 'the relationship between language and society' (Wodak 1997:173). In other words, discourse is inextricably linked with social practice (discourse-as-social-practice: Fairclough, 1992). However, the use of the term macrostructure is deliberately used to separate it from Althusserian and Gramscian notions of ideology and hegemony, which tend to be reductive. While acknowledging the determining power of macrostuctural discourses such as that outlined above, there is contestation and struggle that leads to ongoing discursive adaptation and only occasionally

'rupture' such as the neo-liberal order wrought during the leadership of Reagan and Thatcher (cf. Fairclough 1992: 93). We share Blommaert and Bulcaen's (2000) assertion that

> Hegemonies change, and this can be witnessed in discursive change, when the latter is viewed from the angle of intertextuality. The way in which discourse is being represented, respoken, or rewritten sheds light on the emergence of new orders of discourse, struggles over normativity, attempts at control, and resistance against regimes of power (p. 451) .

Nonetheless, 'discursive formations'—to use Foucault's term—maintain unity, not by epistemologically freezing the object, but by regulating the space in which the 'various objects emerge and are continuously transformed' (Foucault, 1972, p.32). The 'space' within which a discursive formation operates is regulated by the relationship between 'institutions, economic and social processes, behavioural patterns, systems of norms, techniques, types of classification, and modes of characterisation' (p. 45). Thus, when producing a text or an utterance, the subject is always operating within a discursive space, almost invariably unconsciously so: an utterance locates the subject in a particular position within that discursive space (pp. 95 - 96).

We are concerned to evaluate the subject position of those who are implicated in the implementation of community health policy, the intertextual and interdiscursive discursive genesis of which would require a significant other paper. We assume that subjectivity is shaped within discourse, and so is spatio-temporally located; that people have multiple subjectivities; and that subjectivity is therefore inherently unstable (for a fuller account of subjectivity, see McKenna, 2004). The available subject positions are determined by temporal conditions, or 'a particular historical plane of projection of specific projects and programmes that seek to govern humans' (Rose, 1996, p. 300). This means that, over time, discourses come and go not by random chance but as the processes of dialogic and dialectic intertextually and interdiscursively reshape the texts of discourse in the manner suggested by Bakhtin (1981). Because discourses constantly reformulate themselves, the subject, as discourse participant is, to varying degrees, fragmented as they are 'constituted, reproduced and transformed in and through social practice' (Fairclough, 1992, p. 44). Operating in various discourses, some of them contradictory, the subject too is multiple, sometimes being contradictory and variable.

Although there is a degree of agency, Bakhtin asserts that individuals are ‘neither entirely autonomous, self directed entities nor as surface effects of a deep epistemic structure, but rather as reflexive agents embodying a range of socially determined practical capacities, a repertoire of collective skills and resources' (Gardiner, 1992, p. 166). Thus, individuals must adopt diverse subject positions within the various discourses in which they operate. Given that the community-based health policy implies an agentive subject operating as a community member, it is worthwhile noting Rose’s (1996) claims that modernity ‘destroyed the fixed social and cultural formations of community and kinship, which had defined the identity of subjects from outside, [and] embedded the person within a stable order of status, within a transcendental and implacable cosmology’ (p. 301). Thus, we claim, the modern subject is ‘formed in relation to practices of freedom and techniques of the self, by the historically specific complement of procedures, means and instruments by which the self can act on itself’ (Dean, 1994, p. 195). As an active agent, the person for the new times, it is assumed, has autonomy and responsibility that is exercised in informed decisions, thereby fulfilling a personal destiny. However, because the self-determining subject is itself an historical creation (Hunter, 1993, p. 260), ‘the capacity of individuals to comport themselves as the self-reflective subjects of their own thoughts and actions is neither given by nature nor guaranteed by history’ (p. 244). In other words, the ethical, autonomous subject is a discursive possibility within the current conjunction of new times circumstances.

METHOD

The epistemological foundation for data collection and analysis in this study is broadly interpretive qualitative research. We employed two interpretative techniques, which seek to describe, decode, translate and come to terms with the meaning of naturally occurring phenomena in the social world (Van Maanen, 1979; Taylor, 2000). More generally, qualitative research, according to Fryer (1991), is focused on the complexity, authenticity, and shared subjectivity of researcher and the subject. Thus, theory from the qualitative approach is generated from and ‘grounded’ in the data (Glaser and Strauss, 1967) while researchers who aim at constructing grounded theory do not seek to prove their theories, but simply demonstrate the plausible support for these theories (Taylor &

Bogdan, 1998). In particular, interpretivists see social reality as constructed and interpreted by people rather than something that exists objectively 'out there' (Denscombe, 2002). According to the interpretivists, the social world does not have the tangible, material qualities that allow it to be measured, touched or observed in some literal way. It is a social creation, constructed in the minds of people and reinforced through their interactions with each other (Denscombe, 2002). This form of reality exists only through the way people make sense of the world and how they create their social world through their actions and interpretations of the world (Denscombe, 2002).

The research is a two-part discourse analysis based on a corpus of material gathered from 50 people in five focus groups and 1 interview with an Indigenous health worker. Represented on the focus groups were QH staff members, patients and community representatives and interest groups All focus groups contained at least one Indigenous person (usually a health worker or a member of the hospital advisory board). One focus group comprised only indigenous members. This was transcribed for two sorts of analysis. The first analysis is grounded in that the data were analysed by textual analysis, *Leximancer*, without any *a priori* categorisation. The second analysis, a thematic analysis, emerged as we were conducting the interviews as both researchers sought to identify emerging concepts or themes. This thematic analysis was continued by continued 'hermeneutic' readings of the data.

A: Leximancer Textual Analysis

Leximancer, a content-analysis software tool, is an appropriate grounded research technique because it minimises the effect of predetermined concepts on interpretation. *Leximancer* does this by mathematically limiting the human element in its internal system of data analysis and display through concept mapping (Smith & Humphreys, 2005, in press). It codifies text into various groups or categories depending on selected criteria (Krippendorff, 2004). *Leximancer* conceptualises and thematises text through a thesaurus based on the particular corpus. Thus it organizes the corpus into two groups: themes and concepts.

It does this in a 2-step process, and in a way that recognizes the semantic and relational dimensions that give meaning to text. *Leximancer* systematically alternates between

semantic and relational extraction from the co-occurrence of words within any textual corpus, functions which are interdependent. It statistically analyses text knowing it contains both an indirect (semantic) similarity of context and a direct (relational) similarity, the latter being extracted from the episodic segments (using 'sliding windows' of three sentences). Step 1 of the analysis develops a thesaurus from the raw bank of words in the corpus without any prior dictionary. This involves semantic or indirect extraction to construct a hierarchy of 'important lexical terms based on word frequency and co-occurrence usage' (Smith & Humphreys, 2005, p. 2). Step 2 performs semantic classification from this thesaurus to codify the concepts using a set of classifiers to produce an algorithmically derived concept index and concept co-occurrence matrix from the text. This step provides a concept map that visually represents themes and concepts. Concepts are individual words that have significant relations with other words, and is not based on frequency of occurrence. Thus a word may occur frequently, but not appear on the concept map because it is related to so many other words (concepts) as to have too diverse semantic meaning. Thematic groups of concepts (called themes) are also based on concept collocation (Smith & Humphreys, 2005, p.7). Because they are usually the most interconnected or 'parent' concepts within the group, they characterise that region of the concept map. The extent of *Leximancer*'s conceptual and relational analysis leading to thematised outcomes provides discourse research with commonalities and relationships expressed in the thematic patterns that inhere in different texts (Lemke, 1995b, p. 7).

Leximancer caters for the 'polysemic character of texts' by formulating inclusive concepts 'located in determinate semantic and discursive fields' (López, 2003: 143). It assumes that because the concepts correlate as 'textual concepts' their correlation with individual mental states is somewhat probabilistic (Smith & Humphries, 2005, p. 3). Therefore, *Leximancer* calculates concepts statistically and thus scientifies their interpretable range at no less than human level (p. 3). Its bootstrapping technique also helps to avoid 'fixating on any particular anecdotal evidence that may be atypical or erroneous' (p. 2), thereby reducing expectation bias. Analysts using *Leximance*r, however, can change

parameter settings (hand-seeding) and thus influence their results. Hand-seeding was used in this analysis to eliminate distracting elements (*yeah* and *inaudible* were deleted) and to combine similar concepts (*Aboriginal*, *indigenous*, and *black* were combined into a single concept).

Stability is found when little or no variance in content classification occurs over time (Tan & Wee, 2002: 326) within the research process. This is achieved in Leximancer analysis through its consistency of extraction and conceptualisation when the parameter settings are constant (Smith & Humphries, 2005, p. 6–7). Leximancer's analytical strategy ensures coder reliability no matter how often its corpus of text is coded and recoded (p. 7). For this research, such stability was evident at 2000 iterations. Leximancer has been successfully tested for both 'reproducibility' (i.e., comparisons between different [internal] Leximancer analyses) and for 'correlative validity' (i.e., comparisons with other [external] analyses) (p. 20). Internal reproducibility is achieved in Leximancer at the point of attention to the 'similarity in concept network patterns' that is displayed in the stochastic concept map (p. 12). Leximancer's concept maps are derived over several stages of calculation that draw from other techniques of statistics such as Corpus Linguistics, Latent Semantic Analysis, and Computational Linguistics (p. 2). These techniques come to *Leximancer* associated with validity measures tested over a significant breadth of research in the disciplines of (particularly) psychology and statistics (p. 2–5).

The total corpus of interview and focus group material was divided into three arrangements:

a. All five focus groups (excluding the interview)

b. Four focus groups excluding the indigenous focus group.

c. The indigenous focus group and interview with indigenous health officer.

This allowed for comparison between the indigenous and non-indigenous outcomes.

B. Thematic Analysis

Thematic analysis moves above the lexical level used in Step 1 of this research. It draws on the analysts' capacity for identifying themes in the text, although each theme may be expressed in different verbal forms and grammatical constructions (http://academic.brooklyn.cuny.edu/education/jlemke/). Thematic analysis requires familiarity with the subject matter content of the discourse or text (Lemke, 1988, 1990, 1995a). In a sense it replicates the thematic mapping of *Leximancer,* but themes derive not from lexical (concept) relations, but from the analyst's ability to abstract the 'essential meaning relations among key terms' in the discourse (Lemke, 1990). By itself, thematic analysis is highly interpretive and dependent on the analyst's frame of understanding. Thus it is highly contestable. Thus the grounded lexical analysis provided by *Leximancer* provides some form of validation.

A benefit of thematic analysis is that it allows the researcher to identify possible intertextual links. Because '[a]ll meaning is intertextual' (Lemke, 1995b, p. 41), we can better understand the meaning of a particular text by understanding how it fits into the Bakhtinian chain of utterances (Bakhtin, 1994, p. 87). This intertextual analysis, according to Fairclough, provides an important mediating role in linking text to context (1995, p. 211).

FINDINGS

Leximancer Analysis

The three maps below (Figures 1, 2, and 3) identify the outcomes of the Leximancer analysis. This is simplified in Table 1. Of most interest is the thematic comparision of Groups B and C. Because Group B is predominantly non-Indigenous (although each of the focus groups did contain at least one Indigenous member) and Group C is solely Indigenous, they provide an ethnic contrast. Of initial note is that Group B has a thematic intersection (circles intersect) of People and Community and the concepts of People and Community within those themes are relatively close. On the other hand, Community does not appear as a Theme for Group C. This alerts the analyst to a potential line of analysis: viz., whether Indigenous

participants have not incorporated the *community* discourse that the government seeks to incorporate (appropriate) in its policy.

Themes	A	B	C
People			
Community			
Services			
Think			
Time			
Health			
Hospital			
Work			

Table 1: Themes by Group

As Groups B and C have only one theme in common, the possibilities for comparison might initially look limited. However, this is not so as *Leximancer* also provides the strongest concept links (based on lexcial collocation): that is, concepts (lexical items or simply words, if you wish) that occurred within a three window sentence of each other regularly. To pursue this further, two concept links (People and Community and People and Health) were investigated by specifically identifying their occurrences in the text: People and Community, and People and Health.

<u>People and Community</u>

While the members of the predominantly non-Indigenous group did make relatively positive statements about people and communities, there was a considerable negative aspect as well. In fact, the most positive statements of community were made by the staff in the

adminstrative hospital for the district: that is, those charged with the responsibility of implementing the community-based health policy. Typical of these statements are the following that identify the hospital as a social site and a source of community information:

> Item 1
> Ie 1: I'm thinking of just the role the hospital plays in the community. Well apart from the obvious, which is where they come in when they're sick. It is actually a place where they actually socialize with a lot of other people. [QH_B.doc~4.html#S1_1447]

> Item 2
> Ie 3: …we're an information center when people in the community aren't sure how to access different services they can come to the hospital and find out more information how to go about getting appointments for different services or finding out what different services are available in our community. So, yeah I see it as a big information center.
> [QH_B.doc~4.html#S1_1481]

As well, the notion of community itself is seen as one of inter-generational continuity (Item 3) as well as a qualified claim that practical assistance is more likely in remote regions than in the city (Item 4).

> Item 3
> You know, we try to encourage like older people and I believe that I'm an older person living in the community and I certainly believe that I would have some knowledge, and some wisdom, but I believe the generation down from me are the knowledge- holders and it's their role and responsibility to try to encourage these people down here to try to come up.
> [QH_B.doc~4.html#S1_1609]

> Item 4
> Ie : I probably, I just think, I don't know whether it's the lack of the extended families and the lack of family support. Grandmas go to work and mums go to work and people don't take responsibility for their own health, and people don't take like, they think their kid's got a temperature, they go to the doctor or the hospital because they will fix them. And I think it's a lack of education probably through the whole of whether it's generation, but it's like a widespread thing, but like, not so much out here, people do probably have perhaps a bit more family support, or they go and ask their next-door neighbour.
> [QH_B.doc~4.html#S1_1347]

However, community is also seen in a negative light for two reasons. The first reason is the lack of privacy for those seeking health care in small communities.

> Item 5
> Ie 2: Probably, lots of issues around confidentiality. The people are, patients in the hospitals, it happens here, it's like a secret too, and for that to carry on into the community, somewhere along the line, some of that information will have to pass through the channel. [QH_A.doc~1.html#S1_124]

> Item 6
> … they don't offer a women's health nurse at the moment … I guess a needed service to the area, which I suppose as you can imagine, one doctor being in town, that the ladies don't

> really want to go to you … and even for us to be trained up to provide a service, they still have to see us walking down the street, so it's just a, sort of...younger people are becoming more ok with it, but there are quite a few older people in the community that just if that, they just won't , they just won't have it done. [QH_B.doc~3.html#S1_902]

The second negative reason is to do with committee fatigue (Items 6 and 7) and relations of power in communities (Items 8, 9, 10).

> Item 6
> Ie 4: But, but, by the same token, in a small community, the same people are in every bloody group [QH_B.doc~1.html#S1_275]
>
> Item 7
> Ie : … whereas there might be someone else willing to try and run the program or whatever it is, but if they're not of a, like an indigenous, they don't have the opportunity. And it's probably the same thing that happens, the same white community members are on all the committees, and it seems to be probably there's a fear, like there's a group of indigenous people that do go to things, but they seem to be probably the same people that, and it's probably, they might just see it as another thing that they're expected to turn up to. They've got quite a busy life, trying to do all the other things they do. [QH_B.doc~3.html#S1_1105]
>
> Item 8
> Ie 6: … that the very reason that there's not a wider cross-section of people that turn up to some of these committees is the make-ups of them. And it's the very reason that, every meeting you go to, those same power-brokers are there. So other committees say, well if they want to do everything, they can do it. [QH_B.doc~3.html#S1_1111]
>
> Item 9
> Ie : There probably are people that just see the people that are on committees as just control freaks and why bother because … what input am I going to have? And so, yeah, if you can encourage a community meeting of a hundred people, that'd be great rather than the same 15 to 20 that always come. [QH_B.doc~3.html#S1_1144]
>
> Item 10
> Ie : I think ultimately probably, a lot of like, yeah, the same people do show up to the same things, and they're probably on their own boat and they don't really, for all appearances' sake, they're doing it for the community, but at the same time, they're possibly doing it for themselves or feeling that it's just another chance to get together with their group of friends and take control of something. And unfortunately I suppose, I don't know, because I don't know how you'd change that culture, and that might be something that we might be able to learn … that we can sort of perhaps, and even have the strength to say 'well you're involved in these committees, perhaps you can take a back seat and let some other people that would like to develop the same skills come into it in a different way' and say 'well there [are] other people out there that would like to develop the skills that you have' [QH_B.doc~3.html#S1_1130]

Clearly then, the concepts of community expressed in the largely non-Indigenous focus groups are predominantly at odds with the notions of a coherent community with strong social identity that the government policy implies. This is further analyzed in the Implications section. By contrast, the limited text for Group C linking People and Community implies communication as an element of community. Item 11 actually represents community positively in terms of relationships and communication. Yet Item 12 actually narrates an

instance where an Indigenous member feels as though the hospital had failed to let them know about the reasons for not seeing a doctor.

> Item 11
> Ie 6: We've got a closer working relationship now with Queensland Health in this health service. We're communicating a lot more and having meetings and going to each others' meetings and trying to get this on the track where it's not just them and us. It's going to be an all-around community thing if we can get this up and running so that we can work together, not so that you've got Queensland Health over there and people from Aboriginal health working around the corner. [QH_C.doc~1.html#S1_50]

> Item 12
> But, it's only been twelve months ago now that I had to access the hospital and get some surgery done, but with all my follow up stuff, they cancelled three of my appointments to see the doctor, but that was because they were changing over from general public stuff to only accident emergency. They never told us they were doing it and I've already [been] stood up about that and asked them 'why don't you tell people about that?' If it's going to change the system, let people in the community know that you're changing the system, not just say 'we now have a three month waiting list and you need to access your local doctor, your local GP or your downtown GP'. You really need to tell people 'we are now going to be on A and E as it used to be many many years ago. [QH_C.doc~2.html#S1_656]

People and Health

In Group B, the lexical collocation between People and Health tends to be more functional:

> Item 13
>
> a. there's about seven to ten people on the books all the time. [QH_B.doc~3.html#S1_1016]
>
> b. So, if we have all that information, we can give it out while people [are] in hospital and we can direct them into the right place and that sort of thing. [QH_B.doc~4.html#S1_1475]
>
> c. people don't take responsibility for their own health … [QH_B.doc~4.html#S1_1347]

These examples instance speakers who have authority to organise people and occasionally to censure. Nonetheless, there are also instances of collaboration and mutuality:

> Item 15
> a: … but we try and put on services that prevent people from having travel away so much [QH_B.doc~4.html#S1_1465]
>
> b: you just keep on trying until eventually something might work and you might end up with a cure. But the more you try, the more people you're going to capture and if you only capture five or six, you're still capturing five or six, and so you just keep on going and then you get another five or six and another five or six, and word of mouth eventually spreads and while it might only be a little bit, you're probably making more of a difference to those few than what you would to a big group, so while it might be [QH_B.doc~4.html#S1_1530]

albeit sometimes for functional reasons:

> Item 16
> Ie 2: So a lot of things that we get together for, is if people are putting in for a grant, or subsidy, that different groups don't put in for it in competition, so that benefits the town. So that we can share information and health. [QH_B.doc~5.html#S1_1549]

By contrast, Group C's (Indigenous) collocation of people and health implies collaboration, communication, and community as in Item 11 above, and the following:

> Item 17
> Ie 2: … when you actually do get home visits and you talk to people and from that visit and from the other, subsequent visits comes, it helps identify some of the issues people have, the health issues [QH_C.doc~1.html#S1_356]

> Item 18
> Ie 1: And that's why I'm excited about this lifestyle group that's started here in <TOWN> 'cause they cover mental health, they cover physios, they get a whole range of health professionals to come and talk to a group of people and then it's not one person trying to do it all, and you're addressing a group of people. And if you're doing the follow-ups like what you were talking about, it'd be excellent, cause you'd ring them up and say 'how are you going? Have you managed to change much?' [QH_C.doc~2.html#S1_888]

The concept of trust is also evident in the collocation:

> Item 19
> Ie 7: Yeah, getting out and doing home visits on people, and cause building that trust up, cause they're building trust up in you and you're putting trust into them. So home visits in that way play a big part in primary health care. [QH_C.doc~1.html#S1_337]

However, elements of racial discord (Item 20) and a sense of futility (Item 21) were also evident. In 20, an Indigenous health worker was referring to the attitudes of some non-Indigenous health staff who had completed cross-cultural awareness programs: and then a group of them come out and say 'Well we're culturally trained now, bring on the black fellas'.

> Item 20
> Ie 4: Because of the attitude of those particular people. And that's not only in the health, that's in the teaching, it's in everything. [QH_C.doc~1.html#S1_132]

> Item 21
> I mean, I would like at the end of the day that I would be out of a job, cause I don't have to do what I'm doing every other day. I'd like, in twenty years time that there is no more Aboriginal health, there is no more of that because everyone's going to be okay now. I'm talking ideally, but I mean that will never happen, but if we keep doing that charity sort of stuff, and that bringing people in, and I don't know, making things happen for them, they're never going to change. [QH_C.doc~1.html#S1_305]

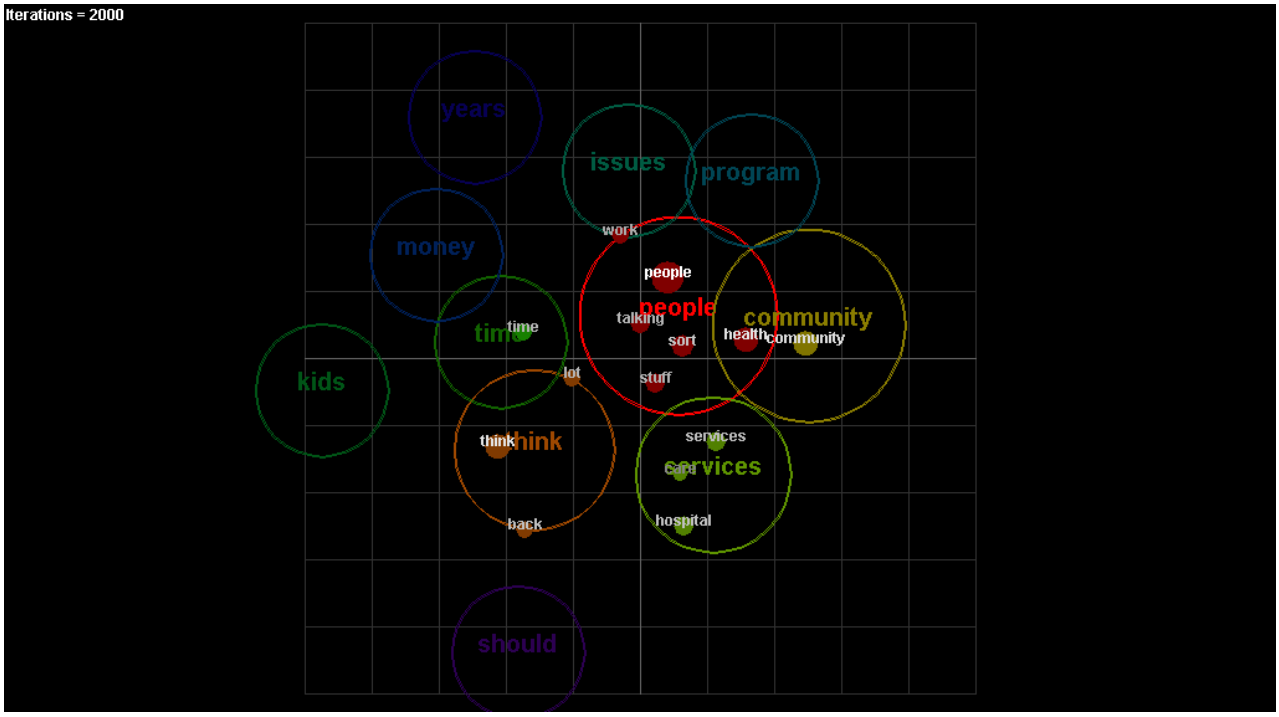

Figure 1: Group A Map of Concepts and Themes (circles)

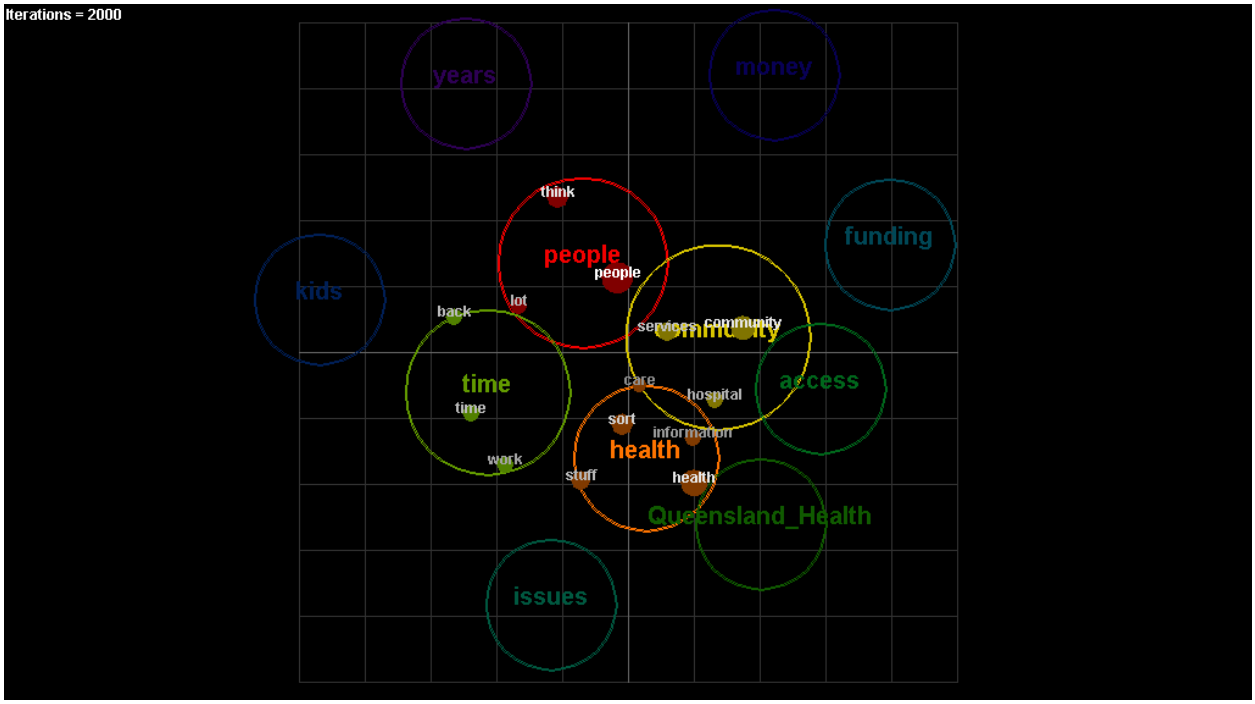

Figure 2: Group B Map of Concepts and Themes (circles)

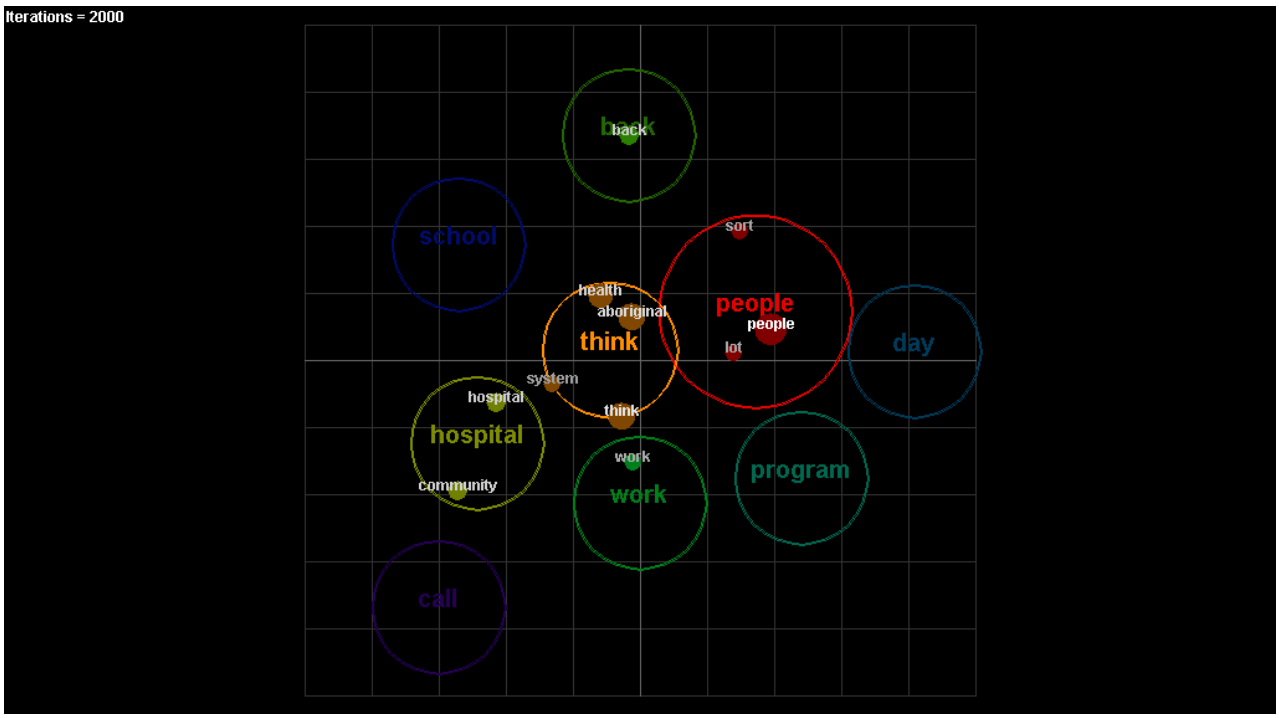

Figure 3: Group C Map of Concepts and Themes (circles)

Key-Words

Given the apparent lack of thematic collocation among such items as Program, Hospital, Services, and Queensland Health related to People and Community (evident in the lack of intersection of these Thematic Circles in any of the Maps above), we sought out the presence of policy key-words in the discourse of the respondents. Such terms occur in the principal statements of Queensland Health outlining their community-based health policy in the *Smart State: Health 2020* direction statement: *quality, sustainable, whole-of-government, partnership, wider perspective* [on health, e.g. wellness and prevention], *better health care, integrated focus, service communities.* They also occur in the Balanced Scorecard device (Kaplan & Norton, 1998) used by QH as an operational and evaluation tool to gauge the effectiveness of these new strategic directions. A simple lexical analysis

revealed virtually little evidence that these terms had been incorporated into the discourse of those most responsible for implementing the policy.

Two hospitals (one of which was the administering hospital) used the term *balanced scorecard* in an administrative sense. Clearly there is an attempt to use the BS to implement community-health policy, but it appears to be uncertain and haphazard.

> Item 22
> Ie 2: ...you'd like that balanced scorecard to get it into that strategy mode. Didn't really include a lot of people initially. And so we developed it up, and it was just like a representative for every health facility and ..under health care. And there were a couple of others on it to say what we thought it needed. [QH_B.doc~5.html#S1_1635]

> Item 23
> Ie 1: Since we've brought this [BS] ... and now we have brought it down to employees, and we say, well these are the four areas on the balanced scorecard for health ... picking the right people that are going to ... and we look at them and say 'well these are our objectives, or this is our service plan for the hospital, what sort of things do you think that you contribute to?' And so that's where we're sort of at now with the performance planning thing. So they'll set goals around what they want to do, and what they're interested in ... and they become goals, but that also fits into our strategies and then she can see a sort of, link up there. [QH_B.doc~5.html#S1_1684]

When instances of community-health arise, speakers often adopt an agentive role even though the geographical circumstances make control over circumstance difficult. For example, in Items 24 and 25, the speakers clearly imply their agentive role despite the fact that the government policy does not provide specialist services. In fact, the Interviewee in Item 24 accepts this service inadequacy because they chose to live there. It is possible that this sanguine, accepting approach may be related to the 'frontier' subject role in which people in remote regions often cast themselves: life is tough and we endure it.

> Item 24
> Ie 1: For me, as a community member it's provide better access to services. And I know it's impossible because, and we choose to live out in these places but there's got to be some way, like with the paediatrician, of working out a better way for people to access services, without having to go all the way to Toowoomba or Brisbane. For me, as a community member, that becomes a real pain in the neck, having to access services outside your area. [QH_B.doc~2.html#S1_707]

> Item 25
> Ie 2: I suppose I see it as a hospital that, yes we do the emergency responses when ...any of that sort of stuff...come in, but we also try and be a, not so much a tertiary hospital in that we offer all the great specialist type things, but we try and put on services that prevent people from having travel away so much. So we try and do as much surgery as we can here, up to a certain level because we only have a certain amount of infrastructure. But also we try

> to move away, we're trying to do that, but we're also trying to offer primary health care and health promotion type stuff. [QH_B.doc~4.html#S1_1465]

Only occasionally is it suggested that community health policy cannot be sustained:

> Item 26
> Ie 4: But even a community like this, where we've been there, done that, we've had fifty million committees, and they've all died down to what's pretty well necessary. They still aren't sustainable. None of them in their own right are sustainable over a long period. [QH_B.doc~1.html#S1_383]

Thematic Analysis

It is important to remember that this thematic analysis is based on the analysts' reading to identify particular patterns of meaning, and is separate from the thematic analysis in the previous section, which is based on lexical relationships. Two major themes emerged from this analysis.

Discordant Elements of 'Community'

If we assume that the underlying ethic implicit in the government's notion of community is oriented to *Gemeinschafte,* then there was clearly a significant discordant note. *Gemeinschafte* which 'starts from an assumption of a unity of wills as an original or natural condition of found pre-eminently in the nature of the relationship between individuals who are related to one another ... [based on] the solidifying psychological and social ties that hold together families and groups' (Christenson, 1984, p.161), clearly is oriented to unity and coherence and mutual identity (for a fuller review of notions of community, see McKenna, 2005). However, references to men's behavior and the role of Indigenous people were at odds with this.

In all sites studied, concerns were raised about low participation rate from men and the Indigenous community, and how to involve them in health care programs and health advisory committees. In particular, there was a low participation of indigenous community members in health initiatives such as 'well person's health check'.

All sites referred resignedly to men's low participation rate in wellness programs. In Site D[ii], for example, even though the Q Fever (a serious and debilitating illness more common in cattle regions) program was heavily subsidized by the Australian Government, it was still difficult to get men to come along to health checks and other community health engagement processes:

> Item 27
> Ir 1: But I'd imagine if you ran something for diabetes, or obesity or skin cancer or farm safety, you mightn't have the same success rate.
> D2: Farm safety I think you might. You'd get the women along to that, I don't know if you'd get a lot of men. …
>
> D2: We're trying to get some things that will be specifically of interest to them [men] ... and we're trying to, I guess, come up with something that will be interesting enough for men to come, but won't be patronizing, and trying to think of some male speakers that could perhaps talk about testicular cancer, and then like ... so we're just trying to see the best way that we sort of implement some education, cause I suppose the women are very like, they do own their own health, and they've very proactive.

Non-Indigenous community members proposed several reasons for poor participation from the Indigenous community members, including seasonal work and lack of transportation. However, overall, respondents felt that there was some complacency from the Indigenous communities to access health check programs as indicated in the excerpts from Site C below:

> Item 28
> Ir 1: What do you suspect is the real reason why say indigenous people don't want to turn up?
> C2: Something that…..depending on the time of the year……if they've been involved in the seasonal work, like cotton picking and things like that.
> C3: A lot of the indigenous people don't have a vehicle, like it's not that far to walk, but they feel that if they haven't got a vehicle, to come up in the early morning, it's a job.
> C3: It happens anywhere...
> C1: They just don't want to take responsibility.

Another major reason proposed for poor attendance for indigenous community members Apart from involvement in wellness programs, Indigenous participation in advisory baords was limited (even though each district allocated at least one Indigenous place) and members usually elderly. An Indigenous health worker suggested that this may be because in Indigenous communities, the less vocal people often command more respect and wield more power in these communities. Consequently, the same set of Indigenous people is found on almost all the health committees as seen below:

> Item 29

C1: I have found that in the indigenous [aboriginal] community, the people that are most respected by the other indigenous people in the community are those that are not vocal, and don't come forward and have an opinion, and so we're losing that...it's always the quiet guys, or whatever, they're, they're the people that we want to get to.

C2: I think very often, people …already got the people picked that they want to be on the committee. And I guess, that happened with the music festival committee and it's like all of the positions were already all decided…(inaudible) …but at the same time all of that was decided before the meeting was ever even held, so perhaps somebody didn't even have the opportunity to become involved because it was already decided.

Rigid social practices based on clans within the Indigenous community can often lie behind Indigenous non-involvement:

Item 30
C2: We've got that just here, you know. We've got a nurse who's really active and would be a fantastic aboriginal health worker, but because she was fostered out and then she came back into their community, she is definitely in the outer. And you know, there's nothing that she can do.

Government's Failure to Support Rural People

Lack of funding and high staff workload characterize the discourse of participants.

Funding issues seem to continually plague attempts to fulfil the community health charter:

Item 31
C3: The problem is, it comes down to more money, not just rearranging the funding we've got. Because everything's run on a shoestring now, and we must maintain the hospital, we cannot afford to close it.
C1: But yeah, we lose everything bar one person.
C3: So you can't do that, so we have to maintain what we've got, and somehow get more money and that's the problem all the time
C4: It's new money into the system that we want, *(Ie 1: absolutely)* not just bridging it.
C3: The funding breaks have taken away our child health

Wellness program activities seem to be chosen relatively randomly with more regard for what is do-able and accessible than the what is carefully strategize within a larger state health policy:

Item 32
C4: we have a meeting and we just sit around and … if something's there and somebody knows about it, they'll throw it in and they'll try and find solutions and some way around it. But, anything from here has to go up through the hospital.

Furthermore, there is little evidence of a management plan that gathers data measuring outcomes that could inform further initiatives.

Item 33
Ir 1: … it would be really lovely to know of those hundred people that have been through in the last two years, have you changed their behaviors?
C2: No idea. …probably a handful of them. I'm sure some of them did change their behaviors initially. When we give the feedback on it, particularly with their cholesterol and glucose, and that was one change that was made for the first and the second year, was actually giving them each a little card with their results on it, so that they could actually see what their result was,

> rather than it being normal or it being high or whatever. … but whether or not they went on to make it an ongoing lifestyle change, I don't know.

A symptom of the isolation, inappropriate staffing (overall staff numbers are probably adequate, but allocation of duties seemed inappropriate with excessive responsibility being placed on the district health nurse, DHN, role) appears to be staff burnout. The vast web of legal, financial, and administrative procedures strains the capacities of remote health workers to get on with their job. These complex procedures operating under managerialist processes of accountability provide structural obstacles that impede the possibility of flexible and innovative action. At C, it was difficult to reassign staff despite decreasing service needs towards the community health program:

Item 34

C1: we need to be looking at other ways of realizing this stuff ... So yes, we are looking at things, but when you start looking at legal, safety, looking at union things, and we can't reduce the number of nurses … that we have.

At D, a burnt-out former DHN referred to similar problems:

Item 35

D2: Just the difficulties I had with staff, that's basically, and unions, that just basically wore me down. It wasn't plain sailing because you had this coming in all the time.

Some participants expressed concern that staff members' heavy workloads were carried out often at the expense of their health:

Item 36

D1 …I have been burnt out and I'm just recovering now, unfortunately, I still get teary thinking about it. But yes, I feel…I was in <NAME's> job for seven months and then regularly doing directive nursing job and it was a battle, very distant and far away from everything and it didn't have enough staff, the whole lot and it was Human Resource issues that were really bad. After I finished, I took four weeks…but the rest didn't fix me in its time.

Item 37

C2: … for me it's hard because I'm the only community health person and that changes every day, and I'm also the school-based health person and that's schools on a regular basis. I also do the majority of immunizations.

Even when there were funds to employ staff, respondents also reported that they still faced two significant problems in the remote areas: lack of people to employ and high staff turnover. Often, many people would not want to work in remote areas: as a Site C member

said, '…it was not always no funding; it's the human resources… we can't just get the person.'

IMPLICATIONS

Leximancer Analysis

To summarize the Leximancer analysis first, the comparative analysis of Group B and C statements collocating People and Community and People and Health yielded little evidence of community in the traditional sense implied in the Queensland Health policy. There is evidence that 'community' is seen by some in terms of its functionality in administering government policy (e.g., 'we can direct them'; grant application writing). However, community is often seen in terms of geographical limitations (travel, time, lack of access to professional services). The most positive community-related statements in the primarily non-Indigenous group derived from staff in the hospital responsible for administering the region. Positively, the hospital is seen as a social site and as a source of information. There is evidence that the community itself is seen as a source of inter-generational continuity where there is likely to be more neighborly and extended family assistance than in the city. However, as health-service users, some people see community as invasive of private health concerns. Furthermore, apparent community-minded action such as involvement in hospital boards, can be seen as exclusionary and self-seeking. It was acknowledged that, regardless of motivation, community members of hospital boards almost invariably were excessively involved in various 'community' bodies.

Indigenous respondents seemed to be more likely (although the data for this are relatively limited) to see community in terms of relationships and communication. In fact, so strong is the sense of community for many young women that it limits their chances of qualifying as nurses given that they would need to travel 500 to 1000 kilometers to city sites for three years of training:

Item 38

> Ie 6: And I think the reason for that is because the accommodation for Aboriginal people to go down there. Because most of them live out this way, you know like Cunnamulla, Charleville, Quilpie and Roma, you know, all around this area. And for them to go down there and leave their family and fend for themselves to get to and from wherever they were doing their training. [QH_C.doc~1.html#S1_63]

Indigenous respondents tended to see health more in terms of trust-building by working at grass-roots level rather than in the hospitals so that they could encourage people to become more involved in wellness-oriented programs; however, the outcomes seemed to be limited (Item 21). The more passionate non-Indigenous respondents similarly spoke of this informal approach outside the hospital precincts: if we can just have a chat with them, [QH_B.doc~4.html#S1_1207] said one non-Indigenous respondent who cried during the focus group discussion.

Thematic Analysis

This part of the analysis seemed to confirm the discordance in the traditional notion of community (*Gemeinschafte*) implied in the government's community health program. The highly gendered nature of community health occurring in the wellness program and in health delivery indicates a significant failing in community participation. As well, Indigenous involvement is clearly highly problematic. Despite relative goodwill by the hospital advisory boards, Indigenous membership was limited and unrepresentative (i.e., quite elderly). There were no Indigenous trained nurses or doctors in any of the hospitals. Indigenous health workers reported feeling unwelcome when they visited people in hospital to assist them:

> Item 39
> up to the hospital and you walk in there, and I don't know about you guys because you work for Queensland Health, like if they know you, but we bowled straight up to the ward to go and see someone, and they've looked at us, like the Aboriginal Health worker from the community…. looking at us up and down and like 'So blokes, what are you two doing up here?' and all that sort of stuff.
> G4: Second class citizens.
> G8: Yeah, and you know, you guys work for Queensland health, but I've been up there in the hospital and the director of nursing and that (inaudible) …look me up and down and 'Don't you use that back door (?) again' and all that sort of stuff'. (inaudible) You know, so pulling that black act off has got to happen sometimes.
> G8 ...went in to the hospital and they've looked you up and down like you've just walked in from a mission or something.

Perhaps, poor participation from Indigenous community members may be explained by their perception of the hospital as a 'white space'. This finding regarding space corroborates previous finding about the differences in the conceptualization and usage of space in different cultural backgrounds. For example, literature in this area indicates that there are similarities and differences across cultures regarding the activities associated with and the use of different spaces (Caudill & Plath, 1966). Also, rules are associated with particular environments that are likely to be culture specific rather than universal. These cultural differences are likely to affect perceptions about privacy (Canter, 1983a) and the use of space. Specifically, Ayoko and Hartel (2003), constructed space as both a psychological and physiological environment and their research indicated that the different perceptions of space by people from different cultures created conflicts in culturally heterogeneous workgroups. Viewing the hospital as a 'white space' may thus clarify why the Indigenous community members did not feel comfortable in the hospital and consequently did not participate in the health engagement initiatives that took place in hospitals and other spaces that symbolized main stream culture. However, rigid social practices in some Indigenous communities based on clans and (understandable) anger towards white communities complicate the issue.

Lack of funding and high staff workload were also identified as themes in the discourse of participants. It may be that this is largely the outcome of staff trying to fulfil competing discourses. A heteroglossia of discourses governs the processes of this Community Health Project combining various competing, as well as complementary, discourses. A market-enterprise discourse was one of these. Within a political-economic hegemony of low taxes and decreased government services, public hospital funding is always going to be limited. One respondent directly challenged the neo-liberal discourse infusing hospital policy by saying 'The cost neutral model of care can't be done' [A1].

It is evident, that infusing the practices of QH's Community Health Project are three discourses: economic, managerial, political, and public health discourses. The economistic nature of the *Health 2020* document (Queensland Health 2002) is evident early in the document. Among the benefits of having healthy Queenslanders is 'a healthy, productive workforce [that] contributes to a strong economy'. Conversely, it also asserts that 'Strong viable provincial, rural and remote communities are vital to the health of rural Queenslanders' (p. 4). Similar space is allocated to the sub-section 'The Changing Economic Environment' (p. 6) as to the summary of Queenslanders' health, which is 'good but it could be better' (p. 7).

Another discourse infusing related documents is New Management Discourse (Chiapello & Fairclough, 2002), which 'part of the broader ideological system of "the new spirit of capitalism"' (p. 4). Essentially, 'to win conviction and enhance the prospects for action,' such texts must address three dimensions of legitimation: stimulation, security, and justice. Stimulation is characterised by talk of 'change, innovation, creativity ... , liberty, and personal development'. The implementation is strongly managerialist in discourse. The *Health Service Districts Pilot Project Interim Evaluation Report* (November 2003) document, produced by the Integrating Strategy and Performance unit, sets out how the department intended to effect this. It states that:

> *The goal of ISAP is to transform Queensland Health into a strategy focussed organisation with integrated planning, service provision and performance management to achieve the Smart State: Health 2020 vision.*
> ...
> *It requires a considerable degree of organisational transformation.*
> ...
> *The ISAP process is expected to contribute toward this change, through*
> *Translation ... into workable objectives;*
> *Development of a system for measuring our progress*
> *Alignment of our business process and activities.*

Thus the state government's ideological agenda is expressed in the discourse of change management (*The achievement of this vision [involves] cultural change*); bureaucratic control (*workable objectives*); and measurement (*system for measuring our progress*).

Consequently it could be argued that the discursive practices of such a process are enormously complex with a strong likelihood of internal inconsistency or incongruity especially for those in remote and rural regions. With little or no training, local nursing staff and hospital advisory board members were required to give effect to complex organisational changes in implementing community-based health policy to replace the more clinically-oriented approach. Furthermore, they were to do this by adopting the Balanced Scorecard as a management process for establishing objectives and measuring outcomes.

We contend that the discourses of contemporary neo-liberal economics and the new managerialism have been combined by the government in this policy change. For the past twenty years or so, public policy and practice has been informed by a neoliberal ideology valorising the market process and rejecting collectivist practices (Peck & Tickell 2002: cf. Brennan 1998; Argy 2003; Pusey, 1998). Inherent in this discourse is 'enterprise language' (Keat and Abercrombie 1991; Du Gay, Salaman et al. 1996): the most significant instance of this is QH's Balanced Scorecard use of 'customer' to represent client, patient, or citizen, each of which has varying degrees of fiduciary relations. The ideology of enterprise language is that the person is held accountable for who they are and the circumstances in which they live (Burchell 1993). This was evident in the inherent acceptance of circumstances among the participants. At the same time as health workers are taking up the responsibility of implementing community-based health policy, the government is withdrawing clinical services in the region. Acute clinical cases must now be sent to larger sites: for example, a heart attack victim in the region would now need to be transported up to 1000km to receive intensive care.

Given that neo-liberal economics has near hegemonic control of the political agenda, it is unsurprising that other discourses emerge to challenge it. For example, other discourses have emerged partly in response to a political dialogic concerned about dwindling social capital. There is already a considerable literature on the link between a community's social capital and community health (Tsouros 1990; Wilkinson 1996; Baum 1999). These

discourses are communitarian. Inflected in QH's discourse are these discourses as well, although they sit awkwardly within a neo-liberal framework.

According to Deetz and Mumby's (1990), ideology articulates 'the connection between communication and power', and helps to 'explain the ways in which patterns of discourse can be linked to the power relations that are a structural aspect of organizations (42-43). If 'ideology is the mediating factor' in the link between ideology, communication, and power as Mumby and Clair (1997, p. 184) assert, then it is crucial that the ideological basis of this discourse is determined. It is when QH participants and stakeholders adopt the discursive conventions of this discourse that they accede to the inherent power relations within that discourse and succumb to 'concertive control' (Barker 1999), adopting the world views, logic, values and assumptions therein. That there was little evidence of managerialist and economistic concepts in the participants' discourse would seem to indicate that, as subjects, they operate mostly in different discursive realms from those of the government. However, it may be the case, paradoxically, that the health workers' subjective identity with the "bush" and its associated tribulations may limit their capacity to perceive the incommensurate discursive environment in which they operate.

REFERENCES

Argy, F. 2003, *Where to from here? Australian egalitarianism under threat.* Allen & Unwin, St Leonards, NSW.

Bakhtin, M. M. 1981. The dialogic imagination: Four essays by M. M. Bakhtin. Austin, TX, University of Texas Press.

Bakhtin, M. M. 1994. Speech genres and other late essays (M. Holquist & C. Emerson, Trans.). . The Bakhtin reader: Selected writings of Bakhtin, Medvedev, Voloshinov. P. Morris. London, Edward Arnold**:** 81-87.

Barker, J. R. 1999. *The Discipline of Teamwork: Participation and Concertive Control.* Thousand Oaks, Sage.

Baum, F. 1999. The role of social capital in health promotion: Australian perspectives. *Health Promotion Journal of Australia 9*(3), 171-178.

Blommaert, J. and C. Bulcaen 2000. "Critical discourse analysis." Annual Review of Anthropology **29**: 447-466.

Brennan, D 1998, 'Government and civil society: restructuring community services', in P Smyth & B Cass (eds), Contesting the Australian way: states markets and civil society, Cambridge University Press, Melbourne.

Burchell, G. 1993. Liberal Government and Techniques of the Self. Economy and Society 22(3): 267-282.

Chiapello, E. & Fairclough, N. 2002. Understanding the new management ideology. A transdisciplinary contribution from Critical Discourse Analysis and New Sociology of Capitalism. Unpublished Paper.

Christenson, J. A. 1984. Gemeinschaft and Geselleschaft: Testing the spatial and communal hypotheses. ***Social Forces***, 63(1): 160-168.

Deetz, S. & Mumby, D. 1990. Power, discourse and the workplace. In J. Anderson (ed.) *Communication Yearbook 13* (pp. 18-47) Newbury Pk, CA: Sage.

Denscombe, M. 2002. Ground rules for good research: a ten point guide for social research. Buckingham. Open University Press.

Du Gay, P., G. Salaman, et al. 1996. The conduct of management and the management of conduct: contemporary managerial discourse and the constitution of the 'Competent Manager'. *Journal of Management Studies 33*(3), 263-282.

Fairclough N. 1992. Discourse and Social Change. Cambridge, UK: Polity.

Fryer, D. 1991. Qualitative methods in occupational psychology: reflections upon why they are so useful but so little used. The Occupational Psychologist, 14, 3-6.

Glaser, B & Strauss, A. 1967. The discovery of grounded theory. Chicago: Aldine

Keat, R. & Abercrombie, N. (eds.) 1991. *Enterprise Culture*. London, Routledge.

Krippendorff, K. 2004, *Content Analysis: An Introduction to Its Methodology*, 2nd edn, Sage, Thousand Oaks, CA.

Lemke, J.L.: 1988, 'Discourses in Conflict: Heteroglossia and Text Semantics' in J.D. Benson & W.S. Greaves (eds.), Functional Perspectives on Discourse, Ablex Publishing, Norwood, NJ.

Lemke, J.L.: 1990, Talking Science, Language, Learning, and Values, Ablex Publishing, Norwood, NJ..

Lemke, J.L.: 1995a, 'Intertextuality and Text Semantics' in M. Gregory & P. Fries (eds.), Discourse in Society: Functional Perspectives, Ablex Publishing, Norwood, NJ, 85--114.

Lemke, J. L. 1995b, *Textual Politics*, Taylor & Francis, London.

López, J. 2003, *Society and Its Metaphors: Language, Social Theory and Social Structure*, Continuum, New York.

McKenna, B. 2004. "Critical Discourse Studies: Where to from here?" Critical Discourse Studies **1**(1): 1-31.

McKenna, B. 2005. "What is this thing called community?" Paper presented to International Conference on Engaging Communities. Brisbane, Australia: 14-17 August 2005. http://www.engagingcommunities2005.org/abstracts/McKenna-Bernard-final.pdf

Mumby, D. K. & Clair, R.P. 1997. Organizational discourse. In T. van Dijk (ed.) *Discourse studies: A multidisciplinary introduction - Discourse as social interaction* (pp. 181-205). London, Sage.

Peck, J. & Tickell, A. 2002. Neoliberalizing space. *Antipode 34*(3), 380-404.

Pusey, M 1998, 'The impact of economic restructuring on women and families', AQ: Journal of Contemporary Analysis, vol.70, no.4, pp.18–27.

Queensland Health 2002. Smart state: Health 2020. A vision for the future: Directions Statement. Brisbane, Queensland Health: 48.

Smith, A. E. & Humphreys, M. S. 2005, in press, 'Evaluation of Unsupervised Semantic Mapping of Natural Language with Leximancer Concept Mapping', *Behavior Research Methods*.

Tan, H. H. & Wee, G. 2002, 'The Role of Rhetoric Content in Charismatic Leadership: A Content Analysis of a Singaporean Leader's Speeches', *International Journal of Organization Theory and Behavior*, vol. 5, no. 3/4, 317–42.

Taylor, G.R 2000. Integrating quantitative and qualitative methods in research. New York: University Press of America.

Taylor, S. & Bogdan, R. 1998. Introduction to qualitative research methods. Canada: John Wiley & Sons, Inc.

Tsouros, A. 1990. *WHO Healthy Cities Project: A Project Becomes a Movement.* Copenhagen, FADL.

Van Maanen, J. 1979. Reclaiming qualitative methods for organisational research: A preface. Administrative Science Quarterly, 24: 520-526.

Wilkinson, R. 1996. *Unhealthy societies: The afflictions of inequalities*. London, Routledge.

Wodak, R. 1997. Critical discourse analysis and the study of doctor-patient interaction. The Construction of Professional Discourse. B. L. Gunnarsson, P. Linell and B. Nordberg. London, Longman**:** 173-200.

[i] http://www.abs.gov.au/Ausstats/abs@.nsf/0/b737f659fcd40455ca256d81007e6cb2?OpenDocument

[ii] Note that this part of the analysis uses leters A, B, C etc to denote sites where the statements were made. Although this is the same material as the corpus for Leximancer, the referencing is different as the data for this is not retrieved from Leximancer files.