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The Complex Realities of Indigenous Health Care Delivery

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The Complex Realities of Indigenous Health Care Delivery

Megan R. Waterman

Fall 2006

SIT Australia, Melbourne: Identity & Public Policy in a Multicultural Society

William McKernan, Academic Director

Dr Chris Watts, Academic Advisor

Acknowledgements

When I applied to this study abroad program, I received a phone call from the SIT headquarters soon afterwards. They were worried about my independent study project proposal, one that hoped to investigate indigenous health in Australia. I was told that it is discouraged for reasons of the over-researched state of indigenous people and because students often run up against trouble in attempting to complete studies involving indigenous issues. 'Let yourself be warned, it's going to be difficult!' everyone seemed to say.

Now, upon completing five weeks of study about indigenous health care delivery, I am so glad I stuck with my original plan. Of course, I was not immune to the troubles foretold, but the support from those around me and (for the most part) the warm welcomes I was met with in interviewing those involved in the field were the reason I was able to pull it off. I must acknowledge these most valuable people, because they have not only made this study possible, but they have been an inspiration to me in their caring, supportive tendencies.

I send a thank you to Andrew Morrison, Colleen Marion, Doseena Fergie, Celeste Liddle, Steve Clarke, Sharon Clews, Peter Waples-Crowe, and Jill Gallagher for taking time out of their busy schedules to sit down with me, have a cuppa, and have a yarn. Each of them is stretched thin in their intense commitment to their community's well being. Their willingness to share a little piece of their lives with me is not taken lightly.

An immense note of gratitude is owed to the staff members and elders of the Aboriginal Community Elders Service, with whom I shared two weeks of my time. Though they showered me with gifts upon my leaving, their warmth, kindness, and humour were gifts enough. I will never forget their stories or their faces. The powerful emotions I feel about this study are largely due to my new relationships with the aunts and uncles at ACES. I will miss them terribly, and I hope that this paper will do them justice.

I am grateful for the intellectual support and involvement of Dr Chris Watts, who volunteered to act as Academic Advisor to me in this project. His articulate comments about the issues discussed within and his ability to understand my sociological background (he is a sociologist, too!) was very valuable throughout the study period. I'm so very glad we came across one another.

To my Academic Director, Bill McKernan, I'm sorry I cried my eyes out in desperation the first week of this project and was beaming with success by the second. My experience seems to have epitomised the 'roller-coaster ride' that is ISP. Thank you for being on the other end of the line, offering advice and support throughout the entire process—it made a world of difference having you there.

To my homestay parents, Roger and Ingrid, I am so very lucky to have shared three months with you. The roles you played as sounding boards for my ideas and your willingness to sit down and help me figure things out were crucial to this final product. Without your assistance, this paper would be a fragmented mess.

Finally, I must thank my parents for sending me on this program and for letting me blossom into the person I've become. You are the most important people in my life, and without you, none of this would be possible.

Enjoy!

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Abstract

The indigenous population of Australia faces a life expectancy that is eighteen years lower than the general population. This study addresses this incredible disparity by exploring the historical, cultural and social forces that impact on health status, focussing especially on health care service utilisation. Qualitative methods of interviewing and participant observation have been used to examine the two sectors of Aboriginal health service delivery in urban Victoria: Aboriginal community controlled health organisations (ACCHOs) and mainstream organisations. Accounting for the complex forces and realities in health service delivery, this is a discussion of the important components of the current realities for ACCHOs and mainstream organisations providing care to indigenous people. Further, it proposes a necessary future direction to improve current care: the forging of partnerships between the two sectors.

Introduction

Australia is one of the healthiest nations in the world. The overall population's life expectancy is 78 years for males and 83 years for females, and these statistics place it amongst the top eight countries in terms of this indicator (Australian Bureau of Statistics, 2005a). From the outside, it appears that all is well in the 'land down under'. In my decision to come to Australia to study health from a sociological viewpoint, the positive outcomes of the Australian health care system as indicated in statistical data seemed to warrant quite an interesting study, considering Australia's overall health status is much better than my home country, the United States. I assumed that Australia's national health insurance system might provide greater equity, leading to the indicated improved health status. However, upon deeper investigation of Australia's health statistics, a staggering disparity surfaces: that of the health status of indigenous Australians. Despite the remarkably high life expectancy for the general population, indigenous males can expect to live only 59 years, and females only 65 years (ABS, 2005b). This is an 18 year difference! Other indicators show similar disparities for indigenous Australians, including infant mortality, low birth weight, maternal death rates, and self-assessed health status (*Ibid.*). In comparison to a very healthy general population, these facts are unacceptable and embarrassing for Australia as a nation.

Further, my lack of awareness to such a gaping disparity within Australia, a country I previously regarded as quite progressive in terms of health, was both a personal embarrassment and an inspiration for my study project. With this new realisation of an alarming disparity, I began structuring the study's approach. Often, study objectives begin with questions and end with answers. This study has been inspired by two questions:

- Why is there such a health disparity for indigenous Australians?
- How is this possible in a country that has been so successful in achieving great health for the general population?

However, sociological research rarely allows for answers; instead, questions beget questions. In an attempt to explore those questions above, several new questions have arisen. It is this paper's intent to propose ways of understanding the questions below in hopes of their ability to apply to the larger ones above. So, this study's findings focus on the following research questions:

- What historical, cultural, and social forces have become embodied as poor health status for indigenous people?
- How do these forces relate to the current reality of the health delivery sector in Australia?
- How can a better understanding of these forces inform future directions to improve this sector?

Though an analytic paper such as this requires a somewhat structured progression from research question to final evidence and discussion, I must emphasise the complexity of this topic. There are many forces that act through a multitude of pathways. I have found that most of these forces impact on nearly every patient and provider in the indigenous health sector, and I have seen them manifested in the everyday realities of these people and their affiliated organisations and institutions. Some of these people and organisations recognise certain forces that are at play; others simply act and interact in a way that implies the underlying existence of such forces. In all cases, it is impossible to pick apart certain forces and their real manifestations without an appreciation of the whole picture. In beginning my presentation of data, I have included a web of observed forces and subsequent realities. Its complexity is an attempted synthesis of the multifaceted understandings reached in carrying out this study. It is my hope that this paper will

examine important sub-relationships within this web, and in so doing, to provide a framework for answering the above research questions.

Methodology

A Starting Place

‘What we have found over the last four years is that research can mean one hundred and one different things. You can have research where people are ringing up saying, “Hey I’m doing my thesis and I am wanting to do a bit on Aboriginal people, what do I do?”... There are other external research projects that have happened and we’ve had a number of proposals that have come in from everywhere and they just want to get Aboriginal endorsement on their proposals. Sometimes they are so far-fetched because of misunderstanding and ignorance.’

-Salina Bernard, Chair of VAHS Health Research Ethics Committee (VicHealth Koori Health Research and Community Development Unit, 2000, p. 19-20)

The indigenous population of Australia is incredibly over-researched, especially by non-Aboriginal people. I entered the planning stages of this research project with an acute sensitivity for the lasting impact of European invasion. The extensive anthropological studies of the ‘primitive race’ or the ‘noble savage’ in early contact times and the ‘cultural essentialism’ that ‘pick[ed] a real Aborigine by his or her “authentic” or “traditional” cultural practice’ created the Aboriginal person as a *subject* of research defined by an outsider’s criteria (Anderson, 1994, p.118). This status as *subject* is important in the parallel subjectivity that is created in current health and welfare research *about* Aboriginal people today. To be a research subject is to surrender control to a researcher. When the researcher is a non-Aboriginal person, it is an unsettling reminder of the anthropological gaze that denied Aboriginal people of forming their own identity and reduced them to a primitive, uncivilised, traditional people. Despite however good an outside researcher’s intentions, her presence brings about this painful reminder. So, I began my study with a background understanding of the power structure of Aboriginal research involving an outsider such as myself. My gut feelings on the issue ironically

aligned with advocates for Aboriginal community-controlled health research. I agreed fully with Salina Bernard's claim:

Aboriginal community-controlled research is the most beneficial research that can be done because it has the involvement, commitment, and the participation of the local people which can open up the doors for the researchers. Without those people and those networks and that commitment, the research is going to go nowhere and you are going to have poor research findings (VicHealth Koori Health Research and Community Development Unit, 2000, p. 20).

Returning control to those being studied nearly eliminates the lingering power inequalities involved in research. Self-determination, empowerment, and control are central points of importance to contemporary Aboriginal rights, and Aboriginal community-controlled research does seem to encompass these points. However, this created quite a predicament. Personal feelings aside, the goal of this project was to carry out a research project about Aboriginal health, and I am a non-Aboriginal person!

The necessary first step was to recognise my status as non-Aboriginal, and this in turn required recognition of the inherent power relations that exist between those with whom I would interview and interact and me. It is impossible to change one's culture or personal history; a researcher in hopes of completing a successful study that requires a bridging of cultural gaps must come to terms with this fact. I hoped to inform my research process with Bernard's statement about 'having the involvement, commitment, and the participation of the local people' (*Ibid.*). Although I am not a member of the local community, I hoped to demonstrate my commitment to Aboriginal health and well-being and utilise networks that were open to me from previous experiences.

Sensitivity as a Hindrance: Networking and the Success of Indirect Contacts

The awareness and sensitivity with which I began this study was a hindrance to the process in several instances. In this special case with the sensitive research history as

mentioned above, the need to be careful and appropriate in my initial approach of potential respondents and organisations seemed to be paramount. Networking and pursuing leads is often the most important part of the research process; I was initially very confident because I had two important contact names, which would allow for a network process that ‘involved the local people’. A previous week-long placement at the Victorian Aboriginal Legal Service (VALS) had allowed me to demonstrate my interests in Aboriginal issues to the CEO of VALS; this CEO then gave me contact details for the CEOs of the Victorian Aboriginal Health Service (VAHS) and the Victorian Community Controlled Health Organisation (VACCHO). I thought my ‘networking’ had been successful, relying on the important CEOs of two large Aboriginal organisations as gatekeepers. Naively, I expected it to guarantee both direction and content for this study.

The draft project abstract, written on 18 October 2006, reads:

Interviews and observation will begin with staff at the Victorian Aboriginal Community-Controlled Health Organisation (VACCHO) and the Victorian Aboriginal Health Service (VAHS). These urban centres will hopefully serve as the home base of primary research. VACCHO is a peak body that works closely with all community-controlled health services in Victoria, so they may recommend specific rural Victorian centres to include as informants (Waterman notes, 18 October 2006).

For a week, I attempted only to contact VAHS and VACCHO, to no avail.

Retrospectively, my unwillingness to contact others with whom I had no direct network was perhaps due to my feelings of a need to only approach those who had been referred to me by ‘involving the local people’ and using name-dropping tactics^{*}. Still, as a week came and went, the need to *get data* overrode the need for a careful and appropriate approach. I could no longer depend on these organisations to ‘serve as the home base of primary research’ nor for them to ‘recommend informants’ to me. This resulted in a new

^{*} ‘The CEO of VALS referred me to you—I am a university student’, read the subject of an email to VAHS. This tactic proved useful in offering a context of understanding for the recipient. Its ethics are legitimate since permission to reference contact persons was obtained before doing so.

process of accessing possible informants: the use of indirect contacts. I contacted a larger pool of possibilities. Two people (and their attached organisations) had been loosely recommended to me from a staff member at VALS. These two contacts were smaller organisations—the Western Suburbs Indigenous Gathering Place and the Yarra Valley Community Health Service Indigenous Health Team—and I had success in completing interviews and interactions with both. My experience at the Gathering Place even begat my discovery of an Academic Advisor/Outside Reader—the organisation’s General Practitioner, Dr Chris Watts. My first lesson of the project had been learned: organisations like VAHS and VACCHO might be the largest and most well-known, but often with larger patient populations comes greater pressure and responsibility and less time to devote to interviews with lowly student researchers.

This lesson was applicable throughout the remainder of the data collection. In addition to contacting the above organisations, I also found other indirect pathways to gaining entry. My host father was able to set me up with a meeting with the Indigenous Liaison Officer from the Victorian College of the Arts’ Willin Centre for Indigenous Arts and Cultural Development, which allowed me to eventually tap into the Liaison Officer for the Faculty of Medicine at Melbourne University. Listening to the indigenous radio station, 3KND^{*}, alerted me to the host of a health show who is also an Aboriginal Liaison Officer (ALO) at the Northern Hospital. The meeting with the ALO was fruitful in obtaining a further list of contact names—it was a possibility to make use of snowball sampling. Most of these contacts were unavailable or did not respond, but one organisation—the Aboriginal Community Elders Services—agreed to a two-week placement/volunteer period. Also during this placement period, a response finally was

* 3KND stands for ‘Kool N’ Deadly’. ‘Deadly’ is a contemporary Aboriginal slang term for ‘really good’.

received from representatives from VAHS and VACCHO, so short interviews at each organisation were conducted.

The study's turn away from the large representative bodies early on and move predominantly towards smaller ones was a decision that was difficult but sensible for a student facing time constraints and few other options for networking. This shift in focus resulted in a larger amount of evidence from less well-known organisations and individuals and a smaller amount of evidence from VAHS and VACCHO. As a result of these large organisations' late entry onto the research scene, the data presented and the conclusions thus made may not be the most representative or all-encompassing for 'Victorian Aboriginal health services'. Perhaps my initial desire for VAHS or VACCHO to serve as 'my home base' was again a result of my incredible sensitivity to my role as researcher. A home base at VAHS or VACCHO would have been a near guarantee that I would have the 'involvement, commitment, and the participation of the local people' (VicHealth Koori Unit, 2000, p.20). However, the impossibility of this due to time constraints and networking issues forced me to negotiate this 'involvement, commitment, and participation' by myself. I am somewhat wary of my abilities in negotiating a representative 'involvement' of the right local people. Snowball sampling is often problematic in this regard. Still, the voices that this study does include are all a part of the picture. I found that every component organisation or liaison officer was aware of many others in the Aboriginal health sector in Victoria/Melbourne. This is one justification for the study's sampling method. Though it offers a broad range of voices, each is an important component of the whole; thus each is useful to learn about and evaluate the current situation for Aboriginal health and service delivery in this area.

Interviewing

The beauty of qualitative research is that it allows for a more human perspective to come through in the data. My pool of interviewees is very diverse in many ways. Each respondent varies in a variety of aspects, including type of organisation they represent, placement in organisational hierarchy, job description, length of experience in health field, length of experience in indigenous issues, length of experience in current organisation/job, and Aboriginal/non-Aboriginal status. Further, each interview varied in length, venue, level of formality, appropriateness of note-taking, and the possible inclusion of other organisation staff members in the meeting. Before each interview, a general set of questions was modified slightly to be more specific to the interviewee's current organisation and experience. However, these question scripts were usually only used as a reference. In general, most respondents willingly began describing the organisation, their personal reactions to their job, and other important issues they felt might be interesting to me. This was probably helped by an explanation of my project goals in my initial contact. For example, a first contact email to a potential respondent read:

My name is Megan Waterman, and I am an American university student studying in Melbourne with the School for International Training. I've been here in Melbourne for over two months, and right now I have about four weeks to carry out an independent study of my choice. I am very passionate about public health, and I hope to go on to get my Masters in Public Health after my undergraduate work. Because of my ongoing interest in public health and health disparity, I have chosen to study Aboriginal health issues for my independent study.

I am very interested in learning more about the social, political, and historical context of Aboriginal health and how community-controlled organisations and effective mainstream programs are playing a large role in dealing with this in a holistic manner. I had a chance to listen to your ---- radio show today, and I thought that you might be have an interesting perspective about health issues, both from your experience running the radio show and as an Aboriginal Liaison Officer at the Northern Hospital. Would it be possible for me to spend some time with you learning about your experiences in working with indigenous health? (Waterman email, 10 November 2006).

Thus, upon arrival for an interview, a respondent was already informed of my general interest from email and phone conversations. Though I still facilitated the interviews by adding in prompts and questions, many of my most interesting information came about simply by letting my respondent speak.

This unstructured method has both advantages and disadvantages. By allowing the respondent to open the interview on their own terms, the range of discussion topics was not limited to a pre-set agenda. This is a likely result of my heightened desire to appear sensitive and ‘acceptably incompetent’ (Lofland & Lofland, 1984, p.38). Especially for interviews with Aboriginal people, who were often more suspicious or doubtful of an outside researcher’s intentions, allowing the interviewee to set the pace and the initial topics was important in establishing rapport. While this method was usually successful in getting a large amount of data, in some cases it was problematic. When a certain order of questioning is not determined from the outset, it is often hard to shift into that mode. After allowing a respondent to speak for a certain period of time, they often would turn to me and say, ‘Okay, so do you have any questions?’ Of course, I had plenty of questions, and many had already been answered in the beginning discussion time. Sometimes, I found myself scrambling to sift through the important questions on the script to find ones that hadn’t been touched upon. My ability to work on the spot was usually related to my comfort level with the interviewee and the general vibe of the encounter. Each respondent was different, and this warranted a different approach in getting useful and informative data. Still, this method does not allow for an exact list of questions and answers from every interview. This study’s comparative conclusions between interviews are based on interesting themes that surfaced during interviews rather

than explicit answers to specific questions. As a result, the interview data are not useful for correlative analysis.

The final issue encountered with this qualitative research was negotiating my role as researcher and my role as a fellow person/advocate. It is impossible to remain fully objective, especially in a politically charged area like Aboriginal rights and health. Reflecting on the interviews, it is clear that I felt personally aligned with the health workers with whom I was speaking. There are few negative observations or remarks in my interview notes with each person. I recognise the power of my personal feelings; these may have caused my data to be biased, shedding too positive a light over the informants. However, in this analysis, an attempt has been made to take a more objective approach in considering the data. The re-reading and highlighting of themes in my interview notes helped as a distancing method in creating a more objective lens. By re-reading these notes, I processed them in a new way: as data rather than immediate personal reflections. Though the notes may have been too positive when first taken, the distance in time and outlook between collection and analysis brought more objectivity. Further, my Academic Advisor and Academic Director were both very helpful as sounding boards for ideas to ensure limited bias. It is the goal of this study to incorporate both the personal advocacy I experienced throughout my data collection and the greater objectivity achieved during analysis into a larger contemplation of the present issues.

Negotiating Participant Observation: Student Placement or Volunteer?

The final two weeks of this study consisted of a student placement/volunteer period at the Aboriginal Community Elders Services (ACES). This organisation has a nursing home and a hostel for high- and low-level residents, and a Planned Activity

Group (PAG) program for those Aboriginal elders who do not live on site. Again, because I wanted to allow the organisation to dictate my findings (rather than have a pre-set agenda), I was unclear about my expectations and my role and thus did not explicitly express them in the beginning of my time at ACES. While spending two weeks at an Aboriginal community controlled organisation offered an opportunity to gain much by way of observation, a sense of reciprocity influenced a desire to act more as a volunteer than a student researcher/observer. This lack of clarity in my role soon resulted in a confrontation with a staff member who was unaware of my identity. This staff member was supposed to be in charge of all student placements, but because I had not been explicit in determining whether I was a volunteer or a student placement, this may have been problematic. My field notes from this day of confrontation reflect this issue:

I needed to be clearer about my identity, my intentions for my placement, and my role there...I think previously I had been so focused on volunteering to ensure reciprocity that I hadn't allowed myself to define what *I* wanted (Waterman field notes, 22 November 2006).

This was another important lesson in the research process. At a certain point, the researcher must take control and dictate her intentions and expectations. With the help of this staff member, I was able to do this. For the time remaining of my placement, I followed a plan of action that I outlined on that day. I spent considerable time in the PAG room with the elders, gaining their respect and listening to their stories. I also attended the Annual General Meeting on 23rd November 2006, which allowed for observation of the internal politics and bureaucratic functioning of the organisation. Finally, to reciprocate in some way, I volunteered my assistance in organising a farewell party for the retiring CEO and in setting up wares tables for the upcoming weekend Fete*.

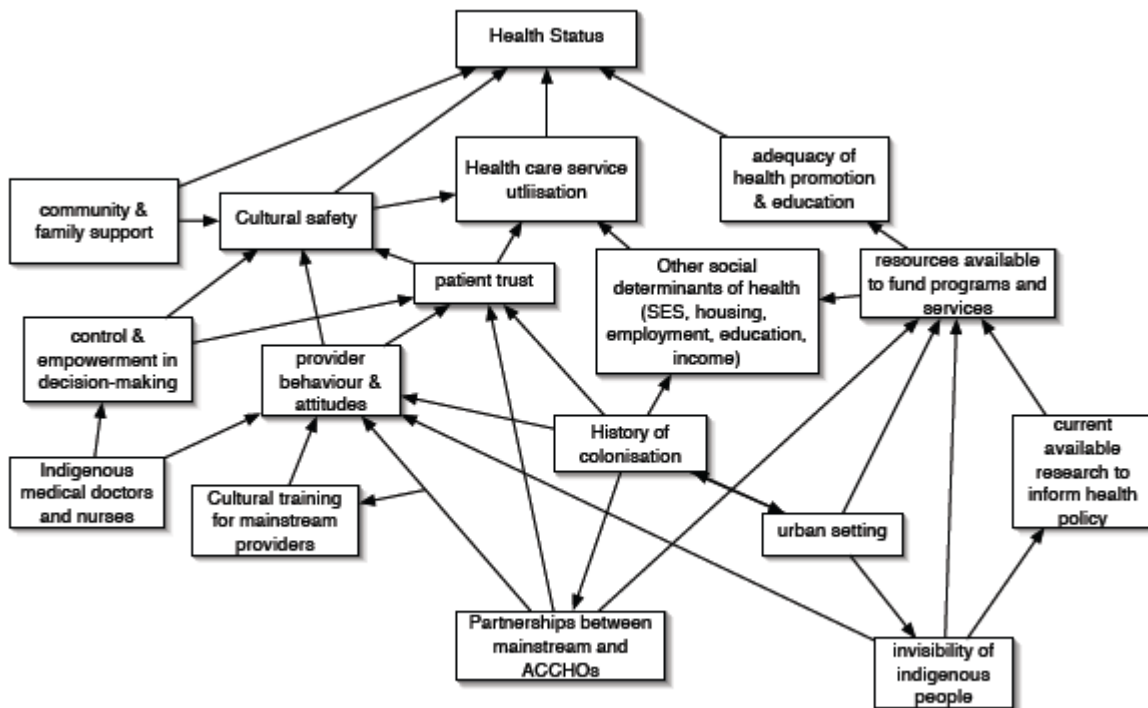
* For the information of non-Australians, a Fete is community fundraising event that usually includes the sale of second-hand donated goods, food, and entertainment.

This two-week placement offered a much different experience to that of an interview. An interview offers only one individual perspective; this perspective is often coloured by that individual's biases, the relationship the researcher has with the individual, and the time constraints inherent in a structured interview. The placement at ACES made the incorporation of multiple perspectives possible. My interactions with many elders and staff members have produced an array of data. Some data is useful in its content; the first-hand accounts of elders' past experiences and current opinions about health are valuable in and of themselves. Further, my ability to exist within the organisation and observe the everyday occurrences has provided another level of data that is useful in its content and its analytic reflections.

Again, I must reiterate the prevalence of personal emotion that was experienced during this placement. While the rapport I built with the elders and staff members was useful in gaining access to their stories, opinions, and experiences, the connection that was made between us is more than a researcher-subject relationship. Still, a more successful effort was made in taking objective notes; by the final stages of observation, the need for objectivity had become apparent. The data gained from this placement may still contain personal bias, despite efforts made. Taking this into account, this paper aims to use the appropriate pieces of interaction and observation, staying true to those people who have to whom it relates, to enhance an understanding of the complex issues in the field of Aboriginal health and well being.

A Complex Web of Forces

A qualitative study is wonderful in its ability to provide a depth and complexity that is unachievable through quantitative research. This study is no different. I wish to open the discussion of this study's findings and implications with a web of forces, below:



Though complex, the use of pictures often can articulate what words cannot. This web conveys that no single force exists in a vacuum; there are many others that are intricately related. All the issues above are important, and I have created a web in which all forces lead to health status, the main inspiration behind this study. In the following discussion, the web will be broken down into smaller pieces, namely: the history of colonisation, its relationship to the urban Victorian Aboriginal person, its relationship to the social determinants of health, the development of Aboriginal community-controlled organisations (ACCHOS), the role of mainstream health services, the meaning and need for cultural safety in each of these models of care, the current problems within health

service delivery, and a direction for improvement. Though these smaller pieces are discussed separately, a constant awareness of their relationship to the whole is necessary to truly understand the forces that are at play and the future directions needed.

The History of Invasion

The indigenous people of Australia are likely the oldest living group of people in the history of the world. Their inhabitancy of Australia has been dated to between 40,000 to 60,000 years in length. This is an almost incomprehensible amount of time. A fellow research student wrote of her observation of a history lesson given to health practitioners visualising this existence:

The opening of the workshop began with the distribution of 1500 black matchsticks. As a team we then had to arrange these matchsticks into a continuous spiral. The spiral was completed by the placement of 6 white matchsticks. We were then told that the spiral represents the thousands of years that Aboriginal people have lived in Australia, and that the 6 white matchsticks represent the time since colonization (Fletcher, 2006, p.7).

This spiral is a very useful conceptual picture, but it is also saddening. In the placement of just six matchsticks, the white invaders have devastated the Aboriginal population's health and wellbeing. Today the Aboriginal people of Australia face remarkably low health status, but their forebears enjoyed a much better health situation before the arrival of British colonists:

Endemic diseases were relatively few, the two most prevalent being trachoma and yaws. Nutrition-related disorders and diseases such as heart disease, diabetes, hypertension and obesity, which are highly prevalent in Aboriginal communities today, were extremely rare. With spiritual and cultural wellbeing, Aboriginal communities lived in harmony with the land (Clarke, Andrews & Austin, 1999, p.31).

So, then, what in the nation's history has brought things to this state of affairs? What actions have occurred so that a 'strong vibrant culture' based on 1500 matchsticks could be so damaged in a mere six (*Ibid.*)?

The 'settlement' of Australia by British colonists was justified by the doctrine of '*terra nullius*', which claimed that 'Australia was an empty land belonging to no one' and was thus free for the taking (Brett, 2001). The large and diverse population of indigenous people, estimated at 750,000 people speaking approximately 700 different languages among them, was regarded as uncivilised (Dept. for Victorian Communities: Aboriginal Affairs Victoria, 2004). This allowed the colonists to deny ownership to the original inhabitants of the land. Their settlement across the country required the 'clearing' of land, resulting in violence by shooting, slaughtering, poisoning, large massacres, and the rape and abduction of women (Clarke, Andrews & Austin, 1999). Diseases brought by the settlers brought death to many more indigenous people who lacked immunity. Still more indigenous people suffered deaths by starvation as their access to native food and water sources was diminished by the presence of the settlers' livestock (*Ibid.*; Reynolds, 1988). The violent dispossession of land hugely impacted on the indigenous population, leaving them without natural food sources and devastating their ability to nurture traditional connections to land.

Some Aboriginal people embraced colonial life, working as 'shepherds, stockriders, shearers, bark cutters and domestic servants' (Government of Victoria, 2004). Others were forcibly relocated from traditional lands onto reserves and missions, 'for better access to food and medical care', in a typical protectionist fashion. Still, the government rations of 'flour, sugar, tea, and tobacco' could not provide the nutritional value that their bush tucker had provided, and this change in diet is a likely factor in the nutritional diseases observed in Aboriginal people's health today (Clarke, Andrews & Austin, 1999, p.36). Also, this relocation often moved indigenous people great distances from their traditional lands and culture groups. For a people who value connection to

land and place as vital, this was very harmful to emotional, spiritual, and social wellbeing.

Lastly, the impact of the government's attempts at assimilation is extremely important. The government implemented policies to 'wipe out Aboriginal culture' and 'absorb them into the mainstream population' (Clarke, Andrews & Austin, 1999, p.38). The most abhorrent government practice is now referred to as 'The Stolen Generations', when the government carried out the forced removal of 'half-caste'* children. The removal of such children was in hopes of assimilating them (usually girls) into white culture and cutting them off from Aboriginal relations. Removed children were placed into homes or in other non-Aboriginal families as servants. Many never saw their families again. This practice had an impact on all Aboriginal families living in fear of the 'welfare', whose arrival signalled the tearing apart of families. Most frightening of all, this practice of child removal without sufficient grounds—children could be taken merely for 'being Aboriginal'—existed until the early 1970s (Human Rights and Equal Opportunity Commission, 1997).

In 1967, a referendum finally gave the indigenous people of Australia citizenship rights. This shift in government policy marked a change in outlook. The need for Aboriginal self-determination and control was voiced, and movements formed demanding these needs. Though progress has been made for Aboriginal people, largely in the community-controlled sector, the Australian government's predominant resistance to a formal recognition of this shameful history of violence and disempowerment resonates in the health and wellbeing field today.

* The term 'half-caste' referred to a child who was of mixed non-Aboriginal and Aboriginal descent.

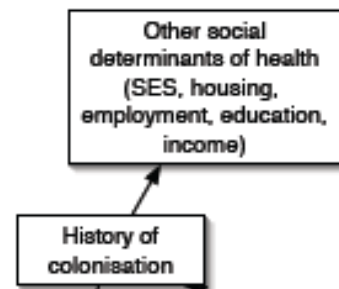
History's Manifestation in the Social Determinants of Health

The social determinants of health are evidently an important part of the current health problem for Aboriginal people. In 2002, the mean equivalised* gross household income of indigenous adults (18 and older) was only fifty-nine percent of that of non-indigenous adults. Indigenous adults were about two and a half times as likely as non-indigenous Australians to be unemployed (13% of indigenous people were unemployed versus 5% of non-indigenous people). Seventy percent of indigenous people lived in rented dwellings, while twenty-four percent of non-indigenous people rented. Only eighteen percent of indigenous adults had completed year 12, whereas forty-four percent of non-indigenous adults had (ABS, 2005b).

It is not the goal of this study to dwell on these quantitative figures, but a holistic understanding of the issues facing Aboriginal health today must include them in the discussion. The embodiment of historical injustices is evident in this statistical data, showing the first force relationship in the complex web.

By the dispossession of land, Aboriginal people were stripped of their self-control and autonomy. They became reliant on a government welfare system and were unable to sustain economic independence. This

has had lasting effects, as seen in the statistical evidence about income, unemployment, housing, and education. Though some might argue that policies have been corrected to allow equal opportunity, many Aboriginal social justice advocates demand better. Larissa Behrendt (2003) calls for an 'outcome-focused liberalism', where a recognition of



* 'Equivalised gross household income is a standardized income measure, adjusted for the different income needs of households of different size and composition. It takes into account the greater income needs of larger households and the economies of scale achieved when people live together.' (ABS, 2005b)

difference results in policies that provide ‘substantive equality’—equality of outcomes through ‘special measures’* (p.172-3; National Policy Office, n.d., p.7). This ideology is based on the fact that history has placed non-indigenous people in a better social location to benefit from policies, despite the policies’ supposed provision of equality in opportunity. The playing field is incredibly uneven. History has placed indigenous people many steps behind the starting line, and only by ‘special measures’ in policy formation can the social determinants shown above be mitigated.

While these larger policy issues are not the focus of this study, a background understanding of the health and social justice movement around indigenous policy has been provided. With this complete, the remainder of this paper will focus on one social determinant in particular—health care service utilisation—in one particular place—urban Victoria.

Urban Victoria: The Invisibility of Aboriginal People

The diversity of the Aboriginal population is immense; hundreds of separate nations, tribes, and clans existed before British arrival. These separate groups varied in terms of cultural practices, traditions, food sources, environments, living styles, languages, and more. When the Europeans arrived, these groups were met with the newcomers at different time periods and in different ways. Because the invasion occurred earlier and more quickly in the south-east portion of Australia, there are longer contact histories for Aboriginal people living in Victoria and New South Wales. As discussed previously, the forced removal and assimilation policies of the 20th century have resulted in a serious loss of traditional practices and cultural identification.

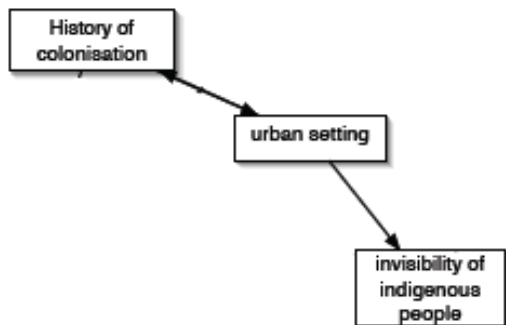
* ‘Special measures’ is a term used in the National Policy Officer discussion paper. A clear definition is as follows: ‘Substantive equality accepts that different treatment is required to properly effect the principle of equality. It is this different treatment that will constitute “special measures”’ (n.d., p.7)

Although the policies did not fully succeed in ‘wiping out Aboriginal culture’ as planned, many Aboriginal people today do struggle with uncertain identities (Clarke, Andrews & Austin, 1999, p.38; Anderson, 1994).

The contact history in remote areas in the Northern Territory, Queensland, and Western Australia is much shorter, and there are more obvious and distinct Aboriginal communities that exist in these places. The issues facing these remote areas in terms of health care utilisation are much different than in urban Victoria; limited geographic access to health care is often the largest issue. An elder from ACES spoke to me about her friend in the Northern Territory who was in labour and had to drive to the hospital many miles away. She lost the baby on the side of the road (placement notes, 30 November 2006). This elder reflected about how lucky she was not to experience those access issues. Often, the dramatic health issues that exist in remote and regional areas are the ones that draw the most attention. The CEO of the Gathering Place and of VACCHO spoke of the government’s current tendency to grant more funding to remote communities and organisations than to urban ones (Marion, 14 November 2006; Gallagher & Waples-Crowe, 24 November 2006). The CEO of VACCHO was especially interesting on this topic because she interacts with the National Aboriginal Community Controlled Health Organisation (NACCHO), the national peak body for community controlled health services. She added that Victoria, the least remote state, has the highest indigenous diabetes rate. This is one example of the fact that though health issues appear to be worse in remote areas, the health status of urban indigenous people is just as poor, if not worse.

So, why is funding going to remote areas instead of urban ones? From my interviews with those involved, it appears that the invisibility of Aboriginal people in

urban Victoria is a large factor. Compared with the national statistics, the population of indigenous Victoria is proportionally much smaller; while indigenous people make up



2.2% of the overall Australian population, only 0.5% of Victorians are indigenous (ABS, 2005b). This has resulted in the present belief by non-Aboriginal Victorians that ‘there aren’t any Aboriginal people in

Melbourne’, as a VAHS staff member recounted she once heard a health provider at a conference say (Clews, 21 November 2006). Also, indigenous people living in urban environments face different access barriers to healthcare, and these are often more socially and culturally intertwined and less obvious than a simpler geographical access barrier. Providing a driving service or a Royal Flying Doctors plane to a distinct remote community is a straightforward solution, but even the task of *locating* the community in an urban environment is difficult, let alone trying to break down social access barriers. A VACCHO staff member voiced this opinion, attributing the lack of research in urban communities with the difficulty faced in identifying them:

Urban communities aren’t well researched because it’s too hard! They are all over the place. When you have a remote community all in one place, it’s easy to go in, do the study, and go out (Waples-Crowe, 24 November 2006).

This lack of research poses a problem, because the current funding schemes for health services and programs often require accountability in the form of evaluative research. Thus invisibility has impacted policy and available resources—resources which could lead to better health delivery and promotion, especially for indigenous-specific organisations.

The invisibility of indigenous Victorians is likely influenced by the changing definitions of 'Aboriginality' that have come about as indigenous people come to terms with their pasts and discover their Aboriginal identities. The relocation away from traditional lands and family groups in recent history has impacted some indigenous people's abilities to form strong cultural identities, and some people live to adulthood without knowing their Aboriginal heritage. During my time at ACES, a man came into the activity room and introduced himself, stating that he had just found out he was Aboriginal several years ago and was trying to learn the identity of his father (placement notes, 20 November 2006). This instance was an example of how Victorian Aboriginal people can remain invisible even to their own communities and family members. A VAHS staff member, an indigenous woman from Western Australia, was able to comment on the 'loss of language and culture' that was striking to her when she came to Victoria from Western Australia, where 'culture is still maintained' (Clews, 21 November 2006). For Victorian indigenous people, being 'Aboriginal' does not necessarily require living in a remote community, eating bush tucker, or participating in traditional ceremonies. Rather, it is about a shared experience in remembering the past and its effects and hoping for a better future (placement notes, 19 November-2 December 2006). This difference is interesting, and it is contradictory to the anthropologists of old who attempted to study 'traditional', 'authentic' Aboriginal culture. The urban community of Victorian Aboriginal people has redefined the term 'culture'. While change is inevitable, the larger system seems to have not responded. Its funding scheme is focused on remote communities and does not deal with the fact that there remains an urban Aboriginal community. It fails to recognise their changing needs, deeming them invisible and less important.

Social Access Barriers: A Population Under Threat

The indigenous people living in urban/suburban Melbourne face different access barriers to mainstream health services than their remote and rural counterparts. These have been identified by the CEO of VACCHO as ‘social access barriers’ that include ‘racism of providers, fear of welfare, and fear of authorities’ (Gallagher, 24 November 2006). Aboriginal people have long been oppressed by white authorities; the history is full of horrible tales of massacres, poisoning, forced relocation, forced child removal, and the current refusal of the government to apologise and recognise this history. Most importantly, this history does not remain in the past—it manifests itself in the fears and assumptions of Aboriginal patients today. The white authorities have historically posed a serious and devastating threat to Aboriginal peoples’ control over their own lives and destinies, and there is a current perceived threat that this control can still be taken away. This ‘under threat’ mentality has been observed throughout this study, and it is extremely interesting in contrast to the existing call for ‘cultural safety’ in health care services for Aboriginal people. Why use the term ‘safety’? What is that specific word expressing?

I argue that the term ‘cultural safety’ is, in its essence, calling for a health care environment with an absence of threat. In the 1970s, when the push for Aboriginal self-determination and self-management was at full force, Aboriginal community controlled health organisations (ACCHOs) came into being to provide health services that maintained a ‘culturally safe’ environment. Now, thirty years later, ACCHOs are still in existence and have been deemed the most effective and culturally appropriate health service model for Aboriginal people by the National Aboriginal and Torres Strait Islander Health Council:

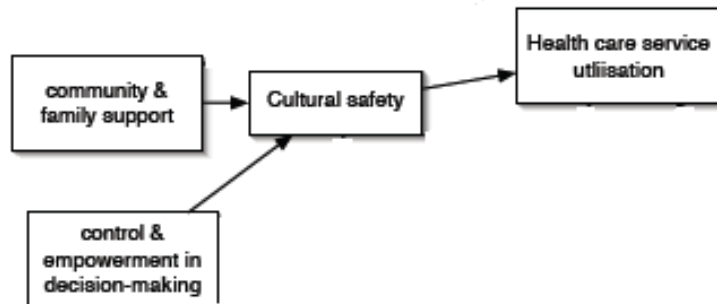
Aboriginal community controlled health services (ACCHSs) are the best practice model for the delivery of comprehensive primary health care to Aboriginal and Torres Strait Islander communities. In many circumstances other provider groups (for example general practitioners and State/Territory government health services as well as private specialists, private hospitals and organisations such as the Royal Flying Doctor Services) provide primary health care services to Aboriginal and Torres Strait Islander peoples. However, while acknowledging that such providers have delivered technically competent health services, only ACCHSs currently provide culturally appropriate health services to Aboriginal and Torres Strait Islander peoples (2003, p.13).

ACCHOs are the ‘best practice model’, and it is because they are ‘culturally appropriate’ and ‘culturally safe’. I wish now to examine the question of *what makes them safe?*

Aboriginal Community Controlled Health Organisations: Providing Cultural Safety

Aboriginal community controlled health organisations are unique in their ability to encompass two important factors in creating cultural safety: a community and family support system, and a

sense of control and empowerment in decision-making. These factors seem to be inherently



present in all ACCHOs, and data from the interviews and the placement observations reflect their importance.

While sitting in the Planned Activity Group (PAG) Room at ACES, it became immediately apparent that family relations and linkages were a very central part of the elders’ lives. They frequently discuss their own family business with the group, and listeners would often interrupt and ask about family connections or add, ‘Oh, yes, she’s related to me, you know.’ The establishment of relational ties, or even community ties, was constant, such as ‘Yes, we worked picking fruit together back when we were young. Koories are the best fruit pickers, you know!’ (placement notes, 20 November 2006 – 30

November 2006). From its centrality to many conversations over the course of two weeks, I believe that community and family are more than just gossip topics for these elders. Their ability to even make connections is important in voicing the strength of their heritage and culture. One of the pastors at ACES spoke with me about his ability to trace his lineage ‘all the way back to the bush, before Europeans arrived’ (Waterman notes, 30 November 2006). This seemed to be extremely powerful to him. Further, the community and family connections allow ACES to become a place of belonging. When an elder would not arrive for the day’s activities, everyone would wonder where they were and if they were all right. The fact that a member is missed signifies that their presence is important. They are a part of the community, and they belong in it.

This community importance is possible because of the existence of Aboriginal staff and board members. These individuals play an essential role in creating an environment where the patient population and the provider population are from the same community. My interviews with Aboriginal staff members and CEOs and my placement at ACES have displayed the intense commitment of these individuals to their organisations and to Aboriginal health and well being in general. Most of these individuals have been involved in indigenous issues their whole lives; in fact, involvement in these issues *is* their lives. While non-Aboriginal people have the ability to step aside and escape, Aboriginal people are living the experience of those in their care. They are not only health workers but community members as well. At a conference I attended about Aboriginal Chronic Disease Management, a representative from VACCHO who had been involved with VAHS from a young age spoke about the Health Service:

VAHS has a wealth of history, family, and sense of belonging. It's not just a job [working at VAHS], it's our belonging place. It puts us in touch with our community. If we don't have that role, we get sick. It's about belonging and having a role (Thorpe, 17 November 2006).

For this woman, her job in Aboriginal health is vital to her sense of belonging and to her personal well being. This intense personal commitment to her role as health worker is unmatched. Another example was made apparent to me in the farewell party for the retiring CEO of ACES. During this, her intense emotional connection to the organisation was clear; she had been the CEO for nearly twenty years. Many tears were shed at the farewell party. She was incredibly special to the elders who were cared for there; this was clear from the interactions between them and the emotional state of all present (placement notes, 30 November 2006). Despite her retirement, she continued to come to ACES for the two weekdays following her farewell. Further, she was elected to the Board of Management, so she will stay connected to ACES. Her inability to cut herself off completely is a good example of her need for 'belonging and having a role', as the VACCHO staff member discussed above. This sense of commitment and community belonging is inherently present in all the ACCHOs that have been observed in this study, and the environment that is created for both patients and workers is incredibly 'safe.'

The second factor that creates 'cultural safety' in ACCHOs is the control and empowerment these organisations grant Aboriginal people. When asked to discuss issues of self-determination and empowerment, the Manager of the YVCHS Indigenous Health Team said:

They [self-determination and empowerment] are incredibly important to social and emotional well being. When people feel that trust and empowerment are given, they have a better health experience. People want to determine how they want to be involved. In all persons, everyone wants to lead their own pathway. Indigenous people are perhaps just more suspicious of not being allowed to do so because of the history behind us (Fergie, 15 November 2006).

ACCHOs are unique in their requirement of a locally elected indigenous Board of Management (NACCHO, n.d.). This rests the control of organisational decisions and programs in the hands of the community that is affected by those decisions. It is the epitome of allowing a community to ‘lead their own pathway’. In an Annual General Meeting of the ACES Association members and board members, I was able to observe this empowered decision-making first hand (placement notes, 23 November 2006). All community members were allowed to attend the meeting; its date and time was publicly announced well in advance. In the meeting, each ACES department head (CEO, Project Officer, CACP* Co-ordinator, PAG Co-ordinator, and Occupational Health & Safety Co-ordinator) gave a written report for all those present to read and voice comments or complaints. The Chairperson of the Board and a financial auditor gave reports as well. Finally, all active members of the Association—Aboriginal people over the age of fifty—voted on elections for the 2007 Board Members. I was struck by the liveliness of the meeting; all those present seemed to know each other, and they took little caution in voicing their opinions on matters, especially pertaining to the election of board members. A new nomination system had been put into place for the election so that nominations were required to be sent in by a certain previous day. Many community members were unaware of this new rule, and so seven nominees who had followed the rule were automatically put in as board members without being elected by vote. One Association member had a serious issue with this and furiously debated its fairness. I spoke with another ACES member the following day, and she said that ‘the new way of nominating was like being told who was chosen rather than being able to choose herself’ (placement

* CACPS stands for Community Aged Care Program and ‘is designed to provide support for the frail Aged and those who have serious ageing related health conditions...[and] to provide services to assist people to remain living at home as independently for as long as possible’ (Waight, 2006, p.1).

notes, 24 November 2006). As I reflect on that day, I think the reason this election was so offensive to the angry woman in the meeting and the staff member I spoke with later is that it harkens back to the history of disempowerment. Being told, 'this is the way it is, you can't have say,' is completely contradictory to the safety that ACCHOs like ACES are intended to provide. The new election process posed a threat to these members' sense of control and their ability to 'get their point across' (*Ibid.*).

Despite this instance of a threat to 'cultural safety', the incorporation of members' and patients' voices in determining the policies under which ACCHOs run is for the most part incredibly successful and effective. Furthermore, the sense of community and family belonging that exists in ACCHOs makes them a safe-space for the sharing of stories, the telling of jokes, the embracing of family members, and the reflecting of hardships and traumas. ACCHOs are truly a 'belonging-place' (Thorpe, 17 November 2006).

Mainstream Organisations: A Lack of Cultural Safety (for the most part)

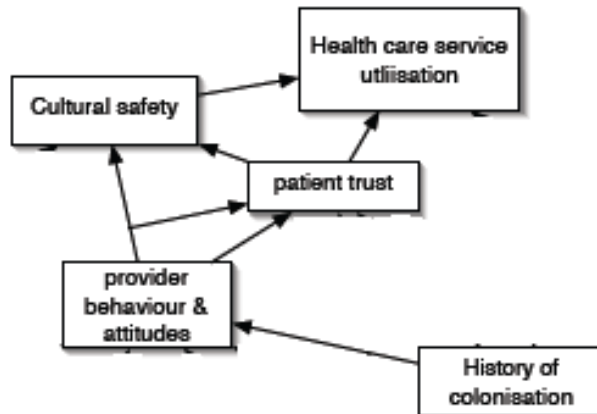
Though ACCHOs have been very successful in creating havens of cultural appropriateness and safety, these organisations are not always available to indigenous people. In the words of a VAHS staff member:

Not everyone can get here. There are 15,000 indigenous people in the greater Melbourne area. Although it [community-control] is the best model, we need some alternatives in outer areas (Clews, 21 November 2006).

The role that mainstream health services can and must play in indigenous health is apparent to this staff member.

However, mainstream organisations must make great efforts to enhance cultural safety for Aboriginal people who utilise their services. While the crux of cultural safety in ACCHOs seems to be the inherent community sense of belonging and empowerment, a slightly different focus seems to be taken in mainstream organisations. Here, many

problems with cultural safety result from health care providers' behaviours and attitudes.



This is where the 'social access barriers' like 'racism, patients' fears of welfare, and patients' fears of authorities' come into play prominently (Gallagher, 24 November 2006). These

behaviours and attitudes impact on Aboriginal patients' trust and often result in less utilisation of mainstream services.

Because the final goal of indigenous-specific health services is, in the words of the ALO at Northern Hospital, to 'make people feel safe', the elimination of threat is necessary (Morrison, 13 November 2006). First, however, the history of the dispossession and disempowerment leading to this threat must necessarily be understood by mainstream health care providers. 'The history needs to be told; everyone needs to understand the Aboriginal point of view,' said the Northern Hospital ALO (*Ibid.*). An elder at ACES spoke of the importance of 'sending out the right vibes' because Aboriginal people 'can sense it' (placement notes, 22 November 2006). For her, this seemed to encompass body language, placement of seating, eye contact, speech, tone of voice, and more. It is both a verbal and a non-verbal issue of communication, behaviours and attitudes. Without a background in history, a mainstream provider might find it quite difficult to 'send out the right vibes.' The YVCHS Indigenous Health Team Manager commented in her interview:

Mainstream professionals need to be competent in cultural safety, and some mainstream people don't think they have to do it. Or they don't know how to handle it, or they are ignorant of it. Some think, 'I know the better way and I'll show you it' when they are

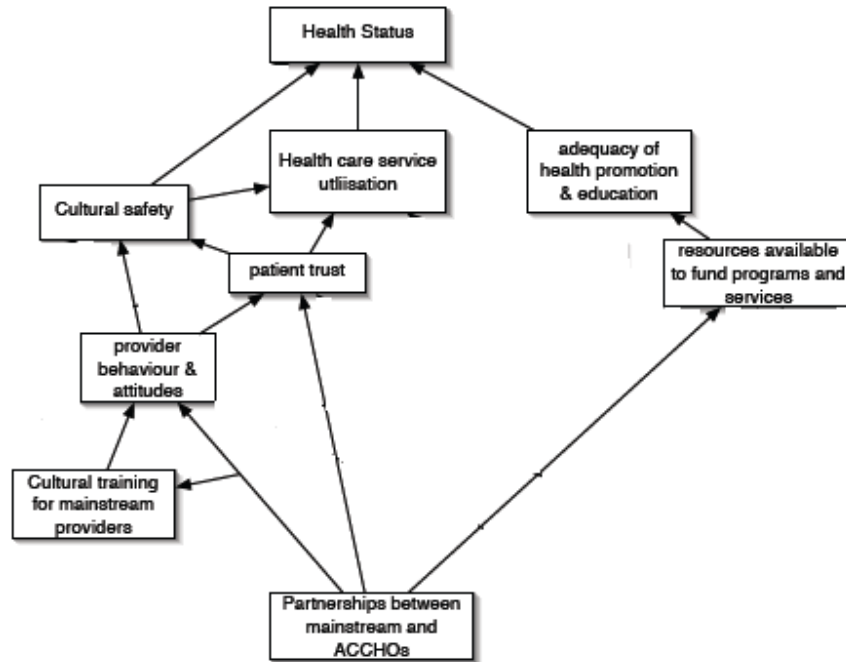
giving health care, instead of acting in a sensitive and understanding way' (Fergie, 15 November 2006).

After hearing repeating themes from several interviewees, I began to understand the idea of a 'culture' of biomedicine, where Western concepts of science and medicine take priority over historical and cultural trust issues (Watts, 17 November 2006; Marion, 14 November 2006; Fergie, 15 November 2006). They spoke of indigenous people's or organisations' abilities in 'informing' or 'changing the culture' of a hospital to one where these social issues are given a priority. This seemed to involve an ALO or ACCHO getting involved with a mainstream organisation and providing information and cultural training to change the provider behaviours and attitudes, and in so doing, create a more trusting patient-provider relationship.

At present, mainstream organisations are not doing enough to enhance cultural safety for Aboriginal people who utilise their services. While many hospitals and mainstream community health centres have hired Aboriginal Liaison Officers (ALOs), these individuals cannot be the sole persons working to promote cultural safety. As the Northern Hospital ALO said, 'Aboriginal patients are *everyone's* patients, not just mine!' (Morrison, 13 November 2006). A change in the larger organisational structure is necessary if more appropriate, safe care is to be provided for Aboriginal people utilising mainstream services.

Partnerships Between ACCHOs & Mainstream: A Future Direction for Positive Change

Partnerships between mainstream and community-controlled organisations can be the future direction needed to effect positive change for indigenous health service utilisation and health status. The component pieces of the web help to illustrate this possible future direction.



As discussed previously, the mainstream sector is lacking in the cultural and historical knowledge to reach a level of truly culturally safe care. However, the community-controlled sector faces difficulties as well. Many ACCHOs cannot allocate sufficient resources to provide truly holistic health services. A VAHS staff member commented on the irony of the Health Service:

There is a huge philosophy of community control and community ownership. The focus seems to be on community, primary care, and health education. But in reality, the work here is reactive. It is mostly medically and clinically driven, and we've fallen into the band-aiding practices instead of focusing on things like education and health promotion (Clews, 21 November 2006).

She went on to emphasise the need to for combining and linking with mainstream organisations, since those organisations have the funding to focus on health promotion and education. Nearly every interviewee was emphatic about the need for partnerships to enhance quality of care. The CEO of VACCHO stated that 'building up the community-controlled sector will not alone solve the health problems that exist' but that 'we also need partnerships' to be able to tackle other social determinants, such as 'education

opportunities, employment opportunities, home ownership, and so much more' (Gallagher, 24 November 2006). By forming partnerships, ACCHOs will be able to access mainstream organisations' programs and services that are made possible by their greater resources, especially for health promotion, education, and social welfare improvements.

Also, the mainstream sector can benefit hugely from building trusting relationships with ACCHOs. While currently there seems to be a devaluing of ACCHOs' abilities to connect with the Aboriginal community and refer people to mainstream organisations, this aspect must be more valued if partnerships are to succeed (Waples-Crowe & Gallagher, 24 November 2006). The CEO of the Gathering Place discussed the relationship trust that her ACCHO was able to build by bringing in outside mainstream staff members to do outreach at the Gathering Place. The indigenous patients involved became familiar with the outreach workers in the culturally safe ACCHO environment, and then they were more trusting when they needed to attend the larger mainstream organisation for care (Marion, 14 November 2006). This is an ideal outcome of a partnership.

Another important benefit from creating partnerships is the ability of ACCHOs to 'change the culture' of mainstream organisations. The Gathering Place CEO spoke of her work with the Western Hospital and how she had 'really changed the culture of the place' (Marion, 14 November 2006). Similarly, the YVCHS Manager spoke of the need for 'individuals on the inside trying to educate the culture of it' (Fergie, 15 November 2006). The implicit education that can occur when a partnership is formed between mainstream and community-control could be very powerful in changing provider attitudes and behaviours. This can bring Aboriginal experiences and their historical disempowerment

into the visible spectrum for some providers who believe that ‘there aren’t any Aboriginal people in Victoria’ (Clews, 21 November 2006). In all cases, formal partnerships would symbolically and officially join mainstream organisations to Aboriginal ones, and this would show a dedication and commitment to the issue on the part of mainstream organisations. A recognition of the need for partnerships could signify a shift in focus, from that of ‘This is the better way’ to that of ‘Tell me how you interpret the problem, and let us discuss a solution together’. Overall, it seems to be an issue of creating two-sided communication, where the views of both parties are heard and valued. Also, value must be placed on the contributions of both parties; the referral by an ACCHO should be understood as equally important to the overall care as the technical service or promotion program provided by a mainstream organisation. Without the access to family connections and community people that ACCHOs can provide for mainstream organisations, many indigenous people would not even be utilising them (Waples-Crowe & Gallagher, 24 November 2006). Partnerships are the key to affecting change in the ability of ACCHOs to provide adequate holistic primary care and the ability of mainstream organisations to provide culturally safe care.

Obstacles in the Building of Effective Partnerships

Unfortunately, these partnerships are not easily forged. Lingering trust issues and the fear of redundancy has negatively influenced many ACCHOs’ desires to work with mainstream organisations (Morrison, 13 November 2006; Waples-Crowe & Gallagher, 24 November 2006). The Northern Hospital ALO agonised over the ‘us and them mentality’ that exists between his mainstream organisation and VAHS. He commented that the Health Services is ‘afraid that we’re [Northern Hospital] trying to take their

clientele'. The impact of history is present in this fear as well; a long history of being taken advantage of and denied basic autonomy creates a sense of doubt of the outcomes of certain partnerships in Aboriginal people. This is reflected in VACCHO staff member's emphasis that 'partnerships be on our [Aboriginal people's] terms' (Waples-Crowe, 24 November 2006). There is still a fear of being obliterated that resonates in the experience of many ACCHO staff members. At the Chronic Disease Management Conference—a true partnership in action with staff members from ACCHOs and mainstream services in attendance—the VACCHO staff member emphasised the need to 'make sure it [community controlled health care] is safe for the future' (Thorpe, 17 November 2006). Even in the company of caring, understanding mainstream staff members, this ACCHO member needed to voice this feeling. It is an understandable fear, considering the past history of injustice and recent abolition of the Aboriginal and Torres Strait Islander Commission (ATSIC), the national body for indigenous affairs, in 2004.

Mainstream partners need to reach an understanding of the threat that history has been imposed on Aboriginal organisations and individuals. Behaviours and attitudes must be changed on both these levels. The non-indigenous General Practitioner (GP) at the Gathering Place spoke of the need to 'see what health problems look like from the other person's [or organisation's] point of view, and tailor your service to that'. He said that 'you need to get alongside them and enlist them' in the process (Watts, 17 November 2006). While this GP was referring to his personal behaviours in patient consultations, this mentality is important to inform organisational partnerships as well. Mainstream organisations must resist the tendency to preach their word as paramount to Aboriginal partners; they need to 'enlist' and value ACCHOs' roles. Because of the trust issues that are pre-existent in the psyches of many ACCHO staff members, a relationship built over

time and with patience is one that will be effective. The Gathering Place GP spoke of the history of poor partnerships, where mainstream organisations wanted to partner with ACCHOs before building trust (Watts, 17 November 2006). To use a metaphor, this method is like a romantic relationship in which one partner has betrayed the other's trust. Before all can be well again, the betraying partner must display his or her deepest apologies and rebuild the trust between them.

On the other hand, the fear of a replayed history of betrayal can only extend so far. In the words of one of the pastors at ACES:

We can't let the past affect our ability to live today and move forward. Lots of Aboriginal people have these chips on their shoulders and its not doing any good (placement notes, 30 November 2006).

When I asked him about the past in impacting present health experience, he replied:

We need to acknowledge the past, but then move forward. Of course I think the government needs to apologise and recognise what's happened, but we can't let that past constantly affect the future (*Ibid.*).

The pastor's wisdom and clarity was truly refreshing. After a month of studying and interviewing about the historical injustices and their manifestations in present health utilisation and well being, a simple statement from a wise elder in the Aboriginal community put my data completely in perspective. Yes, many ACCHOs find it difficult to place their trust in mainstream organisations where they lack complete control, but not all mainstream organisations pose a threat to this control. Only by beginning the conversation between the two sectors can a common ground be reached. If the past limits both sectors abilities to respect and listen to one another, then nothing will ever be accomplished in creating partnerships. ACCHOs will remain largely reactive, aware of the need for holistic primary care but unable to run the health promotion and educational activities that this holistic approach requires. Aboriginal people will remain invisible or

unworthy of substantive attention to mainstream organisations, on the bureaucratic and the patient-provider level. Ian Anderson, a well-known Aboriginal physician, educator, and activist, wrote in a thesis paper in 1988:

Changing needs and situations will continue to challenge those involved in the development of these services, to constantly re-evaluate and adapt their programs to best suit what the Aboriginal community requires (p.124).

Nearly twenty years ago, Anderson saw the need for adaptability in Aboriginal health care. Now, it is evident that the field needs to adapt to allow the growth of partnerships. Despite the obstacles that exist, greater communication and trust needs to be built in order to effectively make this change.

Conclusion

How do history and culture impact health status? This analysis has attempted to shed light on this question and to extend it into an overall discussion of the health care available to Aboriginal people in urban Victoria. The web of forces has been used as an illustrative tool to display the true complexity of the underlying history and culture that encompasses the Aboriginal peoples' experiences with the health system. The history of invasion is inseparable to the current issues of trust, threat, and fear that affect Aboriginal people's willingness to access health services. The role of ACCHOs in providing cultural safety that encompasses an empowerment in decision-making and strong sense of community and belonging is very important. The potential for mainstream services to tap into their greater resources for health promotion and education is great. These two roles must *complement* one another.

I emphasise this need for partnerships so strongly because, as an outsider, I have seen both sides of the coin. The liaison officer at Northern Hospital expressed great

anguish over the fortress-like mentality of the Victorian Aboriginal Health Service. He had incredibly good intentions. He saw the possibilities that a better relationship would bring, especially in creating a more 'culturally safe' environment for indigenous people at the hospital, but he still faces problems getting VAHS to let down the drawbridge and work with him. There are pockets of hope in the larger mainstream organisations, and this liaison officer is one such pocket. A development of these pockets to 'change the culture' would break down a lot of lingering trust issues, and this development needs to come from an effort from both parties.

On the other side of the coin, I have spent many hours in the company of Aboriginal staff at ACES, who are strong advocates for community control. Most of these people have been involved with the Aboriginal health community for a very long time, and their commitment and passion for doing good is obvious. During the time I was there, I observed one Aboriginal staff member's serious mistrust and dislike for a non-Aboriginal worker. I felt torn; is it right to discriminate against non-Aboriginal involvement on the basis of a need for community-control and cultural safety? I could observe that this non-Aboriginal worker was unable to provide the same sense of involvement and community connection, but she worked with the same desire and altruistic intentions to do good for the elders. Where does a passionate advocacy for community-control hinder the organisation's ability to give the best care possible? Creating a fortress protects from the threats that do exist, but it also prevents the friendly ambassadors from entering the castle.

I feel that partnerships are the answer to the current 'us and them mentality'. Organisations like the Gathering Place, which holds frequent outreach sessions between indigenous clients and mainstream workers, are successful models of partnerships in

action. I have spoken with the CEO and Public Health Officer of the peak body for Aboriginal community-control, VACCHO, and they strongly emphasised the need for such partnerships. A health promotion officer from VAHS reflected on the need for linkages and connections with mainstream as well. The evidence is here: partnerships are the key.

Still, as I have shown in the discussion, the history's impact on patient trust, provider behaviours, the changing roles of ACCHOs and mainstream are large and still very existent today. Though the ACES pastor poignantly advised 'to not let the past affect our ability to move forward', many Aboriginal and non-Aboriginal people are allowing past experiences and racisms to manifest in the reality of the present. It is my hope that the pastor's words will spread to the greater community and that this can influence warmer acceptance for the creation of partnerships. This study has opened my eyes to the realities of many different people with many different perspectives. When they remain separate from one another, their passionate demands for improving Aboriginal health status create a lot of incomprehensible noise. Only with better communication and trusting partnerships can these voices come together and create a coherent whole, complementing one another's individual roles in the larger picture.

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Interview/Placement Sources

Sharon Clews (21 November 2006).
Health Promotion/Policy Officer at the Victorian Aboriginal Health Service
186 Nicholson Street phone: (03) 9419 3000
Fitzroy, VIC 3065

Interview took place in office at VAHS. Focus of interview was about community-control and partnerships.

Doseena Fergie (15 November 2006).
Manager of Yarra Valley Community Health Service Indigenous Health Team
phone: (03) 5965 3210

Interview took place over the phone. Focus of interview was about relationships between mainstream and community-controlled services.

Jill Gallagher (24 November 2006).
CEO of the Victorian Aboriginal Community Controlled Health Organisation
5-7 Smith Street phone: (03) 9419 3350
Fitzroy, VIC

Joint interview with Peter Waples-Crowe of VACCHO. Took place in conference room at VACCHO. Focus of interview was about urban Victoria-specific issues, community control and partnerships.

Colleen Marion (14 November 2006).
CEO/Founder of the Western Suburbs Indigenous Gathering Place
200 Rosamond Road phone: (03) 9318 7855
Maribyrnong, VIC

Interview took place at the Gathering Place. Focus of interview was community control and partnerships with mainstream.

Andrew Morrison (13 November 2006).
Aboriginal Liaison Officer at the Northern Hospital
185 Cooper Street. phone: (03) 8405 8476
Epping, VIC

Interview took place in office at the Northern Hospital. Focus of interview was the general reality of indigenous healthcare, the meaning of cultural safety, and the problems faced by an ALO.

Glenda Thorpe (17 November 2006).
VACCHO staff member
See above VACCHO contact information.

No interview took place. References are from her presentation given at the Chronic Disease Management Conference about the role of Aboriginal Health Workers and community-controlled services.

Peter Waples-Crowe (24 November 2006).
Public Health Policy Officer at VACCHO
See above VACCHO contact information.

Joint interview with Jill Gallagher. See above information.

Dr Chris Watts (17 November 2006; 24 November 2006; 28 November 2006; 1
December 2006)

General Practitioner at the Western Suburbs Indigenous Gathering Place
See above contact information for the Gathering Place.

Interviews on 17 November and 1 December occurred in office at Gathering Place. Discussion on 24 November occurred over the phone. Discussion on 28 November occurred at the St. Albans branch of Victoria University. First interview focussed on cultural competency and patient-provider relations, subsequent discussions involved general help and guidance in the structuring of this final work.

Student Placement (20 November 2006 - 30 November 2006)
Aboriginal Community Elders Services
5 Parkview Avenue phone: 9383 4244
East Brunswick, VIC 3057

Placement observations took place at above location, apart from one outing to the Coburg Leisure Centre.