

VACCHO

THE LONG JOURNEY: Colonialism, Community-Control & Indigenous Autonomy



Aboriginal Community-Controlled Cooperative, Robinvale, Victoria.¹

¹ Pic A1500, K3199 Barcode: 11652508 National Library Australia, Canberra, Series accession number: A1500/2.

CONTENTS

	Page
<u>Acronyms</u>	v
<u>Introduction: A Winding Road</u>	
<i>A Context</i>	2
<i>Aboriginal Health in Australia Today</i>	4
<i>A Schema</i>	11
<u>Chapter 1: A Brick in the Road</u>	
<i>The Rise of Aboriginal Community Controlled Health Services</i>	14
<i>Decade of Forums and Peak Bodies</i>	25
<u>Chapter 2: A Great Stride Forward</u>	
<i>Emergence of the Health Strategies</i>	31
<i>Debilitating Factionalism and a Continuing Lack of Consultation</i>	37
<u>Chapter 3: A Foot in the Door</u>	
<i>VACCHO: Incorporation and Capacity Building</i>	46
<i>Intergovernmental / Community Agreements</i>	51
<i>Performance Reviews and Funding Issues</i>	56
<i>Cultural Programs</i>	62
<u>Conclusion: Paving the Way</u>	
<i>Human Rights & Indigenous Autonomy</i>	71
<i>The Mainstream & Community-Control Today</i>	72
<i>Postcolonialism</i>	78
<u>Appendix A:</u> <i>VACCHO Organisational Structure 1996 – 2006</i>	81
<u>Appendix B:</u> <i>Chronology</i>	85
<u>Bibliography</u>	87

Graphs

	Page
1. Age Structures of the Aboriginal and & Non-Indigenous Populations.	9
2. Comparison of Indigenous and Total – Median Ages of Death.	9
3. Percentage of Population Expected to Live to Age Sixty-Five.	9
4. Incidence of Disease / Injury Indigenous & Non-Indigenous.	10
5. Dialysis Rate for Indigenous and non-Indigenous population.	10
6. International Comparison of Life Expectancy Late 1990s.	10

(*see bibliography for references p. 94.)

<u>Images:</u>	Page
1. Aboriginal Cooperative, Robinvale, Victoria	i
2. VACCHO Member Map	7
3. VACCHO Story	8
4. Referendum Leaflet 1	15
5. Referendum Leaflet 2	16
6. Passing the Buck on Aboriginal Affairs_	17
7. VAHS 1973	19
8. VAHS's former premises Gertrude Street, Fitzroy	21
9. VAHS today Nicholson Street Fitzroy x2	21
10. Alan Brown with Aboriginal Health Workers at VAHS 1987	22
11. Aboriginal Organisations	26
12. The inaugural Koori Kollij students, 1982	30
13. The first twenty students to pass the AHW Training Program 1982	30
14. 'Treat Whites, Aborigines the Same'	32
15. 'Chances of Finding a Job...'	33
16. 'ATSIC Delivery Service'	38
17. 'Tickner Putting on a Show...'	39
18. 'Vote Labor – Up/Out	46
19. Nurturing the Community	50
20. Liberal Budget Cruise	61
21. This Time It'd Better Work	61
22. Purro Birik	64
23. Binang Goonj – Bridging Cultures	66
24. Community, Health and Wellbeing	67
25. Advertisement for the Well Persons Health Check	77
26. Painting for the Well Persons Sexual Health Check	77

(*see bibliography for references, pp. 95-96.)

List of Acronyms

- ACAG** – *Aboriginal Community Advisory Group.*
- ACCCHS** – *Aboriginal Community Controlled Health Services.*
- AHDG** – *Aboriginal Health Development Group.*
- AHRCG** – *Health Resources Consultative Group.*
- AHW** – *Aboriginal Health Worker.*
- ATSIC** – *Aboriginal and Torres Strait Islander Council.*
- CAH** – *Council for Aboriginal Health.*
- COAG** – *Council of Australian Governments.*
- DAA** – *Department of Aboriginal Affairs.*
- DHS** – *Department of Human Services.*
- DHFS** – *Department of Human and Family Services.*
- KSIS** – *Koori Services Improvement Strategy.*
- NACCHO** – *National Aboriginal Community Controlled Health Organisation.*
- NAHS** – *National Aboriginal Health Strategy.*
- NAHSWP** – *National Aboriginal Health Strategy Working Party.*
- NAIHO** – *National Aboriginal and Islander Health Organisation.*
- NATSIHC** – *National Aboriginal and Torres Strait Islander Health Council.*
- OAH** – *Office of Aboriginal Health.*
- OATSIH** – *Office of Aboriginal and Torres Strait Islander Health.*
- SEAIHO** – *South Eastern Aboriginal and Islander Health Organisation.*
- ESWB** – *Emotional and Social Wellbeing.*
- SRA** – *Shared Responsibility Agreement.*
- SHSS** – *Special Health Services Section.*
- VACCHO** – *Victorian Aboriginal Community Controlled Health Service.*
- VACKH** – *Victorian Aboriginal Council on Koori Health.*
- VAHS** – *Victorian Aboriginal Health Service.*
- VTCKH** – *Victorian Tripartite Council of Koori Health.*
- WPHC** – *Well Persons Health Check.*

INTRODUCTION
A WINDING ROAD

*Now brood no more
On the tears behind you,
The hope assigned you
Shall the past replace,
When a juster justice
Grown wise and stronger
Points the bone no longer
At a dark race.*

Oodergoo Noonuccal – From ‘Song of Hope’²

² Oodergoo Noonuccal, ‘Song of Hope’, in Oodergoo Noonuccal, *My People*, Brisbane, Jacaranda Press, 1970.

A Context

This is a brief history of the Victorian Aboriginal Community Controlled Health Organisation. It is an account of one community's struggle for recognition, respect and equity. It is a tale of survival, a chronicle of a people who refused to yield to two centuries of abuse and mistreatment, and who today stand as one to demand adequate health and wellbeing. The story does not begin in 1996 when the local Aboriginal community seized the initiative and officially established the organisation. Nor does it begin in the 1970s when the first community controlled medical services were established throughout Australia. It would even be remiss to embark on this narrative journey at the turn of the nineteenth century when European imperialism crashed onto Victoria's shores wreaking the havoc to which the organisation now attends. For this is a story that ultimately began long before any words were ever recorded in the annals of western history. Rather, the tale should begin with Aboriginal Victorian's oral traditions, before time itself, in a land void of shape or form where the great primeval ancestors, those powerful beings, created the land and everything within and around it.

It is said that in ancient times Bunjil, the eaglehawk man, carved images of people out of bark. He breathed life into these people, gave them spears and digging sticks, and bestowed upon them a code by which to live.³ For 30 millennia, some 1,600 generations, Aboriginal Victorians lived by this code, operating within an intimate social structure and drawing on a complex ideology to make sense of the world. They existed in careful equilibrium with an environment that furnished them with material and spiritual nurture, and led a hunter-gatherer lifestyle that maintained a stable and healthy population.⁴ Their varied, largely vegetable diet and regular physical exercise prevented the diseases familiar to sedentary

³ Richard Broome, 'Aboriginal Victorians: A History Since 1800', N.S.W., Allen & Unwin, 2005, p. xvii.

⁴ Sherry Sagers & Dennis Gray, 'Aboriginal Health and Society: The Traditional and Contemporary Aboriginal Struggle for Better Health', N.S.W., Allen & Unwin, 1991, p. 168.

societies, and their simple material and rich cultural life promoted psychological fulfilment.⁵ In short, Aboriginal Australians determined every aspect of their lives, their ‘very being’. The arrival of Europeans was, however, to fundamentally and irrevocably change all this.

The tide of history that swept British colonialism on to Port Phillip’s sandy beaches at the turn of the nineteenth century broke the code by which Aboriginal Victorians lived and threw their society into chaos. Their population was decimated by the brutal acts of early settlers and by the microbes they carried with them. Their subsistence base was destroyed by the dispossession of their land and the intruders’ livestock and pests. And their way of life was turned upside down by the brutally oppressive policies of apathy, indifference and exclusion that were implemented by successive colonial state and federal governments. By the late 1800s, less than 10 per cent⁶ of the estimated 60,000⁷ Aboriginal Victorians inhabiting the area before the European arrival remained. Those who survived bore the brunt of colonial expansion and the cultural arrogance and racism that accompanied it. Their land was stolen, their culture was suppressed, their languages were forbidden, and their families were torn asunder. Yet they endured. They survived. And the Victorian Aboriginal Community Controlled Health Organisation is a symbol of that will to do so.

In her poem *Song of Hope*, the late campaigner for Indigenous rights, Oodergoo Noonuccal, used these historical layers of European injustice to weave the past to the present, and then to satirically bridge the present to a future in which the *justice* of the dominant society in relation to the *darker race* is no longer primitive. She stressed how the *tears* of the past cannot be casually and carelessly wiped away, and in doing so highlighted the fact that Aboriginal health and wellbeing cannot be treated as ahistorical. As one official government document attests, the high levels of Aboriginal disadvantage and ill health “stem directly

⁵ National Aboriginal Health Strategy Working Party (NAHSWP), ‘A National Aboriginal Health Strategy’, NAHSWP, Canberra, 1989, p. ix.

⁶ Richard Broome, ‘Aboriginal Australians: Black Responses to White Dominance 1788-1994’, NSW, Allen & Unwin, 1994, p. 71.

⁷ Broome, ‘Aboriginal Victorians’, p. xxi.

from the dispersal and dispossession of traditional Aboriginal societies that occurred as a result of white settlement; [that] Australian history has left a legacy of Aboriginal inequality”.⁸ Thus, Indigenous health today cannot be discussed meaningfully outside the context of those social forces that have made it both an issue demanding our attention and a problem calling for a resolution – namely, colonialism. And it is within this context that the story of the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) must be placed. For as one community member stated, “our history affects us all in one way or another.”⁹

Aboriginal Health in Australia Today

Aboriginal Victorians constitute 6.1 per cent of Australia’s total Aboriginal population and 0.6 percent of Victoria’s combined total population.¹⁰ It is a young populace, one of few statistics that augurs well for the future (Graph 1 / p. 9). These diminutive numbers should not, however, justify or condone the state and federal governments’ abdication of responsibility to ensure that the Aboriginal community has adequate levels of health and wellbeing. On the contrary, living in an affluent country, rich in resources, in a state that prides itself on its multiculturalism and its ability to cater for the diverse needs of its community, all Aboriginal Victorians should feel justified in expecting just that – adequate levels of health. Yet sadly this is not the case.

Today, despite the claims that we live in a ‘lucky country’, and regardless of the expedient political foil that our nation provides ‘a fair go for all’, Aboriginal Victorians suffer a health status that is grossly inferior to that of the wider community. Their current life expectancy remains up to 20 years below that of the rest of the state (Graph 2/ p. 9). Their wellbeing is

⁸ Department of Aboriginal Affairs, ‘Aboriginal Australia’, Canberra, 1988.

⁹ Nili Kaplan-Myrth and Daniel James, ‘Trends in Koori Health Policy in Victoria: Community Report’, Victorian Aboriginal Community Controlled Health Organisation, Melbourne 2002. Many quotes from this document will not be accompanied by page numbers in order to secure anonymity for those who so desire it.

¹⁰ Australian Indigenous Health *InfoNet*, ‘Overview of Australian Indigenous Health 2006’, N. Thomson, J. Burns, S. Burrow, E. Kirov (eds.), Perth, www.healthinonet.ecu.edu.au 2006, p. 1.

comparable to non-indigenous Victorians almost a century ago. And their general health status is akin to that of much poorer countries such as India, Nigeria, Bangladesh and Vietnam¹¹ (Graph 3 / p. 9). Indeed, it is as if there exist two disparate worlds of health within our borders. Morbidity, mortality, longevity, injury, suicide, violence, substance abuse, adolescent pregnancy, hospitalisation rates, drug dependency, and general medical conditions are all reported at a disturbingly higher rate within the Aboriginal community than within the wider non-Indigenous community¹² (Graph 4+5 / p. 10).

Since the 1967 Referendum thankfully abolished the blatant discrimination enshrined in our constitution at federation, the Federal government has had the power to legislate for all Aboriginal people. It has had nearly half a century in which to find an antidote for Aboriginal ill-health. Yet today, our nation is still ranked at the bottom of a league table of wealthy countries working to improve the health of their Indigenous peoples¹³ (Graph 6 / p. 10). While New Zealand, Canada and the U.S. have taken great strides forward in relation to their Indigenous population's health, narrowing their life expectancy gap to seven years, the situation in Australia remains stagnant. The reasons behind this are not complex.

Firstly, the Australian government's failure essentially lies in its historic lack of recognition and commitment to its Indigenous peoples. As the Australian Medical Association affirmed in its latest *Report Card*, Indigenous health remains 'criminally under-funded' regardless of the fact that there still exist significant financial, geographic, personal and cultural mainstream health barriers for them.¹⁴ Secondly, what action has been taken has been unfortunately characterised by 'a paradox of innovation without change'. Governments have come and gone, varying Indigenous departments have been formed, reformed and abolished,

¹¹ Human Rights and Equal Opportunity Commission, 'Social Justice Report 2006', Tom Calma (ATSI Commissioner) N.S.W, Sydney 2006, p. 28.

¹² Australian Bureau of Statistics and Australian Institute of Health and Welfare (ABS & AIHW) 2005/6, 'The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples', Commonwealth of Australia, Canberra, 2005/6.

¹³ OXFAM, 'Australia Behind on Indigenous Health', VACCHO Newsletter, March 2007, p. 1.

¹⁴ Australian Medical Association Report Card Series 2007: Aboriginal and Torres Strait Islander Health 'Institutional Inequity: Not Just a Matter of Money', Accessed: <http://www.ama.com.au> – 12/06/07.

countless strategies have been devised, innumerable policies formulated, numerous reports commissioned, and several international covenants signed, yet the health of Aboriginal Australians remains depressingly static. As one Aboriginal leader noted, ‘we have produced mountains of thinking around Aboriginal Affairs...[but] as the mountains of papers have accumulated...the situation has gone down.’¹⁵ It is truly a paradox. As Aboriginal writer, activist and commentator Mudrooroo concluded in *Us Mob*, “expensive health programs are foisted on us, but the health of our souls is ignored.”¹⁶

The third and ultimate reason behind the government’s failure to remedy the inferior Aboriginal health status is its repeated refusal to engage the Indigenous community in finding a solution. Increasingly, international best-practice reveals that without Indigenous peoples’ input and consultation, government-led health innovations generally fail. Without Indigenous involvement, the sense of powerlessness and mistrust that have pervaded their relationship with government throughout history is perpetuated. As the Chief Justice of the Navajo Supreme Court noted, as long as governments continue to make decisions that affect the lives of Indigenous peoples without consulting them; as long as they “tell them what they can and cannot do¹⁷,” colonialism remains. Self-determination, ownership and control are essential, that is, self-determination in the sense it was originally meant: “Aboriginal people identifying their needs, planning programs to meet those needs, managing projects and assuming responsibility for the outcomes achieved”.¹⁸

This perennial lack of consultation and control is a problem that the Victorian Aboriginal Community Controlled Health Organisation has been attempting to remedy since its

¹⁵ David Tollner (Member for Solomon), ‘Dissenting Remarks’, in House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, *Many Ways Forward: Report of the Inquiry into Capacity Building and Service Delivery in Indigenous Communities*, Parliament of the Commonwealth of Australia, Canberra, June 2004, p. 254.

¹⁶ Mudrooroo, ‘Us Mob. History Culture Struggle: An Introduction to Indigenous Australia’, N.S.W., Angus & Robertson, 1995, p.127.

¹⁷ Robert Yazzie, ‘Indigenous Peoples and Postcolonial Colonialism’, pp. 39-49 in Marie Battiste (ed.), *Reclaiming Indigenous Voices and Vision*, University of British Columbia Press, Vancouver, 2000, p. 46.

¹⁸ Department of Aboriginal Affairs, ‘Submission to the House of Representative Standing Committee on Aboriginal Affairs’. Canberra. 1989.

inception in 1996. Indeed, VACCHO grew out of this necessity for representation and is today recognised by both the community and the State and Commonwealth Governments as the peak body that represents the collective of twenty-five Aboriginal Community Controlled Health Services in Victoria. The organisation has a unique structure in which each of the 25 member services elect two representatives to attend quarterly meetings arranged by the VACCHO secretariat. From this body, a chairperson and an executive board of seven are elected. In this way, the community decides on policy direction and program development, and thus define the organisation and in turn their own future.



19

Most VACCHO members are multi-functional community organisations with health as a key part of their responsibility. The remainder are those offering full health provisions. Each service is unique, and as a whole they are a reflection of the diverse and complex nature of the broader Aboriginal community. Yet, it is not this diversity that drives VACCHO. Rather, it is the community's commonality. Mudrooroo highlights the importance of Indigenous solidarity in *Us Mob*:

¹⁹ VACCHO & The Cooperative Research Centre for Aboriginal Health, 'Communities Working for Health and Wellbeing: Success Stories from the Aboriginal Community Controlled Health Sector in Victoria, Melbourne, VACCHO, 2007.

*...the commonality of Indigenality cannot be ignored or lost sight of. For if each Aboriginal group asserts its individuality and independence then the community will be divided...*²⁰

Ultimately then, VACCHO was born of a desire to bring the entire Victorian Aboriginal community together to ensure it would speak with a united political voice; to end the factionalism that in the past has debilitated the community. As former Executive Officer Karlene Dwyer stated of VACCHO's role, "though we have our differences...the main thing is that we now have the courage to stand together when the need arises..."²¹ Today, the organisation acts as the channel to coordinate statewide Aboriginal opinion and direct Aboriginal health policies. Put simply, its function is to build the capacity of its membership, to advocate for issues on their behalf, to identify priorities for funding, and to ensure communities' health needs are met in a culturally appropriate manner. All efforts are shaped by a philosophy of community initiation, ownership and control.



*The story and philosophy of VACCHO: sitting groups throughout Victoria symbolising the talking that must go on in Communities to achieve a better life for Kooris. The painting depicts tracks, inspired by the old tracks, which represent the connection between VACCHO members and Aboriginal people across Australia. The figures represent VACCHO members working on behalf of all Victorian Kooris.*²²

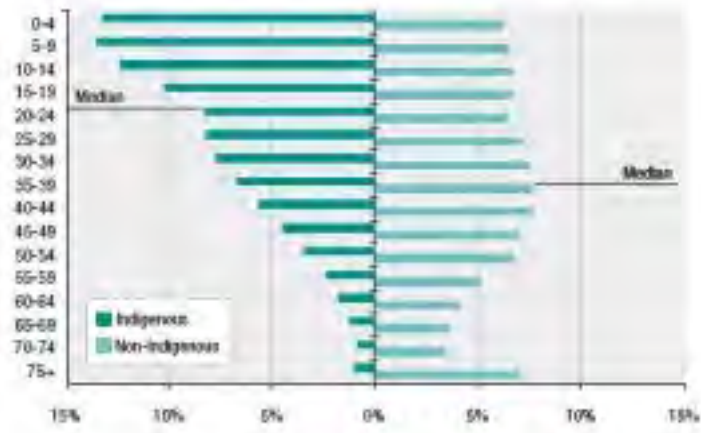
²⁰ Mudrooroo, *Us Mob*, p. 77.

²¹ Rose Ellis, 'Inequalities in Health; The Twelfth National Health Promotion Conference', pp. 25-31, *Aboriginal and Islander Health Worker Journal*, vol. 24, no., 6, Nov/Dec 2000, p. 29.

²² Lyn Briggs (Artist 1997) in VACCHO & The Cooperative Research Centre, *Communities Working for Health and Wellbeing*, p. ii.

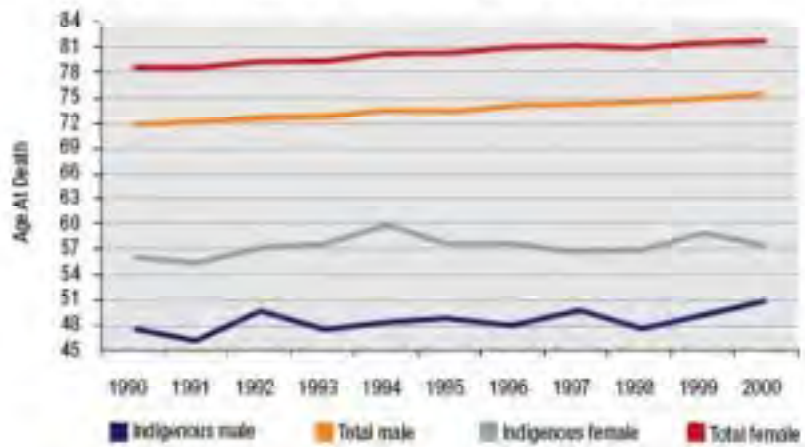
Age Structures Of The Aboriginal And Torres Strait Islander And Non-indigenous Populations

Graph 1

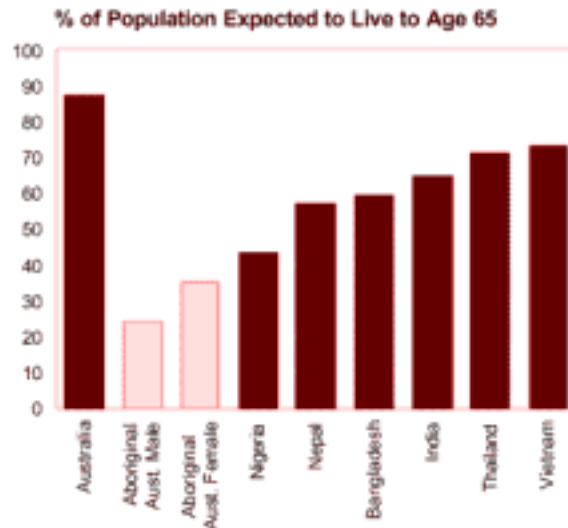


Comparison of Indigenous and Total - Median Ages of Death 1990-2000

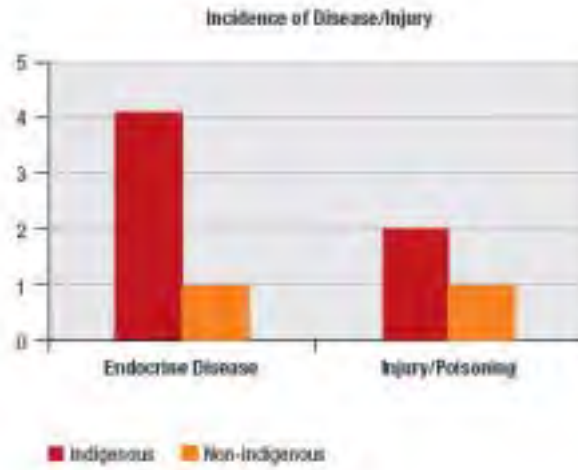
Graph 2



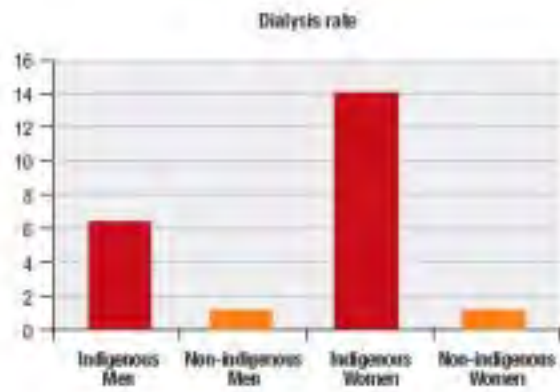
Graph 3



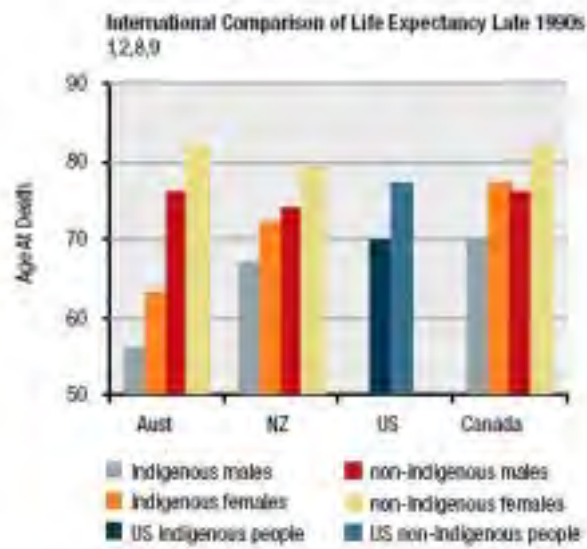
Graph 4



Graph 5



Graph 6



A Schema

Aboriginal Affairs in Australia are multifarious and intensely complicated arenas, and it is the purpose of this thesis to unravel some of this complexity; to detail the history of VACCHO within the overarching framework of colonialism and the Aboriginal struggle for autonomy. The term colonialism is used within to denote the practices, theories and attitudes whereby European societies acquired full or partial political and cultural control of another country, exploited it economically, and subjugated the Indigenous inhabitants. Colonisation was the implementation of this policy.²³ Within this framework it will be argued that improving health for Aboriginal people can only be achieved when they are empowered to act on their own behalf. Beginning in earnest in the early 1970s, the thesis also tracks policy development in the Aboriginal health sector in Victoria - the 'paradox of innovation without change' - and suggests why Aboriginal health has remained static for 40 years. Specifically, it reveals that if the various bureaucratic authorities in Australia had merely listened to, consulted, engaged and supported Aboriginal communities, rather than interfering and often impeding them, then it is probable that Aboriginal health would not be in crisis.

Due to the intricate nature of Indigenous health and health policy development, and also the finite nature of this project, it has not been possible to detail every aspect of the organisation's history, nor the plethora of issues it encompasses. Chapter One outlines the rise of Aboriginal Community Controlled Health Services in Victoria and the varying developments that flowed on from their success. It emphasises the essential nature of the services not only in terms of delivering culturally-appropriate health care, and as sites for community development, but also as a representation of Aboriginal Victorian's desire to define their own future. Chapter Two moves beyond the borders of Victoria and looks at the confluence of national bodies and strategies that eventually gave rise to VACCHO. The

²³ Guido Bolaffi, 'Colonialism', pp. 39-42 in G. Bolaffi, R. Bracalenti, P. Braham and S. Gindro (eds), *Dictionary of Race, Ethnicity and Culture*, London, Sage Publications, 2003, p. 39. – Ellis Cashmore, 'Colonialism', pp. 85-87 in E. Cashmore (ed.), *Encyclopedia of Race and Ethnic Studies*, London, Routledge, 2004, p. 85.

diffuse nature of the situation arising from the *National Aboriginal Health Strategy*, as outlined in this chapter, is a prime example of the complexity of Aboriginal Affairs in this period. Moreover, it underscores the inherent difficulties the Indigenous community face in achieving adequate levels of wellbeing, and the need for effective government collaboration. The final chapter is dedicated to VACCHO and its first four years of operations up to 2000. Its history after this year is well documented, and it would thus be of no benefit to repeat what is already common knowledge. Similarly, this section does not attempt to record all the varying events of that four-year period. Rather, it focuses on the major programs, occurrences, successes, and issues involved in VACCHO's struggle to obtain health equity for Aboriginal Victorians.

Historical investigations have in the past been a one-way process in which researchers have investigated and studied what they wanted, with little or no collaboration or thought of reciprocity for the community. It was with this in mind that the thesis was developed, and thus steps were taken to engage those Aboriginal Victorians who have been involved in the community-controlled sector since its genesis some forty years ago. However, due to a complex and prolonged four-month ethics approval process, I was left with scant chance of interviewing and thus involving those members of the community who should have rightly had far more input in the project than they consequently did. Ironically, the ethics process was to thus have the opposite effect of what was intended.

Fortunately, the several interviews I had time to conduct proved to be a rich and varied historical source. The emotion and candour with which Alma Thorpe talked during our extended two-hour interview provided an invaluable insight into the breadth and depth of the Victorian Aboriginal struggle for respect and wellbeing. In lieu of other personal interviews, the thoughts and impressions of more than 20 prominent Indigenous Victorians who were involved in Aboriginal health over the past four decades (contained in an exhaustive, VACCHO-sponsored oral history project) were available for use in this thesis. They have

proven to be a vital resource. Another veritable trove has been VACCHO's decade of files contained in their overflowing storage unit. Synthesised with the various oral histories, and the long list of community and government reports, studies and evaluations, they form the basis of this thesis.

* * *

CHAPTER 1

A BRICK IN THE ROAD

'25 years ago some elders decided that our people needed a meeting place where we could come and be united. So like animals are drawn to waterholes the people began to come, gathering together like honey ants for there was much work to be done. They fought for self-determination to make decisions on their own, and soon it became more than just a meeting place, for many it was home. Slowly as the years passed by it began to take on shape, triumph and tribulation lying in its wake...good times are still celebrated, hard times still take their toll, but the people have kept walking on to new found waterholes'.

- Aboriginal Community Controlled Health Services Allegory.²⁴

²⁴ Victorian Aboriginal Health Service, 25th Anniversary Video.


The Rise of Aboriginal Community Controlled Health Services

In 1788 Britain cast her Imperial web over Eastern Australia claiming sovereignty and ownership of something that was not hers. This simple declaration locked the original inhabitants of the land into a complex and traumatic relationship with the newcomers, and set in motion the colonial occupation that would ultimately leave Indigenous Australians dispossessed, destitute and pariahs in their own country. Following the violent frontier days, Aboriginal Australians were placed under the control of various ‘protection’ regimes, culminating in the Aborigines Welfare Board in 1957. Despite the benevolence suggested in the successive departments’ titles, each merely acted to bring disorder to the now colonised peoples, straining their ties with their histories, their landscapes, their languages, their social relations and their own ways of thinking, feeling and interacting with the world.

Aboriginal Victorians were not, however, merely passive victims. During those bleak years under what they wryly termed ‘the Destruction Board’,²⁵ they became adept at using the political system and public opinion to resist those who sought to stifle them. In doing so they demonstrated not only their unique inventiveness, but also their ability to react and adapt to their forever-changing environment. Thus, following the abolition of the Welfare Board in 1968, with the Federal Government’s shift from policies of ‘protection’ and assimilation to ‘self-determination’, a new Indigenous leadership arose. Fuelled by the injustices of the past, guided by the political possibilities created by the 1967 Referendum, and supported by the growing political and social consciousness among the general community, the burgeoning Aboriginal leadership ushered in a new era of political activity and cultural reinvigoration. It was in these perhaps frustrating but heady years that Aboriginal Victorians took matters into their own hands and began initiating their own organisations to supply the essential services that governments had failed to adequately provide.

²⁵ Richard Broome, *Aboriginal Victorians*, p. 340.

**RIGHT WRONGS
WRITE
YES**



for

ABORIGINES!

On May 27

Authorised by J. McGuinness, 9 Gough Street, Cairns. Issued by Federal Council for the Advancement of
Aborigines and Torres Strait Islanders.

Leaflet distributed by the Federal Council for the Advancement of Aborigines and
Torres Strait Islanders in the lead up to the 1967 Referendum²⁶

²⁶ FCAATSI, Pic vn311 6836-1x, National Library Australia at www.pictureaustralia.com.au.



Leaflet distributed by the Federal Council for the Advancement of Aborigines and Torres Strait Islanders in the lead up to the 1967 Referendum²⁷

²⁷ FCAATSI, Pic vn312 6836-1x, National Library Australia.

In July 1971, Australia's first Aboriginal Medical Service was established out of a shopfront in Redfern, Sydney. A year later in Melbourne, spurred on by a young female doctor, named Janet Bacon, radical community members such as Bruce McGuinness, Alma Thorpe, Geraldine Briggs and Edna Brown initiated an exhaustive consultation and planning process which resulted in the creation of the Victorian Aboriginal Health Service (VAHS).²⁸ Despite the formation by the then Whitlam Labor Government of a Department of Aboriginal Affairs intended to address Indigenous health, education and employment, both VAHS and the Redfern service were wholly Aboriginal initiatives. That is, their formation did not result in any way from government actions. Rather, they were a response to government indifference, and grew out of the stark reality of the dismal nature of the health and wellbeing of Australia's Indigenous people, and thus the urgent need to provide decent, accessible health services to them. As Margaret Wirrapanda recalls of the situation "...it was devastating, the problems we had...and there didn't seem to be anyone that cared."²⁹ Importantly, it was the Aboriginal community who cared. And it was their aspirations for self-determination and autonomy that would provide the foundations for the Services.

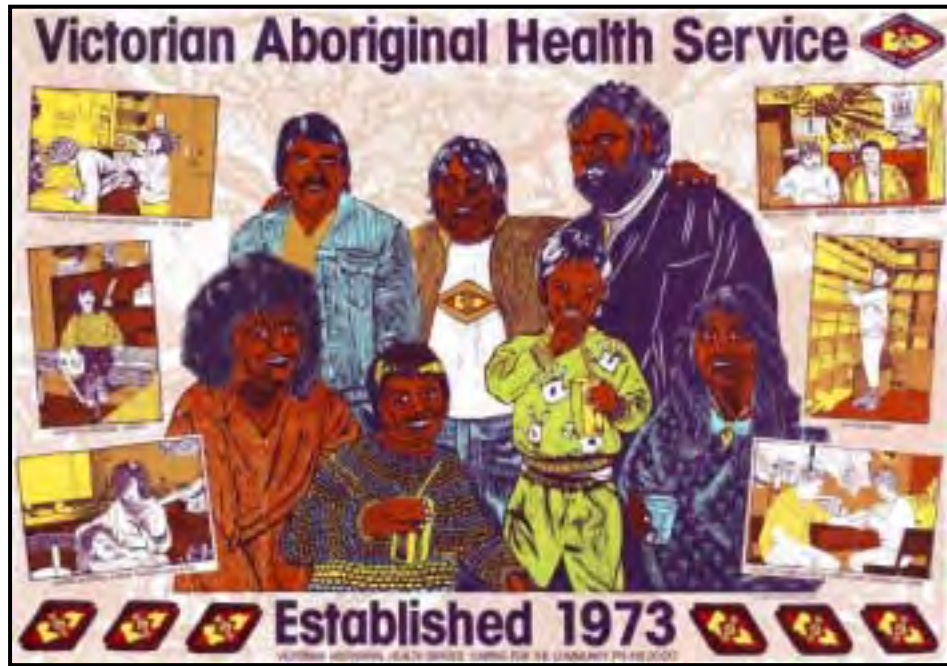


Passing the Buck on Aboriginal Affairs.³⁰

²⁸ VAHS, 'Victorian Aboriginal Health Service Newsletter December 1973', in J. Vickery, A. Clarke & K. Adams (eds), *Nyernila Koories Kila Degaia: Listen up to Koories Speak about Health*, Koorie Heritage Trust Inc, Melbourne University, p. 134.

²⁹ Interview with Margaret Wirrapanda, Victorian Aboriginal Health Service, 25th Anniversary Video.

³⁰ Despite the outward appearances of government assistance, both state and federal bureaucracies merely passed the buck when it came to aiding Indigenous Australians: Alan C. Moir (1974), Pic/9905/9, LOC Drawer 10461-10470, National Library Australia, 2007.



VAHS 1973.³¹

³¹ Kath Walker, 'Victorian Aboriginal Health Service', Australia Way of Life Project, Another Planet Posters, 1986.

The premises VAHS obtained next to the Aboriginal Legal Service at 229 Gertrude Street, Fitzroy, were derelict. “It was a pig-sty,³² a dog house.”³³ With no government funding for its initial eleven months, and then only piecemeal funding thereafter³⁴, the Health Service relied entirely on the community to survive. Regular ‘working-bees’ with would-be clients made the building presentable, and its day-to-day operation was made possible only by those individual community members, and the few radical white doctors, who were willing to work tirelessly in largely unpaid positions.³⁵ As Alma Thorpe recalls of her time at VAHS, “I never actually worked in the health service, I was voluntary. I loved it. I mean that was just the love of my life³⁶.”

VAHS was a success. It arose in response to the needs and strategies of Aboriginal people, was administered by an elected Aboriginal board of management comprised of directors, staff, and elected cooperative members, and had allowed the local community to have a say in its development. In short, VAHS embraced the notion of community-control, the embodiment of the ideal of self-determination, and that is why it succeeded.³⁷ As Bill Roberts, one of the initial VAHS doctors, stated some years ago:

VAHS grew out of people taking action about their own lives to a degree which certainly doesn't happen in the non-indigenous community. Its success is a result of Koori people showing their abilities, their innate strength, in being able to meet their own needs and not be dependent on handouts from white governments. Their struggle has gone from nothing in terms of resources except the people themselves, to an organisation of world standards.³⁸

³² ‘Victorian Aboriginal Health Service Newsletter December 1973’, in J. Vickery, A. Clarke & K. Adams (eds), ‘Nyernila Koories Kila Degaia’ p. 134.

³³ Interview with Jan Chessles, in ‘Victorian Aboriginal Health Service 25th Anniversary Video’.

³⁴ House of Representatives Standing Committee on Aboriginal Affairs, ‘Aboriginal Health’, The Parliament of the Commonwealth of Australia, Australian Government Publishing Service, Canberra, p. 88.

³⁵ Ben Schneiders, ‘How Fitzroy Started an Aboriginal Fight Back’, in ‘The Melbourne Times’, Issue 29, Wednesday, July 28, 2004, p. 8

³⁶ Interview conducted by Michael Hemingway with Alma Thorpe, 22 August, 2007.

³⁷ Ian Anderson, ‘The Powers of Health: The Politics of Self-Determining Aboriginal Health’, pp. 32-37, in *Arena Magazine*, June/July, 1994, p. 34.

³⁸ Interview with Bill Roberts in ‘Victorian Aboriginal Health Service 25th Anniversary Video’.



VAHS's former premises, Gertrude Street, Fitzroy.³⁹



VAHS today Nicholson Street, Fitzroy.⁴⁰



VAHS today, Nicholson Street, Fitzroy.⁴¹

³⁹ Photograph taken by M. Harris, Accessed: www.yarracity.gov.au 11 October 2007.

⁴⁰ Photograph taken by Michael Hemingway, 27 September 2007.

⁴¹ Photograph taken by Michael Hemingway, 27 September 2007.

Though the Service started out as largely a welfare provider, “which also helped people become aware of their health...and their rights⁴²,” by 1979 it had cemented itself as a true community-oriented medical service that provided both an independent and alternative system of health care. It had incorporated the complex notion of holism, which saw health not simply as the physical wellbeing of an individual, but the social, emotional and cultural wellbeing of the whole community,⁴³ and was unique because it was a service determined and delivered by Koories for Koories. In time VAHS, along with the Redfern Medical Service, served as the model for over 150 cooperatives throughout Australia, and inspired international visitors ranging from Canadian First Nation Peoples and Maoris,⁴⁴ to the legendary Mohammad Ali.⁴⁵ At the turn of the decade, VAHS had over 10,000 general medical patients and over 2,500 dental patients.⁴⁶ The fact that many of them viewed the Service as a ‘home away from home’, and believed they would have been “lost, hopelessly lost without it”⁴⁷ is a testament to its success.



Alan Brown with Aboriginal Health Workers at VAHS 1987.⁴⁸

⁴² Alma Thorpe, ‘Personal Communication’, 2007.

⁴³ National Aboriginal Community Controlled Health Organisation, ‘NACCHO Business Plan’, 1996.

⁴⁴ Jack Waterford, ‘Aboriginal Medical Services: A Uniquely Australian Phenomenon’, in *Aboriginal Health Project Information Bulletin*, No. 2, 1982, p. 16.

⁴⁵ Schneiders, ‘How Fitzroy Started an Aboriginal Fight Back’, 2004, p. 9.

⁴⁶ Aboriginal Affairs, *Aboriginal Health*, p. 90.

⁴⁷ Pam Nathan, ‘A Home Away from Home: A Study of the Aboriginal Health Service in Fitzroy’, Preston Institute of Technology, Melbourne, p. 112.

⁴⁸ Patrick McArdell, Pic an23436087, National Library Australia, 18/6/87.

As increasing numbers of *Aboriginal Community Controlled Health Services* (ACCHS) were established throughout Victoria around 1980, it became increasingly apparent that they were more than just effective health care providers. Over time they became a focal point for the community, a place to gather and mingle. It was in this manner that they evolved into important sites where Aboriginal relationships solidified, and where the processes fundamental to the creation of community were sustained. As Indigenous health expert Ian Anderson noted, over the years, in the homely environment of the ACCHS, “Aboriginal people gained a set of transforming experiences vital to their social identity as Aboriginal people.”⁴⁹ Moreover, through employment, engagement, empowerment and social action, ACCHS became key strategic sites for Aboriginal community development. The late Puggy Hunter affirmed this view in 1999: “...the thing is we own the bloody thing...and it is something that I can’t explain – about the ownership and pride it brings”.⁵⁰

Yet ACCHS were not merely about ownership, community development and autonomy. They arose because mainstream facilities had consistently and historically failed Indigenous Australians. And unfortunately the failure persists, the reasons for it being manifold and complex: cultural differences, the injustices of colonisation, and ubiquitous and often subversive racial prejudices. For example, as more than one official document has noted, there are important differences between Aboriginal and non-Aboriginal ways of being.⁵¹ This means there is often a lack of cultural knowledge and sensitivity impeding communication between the health care provider and Indigenous patients. As a result, the very understanding and cultural meanings that inform service provision are often seen by Indigenous Australians as alien and hostile.⁵² As one consultant to the Central Aboriginal Congress suggested in the

⁴⁹ Ian Anderson, ‘Aboriginal Wellbeing’, in Carol Grbich, *Health in Australia; Sociological Concepts and Issues*, Prentice Hall, Sydney, 1996, p. 60.

⁵⁰ Dr Puggy Hunter, ‘Opening Address’, 6th National Rural Health Conference, March 2000, in S. Couzos and R. Murray, *Aboriginal Primary Health Care: An Evidence-Based Approach*, Oxford University Press, Melbourne, 1999, p. 7.

⁵¹ The Royal Commission into Aboriginal Deaths in Custody, ‘Final Report’, Australian Government Publishing Service, Canberra, 1991.

⁵² National Aboriginal Community Controlled Health Organisation, ‘The Failure of Mainstream Services’, NACCHO, 1997, p. 22.

1970s, “it was that the services were *to* the Aborigines, but in no way *of* them.”⁵³ Moreover, Aboriginal Australians have in the past, and still do today, suffer exceedingly high levels of unemployment and disproportionately low levels of education and literacy. This not only means that there are problems associated with acquiring the correct information concerning health and health service access, but also that there are severe financial worries to contend with when considering treatment. Yet, perhaps the most profound problem associated with Indigenous access to mainstream facilities is the continuing issue of discrimination. As the latest Report Card of the Australian Medical Association demonstrated, racist prejudices have been “built into the operations of [Australia’s] social institutions in such a way as to discriminate against, control and oppress various minority groups.”⁵⁴ Thus, Indigenous access to conventional Western medical services, and its provision of health care to Indigenous Australians, has been, and continues to be, both fraught with difficulty and almost wholly inappropriate.

Despite the manifest failure of the mainstream, it appeared evident that neither the state nor the federal government of the 1970s empathised with the need, or Indigenous desire, for Aboriginal-specific organisations. The actions of the *Special Health Services Section* (SHSS), an Aboriginal health unit established by the state government in 1974 to pay ‘special attention’ to Indigenous health needs, underscored this fact.⁵⁵ The Unit’s questionable funding allocations, and its lacklustre planning and consultation processes, led the Aboriginal Health Report of 1979 to state that its approach “could be claimed to illustrate a lack of genuine support for programs designed to improve the health of Aborigines in their state.”⁵⁶ Moreover, when the department did bow to the inevitable outside pressure and trickle some funds into the ACCHS, there was generally a long list of provisos attached which robbed organisations of flexibility and valuable resources.

⁵³ Jack Waterford, ‘Aboriginal Medical Services’, p. 16.

⁵⁴ Australian Medical Association, ‘Inequity, Not just a Matter of Money’, 2007, p. 4.

⁵⁵ Aboriginal Affairs, ‘Aboriginal Health’, p. 82.

⁵⁶ *Ibid.*

Furthermore, the fact that SHSS staff erroneously labelled the Service a ‘militant black power group’ and questioned why Aborigines should receive ‘preferential treatment and privileges beyond those granted to other people’,⁵⁷ highlights the lack of understanding and recognition of the consequences of colonisation, and moreover, the need for Aboriginal community-controlled services. Propelled by such antiquated and apathetic government thinking, VAHS and the other Victorian community-controlled organisations soon became openly, and necessarily, political.

Decade of Forums and Peak Bodies

In July 1974, the Department of Aboriginal Affairs convened a national workshop of community-controlled health services and associated State and Commonwealth government health units. It was a seminal gathering which resulted in a number of influential developments, not the least of which was the establishment of mechanisms that aided ACCHS in dealing with the complex problems they faced with government agencies in their struggle for survival. Held in Albury, NSW, the *Workshop on Aboriginal Medical Services* acted as a forum in which the varying ACCHS could exchange experiences, discuss the provision of health services for other communities, and provide suggestions for training programs.⁵⁸ The community representatives seized the opportunity the workshop presented, claiming that despite popular opinion, Indigenous Australians were still ‘being suppressed by the last vestiges of colonialism’, and that governments were continually failing to recognise and foster the untapped talents and skills of their people.⁵⁹ Importantly, they also called for greater Aboriginal control at the ‘grass-roots level’, a call that would in time become the community’s mantra.

⁵⁷ Pam Nathan, ‘A Home Away from Home’, pp. 99-101.

⁵⁸ Australian Department of Health 1974, ‘Workshop on Aboriginal Medical Services Albury New South Wales, 5-7 July 1974’, Australian Department of Health, Canberra, pp. 31-42.

⁵⁹ *Ibid.*, pp. 18-27.



*The etchings on the outer represent Aboriginal organisations and Community Health Services working together throughout Victoria to achieve Aboriginal wellbeing. The people/family in the centre represent the Victorian Aboriginal population. They are surrounded by message sticks that signify the exchange of health messages.*⁶⁰

⁶⁰ Eileen Harrison (artist), Accessed: www.health.vic.gov.au

The associated community representatives also recommended the establishment of an organisation that would facilitate greater cooperation between the services, channel expertise and material assistance to Aboriginal communities, and provide them with a national voice. The organisation was to have one elected member of each State and Territory, elected from a regional assembly, which in turn would be elected by a local health-focused community. Thus, following exhaustive discussions, a national umbrella organisation made up of ACCHS was established in 1974. Some community representatives voiced a concern that the organisation was merely an attempt to impose a black bureaucracy on Aboriginal people. However, to most it appeared to be a positive and 'concrete step towards Aboriginal self-determination'.⁶¹ The peak body was named the *National Aboriginal and Islander Health Organisation* (NAIHO), and in the context of VACCHO's history, was to be a decisive development. After VAHS established the need for such an organisation, NAIHO was to be the first brick in the road to its realisation.

During its fifteen-year lifespan NAIHO proved to be an essential medium through which the Indigenous community publicised the economic, social and political aspects of Aboriginal health. From the very beginning, the organisation tirelessly lobbied the Commonwealth government to adequately fund community-controlled services, which at the time were seeing government departments receive the lion's share of available monies and resources. For example, in 1978/9, of the approximately \$18 million set aside annually by the Department of Aboriginal Affairs for Aboriginal health, less than \$4 million went to community services, the remainder going to the state health bodies.⁶² This was despite the fact that during that two-year period there were three major, independent studies which clearly stated that ACCHS were the most effective means of delivering primary and preventative health care to Aboriginal people.⁶³

⁶¹ Australian Department of Health 1974, 'Workshop on Aboriginal Medical Services', pp. 32-33.

⁶² Aboriginal Affairs, 'Aboriginal Health', 1979.

⁶³ The Commission Enquiry into Poverty, Third Main Report / The National Trachoma and Eye Health Programme / Aboriginal Health.

In 1979/80, in response to inadequate government funding arrangements, NAIHO developed the *National Black Health Plan*. The strategy wisely foresaw specific future developments and needs in the Aboriginal community-controlled health sector, by calling for a far larger slice of the existing Aboriginal health resources and facilities, and for the number of ACCHS to be more than doubled.⁶⁴ Moreover, it rightly stated that if the plan were to be implemented, the frequently stated government policy of self-determination would have to become a reality.⁶⁵ Unfortunately, the plan was largely ignored by the Fraser Liberal Government, setting what would become a precedent for government responses to Aboriginal devised strategies in the future. It is of little surprise then, that NAIHO only received government funding in 1983, nine years after it was founded. This was also the first year that the federal government sought the organisation's expertise and advice on Indigenous health.⁶⁶

A further critical development that arose from the 1974 Albury Workshop was the formation of NAIHO regional affiliates. After six months of operation by the national body, the *South Eastern Aboriginal and Islander Health Organisation* (SEAIHO) was established by and for the representatives from ACCHS from southern NSW, Victoria and Tasmania.⁶⁷ Though SEAIHO today is rarely remembered let alone mentioned, it was nevertheless a critical organisation. It provided an important platform and voice in the region, offered a template for future community action, and presented a channel through which VAHS was able to establish the highly innovative Koori Kollij and the *Aboriginal Health Worker* (AHW) training program.

⁶⁴ Anderson and W. Sanders, 'Aboriginal Health and Institutional Reform within Australian Federalism', No. 117, Canberra, CAEPR, ANU, p. 8.

⁶⁵ Bruce McGuinness, Gary Foley, Bill Roberts, 'Foreword', in Pam Nathan, *A Home Away from Home: A Study of The Aboriginal Health Service in Fitzroy*, 1979.

⁶⁶ Department of Aboriginal Affairs, 'Annual Report 1982-1983', Australian Government, Canberra, 1983.

⁶⁷ Interview conducted by Michael Hemingway with Alma Thorpe, 22 August 2007.

Using the forum that SEAIHO provided, and with assistance from NAIHO, members of VAHS initiated discussions with Aboriginal communities throughout southern NSW, Victoria and Tasmania to formulate a curriculum and selection criteria for the proposed AHW training. For seven years following the completion of the curriculum, the program coordinators petitioned the Commonwealth and Victorian governments for funding. Each year their calls went unanswered, the *Department of Aboriginal Affairs* (DAA) claiming it 'had no available monies for new initiatives'.⁶⁸ This was despite the fact that a year later the DAA funded its Head of Health, Kerry Wisdom, to travel throughout Australia to consult communities on the creation of a *government-run* health worker training course.⁶⁹ Nevertheless, the community persisted, and in 1981 VAHS received a grant from an 'anonymous trust fund' to finance the first year's operation. In January 1982, Australia's first community-controlled AHW training program commenced, with Alan Brown (VACCHO's first CEO) appointed as its coordinator.

The AHW training program drew on other health initiatives such as China's 'Barefoot Doctors' and the World Health Organisations 'Primary Health Workers'. Each of the twenty individuals who completed the nine months of intensive training was selected by their respective communities as the person who would in the future return to be their 'health resources person'. A former course tutor, Mudrooroo, attributed the program's success to the practice of community-control and holism, emphasising the need for participation of Indigenous people in its design, development and delivery, and holding to the belief that health problems were related to the wider economic, political and cultural problems.⁷⁰ Moreover, the fact that many of the initial students later became instrumental in cultivating and sustaining many of the ACCHS that appeared during the decade, attests to its resounding achievements. By 1984, the Kollij had become so successful that it was

⁶⁸ Alan Brown, 'Introduction', in *Ninini News: 'Health Worker Training Program, Certificates of Graduation'*, Melbourne, VAHS, 1982.

⁶⁹ 'By Blacks for Blacks' in *Ninini News: 'Health Worker Training Program, Certificates of Graduation'*, Melbourne, VAHS, 1982.

⁷⁰ Mudrooroo, *Us Mob*, p. 137.

inundated with prospective students from across Australia. The Hawke Labor government was duly impressed, back-flipping on its original decision and granting the Kollij the funding it so desperately required. However, after eight years the government withdrew its annual funding claiming that there were not enough students enrolled.⁷¹ At the time, Alan Brown angrily maintained that there were 120 students expected to apply for the next round of courses. Without funding, the program soon folded.



The first twenty students to pass the AHW Training Program 1982.⁷²



The inaugural Koori Kollij class, 1982.⁷³

⁷¹ 'Koori Kollij', in Snapshot of Aboriginal Fitzroy, Yarra City Website, Accessed: <http://www.yarracity.gov.au> - 20/06/07.

⁷² 'Ninini News: 'Health Worker Training Program, Certificates of Graduation'', Melbourne, VAHS, 1982.

⁷³ Ibid.

CHAPTER 2

A GREAT STRIDE FORWARD

'I sit on a man's back, making him carry me, and yet I assure myself that I am sorry for him and wish to lighten his load by all means possible, except by getting off his back' ...The answer that we propose to this dilemma is the immediate recognition of Aboriginal rights.

- NAIHO Collective 1982.

The Emergence of the Health Strategies

In September 1980, following a survey of children under the age of five in the Shepparton area, further steps were taken toward enhancing the community-control sector.⁷⁴ The survey report, which highlighted the appalling health of Indigenous Victorians, led the state's Liberal Minister of Health, Mr Borthwick, to meet with representatives of Victoria's ACCHS in order to devise concrete solutions to Aboriginal ill-health. Thus, a *Working Party on Aboriginal Health* was formed. Comprised of ACCHS representatives, the party submitted its report in May 1981 after six months of intensive community consultations by a sub-committee. It was a carefully devised and detailed plan, which amongst other things sang the virtues of community control, consultation, and Aboriginal involvement in decision-making. It noted the essential nature of Aboriginal Health Workers (a recommendation that aided Koori Kollij to secure the funding mentioned above), and highlighted the failure of mainstream services, the abuses inflicted under colonisation, and the links they both had to the ill-health of Aboriginal Victorians. Above all, the report called for Aboriginal participation in policy development and the need for both the state and federal governments to "trust and support"⁷⁵ the community, and to once and for all "positively discriminate towards Aboriginal people in line with the principle of priority needs."⁷⁶



77

⁷⁴ Koori Health Unit, 'Koorie Health in Koorie Hands', Health Department of Victoria, Melbourne, 1988, p. 123.

⁷⁵ The Working Party on Aboriginal Health, 'Working Party Report', Aboriginal Health Section, Health Commission of Victoria, Melbourne, 1981, p. 38.

⁷⁶ Ibid., p. 20.

⁷⁷ Geoff Pryor, PIC 3700/211 Loc Drawer 9311-9340, National Library of Australia, 2007.



78

⁷⁸ Alan C. Moir, PIC 8516/107 LOC Drawer 9271-9280, National Library of Australia, 2007.

Like many other Aboriginal-controlled initiatives, the Working Party was a success. It convinced the Fraser Liberal Government to redirect funds from the Victorian Health Commission to establish the much-needed, community-controlled organisations in places like Morwell, Bairnsdale, Shepparton and Robinvale.⁷⁹ It also initiated what in many respects could be labelled the forefather of VACCHO - the *Aboriginal Health Resources Consultative Group* (AHRCG) - a body comprised of representatives from all ACCHS, the Health Liaison Unit of the Health Commission, the National Aboriginal Council, the DAA and NAIHO. It operated from the Koori Health Unit under the guidance of Kevin Coombes after he became its first Koori manager in 1982.⁸⁰ The Group met on a quarterly basis and guided the DAA on funding priorities and assisted the Victorian Minister of Health with the development of policy.⁸¹ It was an important development in Aboriginal Health because it was the first time that the community had direct access to the Minister and other sections of the Department of Health. As one original member Lyn McInnes recalls of the Resources Group, “we stood together as one, united...[and] fighting for the rights of our people...we really challenged the government.”⁸²

As before, the success of the AHRCG rested on the shoulders of community leaders who were not only willing to work assiduously in unpaid positions, but who were also brave enough to stand up for what they believed they deserved. Jim Berg, the chairperson of the Group and “a pretty outspoken type of bloke”,⁸³ was one of these people and was assisted by others such as Gary Foley, Alma Thorpe, Bruce McGuinness and Bill Roberts. The Group’s achievements were not always grandiose, but they were always significant. One example was Cummeragunja, a former Aboriginal reserve just over the NSW border where Aboriginal people ‘were doing it hard’. “It was the pits,” recalled one member, “the

⁷⁹ Interview with Kevin Coombs in Vickery, Clarke & Adams (eds.), in ‘Nyernila Koories Kila Degaia’, p. 80.

⁸⁰ The Working Party on Aboriginal Health, ‘Working Party Report’, p. 18

⁸¹ Parliamentary Debates Representatives, 3rd Parliament, 1st Session, 3rd Period, vol. H. of R., 1227 -2554, 23 March – 6 May, 1982, p. 127.

⁸² Interview with Kevin Coombs in Vickery, in Clarke & Adams (eds), ‘Nyernila Koories Kila Degaia’, p.101.

⁸³ Interview conducted by Michael Hemingway with Anonymous Participant, August 2007.

sewerage system had broken and each house had raw sewerage running through it, the children were playing in the filth.”⁸⁴ The Resources Group put pressure on the NSW government and the problem was fixed. Not long after Cummeragunja received funding to provide it with adequate infrastructure.

In the late 1980s the AHRCG was abolished. Some say it was due to the community not being able to always speak with a uniform voice⁸⁵ - “...we don’t always agree...black fellas are different nations, a nation of nations.”⁸⁶ Others attribute its demise to the fact that the community wanted the organisation out of the government’s hands, wanted unequivocal control - “we had to do deals [with the government as part of the AHRCG]...that was part of the funding criteria... and that was a hard thing to bear because we could have been autonomous and more proactive.”⁸⁷ Whatever the reasons, it was clear that the decision was influenced by the ATSI Act of 1989 and the completion of the National Aboriginal Health Strategy the following year.

Up until the late 1980s there had been no agreed national plan for Indigenous health, nor had there been the coordinating mechanisms or data available to ensure or measure the success of such a plan. With this in mind, Commonwealth, State and Territory Ministers for Aboriginal Affairs agreed to establish the *National Aboriginal Health Strategy Working Party* (NAHSWP) at a meeting in December 1987. The NAHSWP was chaired by Naomi Myers, the administrator of the Redfern ACCHS, and comprised 19 members, fourteen of whom were Aboriginal or Torres Strait Islanders. It was an historic development in Indigenous health because it was the first time that a national strategy had been developed in

⁸⁴ Interview with Kevin Coombs in Vickery, Clarke & Adams (eds), ‘Nyernila Koories Kila Degaia’, p. 81/2

⁸⁵ Interview with Anonymous Participant in Kaplan-Myrth and James, ‘Trends in Koori Health Policy in Victoria’, p. 108.

⁸⁶ Interview with Alma Thorpe conducted by Michael Hemingway, 22 August 2007.

⁸⁷ Interview conducted with Anonymous Participant by Michael Hemingway.

consultation with Indigenous communities.⁸⁸ Amongst other things the Working Party was to report on community funding arrangements, and to develop strategies to improve not only Indigenous health, but also to maximise the involvement of Aboriginal people in those strategies, something the community had been haplessly advocating for years.⁸⁹ Tabled in 1989 at a Joint Ministerial Forum in Burnie, the *National Aboriginal Health Strategy* (NAHS) emphasised the ongoing role ACCHS played in the delivery of holistic, preventative and curative health care. It also lambasted the all-too-familiar government inter-departmental responsibility-shifting approach, by calling for a more comprehensive whole-of-government approach.⁹⁰

Importantly, the NAHS Working Party also recommended that a *Council for Aboriginal Health* (CAH) comprised of ACCHS, and State and Commonwealth governments be established. The Council's role was to implement the Strategy, counter the problems associated with the intersectoral allocation of government responsibility, develop specific strategies, and advise government on health policy.⁹¹ State affiliates of the CAH were also to be created in the form of tripartite forums to replace the Aboriginal Health Resource Consultative Groups, which the Working Party deemed did not have effective Commonwealth representation.⁹² Theoretically, both bodies were meant to form a real and equal partnership between community and government in which there would be a willingness for each partner to be influenced by the other, as outlined in the NAHS. A final recommendation was for a specialised health branch - the *Office of Aboriginal Health* (OAH) – to be established within the newly formed *Aboriginal and Torres Strait Islander*

⁸⁸ Neil Thomson & Bruce English, 'Development of the National Aboriginal Health Strategy', pp. 22-30, in N. Thomson & B. English (eds), *Aboriginal Health Information Bulletin*, no. 17, May 1992, The Australian Institute of Health and Welfare, Canberra p. 22.

⁸⁹ National Aboriginal Health Strategy Working Party, 1989, 'A National Aboriginal Health Strategy', NAHSWP, Canberra, (reprint) 1996, p. xix.

⁹⁰ *Ibid.*, pp. xxii, 35, 102 – 110.

⁹¹ NAHSWP, 'A National Aboriginal Health Strategy', pp. 36-40.

⁹² *Ibid.*, pp. xx – 36-40.

Commission (ATSIC), a statutory body formed so as to ‘include Indigenous people in the processes of government that affect their lives’.⁹³

Debilitating Factionalism and a Continuing Lack of Consultation

Unfortunately, the principle of partnership and community participation elicited in the NAHS was undermined from the outset. At the Ministerial Forum in Burnie, an *Aboriginal Health Development Group* (AHDG), comprised almost wholly of government nominees, was established to review the implementation of the strategy. Only one representative of the ACCHS sector, Naomi Myers, was included.⁹⁴ Community-controlled organisations were understandably dismayed at the lack of Aboriginal participation, and consensus soon broke down.⁹⁵ To allay the fears of the ACCHS, or perhaps merely to placate them, an *Aboriginal Community Advisory Group* (ACAG) comprised of representatives of ACCHS was formed alongside the Development Group. However, of the two implementation reports completed by the respective Groups, in which there were marked differences in approach and recommendations, only the AHDG’s was wholly considered at the meeting of Ministers in Brisbane in 1990. It was agreed that the NAHS was to be implemented and the Council for Aboriginal Health, its state affiliates, and the Office of Aboriginal Health be created.⁹⁶ This final recommendation – to form a health body within ATSIC - was to make the Indigenous health situation even more diffuse and complicated than it already was. Not only did ATSIC “lack the expertise in health systems, planning and policy development”⁹⁷, but it was also evident that the relationship between itself and the proposed Aboriginal health bodies was not fully considered. In time, this would prove fatal for the CAH and its state affiliates, and in hindsight would have been perhaps best left dormant.

⁹³ Aboriginal and Torres Strait Islander Council, ‘ATSIC at a Glance’, Woden, ACT, 1990.

⁹⁴ Aboriginal Health Development Group 1989. ‘Report to Commonwealth, State and Territory Ministers for Aboriginal Affairs and Health’, Aboriginal Health and Development Group, Canberra, p. 1.

⁹⁵ Anderson and Sanders, ‘Aboriginal Health and Institutional Reform’, p. 12.

⁹⁶ Joint Ministerial Forum of Ministers for Aboriginal Affairs and Health, ‘National Aboriginal Health Strategy Resolutions’, Aboriginal and Torres Strait Islander Commission, Canberra, 1994, pp. 1-5.

⁹⁷ S. Gordon, (Chairman), ‘The National Aboriginal Health Strategy: An Evaluation’, Aboriginal and Torres Strait Islander Commission, Canberra, 1994, p. 31.



The reasons behind the failure of ATSIIC are complicated and diffuse. Needless-to-say, it did not achieve its desired ends.⁹⁸

⁹⁸ Geoff Pryor (1996), PIC 9195/299, LOC Drawer 10041-10050, National Library Australia, 2007.

The under-utilised Community Advisory Group's implementation report had stated that 'the communities were gravely concerned for the future implementation of the strategy if...community participation was passed over'.⁹⁹ Perhaps to allay their fears once again, the Federal Labor Government's Aboriginal Affairs Minister, Robert Tickner, when announcing the implementation of the NAHS, stated that 'a cornerstone of the strategy [would] be the unprecedented involvement of Aboriginal people...'¹⁰⁰ Before long, however, the community was expressing considerable dissatisfaction with their *lack* of involvement, which largely arose out of the role ATSIC was to play in its implementation.



Tickner 'putting on a show' for Aboriginal Australians who know more than what he perhaps believes they do.¹⁰¹

For example, there were lengthy delays in convening the CAH and its state affiliates (in Victoria, the *Tripartite Council of Koori Health*), and the community attributed the tardiness to the processes adopted by ATSIC to appoint community membership. The protocol was perceived as denying appropriate community participation in the selection process and

⁹⁹ Community Advisory Group 1990, 'Report on the Implementation of the National Aboriginal Health Strategy Working Party Report', Canberra, Neil Thomson & Bruce English, *Development of the National Aboriginal Health Strategy*, p. 30.

¹⁰⁰ Thomson & English, 'Development of the National Aboriginal Health Strategy', p. 30

¹⁰¹ Geoff Pryor, PIC 9195/11 LOC Drawer 10011-10020, National Library Australia, 2007.

considered an imposition of defacto Commonwealth control on the Council.¹⁰² Thus, when ATSIC assumed control of the Health Strategy funding in 1992 and became the funding channel for all ACCHS, the relationship between the two bodies was stretched to breaking point.¹⁰³ For unknown reasons, ATSIC failed to pursue formal agreements with the states to secure matching Commonwealth funding.¹⁰⁴ As a result, the ACCHS were thrown into direct competition with the housing and infrastructure related Aboriginal organisations, which were receiving more than three quarters of the Strategy's budget.¹⁰⁵

There was further discontent amongst the community as many believed the funding allocated to the Strategy was inadequate. As one official report noted, it was less than a fifth of that estimated as being needed by the Development Group.¹⁰⁶ With the tide of resentment and disenchantment rapidly rising, the disgruntled ACCHS sector swiftly took action through their national body (NAIHO), which in 1993 was renamed the National Aboriginal Community Controlled Health Organisation (NACCHO). NAIHO's name change not only reflected the diverging needs and aspirations of Torres Strait Islander's, but also the peak body's new direction: a shift from broad political activism to a far more tightly focused health policy, advocacy and service delivery approach.¹⁰⁷ For the next two years, NACCHO unremittingly lobbied the government to have its members' funding taken out of ATSIC, claiming that it was ATSIC which was largely to blame for the failure to implement the Strategy. Their claims were not unfounded. As an evaluation demonstrated some years later, the NAHS 'was never effectively implemented'.¹⁰⁸ Moreover, a review of the CAH conducted in 1993 stated that "ATSIC and Commonwealth Ministers [had] demonstrated a

¹⁰² Briefing Paper, 'Council for Aboriginal Health', Attachment B in Codd, (Principle Reviewer), *Developing A Partnership: A Review of the Council for Aboriginal Health*, Commonwealth Government, Canberra, 1993, p. 1.

¹⁰³ Aboriginal And Torres Strait Islander Council, 'Annual Report' 1991-1992, Woden, ACT, 1992.

¹⁰⁴ Anderson and Sanders, *Aboriginal Health and Institutional Reform within Australian Federalism*, pp. 12-13.

¹⁰⁵ Gordon, 'The National Aboriginal Health Strategy: An Evaluation', pp. 50-51.

¹⁰⁶ The Royal Commission into Aboriginal Deaths in Custody, 'Final Report', Australian Government Publishing Service, Canberra, 1991.

¹⁰⁷ NACCHO, *Business Plan 1993-1997*, National Aboriginal Community Controlled Health Organisation, pp.1-8.

¹⁰⁸ Gordon, 'The National Aboriginal Health Strategy: An Evaluation', p. 3.

distinct lack of will to overcome the problems”¹⁰⁹ involved with the creation of the CAH and thus the implementation of the NAHS.

* * *

In 1993, Paul Keating stood in Redfern Park, the birthplace of Australia’s first ACCHS, and addressed the throng of Indigenous and non-Indigenous Australians who had assembled for the launch of the International Year for the World’s Indigenous Peoples. In his speech, Keating talked optimistically about the formation of the Reconciliation Council, ATSIC, and the role both bodies would play in creating a better future for Indigenous Australians. He unashamedly put before Australians the truth about the past and asked the nation’s people to open their hearts and reach out to Australia’s Indigenous peoples ‘as Australia had once reached out to their ancestors’. He asked the nation to give meaning to the words justice and equity:

*We simply cannot sweep injustice aside...It might help if we non-Aboriginal Australians imagined ourselves dispossessed of land we have lived on for 50 000 years, and then imagine ourselves told that it had never been ours; imagine if we had suffered the injustice and then were blamed for it. It seems to me that if we can imagine the injustice then we can imagine its opposite. And we can have justice.*¹¹⁰

No Australian leader had stated the truth as baldly as Keating did that day. Unfortunately, the hope he assigned to the process of Reconciliation and the creation of ATSIC were not to become a reality. By 1994, both the CAH and the Victorian Tripartite Council of Koori Health (VTCKH) would cease to exist. Despite their short life span, both were important bodies. The purpose of the tripartite forum was to promote the implementation of the National Aboriginal Health Strategy and to play a role in strategic planning at the state level. It had a membership of every ACCHS and community organisation that had a health focus or

¹⁰⁹ Briefing Paper, ‘Council for Aboriginal Health’, p. 2.

¹¹⁰ Paul Keating, ‘Launch of the International Year for the World’s Indigenous Peoples Speech’, 1993 in www.keating.org.au.

any health related program, and also assumed service delivery functions, which at the time were being devolved from the Koori Health Unit.¹¹¹ As one community member recalls, the Council was about linking the State, the community and the Commonwealth and trying to coordinate the funding to deliver the resources in an appropriate way – “it was about trying to make the government responsible.”¹¹²

Unfortunately, the VTCKH was in many ways doomed from the beginning. Its review (tabled in early 1993), which came within the confines of the evaluation of the CAH, had been intended from its inception and was supposed to have been conducted after the second year of its operations. However, because the first meeting of the CAH was convened 22 months late, and because ATSIC had declined on spurious grounds to convene any further meetings after only the CAH’s second engagement in June 1992,¹¹³ the review should have in fact only taken place some time in late 1994.¹¹⁴ That is, there was little time for the state or national Councils to be truly operational. Moreover, both the community and various state government service providers were justifiably concerned at the manner in which the Commonwealth government had instituted the review. It had in effect unilaterally established the review team, comprised wholly of government nominees, once again without community involvement.¹¹⁵

Interestingly, the review stated that VTCKH had been ‘improving substantially’ since its inception. So why was it abolished? Firstly, it ‘lacked support’ from both its national partner and ATSIC. Specifically, the factionalism and ineffectiveness of these bodies proved insurmountable for the state affiliate. Secondly, the tripartite’s structure was largely

¹¹¹ Ian Anderson, ‘The National Aboriginal Health Strategy’, pp. 119-135, in Heather Gardner (ed.), *Health Policy in Australia*, Oxford University Press, Melbourne, p. 129.

¹¹² Interview with Daphne Yarram, in Kaplan-Myrth and James, ‘Trends in Koori Health Policy in Victoria’, VACCHO.

¹¹³ Regardless of the fact that it lacked the Secretariat support from ATSIC, the Council did meet a third time in Perth on 7 February 1993 in conjunction with a national meeting of ACCHS: Briefing Paper, ‘Council for Aboriginal Health’, Attachment B in Codd (Principal Reviewer), *Developing A Partnership; A Review of the Council for Aboriginal Health*, Commonwealth Government, Canberra, 1993.

¹¹⁴ *Ibid.*, pp. 1-4.

¹¹⁵ *Ibid.*

unworkable. Placing all community-controlled health organisations into one forum was a novel concept considering the holistic approach of the ACCHSs, yet it was overly ‘cumbersome’. As one participant recalls, the government had tried to place everything under one banner...and in the end it lacked the teeth to actually do anything.”¹¹⁶ Moreover, as attested to by more than one of the tripartite’s members, the community saw the forum as being an unequal partnership.¹¹⁷ ‘Junior’ government representatives were sent to the meetings rather than the decision makers, which is ironic considering that it had been for these very reasons that the tripartite’s predecessor, the Consultative Group, had been abolished and the tripartite established. Finally, it appeared that the government didn’t truly recognise the forum as the peak body to address Indigenous health issues within the state. This was evidenced in the evaluation of the NAHS, which stated that the tripartite forum lacked significant ‘political support’.¹¹⁸ It was further highlighted by numerous complaints by members that they were merely presented with lists of projects to rubber stamp.¹¹⁹ As one participant said of the government’s involvement, “they still believed they knew what was best for the blackfellas...it was more a paternalistic operation.”¹²⁰

In July 1995 responsibility for Indigenous health was transferred from ATSIC to the *Office of Aboriginal and Torres Strait Islander Health* (OATSIH), which had been established the previous year by the recently reformed *Commonwealth Department of Human Services and Health*.¹²¹ ATSIC was however to maintain a role in health matters in the future. That same year OATSIH established the *National Aboriginal and Torres Strait Islander Health Council* (NATSIHC), the successor of CAH. Its membership consisted of eight NACCHO representatives, three ATSIC representatives and representatives of the Torres Strait

¹¹⁶ Interview with Paul Briggs, in Kaplan-Myrth and James, ‘Trends in Koori Health Policy in Victoria’, VACCHO.

¹¹⁷ Interview with Jim Berg, in Kaplan-Myrth and James, ‘Trends in Koori Health Policy in Victoria’, VACCHO, and Interview with Lyn McInnes in Vickery, Clarke & Adams (eds), ‘Nyernila Koories Kila’, Degaia p. 75

¹¹⁸ Gordon, ‘The National Aboriginal Health Strategy: An Evaluation’, p. 31.

¹¹⁹ M. Codd, (Principal Reviewer), ‘Developing A Partnership; A Review of the Council for Aboriginal Health’, Commonwealth Government, Canberra, 1993, p. 32.

¹²⁰ Interview with Anonymous Participant, in Kaplan-Myrth and James, ‘Trends in Koori Health Policy’, 2002.

¹²¹ Office of Aboriginal and Torres Strait Islander Health 2007. Accessed at <http://www.health.gov.au/oatsih>.

Regional Authority and other various national health bodies.¹²² All that remained was for the creation of a state body to replace the Victorian Tripartite Council of Koori Health.

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¹²² Ian Anderson, 'The Framework Agreements: Intergovernmental Agreements and Aboriginal and Torres Strait Islander Health', pp. 254-272, in M. Langton, M. Tehan, L. Palmer and K. Shain (eds), *Honour Among Nations? Treatise and Agreements with Indigenous Peoples*, Melbourne University Press, Carlton, 2004, p. 264.

CHAPTER 3

A FOOT IN THE DOOR

It is not merely a matter of the provision of doctors, hospitals, medicines. Health to Aboriginal peoples is a matter of determining all aspects of their life including control over their physical environment, of dignity, of community self esteem, and of justice

- National Aboriginal Health Strategy Working Party 1989.

Health does not simply mean the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole community. For Aboriginal people this is seen in terms of the whole of life view incorporating the cyclical concept of life – death – and the relationship to the land. Health care services should strive to achieve the state where every individual is able to achieve their full potential as a human being of their community.

- NACCHO 1993.

Each community needs its own community based, locally owned, culturally appropriate and adequately resourced, primary health care facility. That is our right.

- VACCHO 1996.

VACCHO: Incorporation and Capacity Building

The issues were 1) listen to us 2) we have a right to good health 3) we have rights as people 4) we have a right to decide what we want...So we really needed to get it together, we needed a unified front on Aboriginal Health issues in Victoria...Strength in numbers, twenty-five health services representing thirty thousand Aboriginal people. You have got to listen; you can't play one against the other. Solidarity was needed.

– Alan Brown: VACCHO's genesis.

123

In 1996 the Howard Liberal Government was elected and in many ways Aboriginal Affairs was to take 'two steps backward'.¹²⁴ Over the thirteen preceding years, the Labor Party, under Hawke and Keating, had made significant advances in the Aboriginal sector. Government spending had steadily risen, ATSIC was created, Uluru was handed over to traditional owners, the Native Title Act was pushed through, and the Native Title Tribunal was established. While Aboriginal



health and living conditions remained static, and many promises were left undelivered, the Labor Party would prove to be far more supportive of Indigenous Australians than the incoming Liberal Party. It would soon become apparent that the new government's policies were directed more towards the reduction of cultural differences within Australian society, rather than toward their recognition. In the year of the election victory, the new Aboriginal Affairs Minister John Herron even praised a controversial book that argued that the

¹²³ This cartoon depicts the Labor Government's undelivered promises. If this was the commonly held view of Labor, and they were considered the 'friend of Aboriginal Australians', then the Liberal Government's election victory was not to be good news for Indigenous Australians: Geoff Pryor, PIC 3701/39 LOC Drawer 9341-9350, National Library Australia, 2007.

¹²⁴ Interview with Anonymous Participant, in Kaplan-Myrth and James, 'Trends in Koori Health Policy', 2002.

assimilationist policies of the past did more for Aboriginal people than the self-determination policies of later governments.¹²⁵ For Indigenous Australians it was of grave concern that the Federal Government, was flirting with the long-discredited approach of the 1950s and '60s. By the turn of the millennium Aboriginal Australians would seemingly have less control over their lives than at any time since the 1970s.

Shortly after the Liberal's election success, the Tripartite Council's funding was transferred to VACCHO when it became incorporated under the Associations Act of 1981. On the 16 April 1996, following an interim committee members meeting, the organisation's rules of association were accepted and VACCHO commenced formal operations. Based initially at the Victorian Aboriginal Health Service, VACCHO operated within the National Aboriginal Health Strategy, and in line with the ideology of its national affiliate, NACCHO. The first six months were spent informing the twenty-three members of the organisation's role and function, drafting a constitution and a business plan, and finalising the structure of the secretariat, the membership protocol and the makeup of the executive committee.¹²⁶ With only 'three and a bit staff' it was a hectic, but 'interesting period'.¹²⁷ As VACCHO's first CEO Alan Brown stated at the time, "one forgets how much work there is to be done to get an office running from scratch".¹²⁸ By December 1996 the organisation had obtained accommodation on the second floor at 5/7 Smith Street, Fitzroy. There was a high degree of community interest and a 'real buzz and sense of excitement about the office'.¹²⁹ The building had a long list of maintenance issues, but it had 'a comfortable feel about it and a tonne of room for development'.¹³⁰ More importantly 'it was rent free', one of the benefits that flowed from incorporation.¹³¹

¹²⁵ Scott Bennet, 'White Politics and Black Australia', Allen & Unwin, NSW, 1999, p. 65

¹²⁶ VACCHO, 'Members Meeting', 19/20 February 1997, VACCHO, Fitzroy.

¹²⁷ VACCHO, 'Executive Officers Report', 18/19 February 1997, VACCHO, Fitzroy,

¹²⁸ Ibid.

¹²⁹ VACCHO, 'Executive Officers Report', 2/3 June 1997, VACCHO, Fitzroy.

¹³⁰ Alan Brown, 'Letter to David Murray-Smith, Public Health Division', Department of Human Services, 23 January, 1997.

¹³¹ VACCHO, Executive Officers Report, 18/19 February 1997, VACCHO, Fitzroy.

Over the years, incorporation has proven to be a double-edged. While it has been a means of gaining direct government funding and acquiring property, it has not always lead, as has often been assumed, to greater autonomy. In theory, the direct funding arising from incorporation promotes the idea of self-determination by giving Aboriginal organisations control over resources, thereby ensuring that funding accords directly with their priorities and needs. However, this is not always the case in reality, for the structures available for incorporation often have little to do with self-determination. Rather, they are primarily concerned with self-management.¹³² And there is a vast difference between the two. Self-management tends to focus on efficient management of communities and organisations and is a much more administrative notion which fits the framework of local government. Self-determination, on the other hand, goes beyond this and implies control over policy and decision-making, ‘especially in the determination of structures, processes and priorities’.¹³³ Essentially then, incorporation has meant more adequate funding, yet it has also meant a reduction in ownership and control, and less of an influence on government policy. This ‘unique set of arrangements’ has been described as *welfare colonialism*. As one Indigenous policy expert has noted, it has arisen because the “mechanisms that have developed to provide funding and resources...have overlain older systems of Aboriginal administration”.¹³⁴ That is, because Aboriginal communities have little political leverage or chance for internal economic development without government assistance or ‘welfare’, the bureaucracy is able to regulate their activities by such means as funding guidelines, auditing and performance reviews.

Incorporation has proven to be a mixed blessing in other ways, since it has also demanded administrative skills. As one community member noted, one of the biggest mistakes the government made was to say:

¹³² House of Representatives Standing Committee on Aboriginal Affairs, ‘Our Future Our Selves: Aboriginal and Torres Strait Islander Community Control Management and Resources’, Canberra, 1990, p. 28.

¹³³ Ibid., 1-13.

¹³⁴ Ian Anderson, ‘The National Aboriginal Health Strategy’, pp. 119-135, H. Gardner (ed.), *Health Policy in Australia*, Oxford University Press, Melbourne, 1997, p. 133/4.

“Look, set up an organisation and we’ll give you money”. Which happened – all you need is seven people – and we got it down to a fine art where we could set up an organisation in one evening and have a board of directors elected and have it incorporated within a week. Fine-tuned. And the problem with that is that no one in our community had any experience. We had no expertise in the management of money, administration, or in any of the particular duties they entailed... the mistake was that nobody had any training in anything.¹³⁵

This lack of administrative capabilities was to be one of the many issues in Aboriginal health that VACCHO addressed in its first years of operation. It did so through the capacity-building initiative of *Management Training*. Of the thirteen OATSIH/DHS funded programs run by VACCHO in 1997/8,¹³⁶ this was perhaps one of the most important, for it was at this point that the Howard Government tightened the government purse-strings in Indigenous Affairs, following accusations of the misuse of money by Aboriginal organisations. In light of the close financial scrutiny that followed, the aim of VACCHO’s management training was to provide skills to senior managers and board members to ensure increased viability and sound financial management.¹³⁷ VACCHO believed that the mainstream-style training proposed by the state government would not be effective in the long term as it failed to address the historical resentment to training and training institutions which VACCHO believed was pervasive throughout the community.¹³⁸ Thus, following an in depth needs-analysis by VACCHO members that allowed them to develop and control the nature of the training, a consultant was engaged to provide the tuition program.¹³⁹ The project was completed in December 1998 and was not only successful in providing a management skills base for its member services, but also in developing a culture which embraced training as a central aspect of their operations - a Koori-style professionalism. In light of its success, there

¹³⁵ Interview with Anonymous Participant, in Kaplan-Myrth and James, ‘Trends in Koori Health Policy’, 2002.

¹³⁶ VACCHO, ‘Outline of VACCHO Funded Projects 1997’, VACCHO, Fitzroy, 1998.

¹³⁷ VACCHO, Members Meeting, 12 June 1997, Mildura.

¹³⁸ VACCHO, Members Meeting, 22/23 March 1997, Morwell

¹³⁹ VACCHO, ‘Application to OATSIH for Management Training and Support development within Victoria through VACCHO’, 1997, pp. 1-7.

were suggestions that an ongoing Management Training position be created at VACCHO. It was believed that one-off training was not a feasible means of addressing the issues being faced by member organisations considering the repeated changes in directors. However, additional funding was not provided.



This picture depicts the importance of nurturing the community: message sticks are passed, and wisdom and knowledge are shared. In turn, the community is strengthened and linked together in their efforts to build a safe and healthy future.¹⁴⁰

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¹⁴⁰ Lyn Briggs (Artist), in VicHealth, 'Building Indigenous Leadership', Carlton, Invicium Printing, 2007.

Intergovernmental / Community Agreements

Despite the drawbacks associated with incorporation, it does nevertheless have certain advantages beyond being a means for tapping into government funding. Importantly for VACCHO, it meant that they were able to enter into agreements with government. Significantly, it was at the time of VACCHO's inception there was a renewed attempt by the government to develop a more collaborative approach between the Commonwealth, States and the community. As Ian Anderson notes, this was in part grounded in the Council of Australian Governments (COAG), which was established under the Hawke Labor administration and renewed under the Howard Coalition so as to maximise inter-governmental partnerships.¹⁴¹ Thus, at a COAG meeting in April 1995, Heads of Government endorsed the need for systematic reform of the way Aboriginal health and community services were organised and funded, and the following year two landmark agreements were signed in Victoria¹⁴² - the *Framework Agreement* between VACCHO, the Department of Human Services (DHS), ATSIC, and the Department of Health and Family Service (DHFS), and the *Health Outcome Agreements* between VACCHO and the DHS.

The Agreements were a significant development. As one community member observed, "they were a foot in the door."¹⁴³ They built on *The National Commitment to Aboriginal Services* devised under the previous Labor administration, and demonstrated that the government was finally and officially recognising the importance of ACCHS. Amongst other things, the documents outlined how Aboriginal community control is the fundamental and culturally-valid method for delivering Aboriginal-specific health services. Moreover, it noted the necessity for ACCHS to retain control over the design and delivery of the services they

¹⁴¹ Ian Anderson, Policy Processes, pp. 231-251, in B. Carson, T. Dunbar, R. Chenhall & R. Bailie (eds.), 'Social Determinants of Indigenous Health', Allen & Unwin, NSW, 2007, p. 245.

¹⁴² Health and Community Services Minister, 'Reform of Health and Community Services', Interim Report, 1995, Canberra, p. 1.

¹⁴³ Interview Anonymous Participant, in Kaplan-Myrth and James, 'Trends in Koori Health Policy in Victoria', 2002.

are funded to provide; that improving health for Aboriginal people can only be achieved when they are empowered to act on their own behalf.¹⁴⁴ The Agreements also outlined a commitment to improving access, quality and cultural sensitivity of mainstream services by establishing appropriate planning partnerships and training programs, establishing appropriate data collection protocols, and specifying the roles and responsibilities of the partners within the agreement.¹⁴⁵

A year later, a third policy approach, the *Koori Services Improvement Strategy* (KSIS), was devised by the DHS and VACCHO in order to enhance the original Agreements. The KSIS was aimed at improving the delivery of the Department's services to Aboriginal Victorians, and developing effective working relationships between the communities, government departments and mainstream providers.¹⁴⁶ Like the Agreements, the Strategy went through rigorous community consultation and, as Youth and Community Minister Rob Knowles said at its launch, would be a means to 'establishing a sense of trust, and a sensitivity to cultural needs so that Aboriginal people will feel comfortable when accessing the full range of government funded services.'¹⁴⁷

Initially the community was understandably suspicious of the Agreements. Letters from members to VACCHO demonstrate that, amongst other things, concerns arose over whether the government would use the agreements to justify using monies allocated to Aboriginal Affairs to develop mainstream services, and whether the documents would allow government departments to interfere with the administration and control of the ACCHS.¹⁴⁸

However, their fears were allayed by the consultation and information sessions conducted by

¹⁴⁴ Department of Human Services, 'Achieving Improved Aboriginal Health Outcomes: An Approach to Reform', Public Health Division, DHS, Melbourne, 1997.

¹⁴⁵ Department of Aboriginal Affairs, 'The Agreement on Aboriginal and Torres Strait Islander Health', Canberra, 1996.

¹⁴⁶ KSIS Steering Group, 'Koori Services Reform Strategy Discussion Paper', Aboriginal Affairs Victoria, 1997. pp. 1-3

¹⁴⁷ Kennett Ministry News Release, 'New Partnership Dawns for Victoria's Koori Community with Service Strategy Commitment', August 1998, p. 2.

¹⁴⁸ Letters from Rumbalara Aboriginal Cooperative, Framlingham Aboriginal Cooperative, Ballarat & District Aboriginal Cooperative, Central Gippsland Health and Housing Cooperative, to VACCHO.

VACCHO, which clearly outlined the purpose of the agreements, and which enabled the community to have input in the drafting process.¹⁴⁹ Nevertheless, shortly after signing the documents, VACCHO raised its own concerns. Despite the notions of participation and control espoused in both agreements the DHS failed to involve VACCHO in specific health projects that were being implemented shortly thereafter. Yet, unlike with the implementation of the NAHS, the situation was quickly resolved following a succession of heated letters from Alan Brown to the DHS.¹⁵⁰ Within a year, the three pilot sites for the Health Outcome Agreements were proving to be a success.

The pilot sites at Rumbalara, VAHS, and the Loddon-Mallee region involved a Department employee from the regional office of the pilot sites working with the communities to ensure a coordinated development of the health outcomes, and to observe whether or not mainstream facilities were being delivered effectively. If not, new methods of operation were to be devised and implemented in consultation with VACCHO.¹⁵¹ A large number of interrelated health and service issues were identified during the project, and the subsequent priority recommendations included health promotion issues, data collection, links with mainstream services and cultural-awareness training.¹⁵² The results and the long-term effectiveness of the Outcome Agreements and the Framework Agreements demand a detailed study and are outside the scope of this thesis. Nevertheless, it should be noted that whilst many community members believed that both Agreements were ‘good on paper’¹⁵³, and did achieve many things, in the long-term they had too many obstacles to overcome to be truly successful. As one community member recalls:

¹⁴⁹ VACCHO, ‘Members Meeting’, 31 January 1997, Smith Street Fitzroy,

¹⁵⁰ Alan Brown, Letter to G. Lavender’, Acting Director Public Health, DHS, 1997.

¹⁵¹ VACCHO, ‘Health Outcome Sites Up and Running’, in News Winter, VACCHO, 1997, p. 4.

¹⁵² VACCHO, ‘Aboriginal Health Outcome Agreements: Report on the Key Health and Health Service Issues in NMR’, VACCHO, 1998, p. 13.

¹⁵³ Interview Anonymous Participant, in Kaplan-Myrth and James, ‘Trends in Koori Health Policy in Victoria’, 2002

...it was a significant improvement on pre-framework days where, under the Tripartite Council, you had these Forums which were recommending priorities, policies, agendas...but nothing was happening...Yet in terms of any real outcomes for our community [from the Agreements]...well, certainly from a glimpse, it doesn't seem that much has been happening at all. For example, there haven't been any new health services established here in Victoria for quite some time. And there is certainly a need for it in rural areas.¹⁵⁴

As various community members noted, the success of the Agreements could depend on such seemingly insignificant details as the relationship between the individual members of the government departments and the community. If the relationship was poor, the outcomes were poor. Other community members believed that the services themselves 'did not operate well enough to effectively use the tools they had to implement the plan'.¹⁵⁵ Yet, the major problem with the implementation of the Agreements was that governments never provided sufficient resources for the communities to make effective use of them:

You [ACCHS] get swamped with programs; you get swamped with intervention, with service delivery... The resources in Aboriginal communities just get swamped with demand. It becomes like a little funnel and it just gets choked up by all the varying government sectors trying to get information down into the community and the community in turn trying to get information back up...Its just not possible, not able to get a win.¹⁵⁶

...Framework Agreements and HOA and whole-of-government approaches...they built it on a very small base of infrastructure supporting the Indigenous community. And then they blame the community for inactivity and outcomes. You have to think, we're coming from a different place from the Government bureaucracy. We're

¹⁵⁴ Interview Anonymous Participant, in Kaplan-Myrth and James, 'Trends in Koori Health Policy in Victoria', 2002

¹⁵⁵ Ibid.

¹⁵⁶ Ibid.

*coming from an under-resourced place, both in terms of dollars and, in a lot of ways, skills. It is just such an inadequate and inequitable sort of relationship between community-controlled and government.*¹⁵⁷

If nothing else, however, the Agreements brought all the interested parties to the table, enabled the community to talk, and ensured the government at least listened. Today the Agreements are incorporated in the *National Strategic Framework for Aboriginal and Torres Strait Islander Health*, which was developed under the auspices of NATSIHC (the predecessor of the CAH), and is aligned with the NAHS.¹⁵⁸ Importantly, it differs from the earlier documents in so much as it has a closer focus on outcomes. It provides a more comprehensive set of strategies that compliment the actions agreed to within the Framework Agreements, a fact that must please the community considering the above comments.¹⁵⁹

In many ways, Aboriginal Affairs has been quite drastically reformed since the Agreements were devised. ATSIC was abolished, its responsibilities were transferred to mainstream government departments and portfolios,¹⁶⁰ and the Health Outcome Agreements now come in the form of *Shared Responsibility Agreements* (SRA).¹⁶¹ Unfortunately, like its predecessor the SRAs have got off to a shaky start, with the 'bold experiment' being labelled a failure after the government released damning evaluations of eight separate trials for the approach.¹⁶² Paul Briggs, the initial Chairperson of VACCHO, who was instrumental in the implementation of the Health Outcome Agreements, has also been involved in the SRAs. He attributed the initial setbacks to the same factors that hampered the previous Agreements:

¹⁵⁷ Interview Anonymous Participant, in Kaplan-Myrth and James, 'Trends in Koori Health Policy in Victoria', 2002

¹⁵⁸ Human Rights and Equal Opportunity Commission (HREOC), Social Justice Report 2006, Tom Calma (ATSI Commissioner) N.S.W, Sydney 2006, pp. 80-5.

¹⁵⁹ Ian Anderson, 'The Framework Agreements: Intergovernmental Agreements and Torres Strait Islander Health', pp. 254-267, in M. Langton, M. Tehan, L. Palmer and K. Shain (eds), *Honour Among Nations: Treaties and Agreements with Indigenous People*, Melbourne University Press, Carlton, 2004, p. 267.

¹⁶⁰ Australian Human Rights and Equal Opportunities Commission (HREOC), 'Closure of ATSIC Regional Councils: Statement by Aboriginal and Torres Strait Islander Social Justice Commissioner Tom Calma', Accessed: http://www.hreoc.gov.au/media_releases/2005.

¹⁶¹ HREOC, 'Social Justice Report 2006', p. 137-147.

¹⁶² The Age, 'Plan for Aborigines Slammed', by Annabel Stafford, 23/02/07 p. 4.

lack of resources, unrealistic expectations, poor partnerships, and the fact that the Agreements were not properly understood by either side. The government report concurred. Evidently, the lessons from the past were not learnt. Importantly, however, Briggs denied the trial had been a failure, and preferred to view it as 'the beginning of a process that would improve the lives of Aboriginal people'.¹⁶³

Performance Reviews and Funding Issues

By mid 1997, instead of concentrating directly on Indigenous ill-health, the Howard Government had begun to focus heavily on the accountability of their organisations. As the Prime Minister stated at the time, 'nobody is exempt from the obligation of accounting for money that is given to them from the Australian tax payer'.¹⁶⁴ Thus, with the 'object of achieving better outcomes from available funds', the government began implementing rigorous performance benchmarks and indicators. Since the Labor Administration began employing such reviews in the 1980s as a means to link costs to objectives and evaluate progress towards these objectives, they have remained an area of considerable confusion. The major concern for ACCHS has been the proposition of tying funding to quantifiable changes in health status.¹⁶⁵ For example, many ACCHS have been offered funding on the proviso that they accomplish certain improvements in the Indigenous health status over a designated period. A prominent Indigenous health expert summed up the situation in comments made in 2003:

...that communities would be funded on the basis of a twenty percent reduction in diabetes every two years, well that's almost impossible. Moreover, it lacks an understanding of health and diabetes for that matter...If you could increase access

¹⁶³ The Age, 'Plan for Aborigines Slammed', p. 4.

¹⁶⁴ Weekend Australian 6-7 April 1996, p. 26-31.

¹⁶⁵ Ian Anderson and Maggie Brady, 'Performance Indicators for Aboriginal Health Services', Centre for Aboriginal Economic Policy and Research', (no.81/1995), pp. 187-209, in L Hancock (ed.), *Health Policy in the Market State*, Allen & Unwin, NSW, 1999, p. 196.

*for those with diabetes and thus increase diagnosis and possible treatment by twenty percent per annum that would be fantastic and a worthwhile indicator.*¹⁶⁶

Needless-to-say, the demands are often unrealistic. Moreover, the ACCHS inability to fulfil such stringent and improbable requirements has unfortunately resulted in the bureaucracy using the indicators to imply that the services are ineffective. In turn, the curtailing of funding is seen as justified. Consequently, in July 1997, at a conference in Perth, VACCHO and other state affiliates met with NACCHO in an attempt to agree on a set of standard indicators for Aboriginal health. At the meeting, Commonwealth-proposed ACCHS indicators were analysed, a submission drafted, and a list of government benchmarks devised. The latter were to be directly related to the NAHS and to be used to assess the government's performance at meeting Aboriginal health requirements. ACCHS were determined to make the government accountable for their actions, and the indicators were to be their means. By August 1997 the Australian Health Ministers Advisory Council had endorsed the new set of national indicators and targets against which the government was required to report.¹⁶⁷ Considering the fact that VACCHO representative, Alan Brown, had demanded at the Perth conference for greater transparency in the reporting process of the government, and for far greater participation by the community in the development of performance indicators, this was an important development.

Also arising out of the Perth conference was the recommendation for VACCHO to implement a Victorian Aboriginal health database so as to ensure all ACCHS were able to individually monitor and improve the health profile of their respective communities. The project was to be developed in collaboration with the Koori Health Unit and in line with the Framework Agreement, which had detailed a commitment to improving the availability of

¹⁶⁶ Interview Anonymous Participant, in Kaplan-Myrth and James, 'Trends in Koori Health Policy in Victoria', 2002.

¹⁶⁷ National Health Information Management Group, 'National Summary of the 2000 Jurisdictional Reports Against the Aboriginal and Torres Strait Islander Health Performance Indicators', Australian Institute of Health and Welfare, Canberra, 2003.

'Koori Health Counts'.¹⁶⁸ Its aim was to assist member services in meeting the requirements of the performance indicators and thereby ensure health resources be allocated in an equitable and effective nature. Initially, there was some resistance from members to having the database installed due to concerns over ownership and access. However, the mood soon changed when Alan Brown suggested that Canberra might adopt a funding formula based on the figures from the census. For years, ACCHS have claimed, and government departments have agreed, that Aboriginal census counts are inaccurate. In 1996 community estimates of the population were around 25,000. The census figure was 18,000. Considering that funding was based partly on these figures and the other statistics that the new database hoped to identify, the community was soon in full support of it, and the project was implemented.

Though the database achieved its desired outcome, it has nevertheless been unable to overcome all the problems associated with resource allocation. Funding, and the deficiency of government funding arrangements, has remained a major problem for ACCHS. As one VACCHO staff member surmised:

...Its always been about the money and lack of it, about the piecemeal funding and absolutely absurd process that Aboriginal health services have to go through to get subsistence funding. You know, we were vastly under-resourced, no acknowledgement for the potential or the great work that the organisations do...[Moreover] the Government departments had no idea how to fund Aboriginal health services...There was no plan, no process.¹⁶⁹

Thus, following its establishment, one of VACCHO's primary roles was to rectify this problem by creating an effective funding process wherein financial priorities were identified and adequate resources ensured for its members. Consequently, using the Framework

¹⁶⁸ Koori Health Unit, 'Koori Health Counts', Department of Human Services, Melbourne, 1998, p. 1.

¹⁶⁹ Interview Anonymous Participant, in Kaplan-Myrth and James, 'Trends in Koori Health Policy in Victoria', 2002

Agreement, and in consultation with its signatories, VACCHO established the *Victorian Advisory Council on Koori Health* (VACKH) in order to implement the Agreement and provide a forum for all signatory organisations to work together to improve Aboriginal health.¹⁷⁰ Importantly, the primary role of the Council was to increase funding to ACCHS in an attempt to increase their viability.¹⁷¹

However, shortly after VACKH's creation and despite its membership being drawn from ATSIIC, the Victorian DHS and the Commonwealth Health Department, government-funding cuts were implemented. In March 1997, ATSIIC's *Community and Youth Support Program* was terminated. The program had been developed to promote access by Indigenous people to community support programs and services, and provided assistance to organisations representing the elderly, the disabled, the young and families.¹⁷² As a result of the cuts, many VACCHO member bodies lost administrators, receptionists, finance staff, vital infrastructure and funding for essential services. The flow on effect was that previously free programs became full-fee paying programs as many of the organisations were pushed to the brink of ruin.¹⁷³ Moreover, staff had to work far longer hours to 'fill the gaps', which added to the 'burnout' community-controlled employees experienced due to their emotionally-draining and heavy workload. VACCHO immediately drew up a detailed report on the cuts, but to no avail. Organisations limped along, some accessing philanthropic funding. Following much hard work all services were maintained, though reserve funds were depleted and developmental projects suffered considerable setbacks.

The provision of adequate funding for their members remains a major difficulty for VACCHO and VACKH today, a difficulty exacerbated by the repeated assertion that the government is pouring money into the proverbial 'black hole' that Aboriginal Affairs is

¹⁷⁰ Victorian Advisory Council on Koori Health, 'Terms of Reference', Melbourne, 2000, p. 4.

¹⁷¹ Victorian Advisory Council on Koori Health, 'Draft Role Description', Melbourne, 2003, p. 1.

¹⁷² Aboriginal and Torres Strait Islander Council, 'Annual Report', 1996-97, ATSIIC, Woden, ACT, 1997, p 105/6.

¹⁷³ VACCHO, 'Members Speak out Against ATSIIC Cuts', in News Winter, VACCHO, 1997, p. 3.

perceived to be. The *Sydney Morning Herald* highlighted these difficulties in a recent investigation into the government's misappropriation and consequent misspending of Aboriginal health dollars. It showed, firstly, that hundreds of millions of dollars which the Federal Government claims it spent on Indigenous Affairs have never been spent, been used to benefit all Australians, or have gone toward opposing Aboriginal native title claims. Secondly, it discovered that the Australian government has spent almost \$110 million less than it should have in the Indigenous portfolio. The shortfall included more than \$25 million on health services.¹⁷⁴

In light of these revelations, the Australian Medical Association's call for the government to pledge \$460 million a year over four years to indigenous primary health care, should not be an issue. It would help recoup the shortfalls, and would only equate to an increase of 1.2 per cent of the annual Government health expenditure.¹⁷⁵ Moreover, it would in the long run result in significant future health savings. It is not a large amount - the Federal Government spent \$208.5 million on advertising in 2006 - to help solve the Indigenous health problem by providing culturally appropriate primary healthcare services: VACCHO and NACCHO's aim since their inception.¹⁷⁶ Considering that Indigenous mortality levels are 300 to 500 per cent higher than the non-Indigenous population, it is vital.¹⁷⁷

¹⁷⁴ Sydney Morning Herald, 'Black Dollars Go Everywhere but to Blacks', 22/08/07. Accessed: www.smh.com.au.

¹⁷⁵ HREOC, 'Social Justice Report 2006', p. 12.

¹⁷⁶ National Aboriginal Community Controlled Health Organisation (NACCHO), 'Close the Gap: Solutions to the Indigenous Health Crisis Facing Australia', Oxfam, Melbourne, 2007, p. 7.

¹⁷⁷ Australian Medical Association Report Card Series 2007: Aboriginal and Torres Strait Islander Health 'Institutional Inequity: Not Just a Matter of Money', 2007.



178



179

¹⁷⁸ Alan C. Moir (1997), PIC 8081/19 LOC Drawer 9241-9250, National Library Australia, 2007.

¹⁷⁹ Geoff Pryor, PIC 8053/55 LOC Drawer 9701-9710, Library of Australia, 2007.

Cultural Programs

“Culture is the system of meanings and explanations that particular groups of people develop over countless years to shape and interpret the chaos of facts and events in the world around them...the webs of significance people have spun, and in which they are always suspended.”¹⁸⁰

Culture is an essential factor in any society’s wellbeing. It provides meaning and value to life. It protects people from basic human anxieties and is a critical contributor to one’s mental stability.¹⁸¹ Thus, if a people’s cultural practices have been extensively and persistently suppressed, their psychological health, as well the culture itself, become susceptible to trauma.¹⁸² And there can be little doubt that in real and symbolic terms, Aboriginal culture has been suppressed and traumatized by the arrival of Europeans and their ongoing discriminatory laws and policies. Today, there are unparalleled rates of depression and anxiety amongst the Indigenous community, Aboriginal Australians being four times more likely to die from the consequences of a mental disorder than non-Indigenous Australians.¹⁸³ Thus, for Aboriginal people, the past and the trauma that has accompanied it continue to affect the present. As the Human Rights and Equal Opportunity Commissions’ *Bringing Them Home Report* demonstrated, the effects of colonisation do not stop with those directly involved, but are “inherited by their own children in complex and sometimes heightened ways.”¹⁸⁴ Alma Thorpe’s comments attest to this notion:

¹⁸⁰ Richard Broome, ‘Arriving’, Fairfax, Syme & Weldon, Sydney, 1984, p. 213.

¹⁸¹ Dr. Ernest Hunter, ‘Considering Trauma in an Indigenous Context’, in *Aboriginal and Islander Health Worker Journal*, vol. 22, no., 5, Sept/Oct 1998, pp. 9-18.

¹⁸² J. Atkinson, ‘Trauma Trails, Recreating Song Lines: The Trans-generational Effects of Trauma in Indigenous Australia’, North Melbourne, Spinifex Press, North Melbourne, 2002, p. 17.

¹⁸³ Australian Bureau of Statistics and Australian Institute of Health and Welfare (ABS & AIHW) 2005, ‘The Health and Welfare of Australia’s Aboriginal and Torres Strait Islander Peoples’, Commonwealth of Australia, Canberra, 2005.

¹⁸⁴ Human Rights and Equal Opportunity Commission, ‘Bringing them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families’, Canberra, Australian Government Publishing Services, 1997, p. 222.

[Colonisation] - it happened. We were denied our culture, we had to just grab at the pieces we could find ... [and] that gives you a sadness that will stay with you all your life...you know...you have an ongoing sadness after land has been taken or your identity has been taken. [It's] like you've been in a war zone for six months, it's caused a lot of mental damage - PTS syndrome...all you want is for people to show some kindness.¹⁸⁵

The traumatisation that Alma alludes to occurs when any person suffering from it has no healthy or balanced way of recovering from the loss.¹⁸⁶ Since its inception, VACCHO has been working to provide pathways to redress this problem. For example, in September 1996 it convened a state-wide workshop of all ACCHS and interested parties on Indigenous mental health issues. Held in Marysville, *Going Forward in Emotional and Social Wellbeing* resulted in two major developments.¹⁸⁷ The first was the recommendation for the establishment of a *Koori Mental Health Policy Project*. Named *Purro Birik* (Health Spirit), and implemented in 1997, the project was undertaken as a partnership between VACCHO and the Victorian Mental Health Branch and was based within the three Agreements signed the previous year. Its primary aim was to consult with Aboriginal communities and public health services to propose strategies to improve mental health provision to Aboriginal people in Victoria.¹⁸⁸ By 1998, the project had successfully developed partnerships with mainstream health services that had enabled VACCHO members to provide holistic, high quality, well-coordinated, and accessible social, emotional and cultural wellbeing services to their communities.¹⁸⁹ Shortly thereafter, a permanent mental health unit was established at VACCHO.

¹⁸⁵ Alma's comments are attested to by Psychological Science Lecturer Michael Hollaran who stated in a presentation to the Law and History Society Conference that *cultural trauma* often results in 'anxiety related maladaptive behaviour', the symptomatology of which has been likened to that of Post-Traumatic Stress Syndrome: Interview conducted by Michael Hemingway with Alma Thorpe 22 August 2007.

¹⁸⁶ J. Middleton-Moz, 'Support Team Training. National Conference of the National Association of Native American Children of Alcoholics', Orlando, Florida, 1996, in VicHealth, *Building Indigenous Leadership: Promoting the Emotional and Spiritual Wellbeing of Koori Communities through the Koori Communities Leadership Program*, 2005, p. 14.

¹⁸⁷ VACCHO, 'Going Forward in Emotional and Spiritual Health: Workshop Report – September 1996, Marysville', Commonwealth Department of Health and Family Services, 1996.

¹⁸⁸ VACCHO & Victorian Mental Health Branch, 'Purro Birik Discussion Paper: Koori Mental Health Policy Project', 1999.

¹⁸⁹ G. Atkinson and S. Kerr, 'The Burro Birik Social and Emotional Wellbeing Strategy Evaluation Report', 2002, p. 5.



Purro Birik - Restoring our Spiritual Health: The centrepiece, or mother atom, represents complete emotional and spiritual wellbeing within Indigenous communities. The baby atoms symbolise hope and growth in all areas of mental health. The figures or spirits represent family unity in searching for cultural peace of mind.¹⁹⁰

¹⁹⁰ Joanne Dwyer and Laura Thompson (Artists), in Shaun Coade and Pat O'Leary, 'Purro Birik; Discussion Paper on Koori Mental Health Policy Project', Melbourne, VACCHO, 1999.

The second recommendation, one that was developed alongside Purro Birik, was for an *Emotional and Social Wellbeing* (ESWB) regional training centre. In October 1996, Federal Minister for Health, Michael Wooldridge, announced the launch of the *National Indigenous Mental Health Plan*, and in early 1997, following a submission by a VACCHO Working Party that capitalised on the plan, OATSIH provided funding for the centre for a three-year period. In March 1998, the first regional training centre was established.¹⁹¹ With academic and course accreditation provided by Melbourne University, the centre developed and then delivered counselling training for Aboriginal health workers. It also acted to provide clinical support for the workers, and to cultivate intersectoral and interagency collaboration. By 2003, there were sixteen funded regional centres throughout the nation delivering specifically focused social, emotional and cultural wellbeing training.¹⁹²

Both the Purro Birik and the ESWB training centre initiatives have made significant advancements in addressing the cultural trauma experienced by Indigenous Australians. Another is Kalaya Purro, a cross-cultural training course that ran in unison with VACCHO's Recruitment Program. The aim of the recruitment scheme was to overcome some of the staffing difficulties VACCHO members experienced due to doctors' unwillingness to work in the community-controlled sector. Since the 1970s, almost all ACCHS have faced considerable workforce shortages due to medical practitioners' attitudes – a reluctance to leave metropolitan centres to work in regional areas, an aversion to the isolation, a belief that they are not utilising their skills, a hesitancy to work in the salaried positions offered by the ACCHS, and a view of the experience as a stepping stone.¹⁹³ Thus, the viability of ACCHS has been frequently threatened. The recruitment program, therefore, sought to engage and retain medical professionals in member services. It did so by forming a partnership with the

¹⁹¹ VACCHO, 'Regional Centres for Indigenous ESWB Counselling, Training and Support', 1998, pp. 1-5.

¹⁹² VACCHO, 'Regional Centres for Indigenous ESWB Program: Quarterly Progress Report', 2003, p. 1.

¹⁹³ Recruitment Manger, 'Annual Report', 1998.

Royal Australian College of General Practitioners, a move that proved to be an unequivocal success and led to discussions of the initiative being adopted nationally.¹⁹⁴

Implementation of the program revealed that most healthcare professionals have a limited knowledge of Aboriginal people and their culture, and are thus culturally insensitive when treating Indigenous patients. As a result, in early 1997 VACCHO Recruitment Manager, Glenys Watts, attended a renowned cross-cultural training seminar in Brisbane named *Binang Goonj* ('they hear but they do not listen').¹⁹⁵ Three months later the 'bridging cultures' workshop was brought to Melbourne, and shortly thereafter, the Royal Australian College of General Practitioners approached VACCHO in order to enhance their partnership through the delivery of the training in their curriculum. The focus of the tuition was to sensitise medical personnel to the experiences, culture and life circumstances of Aboriginal people, and to provide them with practical advice about ways to communicate more effectively with Indigenous clients. This included stressing the importance of a holistic approach to health.¹⁹⁶ The training was such a success that it soon became compulsory for all GP registrars.¹⁹⁷ Moreover, in mid 1998, the Koori Health Unit agreed to fund VACCHO to provide cross-cultural training for the Department of Human Services in twelve different regions. From there, VACCHO began empowering its members to develop and deliver their own holistic and cultural awareness programs.¹⁹⁸



Binang Goonj – Bridging Cultures.¹⁹⁹

¹⁹⁴ VACCHO, 'Executive Members Meeting', 23 July 1997.

¹⁹⁵ VACCHO, Members Meeting, 3 April 1997, Framlingham.

¹⁹⁶ Coordinators Report, 'Kalaya Purro Cross Cultural Program', VACCHO, 1999.

¹⁹⁷ VACCHO, 'Executive Members Meeting', 14 May 1997.

¹⁹⁸ VACCHO, 'Discussion Paper on the Proposed Cultural Awareness Package on Koorie Health', 1999.

¹⁹⁹ A. Eckerman, T. Dowd, M. Martin, L. Nixon, R. Gray and E. Chong, 'Binang Goonj; Bridging Cultures in Aboriginal Health', University of New England Press, NSW, 1992.



This design reflects that although health and wellbeing is very much an individual thing, it is the connection that an individual makes with the community that enhances and develops the spiritual make-up of the individual.²⁰⁰

²⁰⁰ VACCHO, 'Going Forward in Emotional and Spiritual Health: Workshop Report – September 1996, Marysville', Commonwealth Department of Health and Family Services, 1996.

Perhaps the most important of VACCHO's programs, however, is the *Aboriginal Health Worker* (AHW) training program. Since the closure of Koori Kollij, there had been no program that could provide Victoria's Aboriginal health services with trained *AHW's*. Moreover, there was no culturally appropriate course which could enhance the skills of the nearly one hundred existing AHWs. Over the years this had proved to be a major dilemma for the state's services as AHW's have been an essential ingredient in the improvement of Indigenous health. Their importance lies in the fact that they bring to their work specific expertise and an indispensable knowledge of their own community, which enables them to deliver culturally appropriate health services to their people, and thus combat the ineffectiveness of mainstream facilities.²⁰¹ Moreover, in health service delivery, AHWs act as 'cultural brokers' and therefore form an integral link between professional staff and the local community. As a result, they can be involved in, and effectively promote, the affirmation of Aboriginal culture and the raising of health skills and knowledge that are central to the process of community development.²⁰² In 1999, after much persistence, VACCHO was approved as a Registered Training Organisation with the State Training Board. The following year, for the first time in Victoria, VACCHO delivered a nationally accredited AHW training course, offering certificate 3 in Aboriginal and Torres Islander Health. By 2001 twenty students had completed the training. Consequently, over half of VACCHO's 23 members gained a qualified health worker.

As with the other projects mentioned above, the success of the AHW training project rested on the use of community participation processes to inform each step of its development. Indeed, the initial decision by OATSIH to fund the development of the project rested solely on the unique structure of VACCHO which provides a means of guaranteeing effective

²⁰¹ K. Adams and M. Spratling (VACCHO), 'Future Directions for Aboriginal Health Worker Training in Victoria; A Report to VACCHO Members about Issues and Considerations Relating to the Development of Aboriginal Health Worker Training', VACCHO, Melbourne, 1999, pp. 9-10

²⁰² Ian Anderson, 'Koorie Health in Koorie Hands', Melbourne, Koorie Health Unit, Health Department Victoria, pp. 115-6

community participation.²⁰³ From its inception in 1998, a philosophy was adopted whereby the community and not the project staff owned the project. VACCHO members, current AHW's and community Elders were all consistently and exhaustively consulted during its development. They defined the structure, content and delivery of the course, and in every way owned and controlled it. As a result, the course was more readily endorsed and seen as credible and significant to all the varying communities across Victoria. Finally, the support provided by both the State and Commonwealth governments throughout the course's development and delivery, reveals what effective partnerships can achieve.²⁰⁴ Government and community organisations have different skills and knowledge and if they work together using their strengths and contributions in a complimentary manner, much can be achieved.

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²⁰³ K. Adams and M. Spratling (VACCHO), 'Keepin Ya Mob Happy: Aboriginal Community Participation and Aboriginal Health Worker Training in Victoria', pp. 116-119 in *Australian Journal of Primary Health*, vol. 7, no. 1, 2001, p. 1.

²⁰⁴ House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, 'Many Ways Forward: Report of the Inquiry into Capacity Building and Service Delivery in Indigenous Communities', Parliament of the Commonwealth of Australia, Canberra, June 2004.

CONCLUSION **PAVING THE WAY**

'Take away our organisations and we have nothing'.

- Anonymous²⁰⁵

International Covenant on Economic, Social and Cultural Rights

Article 12:

...Indigenous people have the right to specific measures to improve their access to health services and care. These health services should be culturally appropriate, taking into account traditional preventative care, healing practices and medicines. States should provide resources for indigenous peoples to design, deliver, and control such services so that they may enjoy the highest attainable standards of physical and mental health...

... [Indigenous peoples] have the right to participate in decision-making processes, which may effect their development...

...promoting health must involve effect community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health...

...a government that is unwilling to use the maximum of its available resources for the realisation of the right to health is in violation of its obligations.²⁰⁶

²⁰⁵ Anonymous in Ian Anderson and Maggie Brady, *Performance Indicators for Aboriginal Health Services*, Centre for Aboriginal Economic Policy and Research (no.81/1995), pp. 187-209, in L Hancock (ed.), *Health Policy in the Market State*, Allen & Unwin, NSW, 1999, p. 204.

²⁰⁶ HREOC, 'Social Justice Report 2006', p. 55.

Human Rights & Indigenous Autonomy

Australia has ratified five international human rights treaties²⁰⁷ that establish a human right to health and which outline not only Indigenous peoples' entitlement to their own culturally appropriate services, but also their right to participate in making the decisions that affect their lives. This thesis has demonstrated that the Australian government has in many respects been in breach of these covenants. Moreover, the Federal government's recent actions in the Northern Territory suggest that such violations are unlikely to cease whilst the Howard administration remains in power. As long as it fails to commit to the treaties and incorporate them by legislation into Australian law, then it cannot be held accountable in the nation's legal system. Standing alone, these documents are therefore in many ways not worth the paper they are written on. If nothing else, however, they should act as a moral imperative by placing pressure on the government to comply with its international responsibilities.²⁰⁸ Unfortunately, they do not achieve this either. And the fact that the government fails to adhere to these obligations speaks volumes for its attitude toward Indigenous Australians, an attitude which has been primarily responsible for restricting Indigenous Australians' right to self-determine.

While there are many difficulties within Aboriginal communities that place obstacles in the way of them achieving 'self-determination', the real problem lies with government. As a number of official documents have noted,²⁰⁹ the Australian government has consistently failed to implement structures that empower Indigenous Australians; it has lacked cultural

²⁰⁷ Convention on the Elimination of All Forms of Discrimination Against Women 1979, Convention on the Rights of Children 1989, International Convention on the Elimination of All Forms of Racial Discrimination 1965, International Covenant on Civil and Political Rights 1966, International Covenant on Economic, Social and Cultural Rights, 1966.

²⁰⁸ Natalie Gray, 'Human Rights', pp. 253-270 in B. Carson, T. Dunbar, R. Chenhall & R. Bailie (eds), *Social Determinants of Indigenous Health*, Allen & Unwin, NSW, 2007, p. 256.

²⁰⁹ House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, 'Many Ways Forward: Report of the Inquiry into Capacity Building and Service Delivery in Indigenous Communities', Parliament of the Commonwealth of Australia, Canberra, June 2004, & House of Representatives Standing Committee on Aboriginal Affairs, 'Our Future Our Selves: Aboriginal and Torres Strait Islander Community Control Management and Resources', Canberra, 1990. HREOC, 'Social Justice Report', Canberra, 2006.

sensitivity and coordination amongst its departments; it has failed to consult and engage the community; and it has placed stringent conditions on how Indigenous organisations spend their funds. All have combined to curb the opportunities Indigenous Australians have to achieve self-determination. Again, the Howard Government's Northern Territory intervention is a prime example. The 'emergency measures' merely highlight its seeming refusal to consult with Indigenous Australians before passing laws that fundamentally affect their lives. Thus, despite the lip service paid to the policy of 'self-determination', it is evident that the Australian government still has an inherent distrust for Indigenous decision-making, and will at almost every turn merely seek to impose its own 'solutions' on the community.

The Mainstream & Community-Control Today

Nevertheless, Aboriginal Victorians continue to define their own lives. And as this thesis has demonstrated, their community organisations are a symbol of that will to do so. Moreover, with the capacity to affect government policy and an ability to increase Aboriginal involvement in decision-making, VACCHO is in many respects the linchpin in this struggle. From its humble beginnings employing only three full time staff and occupying one level of a rather modest office, the organisation has grown exponentially: a reflection of its success. By the turn of the millennium, it employed over 23 full-time staff, ran over ten essential programs, and had assumed all of 5/7 Smith Street (see appendix A). Today, as the peak body continues to expand, its accommodation in turn proves to be increasingly inadequate. With a lack of space, storage rooms are converted into offices, and any vacant recess transformed into storage rooms. There have been repeated attempts to acquire new premises. However, as in the past, nonsensical bureaucratic red tape has stymied its efforts. Importantly, VACCHO continues to be funded, something that is not guaranteed considering the Howard Government's continuing efforts to mainstream Aboriginal health following the abolition of ATSIC in 2005.

Today, with the government's predilection for the mainstream, community-controlled services remain undervalued. Accordingly, VACCHO's future remains somewhat uncertain. This is highlighted by the fact that in relative terms there has been little change to date in funding levels for Indigenous health when compared to mainstream non-Indigenous health.²¹⁰ Not only is this a breach of the treaties discussed above, but it ignores resounding evidence suggesting that the community-controlled sector is the most effective means of securing adequate levels of health for Aboriginal Australians. For example, the current government-enforced compulsory health-checks in the Northern Territory disregard the fact that such health assessments have been taking place in the region since May last year. Moreover, it shows a total disregard for the community-controlled services that have been conducting this work. It is absurd that a wealthy nation such as ours cannot solve a health problem that affects less than 3% of its population. It is even more absurd that the most obvious channel through which this could be achieved is not fully supported.

Indeed, the mainstream does need to be 'harnessed', yet not at the expense of ACCHS. Rather, efforts to improve the accessibility and effectiveness of the mainstream must take place alongside the expansion of the community-controlled sector. It is widely believed that if there is a continued focus on the mainstream at the expense of ACCHS, the burdens the latter face will increase substantially, rendering them less effective. In the long term, Aboriginal health will suffer. As NACCHO notes, the adverse effects of mainstreaming would be numerous. It would create an increased demand on the Aboriginal sector from the varying government departments for consultation, advice and coordination. It would lead to a lack of focus, experience, knowledge, cultural sensitivity and coordination in the departments and the mainstream services. And it would also create difficulty in developing policy expertise in Indigenous Affairs when it is seen as a tertiary part of a department's activities.²¹¹ As

²¹⁰ HREOC, 'Social Justice Report 2006', p. 65.

²¹¹ HREOC, 'Social Justice Report 2006', pp. 89-90.

Aboriginal spokesman Pat Dodson stated earlier this year, “to try and destroy and decimate the Indigenous populations of this country in a mainstream fashion is not the solution.”²¹²

The community-controlled sector is not, however, without its own internal problems. Perhaps the most pressing is the growing concern that the essence of community-control is no longer what it was, or was meant to be:

*...many times we would have meetings where the people would be in the fore and you got your answers through that [the people], but its not done in the same way now...What happens today is that it's a representative of that particular health service...it's one person and he mightn't speak for the community...he might be bluin' with the community.*²¹³

While it is undoubtable that internal politics do affect representation and consultation within ACCHS, the fact of the matter is that the services do not have the time, resources, facilities or infrastructure to cope with or manage the infinite number of tasks that are demanded of them. This unfortunately at times includes the processes of consultation and representation. As a result, fissures within the communities appear; internal disagreements arise about how best to utilise the finite time and resources; basic issues become magnified; internal politics are heightened; and factionalism is thus increased. Mudrooroo's insistence that Indigenous communities do not lose sight of the bigger picture – their commonality – is thus particularly pertinent. Unity is essential. Alma Thorpe presents another factor that is perhaps contributing to the changing landscape - community-control. She believes the government's recent actions in the Northern Territory fly in the face of everything she and her fellow community members have been struggling for over the years, and for many this is the final straw: “...it's terrible on the people who did fight the fight, people who were proactive...And that's why

²¹² Russel Skelton, 'Wither the Spirit of the '67 Push for Indigenous Justice?', in *The Age - Insight*, p. 5 13/06/07.

²¹³ Interview conducted by Michael Hemingway with Anonymous Participant, 2007.

you can't get up...why no one's saying anything. Well you don't say nothing because you're tired...and whatever is going to happen will happen..."²¹⁴

VACCHO has not been safe from criticism either. The major concern is that while the organisation was initially set up to develop policy and to advocate on behalf of its members, by moving into the area of service delivery and program development, it has thus departed from its original intent. As one community member stated, "it is spreading itself too thin...it needs to get the capacity for policy analysis, policy critique, back into the service sector, back into its core work."²¹⁵ Others in turn suggest that the organisation "lacks political clout".²¹⁶ Yet, once again, such criticism should be directed more at the inadequacy of government funding and funding arrangements than the organisation itself. And this is not merely a case of laying blame at the government's feet. The fact that VACCHO has moved in a program and service delivery direction instead of concentrating solely on policy is ironically because the government, whether deliberately or not, provides funding for one and not the other. As an ex-staff member suggested, "if we didn't accept it [the program funding] the communities wouldn't get it... so it is the hard and fast line".²¹⁷ In other words, the current arrangements enable VACCHO to provide more essential services and programs, yet it perhaps does so at the expense of, for example, policy development. The comments of several community members perhaps best explain the situation:

*I think for VACCHO it has been difficult. It has been asked to do numerous tasks in the last few years. The government is saying they are looking to VACCHO to provide expertise, but they're not providing the resources so that we can provide more expert comment or expertise on any given policy, document or program that the government is looking for us to provide advice for.*²¹⁸

²¹⁴ Interview conducted by Michael Hemingway with Alma Thorpe.

²¹⁵ Interview with Anonymous Participant, in Kaplan-Myrth and James, 'Trends in Koori Health Policy', 2002.

²¹⁶ Ibid.

²¹⁷ Ibid.

²¹⁸ Ibid.

*...VACCHO is restricted in relation to development of policy because of the consultation process...When it needs to make a decision fairly quickly it doesn't have the capacity to provide that advice.*²¹⁹

Nevertheless, the essential nature of VACCHO remains, and examples of the importance and success of the community-controlled sector abound. For instance, a recent report suggested that Indigenous people who attend Indigenous-specific health services are more likely to be appropriately treated for communicable diseases than those Indigenous people who attend a general practitioner. This is evidenced by the fact that in one region the prevalence of certain sexually transmitted diseases was reduced by up to 50% as a result of community-controlled programs.²²⁰ A prime example of such an initiative is VACCHO's *Well Persons Health Check* (WPHC). Conducted by the organisation's Sexual Health Unit under the leadership of current CEO Jill Gallagher and Order of Australia winner Bev Greet, the WPHC was a response to the State and Federal governments' *Indigenous Sexual Health Strategies* of 1997/8.²²¹ The project targeted eleven rural regions over a three-year period, and was designed and driven by the individual local communities. It sought to prevent the spread of STDs and blood-borne viruses by improving diagnosis and treatment, removing barriers to screening, increasing awareness, building community capacity, and enhancing effective partnerships with the mainstream.²²² It was a success. Yet, regardless of the continuing need for such a service, further resources were not made available. As one community member stated, this is not uncommon: "...too often projects end with the funding and results...fade without being written up or built on."²²³

²¹⁹ Interview with Anonymous Participant, in Kaplan-Myrth & James, 'Trends in Koori Health Policy', 2002.

²²⁰ HREOC, 'Social Justice Report 2006', p. 65.

²²¹ VicHealth Koori Health Research and Development Unit, 'We Don't Like Research: But in Koori hands it could make a difference', Centre for the Study of Health and Society, Melbourne University Press, 2000, pp. 17-18.

²²² VACCHO & the Sexual Health Centre, 'The Victorian Well Persons Health Check Report: Sexual Health', Victoria, 2003.

²²³ VACCHO and The Cooperative Research Centre for Aboriginal Health, 'Communities Working for Health and Wellbeing', p. 16.



Advertisement for the Well Persons Health Check²²⁴



Painting for the Well Persons Sexual Health Check²²⁵

²²⁴ VACCHO & The Cooperative Research Centre for Aboriginal Health, 'Communities Working for Health and Wellbeing', 2007.

²²⁵ VACCHO and the Melbourne Sexual Health Centre, 'The Victorian Well Persons Health Check Report: Sexual Health', Melbourne, VACCHO, 2003.

Postcolonialism

In many respects, this limited study has only scratched the surface of the complex circumstances and issues encompassed in the history of VACCHO. Nevertheless, its outcome has been threefold. Firstly, to demonstrate that Aboriginal community-control is the most effective means of providing primary and preventative health care to Aboriginal people, and therefore, that improvements in Aboriginal health will only be achieved when Aboriginal people are empowered to act on their own behalf and make the decisions that affect their future.

Secondly, it is believed that this thesis has offered some answers to the seeming ‘paradox of innovation without change’. New programs and bodies are continuously developed, yet because they are always defined by the same government thinking, they are destined for failure. The paternalism that underlies the Australian bureaucracy is merely an obstruction. Both the state and federal governments have consistently failed to understand and accept the right of its Indigenous peoples to be allowed the fullest rights of self-determination. That is, instead of merely listening to, consulting, engaging and supporting the Aboriginal community, the government’s actions have more often than not resulted in impeding it. And this is chief among the reasons why Aboriginal health has remained static since the Commonwealth government assumed responsibility for Indigenous health in 1967. As Social Justice Commissioner, Tom Calma, recently stated, ‘perhaps this responsibility should never have been granted’. On the fortieth anniversary of the referendum his remarks were pertinent. He continued: “it is time to confront and deal with the lost promises of the 1967 Referendum...for we cannot be asking the same questions in another decade.”²²⁶

²²⁶ Tom Calma (Guest Speaker), ‘Delivering on the promises of the 1967 Referendum for Indigenous Australians’, at *Hyllus Maris Annual Memorial Lecture*, Latrobe University, Bundoora 21/8/07.

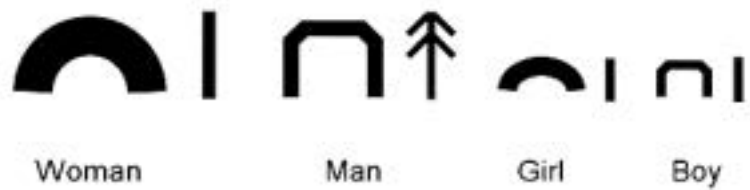
Finally, this thesis has demonstrated the importance of the past, how it is forever informing the present, and thus, how the effects of colonisation for Aboriginal Australians are far from dead and buried. In a country that has such a hotly contested past, it is amazing that any secondary school student would have to undertake Distance Education to learn about the years which shaped this nation, and in turn, the experiences of its Indigenous peoples.²²⁷ As Alma Thorpe alluded, if there is to be any significant change in the lives of Aboriginal Australians, and indeed their relationship with the broader Australian public, there will have to be a considerable shift in the Australian psyche.²²⁸ And education remains the key. The broader Australian society must understand what the past means to Aboriginal Australians, and how the weighty hand of colonialism is still reaching out to affect their lives today. Indigenous Australians have done more than enough to secure this nation's respect. They have such a rich and varied culture and much to contribute to the future of this nation. Yet many Australians remain ignorant of their achievements, traditions and customs. They are not afforded the respect they deserve, and remain, in many senses, on the fringe of our society. Unfortunately, with the current leaders of this country unwilling to face the realities of our past, let alone apologise for them, it may regrettably be some time longer before this situation changes.

Post-colonialism will only arrive for Indigenous Australians when they are able to make the decisions that shape their lives. Nevertheless, with the advent of Aboriginal community-controlled organisations, and more specifically and importantly, with the establishment of VACCHO and other such bodies which have the capacity to affect government policy and ensure Aboriginal involvement in decision-making, the notion of a *post-colonial* Australia becomes more realistic. Indeed, there are people who would argue that VACCHO is just

²²⁷ In Victoria there is no detailed curriculum requirement and no particular timetable allocation to teach Australian history. It is only very recently that Prime Minister Howard has indicated that all states will be forced to introduce compulsory Australian history in the early years of secondary schools. Teachers will be required to teach from more than 70 milestones in a nationally consistent curriculum, which will include such events as the Myall Creek massacre in 1838 when over 30 Indigenous Australians were viciously slaughtered by European settlers: Jewel Topsfield, 'PM to make Australian history compulsory', *The Age*, 11/10/2007, p 1.

²²⁸ Interview with Alma Thorpe conducted by Michael Hemingway, 22 August 2007.

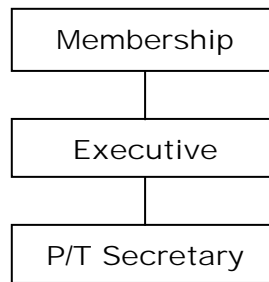
another example of Indigenous peoples seeking to ‘build their lives in the crevices of a colonial power’. Yet, what VACCHO is attempting is to actively create a *post-colonial* world for Aboriginal Victorians, a world akin to that before colonisation where they were intact as Indigenous peoples, where they had absolute authority over their lives and were born into and lived in a universe of their own making. While it is not possible to recreate this pre-colonial world in its entirety, it is evident that VACCHO, founded on the notion of community-control and infused with an ethos of self-determination, is paving the way for Indigenous Australians to be able to create a world in which all Aboriginal people are involved in making decisions that affect their lives; a world in which Aboriginal people define their own lives; a truly *post-colonial* world.



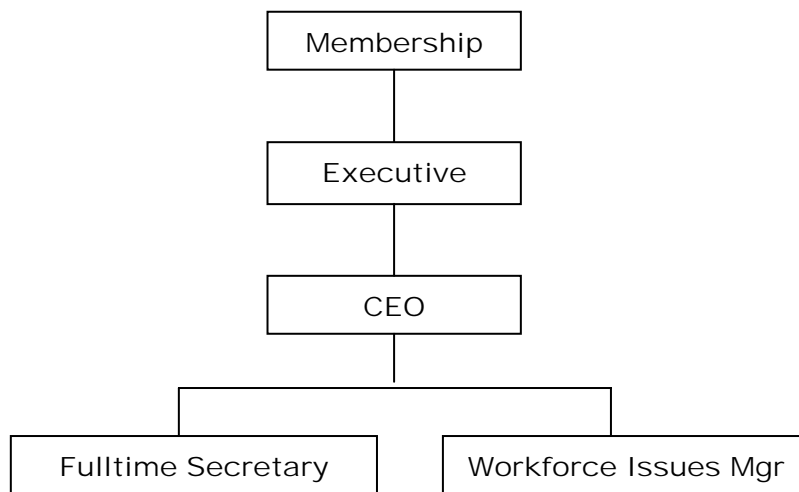
COMMUNITY.

Appendix A.

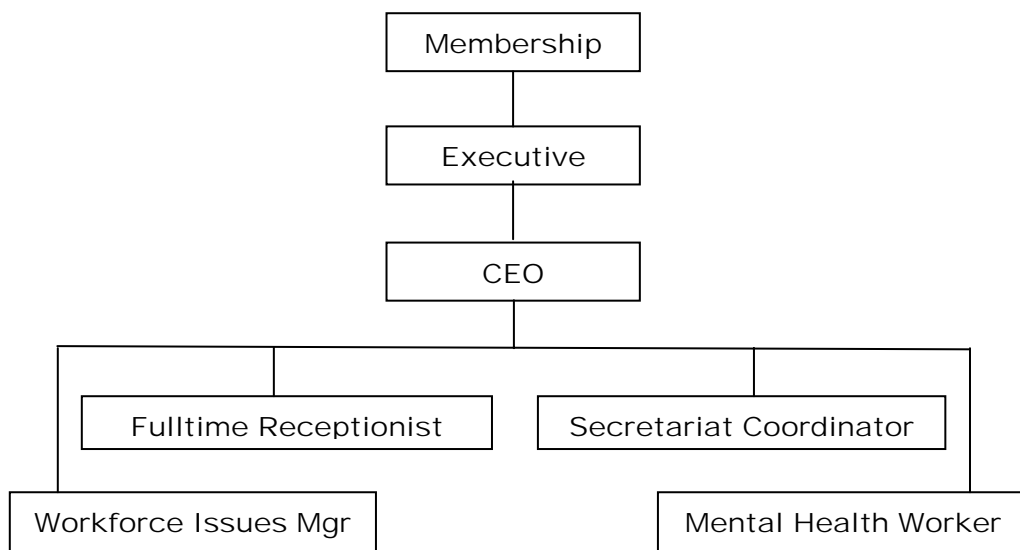
VACCHO STRUCTURE 1996



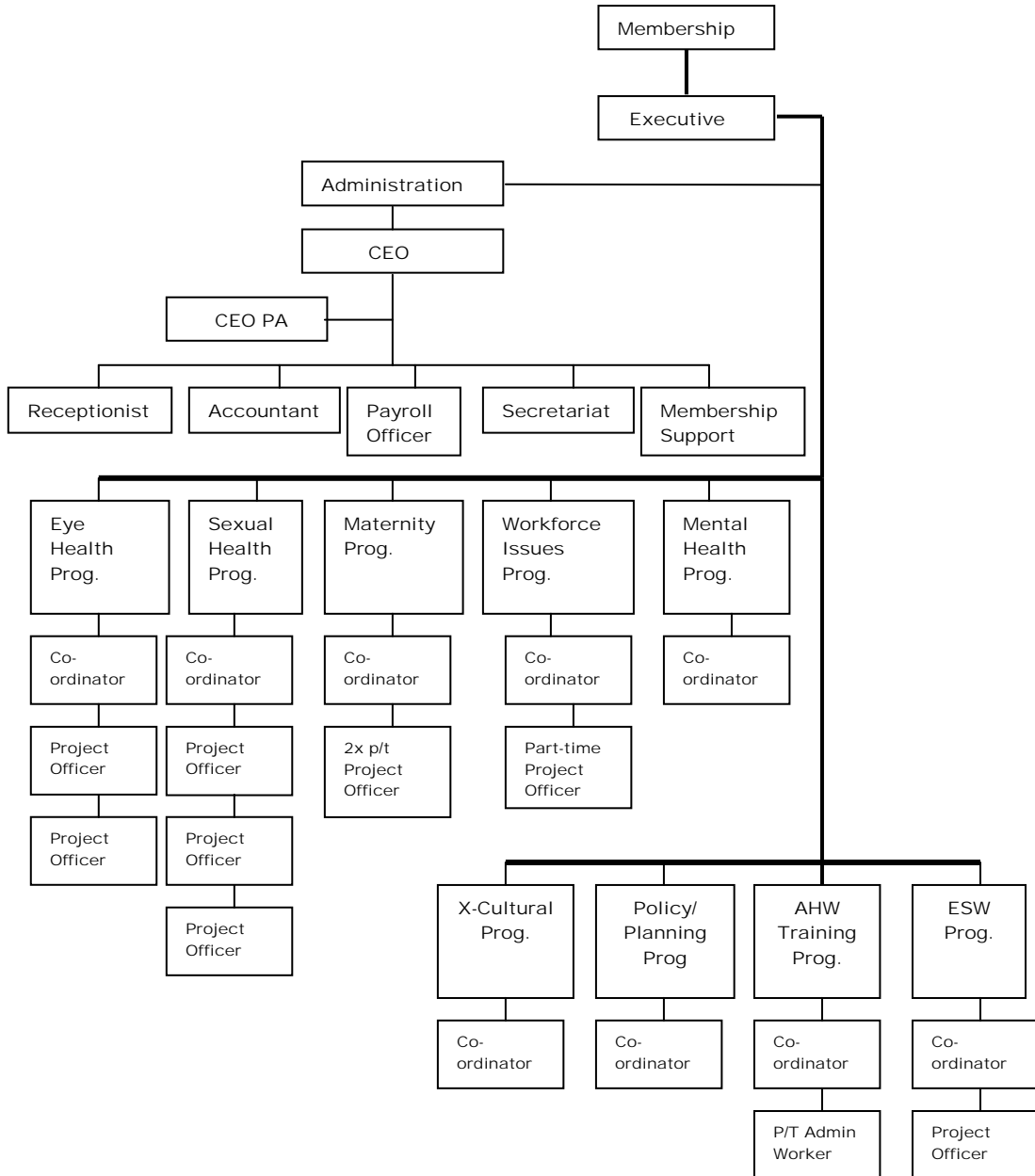
VACCHO STRUCTURE 1997



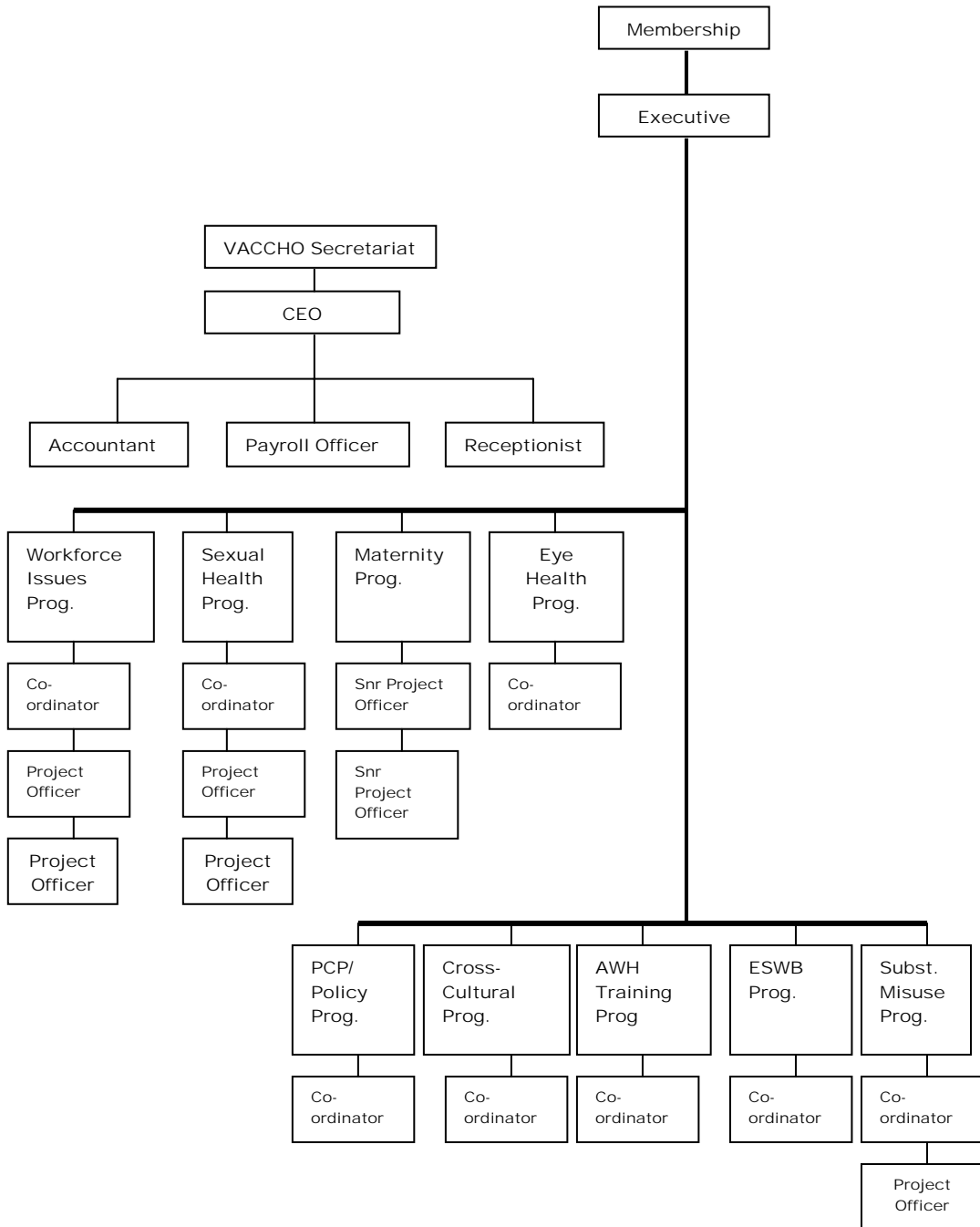
VACCHO STRUCTURE 1998



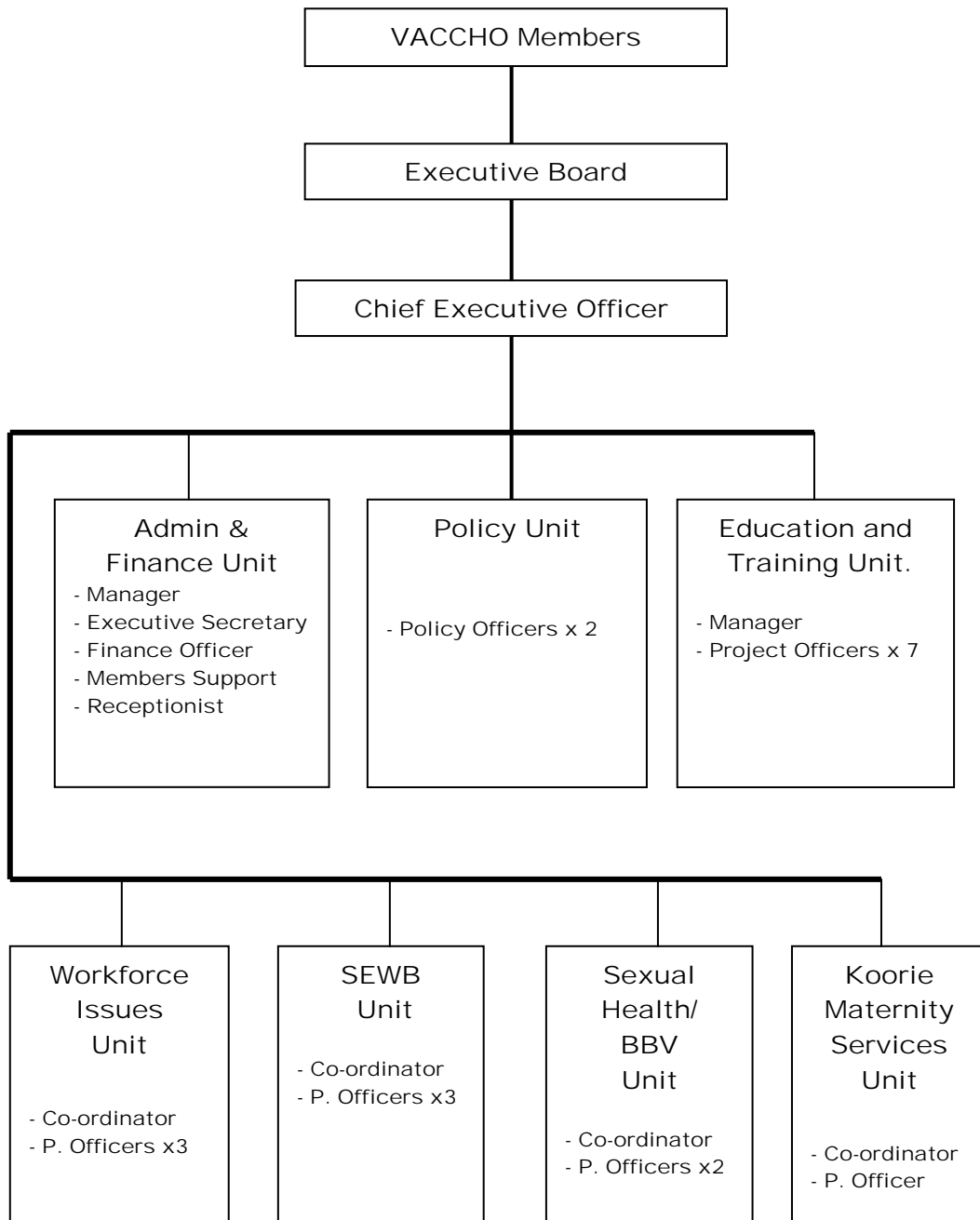
VACCHO ORGANISATIONAL STRUCTURE 2000



VACCHO ORGNISATIONAL STRUCTURE 2001



**VACCHO ORGANISATIONAL STRUCTURE
CURRENT**



Appendix B.

CHRONOLOGY:

- 1967 Referendum**

- 1972 - Department of Aboriginal Affairs**

- 1972 - Redfern Aboriginal Medical Service - Sydney**

- 1973 - Victorian Aboriginal Health Service - Fitzroy**

- 1974 - The Special Health Services Section**

- 1974 Workshop on Aboriginal Medical Services**

- 1974 – 1989 National Aboriginal and Islander Health Organisation**

- 1974 – 1984 South Eastern Aboriginal and Islander Health Organisation**

- 1980 Victorian Working Party on Aboriginal Health**

- 1981 – 1990 Aboriginal Health Resources Consultative Group**

- 1982 – 1989 Koori Kollij & the Aboriginal Health Worker Training Program**

- 1987 National Aboriginal Health Strategy Working Party**

- 1989 National Aboriginal Health Strategy**

- 1989-1990 Aboriginal Health Development Group / Aboriginal Community Advisory Group**

- 1990 - Aboriginal and Torres Strait Islander Health Organisation**

- 1990–1994 Council of Aboriginal Health**

- 1990–1994 Victorian Tripartite Koori Council of Health**

1990–1995 Office of Aboriginal Health

1993 - National Aboriginal Community Controlled Health Organisation

1993/4 Review of the Council for Aboriginal Health & An Evaluation of the NAHS

1994 - Office of Aboriginal & Torres Strait Islander Health

1994 - National Aboriginal and Torres Strait Islander Health Council

1996 - VACCHO

1995 - Council of Australian Governments

1996/7 Aboriginal Health Framework & Outcome Agreements

1996 - Victorian Advisory Council on Koori Health

1998-2003 Koori Services Reform Strategy

1997/8 ATSIK's Community and Youth Support Program

1997–2000 VACCHO Programs

- Management Training.
- Victorian Aboriginal Health Database
- Purro Birik (Health Spirit).
- Emotional and Social Wellbeing (ESWB) Regional Training Centre
- Recruitment Program
- Kalaya Purro.
- Aboriginal Health Worker Training Program.

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