SPLIT THREE ATOMS AND REPORT TOMORROW:

THE FUNDING RELATIONSHIP BETWEEN ABORIGINAL COMMUNITY CONTROLLED HEALTH ORGANISATIONS AND GOVERNMENT DEPARTMENTS

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SUMMARY

AIM

The overall aim of this research is to contribute to policy development and program implementation designed to improve the funding relationship between ACCHOs and government departments. This study investigates the funding relationship between management staff of an Aboriginal Community Controlled Health Organisation and government staff who manage the funding contracts; their perceptions of trust and accountability in their work with each other and whether trust is perceived as enabling more effective working relationships, and the barriers they face in negotiating and maintaining these working relationships with each other. This study adds to the limited knowledge in this area and offers a synthesis of knowledge about trust and accountability and its implication in the funding relationship. Finally, it provides a framework to guide government departments and ACCHOs in strengthening the relationship, to become better aligned with ACCHOs' core business and to reduce the burden on (mostly administrative) resources for both sectors.

METHODS

This research is situated within an Indigenous research approach using a case study method. The conceptual analysis is bound by contract theory and has been conducted as follows:

1. A literature and document review to analyse current funding relationships based on ACCHO and government data and publicly available documents.
2. Interviews with staff of the ACCHO and their government funding bodies.
3. Coding and analysis of the transcribed recordings of interviews, to identify major themes and answer the main research question.

RESULTS

This study found a lack of trust in the funding relationship, and the goodwill of ACCHO and funding staff to improve the relationship mirrors the national relations between Australia's First Peoples and other Australians. The importance of building strong relationships with each other is acknowledged and written into Aboriginal health policies. However, there is a lack of national strategic direction and funding by government to support activities with Australia's First Peoples' leaders and organisations to this end. Building or resetting the relationship is assumed to occur in the 'top down' processes of accountability, funding and activity reporting to government.

Distrust is perpetuated when there is a lack of agreed understanding about purpose and function of ACCHOs – this is to do with history, effects of colonisation and Commonwealth bureaucratic constraints. This is reflected in the current contractual arrangements with ACCHOs that are founded on distrust (which may have two-directional components of negative stereotyping). Government funders have the upper hand in terms of the power and resources to change the way they fund ACCHOs. They could take the lead to reset the relationship by introducing a relational contracting approach. This would demonstrate their commitment and a willingness to achieve mutual goals to work differently with each other.

CONCLUSION

There is the need for dialogue between ACCHO staff and government funding staff that facilitates negotiations incorporating each party's beliefs and values in terms of identity, history, accountability, boundaries and commitments in relation to each other. This will require a re-setting of the relationship in neutral spaces, firstly to gain a reality check of the complex contextual nature of service delivery for the ACCHOs, and secondly, to build a mutually agreeable framework that enables actions and mechanisms for reciprocal accountability. Such a process could be

guided by the facilitated use of Indigenous philosophy such as Ganma and Dadirri - the sharing of knowledge to create new knowledge using a deep form of listening and reflection to respectfully problem-solve issues together.

LESSONS LEARNED

I am hopeful that ACCHOs and relevant government funding departments can benefit from this work, and that it will lead to strategies that develop and maintain long-term relationships between the sectors for continuity of care, workforce sustainability and system development. It is hoped that a framework for dialogue can underpin the maintenance of long-term relationships and lead to simplification of the administrative and reporting requirements attached to funding; better and more focused collection of data, and ultimately to improved health and wellbeing for Australia's First Peoples. Relationships of trust based on reciprocal accountability between ACCHOs and government departments are imperative in strengthening the funding relationship. This research adds to knowledge about the funding relationship between government departments and ACCHOs and provides a framework for dialogue – knowledge which is also applicable to broader health care funding and provision, and potentially applicable to funding and provision of other human and environmental services.

IMPLICATIONS

By understanding the causes of (dis)trust, tensions and barriers in the funding relationship, ACCHOs and government departments may find realistic ways to engage around agreed accountability, governance and community participation goals for effective health care delivery with and for Australia's First Peoples – hence, better health outcomes.

DECLARATION

I certify that this dissertation does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Signed

Kim M O'Donnell

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This dissertation was written on the land of the Kaurna people, the custodians of the Adelaide region. I acknowledge and respect their spiritual relationship with country and their cultural and heritage beliefs that remain important to the Kaurna people today.

PLEASE BE ADVISED

This dissertation includes names of deceased people which may cause sadness or distress to our families.

DEDICATION

This dissertation is dedicated to Elders and family, past, present and future. In particular, to those who have passed away during this research and dissertation write-up (2010–2014) and whose memories remind me to continue to work for our rights to equitable, accessible and effective health care for our people:

Aaron Jones
Alan Wilson/Hunter
aunty Edna May Hunter
aunty Elsie (Pam) Coombs
aunty Margie Anne Whyman
aunty Rita Wilson
Barbara Jayne Hunter
Colin O'Donnell
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Jeffery (Jimmy) Kirby
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Kalinda Bates
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Kayleen Kerwin (Jr)
Leslie (Peanut) Whyman
Mervyn (Humphrey) Bugmy
Maxine Hunter
Rhonda Johnson Riley
Shannon O'Donnell
Stanley O'Donnell
Sugar Webster
Vili Fisi'ikaile
Virginia O'Donnell

ABBREVIATIONS

ACCHO	Aboriginal Community Controlled Health Organisation
ACCHS	Aboriginal Community Controlled Health Service
AHMAC	Australian Health Ministers' Advisory Council
AHREC	Aboriginal Health Research Ethics Committee SA
ATSIC	Aboriginal and Torres Strait Islander Commission
CALD	Culturally and linguistically diverse
CSHISC	Community Services and Health Industry Skills Council
CEO	Chief Executive Officer
COAG	Council of Australian Governments
DFC	Department of Families and Communities SA
DCSI	Department for Communities and Social Inclusion
DoHA	Department of Health and Ageing
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
ICC	Indigenous Coordination Centres
NAHS	National Aboriginal Health Strategy
NATSIHC	National Aboriginal and Torres Strait Islander Health Council
NGO	Non-government organisation
NIRA	National Indigenous Reform Agreement
NPM	New Public Management
NSFATSIH	National Strategic Framework for Aboriginal and Torres Strait Islander Health
OATSIH	Office for Aboriginal and Torres Strait Islander Health
PHC	Primary health care
UNDRIP	United Nations Declaration on the Rights of Indigenous Peoples

DISSERTATION GLOSSARY

Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHOs): agencies that are incorporated under the governance of a (predominantly) Aboriginal and/or Torres Strait Islander community board, rather than being owned by government or non-Indigenous owners (referred to as non-government organisations or NGOs in the report). Many ACCHOs are members of peak bodies in each state and territory. Peak bodies are representative organisations that provide services to the member organisations (corporate support, strategic planning advice and assistance, help with funding negotiations, mediation etc) and advocate on behalf of members with governments and other parts of the health industry. Each state and territory peak body is an affiliate of the national peak body – the National Aboriginal Community Controlled Health Organisation (NACCHO).

Aboriginal or Torres Strait Islander: a person who identifies as such and is accepted by the community in which he or she lives, according to s51 (25) of the High Court ruling in *Commonwealth v Tasmania* (1983) 46 ALR 625.

'Close the Gap' and 'Closing the Gap': 'Close the Gap' was adopted as the name of the human rights-based campaign for Aboriginal and Torres Strait Islander health equality led by Aboriginal and Torres Strait Islander Social Justice Commissioner, Dr Tom Calma and the Campaign Steering Committee in 2006. The term 'closing the gap' entered the policy lexicon as a result of the campaign's activities and has since been used to tag Council of Australian Governments (COAG) and Australian Government Aboriginal and Torres Strait Islander policy-specific initiatives aimed at reducing disadvantage – from the Close the Gap National Indigenous Health Equality Targets 2008 to the seven National Partnership Agreements on Closing the Gap in Indigenous Health Outcomes (2008).

As a general rule, any initiative with 'closing the gap' in the title is an Australian Government or COAG initiative. There is a very important difference in the

meaning and intention between 'close the gap' and 'closing the gap' and it is important to note that 'closing the gap' does not necessarily reflect the human rights-based approach of the Close the Gap Campaign, nor does the use of the term reflect an endorsement by the Campaign Steering Committee.

Core funding: funding for primary health care delivery, administration and rent, including relevant salaries, goods and services.

Country: when Australia's First Peoples talk about 'country', the meaning goes beyond the dictionary definition and, as Mick Dodson (2009:1) so eloquently stated:

> 'For us, country is a word for all the values, places, resources, stories and cultural obligations associated with that area and its features. It describes the entirety of our ancestral domains. All of it is important – we have no wilderness, nor the opposite of wilderness, nor anything in between. Country is country – the whole cosmos. Country underpins and gives meaning to our creation beliefs – the stories of creation form the basis of our laws and explain the origins of the natural world to us – all things natural can be explained.'

While we may all no longer necessarily be the title-holders to land, Australia's First Peoples consider ourselves to still be connected to the country of our ancestors and most consider ourselves the custodians or caretakers of our land.

Culture:

> 'Culture involves complex systems of concepts, values, norms, beliefs and practices that are shared, created and contested by people who make up a cultural group and are passed on from generation to generation. Cultural systems include variable ways of seeing, interpreting and understanding the world. They are constructed and transmitted by members of the group through the processes of socialisation and representation. Culture is dynamic. It changes because people's contexts change…' (Australian Curriculum Assessment and Reporting Authority 2011:13)

Custodian: Australia's First Peoples who are responsible for looking after their country.

Elders: capitalised when referring to Australian Indigenous Elders.

First Peoples: I have chosen to use this term throughout for consistency, even in historical contexts, eg First Peoples and the 1967 referendum to refer to both Aboriginal and Torres Strait Islander peoples, the two original peoples of Australia. The term was introduced into the Australian vernacular by the National Congress of Australia's First Peoples when it was incorporated as a company in April 2010. The role of the company is to advocate for the recognition of Aboriginal and Torres Strait Islander peoples' rights, inclusive of securing an economic, social, cultural and environmental future for First Peoples and building new relationships with government, industry and among communities. As a company the Congress is owned and controlled by its membership and is independent of government.

The First Peoples of Australia are not a single homogeneous group. They are diverse Aboriginal nations, each with its own language and traditions, and have historically lived on mainland Australia, Tasmania or on many of the continent's offshore islands. Torres Strait Islander people come from the islands of the Torres Strait, between the tip of Cape York in Queensland and Papua New Guinea. Torres Strait Islanders are of Melanesian origin and have their own distinct identity, history and traditions. Many Torres Strait Islanders live on mainland Australia.

Funding and regulation: are used to mean the finances that primary health care providers receive largely from governments, the conditions of funding, reporting requirements and accountability measures, and the way the providers and funders relate to each other.

Indigenous: I acknowledge the objections of some Aboriginal and Torres Strait Islander people and organisations to this term. It is used sparingly in the dissertation, where appropriate (for example, 'non-Indigenous people'). It is also

used where repetition of 'Aboriginal and Torres Strait Islanders' would make the text harder to read. This has allowed me to avoid applying the abbreviation ATSI to people, however I do use it to apply to organisations, such as OATSIH. The term 'Indigenous' is capitalised, in keeping with current practice, to indicate its specific use in applying to Australian Aboriginal and Torres Strait Islander peoples. It is not capitalised when used generically to refer collectively to the first peoples of Australia, New Zealand, Canada, North America and other countries around the world. The use of the term 'indigenous' has evolved through international law. It acknowledges a particular relationship of indigenous first inhabitants to the territory from which they originate.

Inter-cultural: describes the collaborative space where Australia's First People and other Australians are working together towards change and progress. This could be any setting in any part of the country—formal or informal.

Mainstream: a generic term that in its use obscures the fact that white people, systems and ideologies constitute the 'main' in the 'stream' (Anderson 2009). It is a term used by Indigenous Australians to refer to non-Indigenous systems, institutions and practices.

Non-Indigenous: individuals/populations of countries that do not identify as members of the community of First Peoples.

Other Australians: members of the dominant communities in Australia.

Primary Health Care (PHC): The National Strategic Framework for Aboriginal and Torres Strait Islander Health (NATSIHC 2003:17) identifies that PHC includes at least the following elements:

- clinical services (for management of chronic and communicable disease, acute care and emergency care)

- illness prevention services (including population health programs such as immunisation, screening programs and environmental health programs)
- specific programs for health gain (eg antenatal care, nutrition, physical activity, social and emotional wellbeing, oral health and substance misuse)
- access to secondary and tertiary health services and related community service (such as aged and disability services).

The concept of PHC is grounded in the Declaration of Alma-Ata, which resulted from the 1978 International Conference on Primary Health Care. There are several elements within the declaration that serve to constitute PHC:

> It is the first level of contact of individuals, the family, and community with the national health care system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. (WHO 1978: vi)

The declaration further asserts that:

> Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. (WHO 1978: vi)

Sorry Business: the period of bereavement for our First Peoples who have passed away.

Self-determination: is fundamental to improving Indigenous health and wellbeing. It means equal entitlement to be in control of our own destinies while living with governing institutions (O'Mara 2012:9).

OUTLINE OF THE DISSERTATION

This dissertation is organised into five main chapters, including researcher reflections.

Chapter 1 introduces the research and includes information about the background, aims and objectives, research questions, justification for the study and its limitations, and outlines the methodology.

Chapter 2 discusses the literature relevant to the funding relationship between the ACCHO and government funding departments responsible for the management of the ACCHO funding contracts that influence in practice how they treat each other. It outlines the literature on principles, history and key elements of ACCHO participation in health care delivery with government.

Chapter 3 presents an Indigenous approach to the methodology by which the research was conducted, including the theory framework that informs the research plan, recruitment, ethical considerations, data collection and management of the data.

Chapter 4 presents the results of the study and analysis, including information about the participants and characteristics of the ACCHO and relevant government-funding departments.

Chapter 5 presents the discussion and conclusion and outlines the implications of the results for professional practice, policy and further research. It concludes with a framework to promote safe places for dialogue between the ACCHO and government funding departments responsible for contract management.

CHAPTER 1: INTRODUCTION

1.1 CONTEXTUALISING THE RESEARCH

Australia's First Peoples continue to experience high levels of mortality and morbidity rates compared to other Australians and indigenous peoples of Canada, Aotearoa (New Zealand) and the United States of America – countries with similar colonial histories (Anderson 2006). This has led to significant community activism in Australia and other Indigenous contexts for community control of health services as reflected in the United Nations Declaration on the Rights of Indigenous Peoples (UN 2007: Articles 23 and 24). The declaration states that health care is a high priority for indigenous peoples around the world who have fought to secure more control over community-based health services, in the hope of improving access and responsiveness.

ACCHOs occupy a unique position as a major provider of essential Primary Health Care (PHC) to Australia's First Peoples*. There are over 150 Aboriginal Community Controlled Health Care Organisations (ACCHOs) across Australia, providing approximately 1.5 million episodes of care in 2005–06 (DoHA and NACCHO 2008).* ACCHOs integrate principles of self-determination with PHC principles in the way they govern, manage and set priorities in the delivery of health care. Efforts to implement funding programs and accountability arrangements constructed on government policy and the integration of these principles are characterised by conflicting goals among multiple parties and by implementation problems. These difficulties arise in contested contexts regarding claims for collective participation and control over health care resources by First Peoples' communities, in spite of official policy statements that support these claims (Dwyer et al. 2011; Anderson 2006).

However, while ACCHOs have similar experiences to other NGOs in regard to funding and reporting arrangements it is the only major sector of the health care system where fragmented contracting is the principal funding mode (Flack and

Ryan 2005; AIHW 2006; McGregor-Lowndes and Ryan 2009; Productivity Commission 2010). This is reflective of a broader policy context of ambivalence from government regarding self-determination and indeed reflective of the broader relationship between Indigenous and non-Indigenous people.

Health care system

In this context, the development of respectful working relationships between the contracting parties is important for both sides, and for the delivery of responsive health care. However, there is limited understanding about what works in the funding relationship between management staff of ACCHOs and staff of government funding departments. Staff on both sides, work under enormous pressures. The ACCHOs are, first, under pressure from community expectations to provide a suite of PHC services that the community require. They often struggle (particularly the small organisations) to keep up with the reporting regime to justify expenditure of public funds – to the detriment of capacity for monitoring and reporting health impact (Dwyer et al. 2011). Government staff, on the other hand, are under pressure from the higher echelons of bureaucracy (which have a large role in determining the formal nature of funding contracts) to provide reports within restricted timeframes (Dwyer et al. 2011). Both the ACCHOs and government funding staff are affected by onerous reporting and administrative requirements, which impact on their working relationship. The Productivity Commission (2010), in an assessment of the relationship between governments and non-government organisations (NGOs), argued that reform is urgently needed to redress the burden, specifically for organisations that provide community services for Australia's First Peoples. The inflexibility of Government funding and reporting regulations for ACCHOs was described by a funder as 'split three atoms and report tomorrow', hence the title of this dissertation.

The funding or working relationship involves middle management government staff including Project Officers, whose role is to provide support to ACCHOs to ensure compliance of funding and reporting regulations and ACCHO management

staff, eg the CEO, Community Board, Program and Financial managers. Communication is primarily by email and phone with limited face-to-face contact.

This work is a case study, underpinned by an Indigenous research approach that originates from the central belief that knowledge is relational and is shared with all human communities and therefore cannot be owned or discovered (Chilisa 2012). The research methods in the study reflect these beliefs and the obligations they imply (Wilson 2001) and these methods are synthesised with Western understandings of knowledge creation, which are explained in more detail in the methodology chapter of this dissertation.

This study is written from a strengths-based perspective privileging the voices of both ACCHO management and government-funding staff. It is written in the first person to situate my position as a Malyangapa/Barkindji woman and to capture my personal journey and the challenges, reflections, concerns and learning that transpired along the way.

1.2 RESEARCHER STANDPOINT

I would like to begin by sharing some personal history and experiences over the years that have led me to this research. I was raised with a strong and proud sense of my identity as an Aboriginal woman and later, in my twenties, I learned I have Irish and German ancestry. Where and how these cultural intersections occurred in my past is research I hope to pursue with my Elders at the completion of this study.

I am a descendant of the Malyangapa/Barkindji peoples; a custodian of the Mutawintji Lands, Western New South Wales, and a mother, academic and public health researcher with a life-long commitment to improving the health and wellbeing of our people and country. My interest in the relationships between black and white Australia has grown from my upbringing and experiences (both good and bad) among and between both groups. In the early 1970s, when I was ten years old, my family moved from the small country town of Wilcannia in Western

New South Wales to Sydney. It was a time of social and political movement in Australia and other parts of the world, particularly in countries of similar colonising and dispossessing backgrounds for Indigenous peoples, as explained in more detail in Chapter 2.

My mother sought employment at the Redfern Medical Service, the first ACCHO in Australia, and was employed as the first female bus driver within the organisation. My sisters, cousins and I were often taken to social movement activities by mum and aunties - the street marches about land rights and social justice. There are memories of being dragged along to numerous adult meetings that I thought at the time were quite boring to a ten year old child. In hindsight, these were safe spaces where elders (both black and white) strategised ways to address the systemic racism experienced by our people, the ill health and premature deaths, and the need for equitable access to treatment in health services, to ensure our First Peoples understood diagnosis and treatment and were regarded with respect and empathy by the health care system staff. In the early 1990s I was also employed by the Redfern Medical Service to assist Elder, Dulcie Flowers in the data collection and analysis of a hepatitis B project. The experience was my first introduction to researching Aboriginal health. However, I didn't pursue a career in the area until many years later - in 2002, after working in a variety of careers as a primary school teacher, small business operator, flight attendant, and becoming a mother– a life-long responsibility.

I've chosen to write this dissertation from a 'glass half full' perspective, which is a reflection of how I live my life. This does not imply glossing over the stark realities of the causes of ill health of Australia's First Peoples and the continued lack of access to appropriate health care. Rather, I acknowledge the multiple realities and structures that work towards solutions and those that obstruct.

1.3 CONTRIBUTION OF THIS STUDY

I seek to contribute to the understanding of solutions and barriers through this study by providing knowledge for both ACCHOs and government departments that may help to strengthen their relationship for effective health care delivery. This work builds upon my participation in the Overburden project that found trust in the funding relationship is significant in negotiating accountability between ACCHOs and government funders and that this is an area for further investigation (Dwyer et al. 2011). This research is a separate study that contributes to one specific aspect of the ways government departments and ACCHOs work with each other. It explores the funding relationship from their perspectives, that is, their understanding of accountability to each other, and the extent to which the funding contracts enable the foundational building of equivalent partnerships in the funding relationship.

1.4 AIM AND RESEARCH QUESTIONS

1.4.1 AIM

This study aims to add to knowledge about how problems in the funding relationships might be better managed or resolved, from the perspectives of the participants themselves. It examines whether trust is perceived as enabling more effective working relationships, and the barriers they face in negotiating and maintaining accountable relationships with each other. Finally, it aims to provide a framework to guide government departments and ACCHOs in building upon relationships that are better aligned with ACCHOs' core business and to reduce the burden on (mostly administrative) resources for both sectors.

1.4.2 RESEARCH QUESTIONS

This study set out to answer this question- How do staff from ACCHOs and government funding staff think about trust and accountability in their funding relationship with each other and how can this relationship be strengthened for better health care for Australia's First Peoples?

The study addresses four sub questions:

1. How do staff in an ACCHO think about and enact their accountabilities to community and government funding departments?
2. How do staff in government-funding departments think about and enact their accountability to the ACCHO and community?
3. What are the gaps, overlaps or conflicts between the parties of the funding relationship as they seek to meet their own accountability requirements and negotiate the relationship?
4. How might tension between the two be resolved or reduced?

1.5 JUSTIFICATION OF STUDY

In general, we know that most Australians believe the relationship between Australia's First Peoples and other Australians is important and that Australia's First Peoples' cultures are important to Australia's identity as a nation. However, when it comes to trusting each other, numbers in both groups are low and only around half believe it is strong and improving (Auspoll 2012). This shows there is goodwill but it is not translating into better relationships. If better relationships are to be built, all Australians must first understand the underlying values and perceptions that shape the relationship. The low levels of trust between Australia's First Peoples and other Australians suggest relationships are less likely to begin and are more likely to break down (Auspoll 2012). Trust in relationships between funders and providers of PHC in this context is developed and maintained based on agreed mutual responsibilities and the day-to-day negotiation of separate accountability requirements. By understanding the causes of tensions and barriers in the relationship, the ACCHO and government staff may find realistic ways to enhance their funding relationship and thereby better support agreed service delivery, governance and community participation goals in support of better health outcomes for Australia's First Peoples.

This work explores ways of talking about the funding relationship between ACCHOs and Australian government staff who manage the funding contracts. It explores

what works, why and how, in relation to the different tensions and barriers these groups face in their accountability to each other. This study challenges the funding contracts that are based on distrust that government apply to ACCHOs.

1.6 LIMITATIONS

There are three key limitations to my analysis. Firstly, my perspective as a researcher of Aboriginal descent is deeply engaged in the issues the ACCHO sector addresses. In order to address the potential for bias in my analysis, I made a conscious effort to attend to the perspectives of government funding staff, recognising that this study required a balanced understanding of both perspectives. Secondly, this study is also limited by the absence of the perspectives of the ACCHO. Thirdly, the fact that this study examines the perspectives of a small group of management staff in one ACCHO and their funders may also be seen as a limitation. The case study approach was chosen to enable in-depth understanding of the experience on both sides of a particular case of the funder-provider relationship. The limitations of case studies are acknowledged, and claims for generalisability are not made on the basis of the data. However, other researchers may use the theoretical analysis developed from the data to make predictions about contracting in their environment.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

This chapter presents an overview of policy and services for Australia's First Peoples' health, in the overarching context of colonisation. First, I explore the role, history and models of ACCHOs and their significant role within the health care system. Second, I highlight the history of Aboriginal health policy within the broader policy context and the public administration methods known as New Public Management. Thirdly, I provide an account of ACCHOs' engagement with government, followed by NACCHO perspectives on health care and principles of engagement. Finally, I discuss contract, trust and accountability theory in the context of Indigenous health. I have written about the NACCHO principles in detail to reiterate their significance for government staff when engaging with ACCHOs. The development of trust and accountability in the management of the contractual relationships continues to be fraught, due in part to the unresolved tension between NPM-inspired approaches on the one hand, and methods of engagement preferred by Aboriginal health organisations on the other. Literature used to inform both the methodology and methods of analysis is discussed in Chapter 3.

My approach to this review is framed by a strengths-based perspective in opposition to government policies and practices that 'talk the deficit talk' about Australia's First Peoples' health followed by 'the deficit walk' in terms of how they contract and (dis)engage from a more constructive funding relationship with ACCHOs, thus preventing ACCHOs from exercising, in particular, their right to development in accordance with their own needs and interests (UNDRIP 2007). I was particularly interested in literature that explains what works, why and how, and what requires change to strengthen the relationship. This approach also discusses Indigenous theories that promote psychological safety for open and honest dialogue, particularly in intercultural/inter-racial settings that is, Aboriginal health (Chapter 3).

In this chapter I aim to present information in a way that is respectful of Australia's First Peoples' history and acknowledges our perspectives of events, past and present. This chapter provides evidence for the need to address an alternative approach to contracting with ACCHOs, one that promotes the building of respectful funding relationships with Australia's First Peoples in a way that does not perpetuate the colonising acts of the past and present. This review presents the story synergistically to provide a deeper understanding about ACCHO and government departments' accountability relationship to each other from the ground up.

2.2 METHOD

A focused and selective review that examined the funding relationship between ACCHOs and government departments was undertaken. Subsequent reviews of more recently published literature continued throughout the research period (2010-2013). The review approach was underpinned by Indigenous research theory to challenge deficit thinking and pathological descriptions of colonised peoples and to reconstruct a body of knowledge that carries hope and promotes transformation and social change (Chilisa 2012). The approach acknowledges that multiple realities are socially constructed with multiple connections that human beings have with the environment, the cosmos, the living and the non-living (Chilisa 2012). Emphasis is placed on valuing and promoting respectful representation, reciprocity and self-determination of Australia's First Peoples. The primary criteria were that the literature explored a link between ACCHOs and government departments' understandings of their funding relationship with each other in the delivery of health care to Australia's First Peoples.

An electronic search was conducted on Flinders University library databases using the keywords 'trust', 'relationship', 'community control', 'government', 'Aboriginal', 'Indigenous', 'First Peoples', 'health' and 'accountability'. The search was limited to journal articles that were refereed and available in full text.

The primary search provided a base for understanding some of the methodological complexities and rigorous debates in this field. In my search, I found many studies that focused on the health and other deficits experienced by Aboriginal people. But the results were few when the search was narrowed for materials on the concepts of trust and accountability between ACCHOs and government departments. The primary search also highlighted that there was a substantial gap in qualitative research examining this relationship and in particular, those relationships from an Indigenous research approach. Additional searches on other published literature, including books and texts, were also conducted, with reference lists from articles kept for inclusion in the review. These sources were used to search for further relevant studies in relation to understanding the relationship between government departments and PHC providers, and implications for effective PHC delivery for Australia's First Peoples.

Given my theoretical interest in relationships between Australia's First Peoples and other Australians, a secondary literature search was conducted in strengths-based approaches to research with First Peoples. The search included journal articles that were refereed and available in full text, as well as hard-copy published texts. The secondary search was essential methodologically for support with research design, analysis, theory generation, and defining of concepts and terms pertinent to the proposed area of study. Literature from the secondary search is discussed in greater detail in Chapter 3. Grey literature in the form of government and organisational reports, reviews, discussion papers, working papers, briefings, conference papers and speeches also informed this research.

2.3 OVERVIEW OF ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

There are approximately 550,000 people who have identified as Aboriginal and/or Torres Strait Islander descent, equating to around 2.5% of the Australian population (ABS 2011). Up to 75% of Aboriginal and Torres Strait Islander people

are located in major cities and regional areas, with the remaining 25% located in remote areas (CSHISC 2012:8). To understand the health needs of Australia's First Peoples, it is important to be mindful of the needs of all Australia's First Peoples living in urbanised, rural and remote settings and that these needs may be quite different depending on social, political, historical and environmental circumstances.

In comparison with the wider Australian population, Australia's First Peoples on average die younger, have drastically higher rates of ill health and are more likely to have a disability. The majority of health concerns experienced by Australia's First Peoples are those of a chronic nature, such as cardiovascular disease, cancer, respiratory disease, diabetes, mental illness and oral health problems. The health issues experienced by Australia's First Peoples are shaped by high levels of socioeconomic disadvantage (CSHISC 2012:8) and contextual circumstances over time.

As summarised by Mason et al (2013:184) - in 2008, 26% of Australia's First Peoples aged 15 years and over reported problems with accessing health services. Access problems were higher in remote areas (36%) than non-remote areas (23%). Of the people reporting problems accessing services, almost 20% reported problems accessing dentists, followed by doctors (10%), hospitals (7%) and Aboriginal and Torres Strait Islander health workers (6%). The major barriers identified in accessing health services include:

- long waiting times and/or help not available at the time requested (52%)
- not enough services in the area (42%)
- no services in the area (40%)
- transport/distance issues (34%)
- cost of the service (32%)
- distrust of services (10%)
- services not culturally appropriate (7%) (AHMAC 2012)

Chronic disease is identified in the Aboriginal and Torres Strait Islander Health Performance Framework 2012 as a major area of concern. The Department of Health and Aging (DoHA) was advised that during the development of the National Aboriginal and Torres Strait Islander Health Plan (2013-2023), numerous health experts and Aboriginal and Torres Strait Islander community members suggested that barriers to early detection of chronic disease include a lack of understanding of the role of PHC services, limited understanding of how welcoming services are to Aboriginal and Torres Strait Islander people, the importance of the relationship with health care providers as well as trust in the providers, and communication issues (Mason et. al. 2013). These issues are not new to ACCHOs and other First Australian organisations and their partners, who have advocated over many years for Australian governments to improve their relationship with Australia's First Peoples, with the hope that the flow-on benefits will improve the equitable distribution of funding and how health care is delivered for early treatment and prevention that leads to better health outcomes for Australia's First Peoples.

2.3.1 THE ROLE, HISTORY AND MODELS OF ACCHOs IN THE AUSTRALIAN HEALTH CARE SYSTEM

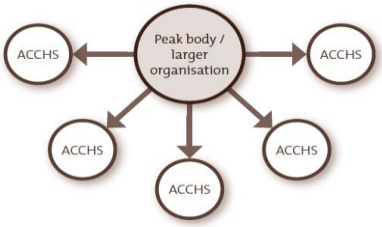
ACCHOs are significant providers of health and wellbeing services to Australia's First Peoples. They are well placed to work with local communities to grow and provide health care services and programs that effectively meet community needs.

ACCHOs are generally governed by an elected Board, and vary significantly in scope, organisational structure and geographic location. They range in size from small remote clinics that may employ some resident clinical staff and/or are dependent on fly-in fly-out clinical support , to large, complex multifunctional organisations in urban and regional communities that employ doctors and other clinicians (Silburn, Thorpe & Anderson 2011). *See figure 2.1.*

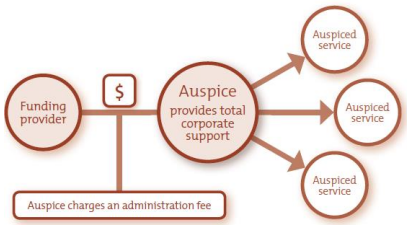
ACCHOs emerged in the early 1970s to provide access to culturally appropriate PHC that many First Peoples were not receiving in mainstream organisations due

primarily to systemic racism - a 'failure of the health care system to provide an appropriate and professional service to people because of their colour, culture or ethnic origin' (NATSIHP 2013-2023:51). Most early ACCHOs were established in urban settings and were proactively led by Australia's First Peoples and activists in an environment of strong political activism with other Australians and communities. International commitment to PHC was formalised in the Declaration of Alma-Ata (WHO 1978) – less well known is the influence and participation of Australia's First Peoples in the drafting of the declaration (People's Health Movement, 2011). Essentially, ACCHOs aim to provide communities with more control over their own health and wellbeing, (Silburn, Thorpe & Anderson 2011).

Figure 2.1 Four main models of ACCHOs (Silburn, Thorpe & Anderson 2011:36)

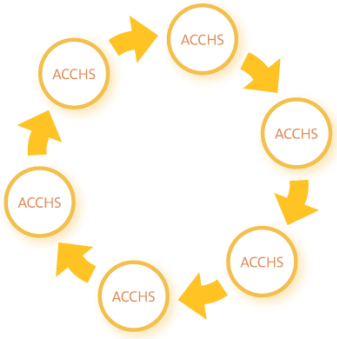


Large or peak organisation model – Queensland Aboriginal and Islander Health Council



Auspice model – Central Australian Aboriginal Congress

Regionalised or central support model – Katherine West Health Board



Peer support model – Bila Muuji Health Services Incorporated

Today there are more than 150 ACCHOs in rural, remote and urban areas across Australia, representing a significant sector of the Australian health care system (Martini et al. 2011). In some remote communities, ACCHOs are the main providers

of health care, and some ACCHOs also provide care to significant numbers of non-Indigenous people living on isolated properties and/or have personal relationships with Aboriginal and/or Torres Strait Islander People, e.g. Katherine West Health Board in Northern Territory and Maari Ma Aboriginal Corporation in Western New South Wales. Consequently, ACCHO viability and sustainability as part of the health care system is critical.

The nature of funding ACCHOs and current funding arrangements

Over many years ACCHOs have succeeded in obtaining 'patchwork' funding from Australian governments - the main funder is the Australian Government (Commonwealth). Similar funding arrangements also occur in Canada and Aotearoa (New Zealand) between governments and indigenous peoples with comparable colonial backgrounds (Lavoie 2005) founded on systemic racism. Australian governments have established a range of funding programs and contractual arrangements to support the ACCHO sector. However, over the years funding arrangements have become increasingly complex and uncoordinated, resulting in more reporting and more complicated bureaucratic processes, described by Dwyer, O'Donnell et al. (2009) as an 'overburden' on ACCHOs. Intermingled with changes related to funding are overall changes to business practices and technological developments which have increased the complexity of the way organisations operate. In reality, these multiple changes frequently require considerable skill levels outside those currently accessible to many community members who are required to manage services, creating a dependency on people from outside communities (Palmer 2005). There is a lack of relative resources flowing to the sector compared to the health needs of Australia's First Peoples' populations which is further compounded by the increase in complexity of operation, management and functioning of ACCHOs (Palmer 2005). Silburn, Thorpe and Anderson (2011), reported that ACCHOs generally receive very little funding to support the corporate functions of their services because numerous government funding allocations are program or project-based.

The principle of community control

The principle of community control requires that ownership and management of the health organisation is vested in the local First Peoples community, generally through the mechanism of a local Aboriginal and Torres Strait Islander board of management. The process is seen to enable the local community to decide on its priorities, policies, management structure, staff and service profile (within funding guidelines) when most of the funding comes from governments (Dwyer, Shannon & Godwin 2007).

Decision-making authority over health care is entrusted to the local community level within the constraints of funding and regulation which is the stated policy intention. The model is founded on the central role of the community and its delegation of decision-making responsibilities in health to the Aboriginal community-controlled health board. Formal state and national government partnership and funding arrangements influence the way in which the organisation is managed, as does a range of other linkages with mainstream service providers and non-health sector organisations (Dwyer, Shannon & Godwin 2007).

The ACCHO experience has much in common with other government-funded non-profit organisations (Flack and Ryan 2005; AIHW 2006; McGregor-Lowndes and Ryan 2009; Productivity Commission 2010); however, there are several significant differences. As noted by Dwyer et al. (2009, 2011), firstly, the ACCHO sector occupies a unique position as a major provider of essential PHC to Aboriginal and Torres Strait Islander communities, providing approximately 1.5 million episodes of care to Aboriginal and Torres Strait Islander Australians in 2005–06. The immunisation coverage rate for two year old Aboriginal children is now nearly at the same level as the general population (Aboriginal children 92.3% compared to 92.6% of other children) (DoHA and NACCHO 2008). This is the only sector of the health care system where patchwork contracting is the principal method by which Australian governments fulfil their responsibility for essential PHC.

Secondly, ACCHOs incorporate principles of self-determination with principles of PHC in their approaches to governance and management, priority setting and health care delivery. Attempts to implement funding programs and accountability arrangements based on government policy inclusive of these principles are characterised by conflicting goals among multiple parties and by implementation problems. These problems arise in an intercultural environment of underlying disagreements regarding rights for collective participation and control over health care resources by Aboriginal communities, in spite of official government policy statements that support those rights (Anderson 2006).

For indigenous providers, the relationship that underpins the contract is as important as the document or the agreement itself (Boulton 2005). To understand ACCHOs, their struggle and significant role within the health care system, it's important to consider the overall policy context in which Aboriginal and Torres Strait Islander health improvements are situated.

The National Aboriginal and Torres Strait Islander Health Plan (2013-2023)

In Australia the new guiding policy document is the National Aboriginal and Torres Strait Islander Health Plan (NATSIHP 2013-2023). For the first time, the policy is founded on a human rights approach, that is, the United Nations Declaration on the Rights of Indigenous Peoples (2007) and other rights-based policies. The aim is to provide equitable opportunities for health by ensuring the availability of quality, comprehensive PHC services that are accessible and acceptable to Australia's First Peoples. The plan links both policy development and the development of goals and targets and highlights extra risks and opportunities for health and wellbeing programs prior to any financial decisions being made. The policy states that a rights-based approach is not primarily about more services but about improving services already established through better-informed policy, practice and service delivery decisions and to put in place processes that enable Australia's First Peoples to participate in all levels of health care decision-making.

The national plan acknowledges for the first time that many Australians support the need for constitutional reform - one that acknowledges Aboriginal and Torres Strait Islander Peoples as the First Peoples of Australia and the oldest surviving culture in the world. The health plan recognises the need to address systemic racism in order to maximise First Peoples' engagement and ongoing participation in all levels of decision-making affecting health needs. It suggests Governments take the lead to grow opportunities for engagement and collaboration with individuals, ACCHOs and other health-related services to enable community control in decision-making, to support a skilled and appropriate workforce and is adequately funded and valued as a critically important part of the health care system (NATSIHP 2013-2023:17). In rhetoric, the health plan fits with ACCHOs' values and principles of community control and self-determination. However, national dialogue between the public (governments), private (for profit organisations) and community (not for profit, community networks) in terms of a formal process of how implementation of the plan across states and territories is achieved is yet to occur.

2.4 INDIGENOUS POLICIES AND PRACTICES SINCE 1788

This dissertation is underpinned by Robert's policy definition quoted in Jenkins (1978:15) as:

> A set of interrelated decisions taken by a political actor or group of actors concerning the selection of goals and the means of achieving them within a specified situation where these decisions should, in principle, be within the power of these actors to achieve.

This section briefly describes the major policies, practices and beliefs that have impacted on Australia's First Peoples since colonisation in 1788. The literature argues that all legal Acts imposed on Australia's First Peoples from the 1890s are reflective of racism entrenched in cultural violence and enacted by government institutions (Eckermann et al 2006). These broader policies and practices are summarised in Table 2.1 below.

Because this research is based in South Australia, it's important to understand the broader historical context of this particular state compared to other states and territories and the implications this had/has on relations between Aboriginal people from South Australia (with connection to country) and other cultures that have moved to South Australia over time.

South Australia - a humanitarian colony

The British history of South Australia (SA) is somewhat different to the invasion of other states because SA was established as a humanitarian colony. In other words, it was invaded by 'free' people as opposed to convicts, in other states known as penal colonies (Gale 1972).

Understanding SA history has particular relevance to this research because values and beliefs assumed to be operating in SA as a humanitarian colony at the time (including general ideas of social reform, humanitarian ideals and freedom), were intended to enable Aboriginal people to assimilate and become an intrinsic part of South Australian society (Gale 1972), with the same rights as other South Australians. In 1834, Governor Hindmarsh proclaimed that mistreatment of Aboriginal people would be a punishable offence (Gale 1972). In spite of good intentions, the reality of colonial experiences within SA became similar to those in the penal colonies.

The pursuit for land, and resources dominated by European culture and ideology, was and continues to be contested to the detriment of Australia's First Peoples cultures today. This demonstrates a continued point evident in the forthcoming sections – that throughout Australian history there was goodwill with respect to Aboriginal people, however, conflicting intentions and priorities of the powerful groups got in the way of improving the health and wellbeing of Australia's First Peoples. As stated by Hemming and Rigney (2010), there remains unfinished business fundamentally affecting the ethics of the relationship because equitable settlement between Indigenous people and the State, based on the spirit of the original Letters Patent of 1836, and the foundational document of South Australia

(see Berg 2010; Trevorrow et al. 2007), is yet to be achieved between government researchers and Indigenous nations such as the Ngarrindjeri.

Table 2.1 Australian government policies, practices and underpinning beliefs (1788 - 2013)

Policy Direction	Years	Policy intent & underpinning beliefs
Terra Nullius European invasion	1788 - 1880s	Empty land-belonging to no-one Indigenous people constructed as having no culture, or humanity-labelled as the 'missing link' in Darwinist theory
Protectionism or segregation	1890 - 1950s	'Smoothing the dying pillow' - intent to care for Indigenous people until their inevitable extinction, a duty to 'civilise the savages' Growth of Missions and missionaries Establishment of Reserves
Assimilation	1950 - 1960s	Indigenous people expected to assimilate into white communities
Integration	1967-1972	Pressure to make up for past mistakes 'Choice' to integrate or not, and to express what is needed
Self determination	1972-1975	Multiculturalism - recognition of different cultures Should be in charge of own affairs
Self-management Stage 1	1975-1988	Aboriginal people should be accountable for their decisions and management of own affairs/finances
Self-management Stage 2	1988-1996	Aboriginal affairs to be organised under Aboriginal and Torres Strait Islander Commission (ATSIC) - take responsibility for housing, welfare, health, education and employment. High Court recognition of prior ownership of Australia (Mabo case)
Reconciliation - Economic Rationalism	1996-2004	Stolen Generation Inquiry - reluctance by government to accept impact of colonisation. ATSIC dismantled by the Howard government due to corruption allegations and litigation. Criticised by Indigenous women for being dominated by males.

Mutual obligation	2005-2007	Intent to share responsibility; for health and wellbeing with government. Indigenous people were to show their commitment to improve living standards in exchange for infrastructure and services most mainstream communities already accessed. Characterised by the example of a remote WA community given a petrol pump in exchange for Aboriginal families 'ensuring their children's faces were washed and that they attended school. (McCausland & Levy, 2006)
Northern Territory Emergency Response or 'Intervention' (NTER)	2007 - ongoing	Australian Government response to report into child sexual abuse in remote Indigenous communities. The policy suspended aspects of the Anti-Discrimination Policy, introduced income management for welfare recipients and sought to take over land leases to provide access for programs of infrastructure development.
Closing the Gap	2008 - ongoing	Aimed at addressing the discrepancies in Indigenous life expectancies and disadvantage through education and employment.
The Apology	2008	Prime Minister Kevin Rudd presents the apology accepted widely among both Indigenous Australians and the non-indigenous general public.
Endorsement of the UN Declaration on the Rights of Indigenous People	2009	Although Australia was one of four countries (along with the United States, Canada and New Zealand) that didn't sign the Declaration in 2007, the Federal Government revised its position and announced its official endorsement of the Declaration on 3 April 2009.
Congress of Australia's First Peoples	2010	Establishment of a national representative body for Aboriginal and Torres Strait Islander peoples - 6 years after abolition of ATSIC. Congress of Australia's First Peoples applies gender parity of Board members.

Adapted from Eckermann et al. 2006 & Taylor 2011

Australian Government policy relating specifically to the health of Australia's First Peoples dates from the 1967 referendum, which provided the Australian Government with powers to legislate for Australia's First Peoples. Prior to the 1967 referendum, health services for Australia's First Peoples and all other services were exclusively a state responsibility and were not delivered within a national policy framework (NATSIHP 2013–2023).

Between 1967 and 1995 there was insufficient action at the Australian government level to improve services for Australia's First Peoples in the mainstream. Between 1995 and 1996 responsibility for Australia's First Peoples' health and substance misuse programs was transferred from the Aboriginal and Torres Strait Islander Commission (ATSIC) to the then Department of Health and Aged Care (NATSIHP 2013–2023).

Numerous authors argue that the development of future policies must be informed by the policy history, with particular inclusion of past implementation failures, and should be underpinned by existing agreed principles for which there is strong evidence (NACCHO 2012; Brands & Silburn 2013). Significant Indigenous policy and practices that relate to this dissertation are:

- The National Aboriginal Health Strategy (1989)
- The National Strategic Framework for Aboriginal and Torres Strait Islander Health (2003)
- The United Nations Declaration on the Rights of Indigenous Peoples (2007)
- Close the Gap (Oxfam)
- Council of Australian Governments - Closing the Gap reform agenda (2008)
- National Health and Hospitals Reform Commission (NHHRC 2009)
- Establishment of the National Congress of Australia's First Peoples (April 2010)
- Leadership meetings facilitated by Congress
- The National Aboriginal and Torres Strait Islander Health Plan (2013-2023)

2.4.1 THE NATIONAL ABORIGINAL HEALTH STRATEGY

In 1973, the National Policy for Aboriginal and Torres Strait Islander Health aimed to improve the health of First Peoples up to the level of other Australians within ten years. The failure of the plan and the successive Aboriginal Public Health Improvement Program (1981–1985) steered Commonwealth, state and territory Ministers of Health and Aboriginal Affairs to agree in December 1987 to the development of a National Aboriginal Health Strategy (NACCHO 2012). A Working Party inclusive of strong representation from community-controlled health services was established, followed by a year of extensive consultations and the delivery of the National Aboriginal Health Strategy (NAHS) to a joint Ministerial Forum in March 1989 (NACCHO 2012).

The Australian Government assigned responsibility for implementation of the NAHS to an inter-departmental Aboriginal Health Development Group, which, significantly, did not include any Aboriginal representation. In 1990 the Australian Government's commitment of $232 million over five years was less than 20% of the cost of implementing the NAHS as estimated by the Development Group, with full implementation dependent on extensive contributions from state and territory governments (NACCHO 2012). The 1994 NAHS Review concluded that the NAHS had never been fully implemented.

2.4.2 THE NATIONAL STRATEGIC FRAMEWORK FOR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH (2003)

In 1999 the newly established National Aboriginal and Torres Strait Islander Health Council (NATSIHC) (a sub-committee of the Australian Health Ministers' Advisory Council on which all jurisdictions were represented) proposed the development of a new Aboriginal health strategy. The National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH) was endorsed by all Australian state and territory governments in July 2003.

Each government was committed to developing accountability and monitoring processes for the implementation of the framework within its own jurisdiction and, disappointingly, the provision of funds for implementation was deferred, to be determined by each jurisdiction's budget processes. In other words, the national policy lacked both the resources and performance targets.

In April 2004, the government (made up of members of the Liberal–National Coalition) led by Prime Minister of Australia John Howard announced the introduction of significant changes to the delivery of services to Australia's First Peoples, distributing across all relevant government departments the responsibility to implement coordinated programs for Aboriginal and Torres Strait Islander people via a whole-of-government approach (Altman & Hinkson 2007; Sullivan 2009). The emphasis on improving the performance of the public health sector through the adoption of the process saw the trialling of the integration of policy development, service delivery and engagement with communities, with a focus on achieving outcomes (Dugdale & Arabena 2008). These approaches were expected to motivate national advancement in the delivery of services to Australia's First Peoples and organisations implementing the approaches were required to commit to the implementation of the policy frameworks. It was believed these and other types of government initiatives had the potential to overcome the disadvantage experienced by Australia's First Peoples and to effect inter-generational change (Anderson 2006).

However, the Australian Government discarded national and regional representative structures for Indigenous Australians by removing ATSIC, which was the national mechanism or representative voice that government agencies could use to consult and engage Australia's First Peoples as a collective in activities that impact on housing, employment and other outcomes. ATSIC dissolution did not affect ACCHOs per se because ACCHOs operate under the health departments' structure. However, the 2004 policy changes disengaged collective, legitimate relationships between governments and Indigenous citizens, necessitating a rethink

of how to broker health improvements nationally with Australia's First Peoples (Dugdale & Arabena 2008).

Accepting responsibility for appropriate engagement and designing policies and programs that are accessible to Indigenous communities is crucial. Unfortunately, the national health care system has underperformed in promoting Aboriginal health and continues to facilitate and fund mainstream programs that are inaccessible to large populations of Australia's First Peoples (NHHRC 2008; Eckermann et al. 2010).

2.4.3 COUNCIL OF AUSTRALIAN GOVERNMENTS – CLOSING THE GAP REFORM AGENDA (2008)

In March 2008 the Council of Australian Governments (COAG) agreed to six targets for closing the gap between Indigenous and non-Indigenous Australians, including closing the life expectancy gap within a generation and halving the gap in mortality rates for children under five years of age within a decade. Commonwealth and state/territory governments agreed to fund against seven 'building blocks' (early childhood, schooling, health, economic participation, healthy homes, safe communities, governance and leadership) contained in the National Indigenous Reform Agreement (NIRA). Unfortunately, there was limited Aboriginal participation in the 'Closing the Gap' reform process, resulting in a lack of focus on some key strategies, including the importance of community-controlled PHC and the need for an evidence-based approach (NACCHO 2012).

2.4.4 NATIONAL HEALTH AND HOSPITALS REFORM COMMISSION (NHHRC 2009)

Following the election of the Rudd Labor government in 2007, the National Health and Hospitals Reform Commission was established to conduct an extensive review of Australia's health care system. It made a number of key recommendations regarding Aboriginal health, including (most critically) the establishment of a National Aboriginal and Torres Strait Islander Health Authority as a concentrated funding source for Aboriginal and Torres Strait Islander health and to ensure all

health services are accountable for addressing Aboriginal health issues (NHHRC 2009). The need to reorientate the health care system towards comprehensive PHC was identified (including the important role of community-controlled health services); improved training for the Aboriginal health workforce and increased funding for Aboriginal health was also recommended.

2.5 NEW PUBLIC MANAGEMENT: STRUCTURAL PRESSURES

For the past thirty years, government agencies and non-government agencies (including ACCHOs) that are funded by governments have been required to reduce or abandon mutual forms of decision-making. This has intensified in recent years with the shift away from 'grants' to 'contracts' that reduced flexibility for the service providers and increased reporting and audit requirements. The shift was influenced by specific assumptions about human behaviour focused on individualism, instrumentality and individual rationality, which formed the basis of neo-liberalism and was expressed in the public sector as New Public Management (NPM) (O'Flynn 2007).

The NPM program included new performance-motivated administration and institutional arrangements, new structural forms and new managerial policies (O'Flynn 2007; Kelly 1998; Lynn 1998). The core principles of NPM are:

1. Economic markets should be the model for relationships in the public sector.
2. Policy, implementation and delivery functions should be separated and constructed as a series of contracts.
3. A range of new administrative technologies should be introduced, including performance-based contracting, competition, market incentives and deregulation (O'Flynn 2007; Kaboolian 1998).

There are a series of weaknesses in the practical implementation of NPM in the health care system that have created fundamental tensions (O'Flynn and Alford 2005), particularly in the delivery of health care services to Australia's First Peoples

(Dwyer et al 2011). Entwistle and Martin (2005) demonstrated that the competitive regimes commonly adopted in NPM are often costly to implement and rarely deliver genuine competition. As a result, these approaches have increased transaction costs due, in part, to the high costs of preparing, monitoring and enforcing contracts (Entwistle & Martin 2005; O'Flynn and Alford 2005).

O'Flynn and Alford (2005) found that competitive government models do not support the building or maintenance of relationships within the health care system and may influence destructive behaviour between those organisations competing for the funding. More broadly, the fundamental values of public service organisations have been undermined by competition and the NPM (Minogue 2000; O'Flynn 2005). Lawton (1998, cited in O'Flynn 2005:7) provides a comprehensive list of NPM problems including:

> 'the demoralising effects for public managers of working with limited resources; conflict between individual demands and the public interest; an erosion of accountability and responsibility due to fragmentation; and the potential for risk-taking and ethical challenges which come from increased managerial freedom'.

These problems are challenging to manage for ACCHOs, particularly the small organisations struggling with a lack of funding and without the capacity to compete for funding against the larger ACCHOs and mainstream services. The Organisation for Economic Cooperation and Development, an advocate for NPM, acknowledged in a 2003 report that the 'reforms produced some unexpected negative results' (OECD 2003:2). March and Olsen (1989) argue that reform seldom fulfils the intention of those who initiate change. In part, this reflects the misguided thinking that one size fits all or 'the wholesale application of private sector models and the failure to understand the interconnected and interdependent nature of the public sector'.

(O'Flynn 2007:7). More significantly, the competitive government model 'failed to understand that public management arrangements not only deliver public services,

but also enshrine deeper governance values' (OECD 2008:69). For all these reasons, NPM does not fit with the PHC values of community control and self-determination in the management of ACCHOs, nor does it incorporate mechanisms for equivalent engagement between funders and providers.

While there are advantages to this form of administration, it is prescriptive and inflexible in the manner that contract-funded organisations (particularly ACCHOs) can operate and help people. It can also pressure both provider and funder staff to lose touch with the community they are supposed to serve because they develop their own individualistic need to succeed and be perceived as successful by the bureaucracies to whom their government contracts hold them to account (Dugdale & Arabena 2008).

2.6 ACCHO ENGAGEMENT WITH GOVERNMENT

We know in general that governments' track record of engagement with Australia's First Peoples is appalling and their efforts to find mechanisms for engagement of Indigenous people are not new. At the national level, the Royal Commission into Aboriginal Deaths in Custody emphasised this argument in terms of 'persistence of a government desire for a single, representative Aboriginal political voice' at the national level (RCIADIC 1991:1). However, three organisations established by governments for this purpose (the National Aboriginal Consultative Committee, the National Aboriginal Congress and, most recently, the Aboriginal and Torres Strait Islander Commission) have all been abolished (Hunt 2013). This move generally followed tensions in the relationship and differing perceptions about powers and roles. The most recent national organisation established by Aboriginal and Torres Strait Islander people, is the National Congress of Australia's First Peoples. This organisation is independent of government but (was) funded by it. In September 2012, the Congress released a framework for its engagement with Australian Government agencies. The framework clarified the roles and responsibilities of each partner, the principles on which such engagement should be based and protocols for engagement. It also provides some operational

arrangements, particularly for high-level engagement between the Australian Government and the National Congress of Australia's First Peoples (Hunt 2013).

In the health sector, the Congress has joined with eleven national Indigenous health organisations to form the National Health Leadership Forum. This forum worked with government on a national health equity plan (Commonwealth of Australia, 2013; National Congress of Australia's First Peoples 2011). This is an important development: Australia's First People leaders are at the table with governments to plan. While engagement at the national level is necessary from a national policy perspective, there are many different levels of engagement that need to be supported at the regional and local levels by the higher echelons of bureaucracy if we are to achieve significant improvement in the health and wellbeing of Australia's First Peoples. To this end, various approaches have been trialled by governments to find appropriate avenues (Hunt 2013), however these trials are plagued by short term funding, and until recently, the lack of a national approach to implementation of the Plan, which is yet to be actioned.

The Office for Aboriginal and Torres Strait Islander Health (OATSIH) provides core funding to practically all ACCHOs in Australia. Within the Department of Health and Ageing (DoHA), OATSIH has operational responsibility for policy development, funding allocation, contract management and reporting services for Indigenous health, including services provided by ACCHOs and mainstream providers of Indigenous-specific services. Indigenous Coordination Centres (ICC) operates as part of each Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and is funded by the Commonwealth. There are 29 ICCs located in urban, regional and remote areas in all states and the Northern Territory, with the Australian Capital Territory being managed by the New South Wales State Office. The ICCs' role is to engage with Indigenous communities, other levels of government and service providers to support initiatives that help close the gap on Indigenous disadvantage and provide funding for community initiated programs (FAHCSIA, 2012). Program funding is also provided by various state and territory departments as is illustrated in the simplified diagram (Figure 2.2).

In 2009, the Chairman of the Productivity Commission identified success factors for work in overcoming Indigenous disadvantage – cooperative approaches between Australia's First Peoples and government; community involvement in program design and decision-making; good governance and ongoing government support. He noted that these success factors have been noted in numerous reviews over many years (Banks, 2009). However, a recent Productivity Commission report (2013:62) on Indigenous policy stated that 'whatever the policy intentions, the system is broken'. It concluded that a focus on understanding the systemic barriers that prevent effective engagement with Australia's First Peoples is paramount, which is in contrast to the work accomplished by the Victorian government as described in the next section.

2.7 VICTORIAN GOVERNMENT: PRINCIPLES OF ENGAGEMENT

The Victorian government's Aboriginal Affairs Framework (2013–2018) specifically discusses the significance of engagement in the relationship between Indigenous organisations, the communities they represent and government departments. These relationships are fostered and maintained through established state and regional partnerships – engagement arrangements that have been proven to be successful with Aboriginal leaders and organisations. In March 2011 new engagement structures at a ministerial level were introduced into the Aboriginal Affairs Framework following a commitment by the Premier of Victoria, Ted Baillieu. These structures provide a minimum of three roundtable discussions each year to bring together Ministers and Aboriginal leaders with the aim of informing policy and priorities, building mutual understandings, and providing for the sharing of information and worldviews. Sub-regional forums were also introduced to enable effective engagement with government; to complement existing advisory structures; explore and share areas of interest; enable local voices and experiences to be heard, and to provide an important source of advice to departments and government.

Nine principles of engagement have been identified by Aboriginal Victorians to guide dialogue with government (Department of Premier and Cabinet, 2012).

These principles are acknowledged by government as critical to the success of structural arrangements and the way that engagement occurs with Aboriginal people:

- **Strength-based approach** - Engagement to build upon community strengths and self-reliance, capability, to foster positive change and promote and celebrate achievement.
- **Respect** - Respect the skills and ability of Aboriginal people, communities and organisations to provide information which fosters good decision-making. Ensure adequate time for genuine engagement has been provided.
- **Focus on youth** - In recognition that Aboriginal young people represent more than half of the Victorian Aboriginal population, actively seek to engage youth in consultation, seeking input and developing their leadership and other capacities, while appreciating their relationships with the Aboriginal community.
- **Partnership between community and government** - Trusting relationships are central to successful partnerships between Aboriginal people and Government and shared responsibility for identifying solutions and [improving] outcomes.
- **Cultural understanding** - Engage in a way that demonstrates cultural awareness, respect and recognition and utilises culturally appropriate methodologies and accessible forms of communication.
- **Clear and consistent flow of information** - Provide information in a range of accessible and appropriate communication styles to strengthen understanding between Aboriginal people and government.
- **Recognition of diversity in Aboriginal communities** - Engagement to include diverse groups of Aboriginal people and communities in Victoria and recognise, embrace and respect difference.
- **Recognised Aboriginal leaders** - Engage in a way that respects recognised leaders and Elders as acknowledged by the Aboriginal community.
- **Accountability** - Value engagement with Aboriginal people and communities. Be clear on the intended outcomes of engagement arrangements and ensure

> feedback is provided on how input has been utilised or has informed policy in a spirit of mutual respect. All parts of government and organisations funded by governments to deliver services for Aboriginal Victorians need to be accountable to the Aboriginal community (Department of Premier and Cabinet, 2012:24).

A literature review of theoretical and practical models for implementation of innovations in Indigenous health care found that those providing general principles, rather than prescriptive checklists, appear most relevant to the contexts of Australia's First Peoples (Brands & Silburn 2013). Principles (which both parties agree to uphold) enable the ACCHOs to provide health services with as much flexibility as possible in selecting and using an innovation. However, before an innovation is introduced, Brands and Silburn (2013) suggest that core principles of the innovation should be clearly separated into two groups – those principles that can be modified to suit the context of the organisation and those principles that cannot be modified – in order to understand areas of (non)adaptability to local needs. It is important that 'there should be a good fit between an innovation selected for implementation, the context in which it might be used, and the process of implementation' to avoid large-scale innovations being rolled out that are not suited to the ACCHO context of service delivery and, as a result, increase inequities in access and delivery of health care (Brands & Silburn 2013:39). For example, large well-established ACCHOs can benefit more from the results of new programs and practices than those that are smaller and less resourced. More understanding about how to prevent implementation processes from increasing inequity is required (Brands & Silburn 2013). NACCHO has developed seven key principles to guide against increasing inequity within the health care system for Australia's First Peoples.

2.8 NACCHO PERSPECTIVES ON HEALTH AND HEALTH CARE

During the consultations conducted as part of the development of a new Aboriginal Health Plan (NATSIHEC 2013), NACCHO developed a set of seven key principles.

NACCHO argued that for the plan to be effective, it must address problems of both content and process, be based on what is already agreed (of which there is strong evidence), and must be inclusive of the following seven key principles:

1. a holistic definition of health
2. a social determinants approach
3. comprehensive Primary Health Care focus
4. community control
5. a national commitment by all states and territories
6. effective accountability and monitoring processes
7. Aboriginal and Torres Strait Islander leadership

These principles and the evidence, perspectives and values on which they are based are an important contemporary statement of First Peoples' perspectives, and are explained in detail below.

2.8.1 PRINCIPLE ONE: A HOLISTIC DEFINITION OF HEALTH

Principle One is inclusive of the ongoing health effects of colonisation and past government policy and practice. The definition of health in the Aboriginal and Torres Strait Islander context is a complex and multi-layered concept that includes the physical, social and emotional health of individuals and the wellbeing of whole communities. The National Aboriginal Health Strategy (NAHS 1989:6) provides a clear definition of health:

> 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. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity.

The definition is inclusive of broader concerns of social justice, wellbeing and equity – key aspects of health for Indigenous peoples – and is similar to the definition adopted by the World Health Organisation in the 1978 PHC Alma Ata

Declaration: 'Health is a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity… [it] is a fundamental human right.' (WHO, 1978:1).

An all-encompassing definition of health is also reflected in the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NATSIHC 2003:4)*:*

> For Aboriginal and Torres Strait Islander peoples, health does not just entail the freedom of the individual from sickness but requires support for healthy and interdependent relationships between families, communities, land, sea and spirit. The focus must be on spiritual, cultural, emotional and social well-being as well as physical health.

NACCHO (2012) argues that when one reads between the lines of the definition of health, embedded is a strong link to historical and ongoing causes of ill health in contemporary Aboriginal communities that continues to introduce threats to the physical health of individuals, thereby undermining the health and wellbeing of whole communities. For example, the use of military force in the 2007 Northern Territory Intervention disempowered whole communities by removing rights to various self-determination measures. The effects of past and current policies of dispossession and marginalisation are widely documented as a continuing determinant of poor health in Indigenous communities (NATSIHC 2003:5).

Thus NACCHO's perspectives emphasise the holistic definition of health and the continuing effects of past and contemporary policies on the health of Australia's First Peoples, as well as efforts to improve the physical component of Aboriginal health. However, there remains the need to embed understanding of cultural respect, self-determination and community wellbeing into Australian social systems and the negative impact on Aboriginal peoples' health when these aspects are not addressed in respectful ways also remains.

2.8.2 PRINCIPLE TWO: A SOCIAL DETERMINANTS APPROACH

A social determinants approach acknowledges that there are many causes of ill health that lie outside the direct responsibility of the health sector. The approach is underpinned by a holistic concept of health that requires a collaborative, inter-sectoral approach. A person's social and economic position in society, his/her early life experiences, exposure to stress, educational attainment, employment status and exclusion from participation in society – all aspects are powerful influences on an individual's health throughout life (Booth 2005; Baum 2008). The analysis is now robustly supported by substantial evidence. Although much evidence is international, or from mainstream populations, the literature on the social determinants of health of Australia's First Peoples is increasing and includes recognition of problems such as racism and control as key social determinants of Aboriginal health (WHO, 2008; NACCHO, 2012; Gallaher, 2009; Anderson et al. 2004).

The National Aboriginal Health Strategy (NAHS 1989) recognised the need for such an approach before the social determinants theory was widespread, through a focus on inter-sectoral collaboration. The NSFATSIH (2003:1) also acknowledged the need for a coordinated, whole-of-government approach: 'Independent approaches by individual portfolios within governments, operating without the support and partnership of Aboriginal and Torres Strait Islander communities, have little positive impact.'

2.8.3 PRINCIPLE THREE: COMPREHENSIVE PRIMARY HEALTH CARE FOCUS

International evidence demonstrates that stronger PHC systems are linked to better health outcomes, particularly in relation to low birth weight, infant mortality, lower mortality rates in general, and lower health care costs. These have been proven to counter-balance some of the harmful health effects of socio-economic disadvantage and inequality (Griew 2008).

The National Aboriginal Health Strategy (NAHS 1989) highlighted PHC as the main approach, followed fourteen years later by the NSFATSIH (2003:1): 'Within the

health care system, the crucial mechanism for improving Aboriginal and Torres Strait Islander health is the availability of comprehensive PHC services.' Magnussen et al. (2004) argue that selective primary care (disease-specific approaches) or those that focus more exclusively on the treatment of illness (primary medical care) should operate within a comprehensive framework of PHC, which is well documented and universally accepted as the most effective way to address Aboriginal ill health. The holistic definition of health and the social determinants approach described above align with Magnussen's argument.

NACCHO (2009, 2012) defines comprehensive PHC as including the provision of medical care, with its clinical services treating diseases and its management of chronic illness. PHC includes services such as pharmaceuticals, environmental health, counselling, rehabilitative services, preventive medicine, health education and promotion, antenatal and postnatal care, maternal and childcare programs, and necessary aspects of health care resulting from social, emotional and physical factors.

Comprehensive definitions that are similar to NACCHO's definition have been adopted by major PHC research organisations: APHCRI (2008), the Australian Medical Association (2010), the Australian Division of General Practice (2005) and government policy documents:

> Comprehensive PHC, encompassing clinical/medical care, illness prevention services, specific population health programs for health gain, access to secondary and tertiary health services and client community support and advocacy, is the centrepiece of the health system for Aboriginal and Torres Strait Islander peoples. (NATSIHC 2003:13)

2.8.4 PRINCIPLE FOUR: COMMUNITY CONTROL

NACCHO argues that community control is a key principle of ensuring appropriate and accessible health services for Indigenous peoples. Developing, sustaining and extending processes of community control of PHC also counter balances those

historical practices which have disempowered and marginalised many Aboriginal communities and individuals (NACCHO 2012). The NAHS (1989: xxv) established strong principles of community control: 'The Working Party recommends that primary level Aboriginal health services presently being delivered by State (and Territory) governments should be transferred to existing or proposed Aboriginal community controlled primary level services.' This is consistent with the Alma Ata declaration, the foundational statement, which states that PHC 'requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation, and control of PHC.'

NSFATSIH (2003:3) reiterated the commitment to community control by asserting it as one of the main principles underpinning the framework of the community control of PHC services:

> Supporting the Aboriginal community controlled health sector in recognition of its demonstrated effectiveness in providing appropriate and accessible health services to a range of Aboriginal communities and its role as a major provider within the comprehensive PHC context. Supporting community decision-making, participation and control as a fundamental component of the health system that ensures health services for Aboriginal and Torres Strait Islander peoples are provided in a holistic and culturally sensitive way.

It also determined that 'Aboriginal community controlled health services (ACCHSs) are the best practice model for the delivery of comprehensive PHC to Aboriginal and Torres Strait Islander communities' (NSFATSIH 2003:13).

There is increasingly powerful evidence that supports this standpoint – both in national and international health policy and agreements. Not being able to control one's life is a key contributor to ill health (Wilkinson 2003; Tsey 2009) and approaches that empower individuals and communities can provide better health outcomes (Wallerstein 2006; WHO 2008). Lavoie et al. (2009) argue that community control is the formal governance process by which the Aboriginal

community controls and operates its own PHC service and is the highest expression of the right of Aboriginal people to participate in decision-making, and that community-controlled health services have a fundamental advantage in addressing concerns of cultural safety, engagement and participation. In a separate paper, Lavoie et al. (2010) have demonstrated that communities that have secured a higher level of community control over their community-based primary health care services have better health outcomes (measured as lower rates of hospitalisation for ambulatory care sensitive conditions).

Sullivan (2011) argues that Aboriginal community-controlled organisations are not only service providers, but also provide a practice of communal or local-level governance and are a major expression of Aboriginal and Torres Strait Islander civil society. They are key leaders for positive Indigenous social change and are evidence of such social change and Aboriginal modernisation. In 2009 Australia became a signatory to the United Nations Declaration on the Rights of Indigenous Peoples, which acknowledges the right of Indigenous peoples to be actively involved in developing and shaping health programs and providing health services through their own institutions wherever possible (United Nations 2007).

2.8.5 PRINCIPLE FIVE: A NATIONAL COMMITMENT BY ALL STATES AND TERRITORIES

Progress with previous Aboriginal health plans has been undermined by weak implementation structures and processes. Crucial to the failure was under-funding and/or non-funding of Aboriginal health plans, plus an increase in the administrative burden on Aboriginal health services, and the lack of appropriate inclusion of Aboriginal community participation in implementation decisions (NACCHO 2012). For example, the NAHS was partially funded, but the 1994 evaluation revealed the strategy was never effectively implemented due to:

- underfunding
- a lack of commitment from ATSIC, Commonwealth, State and Territory Ministers
- a lack of accountability

- the lack of partnerships with Aboriginal peoples
- poor inter-sectoral collaboration (NACCHO 2012; ATSIC 1994).

Implementation of the NSFATSIH, including the allocation of funding, was the responsibility of each jurisdiction and, as a result, increases in expenditure were limited. The Australian Institute of Health and Welfare (AIHW 2011) demonstrates that from 2001–02 to 2008–09 Australian Government health expenditure increased at an annual average rate of 7.4%. Regardless of the significant position of community-controlled health organisations in the NSFATSIH, grants to community-controlled health services from the source increased at a much lower rate of 3% per year over the period. State and territory governments' expenditure increases were also considerably less at 5.1% per year, with the vast bulk of the increase due to admitted patient services in public hospitals (NACCHO 2012; AIHW 2011).

Thus, funding for comprehensive PHC delivered to the community-controlled sector has been limited under the NSFATSIH. *The Overburden Report* (Dwyer et al. 2009) illustrates that real change has been further hampered by a significant increase in complexity of funding mechanisms for PHC and a heightened administrative burden for these organisations. Structures and processes inclusive of Aboriginal and Torres Strait Islander communities and organisations in decision making about implementation have been patchy. For example, the Northern Territory Aboriginal health sector plays a major role in planning and decision-making; however, in other jurisdictions the involvement is less organised.

NACCHO (2012) argues that given the experiences of past non-implementation of Aboriginal plans, it is critical that all governments, the ACCHO sector and other NGOs learn from these experiences. For the new health plan to gain traction – to make real change happen – governments should 'ensure that the new health plan is funded; reduce the administrative burden of getting funds to service providers; and genuinely involve and support Aboriginal communities and organisations to take part in implementation decision-making' (NACCHO 2012:8).

To enable the above points to be implemented, NACCHO supports the recommendations of the National Health and Hospital Reform Commission for increased funding for Aboriginal health and a National Aboriginal and Torres Strait Islander Health Authority to 'centralise funding to purchase and commission health services, and to hold all health services to account for providing the right services for Aboriginal and Torres Strait Islander people' (NACCHO 2012:8).

2.8.6 PRINCIPLE SIX: EFFECTIVE ACCOUNTABILITY AND MONITORING PROCESSES

One of the barriers to the successful implementation of previous Aboriginal health plans has been the lack of inclusive and mutual, long-term processes for monitoring accountability and implementation. The Aboriginal health sector played an instrumental role in developing the NAHS, but it was largely excluded from the development of accountability and monitoring processes. At the time, the Council on Aboriginal Health (with a majority of Indigenous leaders) was cast aside by the role of the new ATSIC. State and territory 'tri-partite forums' (including government, Aboriginal organisations from all sectors and ATSIC) were established as a mechanism to monitor processes; however, the forums were inconsistent in effectiveness (NACCHO 2012; NAHS Evaluation Committee, 1994).

Accountability is strongly endorsed in the NSFATSIH (2003:3):

> Accountability: including accountability for services provided and for effective use of funds by both community-controlled and mainstream health services. Governments are accountable for effective resource application through long-term funding and meaningful planning and service development in genuine partnership with communities. Ultimately, government is responsible for ensuring that all Australians have access to appropriate and effective health care.

The plan also included a number of accountability processes:

- annual reporting against the national implementation plan, with responsibility of monitoring by the Australian Health Ministers' Advisory Council (AHMAC)

- a biennial (two-yearly) report to AHMAC against the Aboriginal and Torres Strait Islander Health Performance Framework to provide the basis for measuring the impact of the NSFATSIH.

However, regardless of the robust commitments to accountability and monitoring in the documents, the actual process of monitoring the implementation of the NSFATSIH was unsatisfactory (NACCHO 2012). For example, while the Health Performance Framework reports were completed regularly in 2006, 2008 and 2010, the implementation reports were only published for the first three years of the NSFATSIH (2004–05, 2005–06 and 2006–07) and only covered Commonwealth responsibility. Apparently they have since ceased (NACCHO 2012).

Under the COAG reforms, accountability is upheld through annual reporting by the COAG Reform Council against baseline data for 27 indicators arranged under the six targets. All responsibility for the process lies within the Commonwealth and state/territory governments. NACCHO is concerned that there is no Aboriginal participation or oversight for accountability within the process. It argues that history and experience has demonstrated incomplete monitoring and accountability, and therefore the new 2014 Aboriginal health plan must establish and maintain funded monitoring processes to ensure that implementation of the plan advances according to agreed commitments. This includes assurance that monitoring and accountability processes are:

- robust – resourced and supported to ensure their effectiveness
- durable – maintained over time
- inclusive – of all parties with an interest in the implementation of the plan
- appropriate – measured with suitable evidence-based indicators founded on quality data collection processes
- reciprocal – 'upwards' accountability of the Aboriginal community-controlled health services sector to government is balanced with 'downwards' accountability of government structures that are flexible enough to respond to innovation and complexity in an effective way.

The reciprocal point implies that there will need to be monitoring and evaluation of performance against partnership agreements and health outcomes, rather than solely through contract management processes (NACCHO 2012).

2.8.7 PRINCIPLE SEVEN: ABORIGINAL AND TORRES STRAIT ISLANDER LEADERSHIP

International, national and local literature affirms that for any people to take responsibility for their health problems, they must be included in the processes of resolving these problems (NACCHO, 2012). For Australia's First Peoples to own their health problems and be part of the solution necessitates mechanisms throughout implementation and accountability structures and processes where First Peoples' representatives can monitor and provide feedback on implementation concerns (NACCHO 2012; Brands 2013). These should be coupled to existing structures; for example, the National Health Leadership Forum. The forum is sponsored by the National Congress of Australia's First Peoples and includes eleven Aboriginal and Torres Strait Islander health organisations; OATSIH, NACCHO and Public Health Medical Officer networks and NACCHO affiliates for monitoring and review at the jurisdictional level (NACCHO 2012).

These principles stand in contrast to the thinking of New Public Management, and provide an important framework for understanding Australia's First Peoples' perspectives on health and health care. The mechanism to implement these principles is missing from the implementation tool, which is the contract used by Australian governments with ACCHOs that is founded on the distrust inherent in classical contracting.

2.10 CONTRACT THEORY

This study began with a theoretical framework based on contract theory and an understanding of the distinction between classical and relational contracts (also referred to as 'alliance'). These are the two main types of contracts used by governments and organisations to arrange the transaction of money for goods or

services (MacNeil 1978). The services in this context, is the delivery of health care programs by over 150 ACCHOs across Australia for Aboriginal and Torres Strait Islander People. The following table summarises at a glance the differences between these contracts which are explained in more detail below:

Table 2.2 Classical and Relational contracting characteristics

Classical Contracts	**Relational Contracts**
Competition	Negotiation and collaboration
Transactions are quantified in advance with clear purpose and timeline	Difficult to quantify detailed transactions in advance
Inflexible to changing circumstances	Flexibility to changing circumstances
Short term (1-3 year) contracts	Long term contracts (minimum of 5 years)
More formal processes of engagement	Less formal/less legal enforcement
Less opportunities to resolve problems together	More opportunities to resolve problems together
Distrust	Mutual trust and benefit
Auditing for control	Auditing for strategic planning

Source: Dwyer et. al 2011

Classical contracting is the 'business as usual' model based on competition and (in the context of Aboriginal and Torres Strait Islander health) fear of change that promotes self- determination. Classical contracting is also based on the concept of the 'agency problem.' This is where a conflict arises when people (the agents) entrusted to take care of the interests of others (the principals) use the authority or power for their own benefit instead.

This is a widespread problem and occurs in practically every organisation, whether a business, church, club, ACCHO or government department. Organisations try to resolve this problem by instituting rigid measures such as tough screening processes, incentives for good behaviour and punishments for bad behaviour, watchdog groups and so on, but no organisation can be rid of the problem completely because sooner or later the costs of doing so outweigh the worth of the results, as is reflected in government administration of Aboriginal-specific funding. The agency problem is also referred to as the principal-agent problem or principal-agency problem (http://www.businessdictionary.com/definition/agency-problem.html).

In some circumstances, ACCHOs compete against each other, and mainstream organisations, for funding. Many small ACCHOs are often excluded from this process because they lack the resources to compete with the larger organisations that have the capacity to enter competitive tendering processes. The contract transactions are quantified in advance with clear targets and reporting timelines, which is inflexible to changing circumstances for ACCHOs. For example, an infectious disease outbreak requires an immediate effective response, and may disrupt other health care activities.

The nature of classical contracting is short term funding (1-3 years) which restricts ACCHOs from planning for long term sustainability of their services. The processes for engagement are more formal with more potential for recourse to legal action. The addition of enforceable 'gag clauses' to prevent public advocacy or criticism of government is an example. Classical contracting is intended to allocate risks clearly to one or other of the parties, and to minimise shared risk. This type of contracting may work in the short term but problems in the funding relationship inevitably return because classical contracting limits opportunities for risk sharing, collaborative approaches to risk reduction, or for resolving problems together. Distrust is perpetuated when the auditing of ACCHOs is too readily imposed 'top down' by government, with a negative impact on the enactment of self-determination.

Relational contracting, on the other hand, enables negotiation and collaboration between governments and ACCHOs that is built on a shared understanding of an inter-dependent relationship. Governments (contractor) require ACCHOs to provide health care services particularly in remote and rural areas where ACCHOS may be the only agency. ACCHOs (agency) require government (contractor) to provide funding and other supportive mechanisms to enable the management and delivery of health care services by Australia's First Peoples. In circumstances where it is difficult to detail specifically the health care transactions in advance, government and ACCHOs work to maximise the common interests of each party in the funding relationship. Relational contracting also enables flexibility and cooperation to manage risks and resolve unexpected problems in changing circumstances. These contracts are long term with committed funding of five years or more and have less formal enforcement because each party values the maintenance of sustainable relationships with the other (Palmer 2000).

Expectations to maintain good reputation is by self-enforcing practices to guarantee the fulfilment of the contract (Perrot 2006), with reliance on mutual trust and benefits. In partnerships between government and the private sector, the relational approach has become more popular with the move to subcontract (or outsource) aspects of businesses, and is commonly referred to as alliance contracting.

In the 1990s alliance contracting was first used in Australia for major infrastructure projects and continues to be used for many public–private partnering projects and subcontracted (outsourced) functions of businesses. In alliance contracting the partners have incentives to focus on what is best for the project or service and on improved risk management, and to ensure transaction costs are reduced. However, alliance contracting requires more involvement from senior managers than 'business as usual' contracts, brings increased risk of decision-making stand-offs and needs acceptance of risk management by all partners (Department of Treasury and Finance Victoria 2006; Queensland Government Chief Procurement Office 2008; Dwyer et al. 2009, 2011).

In settings where a joint problem-solving task is required, where communication is consistent and where alliance partners have the capacity to resolve conflicts through discussion, Ruuska and Teigland (2008) found that alliance contracting is the preferred option. Both contracting styles are applied in the health sector. Palmer and Mills (2003, 2005) found that where government is the purchaser and there is a lack of competition, contracting in health services tends to be more relational and less formal, resting on a degree of mutual dependency between the provider and the purchaser. When the services to be provided under the contract are comprehensive, contracts are more likely to be relational than when, for example, a specific service such as diagnostic testing is being purchased (Parker, Harding and Travis 2000; Palmer and Mills 2003, 2005; Macinati 2008; Dwyer et al. 2011).

Governments are increasingly using contracts and contract-like structures which have, in effect, changed the nature of accountability arrangements (Cribb 2006). The principles of New Public Management (NPM) have influenced governments to shift away from trust-based relationships (Hughes Tuohy 2003). The shift to contract-defined relationships has reshaped the role of the government, to purchaser and contract monitor, focused on deliverables (indicators of outputs and ideally of outcomes) that can be audited (Dwyer et al. 2011). However, as a consequence, government is increasingly defining and controlling how health care should be provided by ACCHOs, which does not fit with the way that ACCHOs want to provide health care.

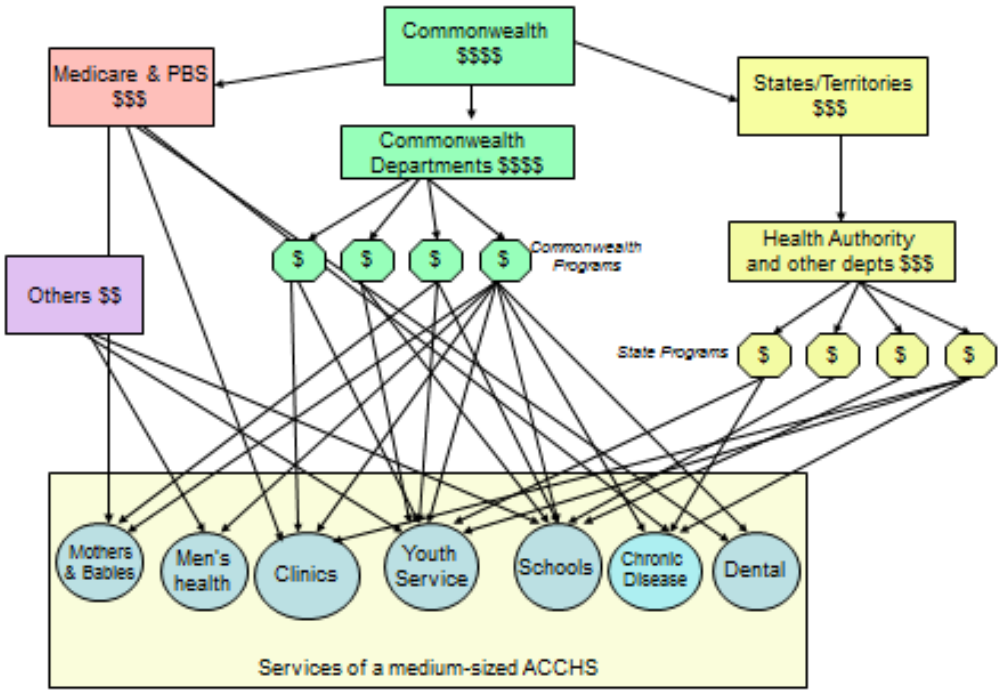
2.10 CONTRACTING IN AUSTRALIA'S FIRST PEOPLES HEALTH

In this present context, contracts are arrangements by which government funders agree with providers of services about the services or other activities that the government is 'purchasing' on behalf of the community, the amount of funding, and the reporting and other accountability requirements. These arrangements are detailed in service or funding agreements between the funder and the provider (in this case, the ACCHOs) (Dwyer et al. 2011). The resulting contractual environment is characterised by 'a multiplicity of fragmented, often proposal-driven, contracts

with high administrative costs' (Lavoie 2005:2), duplication and reporting overburden for the ACCHOs (Dwyer et al. 2009).

This situation was analysed in detail in Dwyer et al. (2009) and the complexity and fragmentation of the funding contracts is represented in Figure 2.2 below, which shows the average situation for ACCHOs that participated in a 2008–09 survey of their 2006–07 funding.

Figure 2.2 Typical funding to a medium-sized ACCHO



ACCHS: Aboriginal community controlled health services; PBS: Pharmaceutical Benefits Scheme. Source: Dwyer et al. 2009

The relative roles of the national and jurisdictional (state/territory) governments in funding health care for Australia's First Peoples are overlapping and unclear and contribute to the complexity shown above (Dwyer et al. 2011). Both levels of government provide direct funding for Aboriginal-specific health care providers in remote, regional and urban settings. Unlike the situation in comparative countries (including Aotearoa, Canada and the United States), legislative responsibility for indigenous health is not specifically defined for any level of government (Howse 2011; Ring and Firman 1998; Alford, 2005:35).

2.11 TRUST AND ACCOUNTABILITY

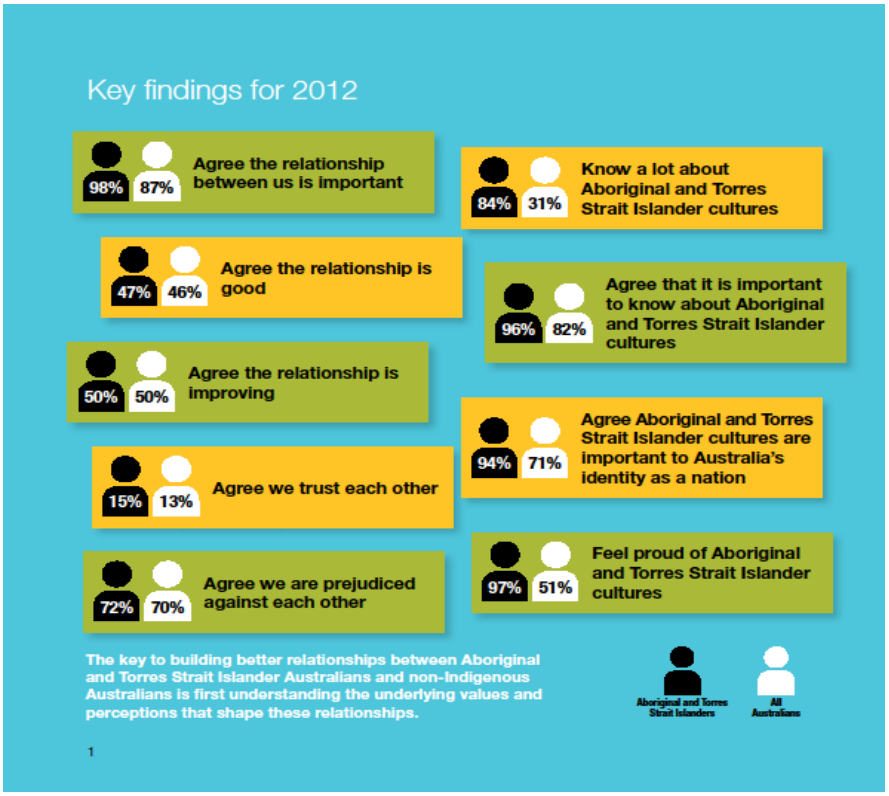
The accountability of ACCHOs and government departments for fulfilling the terms of the contract provides the basis of the relationship, but trust and communication are always important (for both performance and satisfaction). The literature from the field tells us that both processes of accountability and trust are problematic in shaping the relationship (Dwyer et al. 2011, Hunt 2013). Accountability is about power and the distribution of responsibility between participants. ACCHOs, similar to many other non-government organisations, carry direct accountabilities to their communities and consumers. Although the need for accountability of public funds is accepted, there is a need to ensure that the compliance, monitoring and reporting arrangements are justified on the basis of meaningful and proportionate accountability and that they address accountabilities to consumers, as well as funders.

Auspoll (2009, 2012) conducts a national biennial study that measures the progress of reconciliation between Australia's First Peoples and other Australians. If better relationships are to be built, all Australians must first understand the underlying values and perceptions that shape the relationship. The studies gauge whether these values and perceptions of the relationship are improving. The results show that most Australians believe the relationship between Australia's First Peoples and other Australians is important; however, only around half believe it is strong and improving. This indicates there is goodwill but it is not yet translating into better relationships. When asked about specific features of the relationship, the results indicated focus was required on efforts that build strong foundations. The low levels of trust suggest relationships are less likely to begin and are more likely to breakdown (Auspoll 2012).

Government practices of intergenerational dispossession and Australia's First Peoples' experiences of continued dispossession is the great trust divide. The 2012 Reconciliation Barometer by Auspoll found First Peoples and other Australians agree that the relationship is important and that Australia's First Peoples' cultures are important to Australia's identity as a nation; however, when it comes to

trusting each other, numbers in both groups are low. The ACCHO and government-funding relationship is also reflective of this great trust divide:

Figure 2.3 Key findings for 2012 - Auspoll (2012:1)



Australian Reconciliation Barometer 2012

High levels of prejudice and discrimination reflected low levels of understanding about each other. This is partially explained by the limited personal contact many people in the general community have with Australia's First Peoples. As a result, most Australians' views about First Peoples are shaped by powerful secondary sources; for example, the media, which in many instances may not present a balanced perspective (Auspoll 2012). Distrust is also reinforced by the political sensitivity of Australia's First Peoples' human rights concerns which interrogate government foundational ideas of national identity (Sullivan 2009) and continuous historical tension in the relationship between indigenous communities and colonising populations (Havemann 1999).

ACCHOs are in a paradoxical situation: activism offers a way of gaining attention for their members' needs, but it tends to lead to top-down over-accountability. On the other hand, government policy and funding staff confront an increased demand to show value for money, as well as managing the challenges of political sensitivity – that is, using government power, privilege and control tactfully when they respond to ACCHOs' non-compliance with government accountability measures (Dwyer et al. 2009).

The current government approach to accountability does not recognise or understand that these organisations can represent their members – a fundamental additional role of Indigenous community-controlled organisations. Rowse (2005) points out that Australia's First Peoples need community sector organisations in order to become visible as citizens (see also Sullivan 2010). These organisations are not simply providers of health care but are also the representative voice of service users themselves, and can demand accountability from the government that purchase the services. ACCHOs have the right to question this top-down accountability approach by government as the representative of a unique kind of citizen - Australia's First Peoples. Contractual accountability arrangements for these organisations may require more mutual methods of working between government and providers, as well as the need for providers to engage and report meaningfully to their communities (Auditor General of Canada 1996; Dwyer et al. 2011). These conditions make accountability visible in public administration. These conditions also authorise power relationships and specify the performance of responsibility between partners, in this case the state (government) and Indigenous organisations (Lavoie et al. 2010). Boulton's (2005) contracting study of the experience of Maori mental health providers articulated how Indigenous staff viewed the relationship with their funders – that the relationship underpinning the funding contract is as important as the document or the agreement itself. In this context, the contract represents a microcosm of the overall relationship between the funder and the provider.

Under NPM, government policies and thinking take a view of accountability as a top-down exercise whereby accountability is generally defined as a power relationship where an accountability holder (government) has the right to information, auditing and scrutiny of the actions of an accountability giver (ACCHOs) (Mulgan 2002:3). Sullivan (2009:66), in a paper that considers the limitations of NPM approaches to accountability in Australian Aboriginal affairs, offers an alternative understanding of an accountability environment in which accountability is 'the activity of rendering an account within a group and between groups so that the actors negotiate their identity, obligations and commitments in relation to each other, producing an environment of reciprocal accountabilities'. The Overburden Report (Dwyer, O'Donnell et al. 2009) found that ACCHO and government staff, experience their relationship in a more reciprocal way, that is, behaviour characteristics of relational contracting co-exist with classical contracting approaches.

Trust can be defined as 'a state of favourable expectations regarding other people's actions and intentions' (Möllering 2001:404).Basically, trust is seen as the foundation for individual risk-taking behaviour (Coleman 1990), cooperation (Gambetta 1988), reduced social complexity (Luhmann 1979), order (Misztal 1996), social capital (Coleman 1988) and so on (see also Sztompka 1999). However, Möllering (2001) argues that Simmel (1950) recognises a 'further element', a kind of leap of faith that is required to explain and understand trust and its unique nature. This leap of trust is still underdeveloped. Möllering (2001) conceptualises trust as a mental process of three elements that further research should embrace: expectation, interpretation and suspension. Expectation is the state (outcome) at the end of the process. It is preceded by the combination of interpretation and suspension. Interpretation concerns the experiencing of reality that provides 'good reasons'. It is recognised that current trust research already moves away from the rational choice model and allows for demonstrative and moral trust bases. However, any form of interpretation is limited and does not inevitably enable expectation. Therefore, an additional element (in line with Simmel) is introduced by Möllering – suspension. This is the mechanism of bracketing the unknowable,

thus making interpretive knowledge momentarily certain. Suspension enables the leap of trust. Functional consequences of trust such as risk-taking, cooperation, relationships or social capital should not be confused with trust.

A richer understanding of the nature of trust, in particular, the inbuilt dualities of knowledge/ignorance and interpretation/suspension (which Simmel's work suggests) can promote a reflexive (rather than a deterministic) view of human relations and society to enable learning from these intercultural/inter-racial experiences, both past and present. In the context of this study, for the funding relationship to improve sustainably the right conditions need to be established so that the partners in the relationship can make a leap of trust. This would include trust in Australia's First Peoples' knowledge systems and capabilities (in order to begin the restoration of Aboriginal and Torres Strait Islander peoples' trust in government) and enable trust by ACCHOs of government's good faith and shared goals. Although race theories (mostly written by white men) have been proven invalid, the thinking or the perception of the thinking (intentionally or unintentionally), is played out in these intercultural relations that lead to the continued stereotyping of Australia's First Peoples, particularly in mainstream media. So if one is not working with, or has equivalent relations with Australia's First Peoples, then there is not an avenue to counter this view.

Hollingsworth (2005) highlights that an understanding of racism as an ideology is important for deconstructing representations in media, television and the press, and representations within research should not escape a similar scrutiny. Hall (1992) provides an insightful and critical analysis for both the construction and deconstruction of racialised identities at national and global levels, as well as in the media generally (Hall, 1997). These works provide valuable glimpses into identity theory and how such insights may be drawn upon to understand the representations and context of Australian identities within the media – especially Australia's First People identity – and the effect of such representations on positive self-image and self-esteem. Racism attacks peoples' identity and impacts on their

emotional and spiritual wellbeing. Breaking down racial barriers is critical to improving Aboriginal health and understanding.

SUMMARY

This literature review demonstrates that it is in the relationship that the larger social/political/historical forces and interests are played out and negotiated. Thus, this study, in examining the funding relationships at the micro level, seeks to shed light on understanding two important, interacting challenges - trust and accountability in the experiences of those working on both sides of the funding relationship. That is, the dominant style of contracting (based on the methods of New Public Management) is both inappropriate to the complex, responsive business of primary health care and is based explicitly on an assumption of distrust between the contracting parties. This distrust is further perpetuated because it's embedded in government bureaucratic and legalistic language, rules and regulations symbolised by the contract itself. These types of contracts require more formal top-down enforcement by governments which continue to devalue the maintenance of equivalent sustainable relationships with Australia's First Peoples. While this problem applies to the non-government sector generally, in the case of the ACCHO sector it is amplified and complicated by the fact that there are low levels of trust in the relationship arising from broader past and present intercultural/inter-racial interactions founded on colonisation and continual dispossession.

CHAPTER 3: THE RESEARCH WEAVE - METHODOLOGY

3.1 INTRODUCTION

> Research with the Indigenous community is a commitment that extends well beyond the final report, dissertation, peer-reviewed article submission, or conference presentation. It is a lifelong relationship and commitment.
>
> **(Lynn Lavallee 2009:24)**

The core responsibility of lifelong relationships and commitments helps me to speak up to institutions that produce knowledge about Australia's First Peoples without the responsibility to develop respectful relationships inclusive of First Peoples from the beginning. Research with Indigenous communities and their representative organisations is more than an academic exercise of peer-reviewed journals and conference presentations. The development of respectful relationships with Australia's First Peoples has to be more than this because Indigenous ill health is situated among disparate positions of power, wealth and privilege characterised by government dispossession that has resulted in a ravine of distrust between Indigenous and non-Indigenous Australians. Indigenous research does not operate in a vacuum relationship, and as an Indigenous woman I carry deep responsibilities to represent the voices of research participants in appropriate ways that can facilitate practical, lasting improvements in the health of Australia's First Peoples. The methodology of this research cannot be treated objectively or as an exercise alone because this particular approach does not necessarily support or value relationship-building as foundational to research with Indigenous communities.

3.1.1 RESEARCH CONTEXT

This study is framed by research underpinned by ethical practice conducted with First Peoples' organisations in Australia. This research is linked to the work of

ACCHOs across Australia and, in particular, by:

- The Lowitja Institute (Australia's National Institute for Aboriginal and Torres Strait Islander Health Research) and evidence-based research conducted by its partners, which are relevant to the review of the literature that informs this research, particularly the easy access to up-to-date knowledge about Indigenous health and policies available on the Lowitja website.

- *The Overburden Report* (Dwyer et al. 2009), which demonstrates that real change has been increasingly obstructed by a significant increase in the complexity of funding processes for PHC and an intensified administrative burden.

- The *Funding Accountability and Results for Aboriginal Health Services* (FAR) project that studied funding and accountability reforms to PHC for Indigenous communities in the Northern Territory and Queensland. This project aims to explain successes and failures, both in the processes of implementation and in the policy goals and settings of governments, because current approaches to funding and accountability are fragmented and complex and access to PHC is inequitable. However, in the Northern Territory and Queensland, funders and providers are advanced in planning fundamental reforms that aim to increase access to community-controlled PHC and streamline the complex contractual environment with emphasis on operational effectiveness. (http://www.lowitja.org.au/funding-accountability-and-results-aboriginal-health-services)

- The small ACCHO located in rural South Australia - description is limited to protect identity as agreed with the CEO and Board.

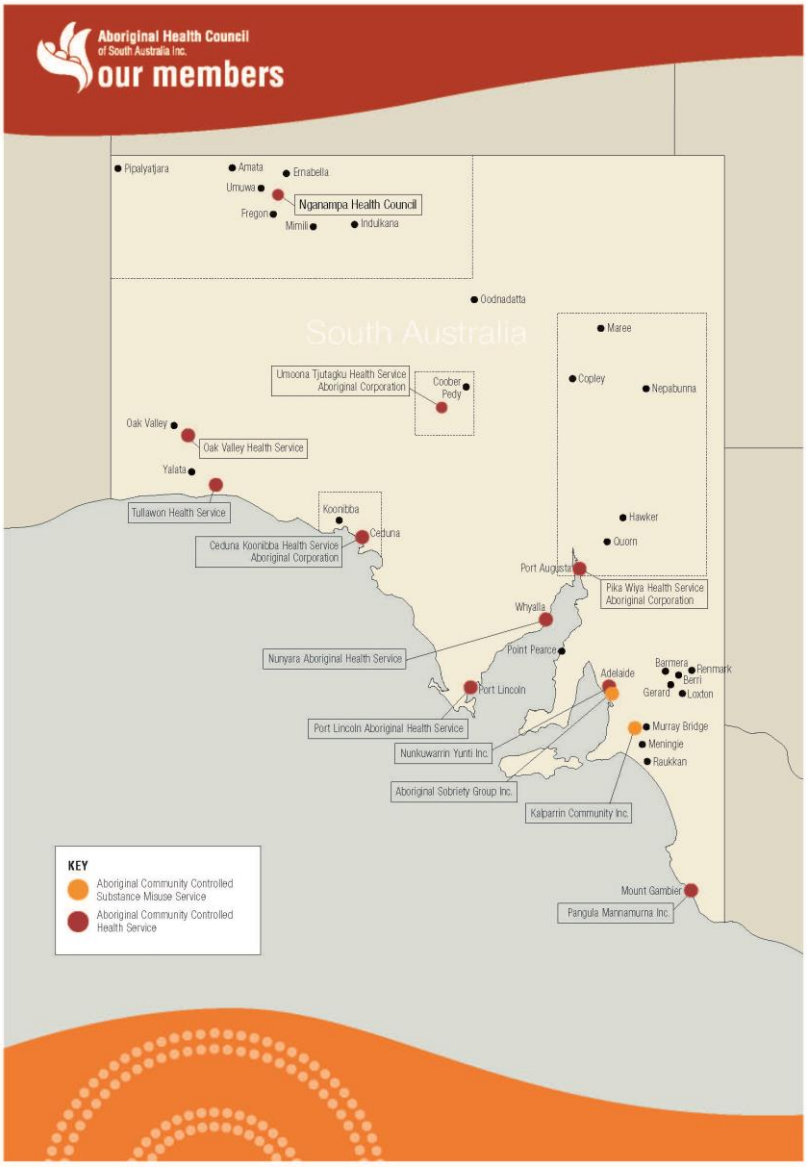
- Government funding staff located in South Australia - from the Indigenous Coordinating Centre (ICC), Office of Aboriginal and Torres Strait Islander Health (OATSIH) and Department of Families and Communities SA (DFC) (now Department for Communities and Social Inclusion - DCSI).

Structures and mechanisms inclusive of Australia's First Peoples' communities and organisations' in decision-making about funding implementation have been slow and inconsistent. This dissertation is interested in the funding relationship, also referred to as the working relationship, from the perspectives of both ACCHO and government staff responsible for the management of the funding contracts. It unpacks the imbalance of power and control in the working relationship, how ACCHOs respond and the impact this has on both parties.

The overall aim of the research is to contribute to safe policy development designed to improve the working relationship between ACCHOs and government departments. Additionally, the research offers a synthesis of knowledge about trust and accountability and its implication for the funding relationship.

This chapter describes how the research was methodically framed to answer the key research question.

Figure 3.1 ACCHOs located in South Australia



Source – Aboriginal Health Council of South Australia Inc (AHCSA)

3.2 INTRODUCING THE RESEARCH

3.2.1 RESEARCH QUESTION

This study seeks to answer the main question:

What do staff from ACCHOs and government funding departments think about trust and accountability in their funding relationship with each other and how can this relationship be strengthened for better health care for Australia's First Peoples?

The study addresses four research questions:

1. How do staff in an ACCHO think about and enact their accountabilities to community and government funding departments?
2. How do staff in government-funding departments think about and enact their accountability to the ACCHO and community?
3. What are the gaps, overlaps or conflicts between the parties of the funding relationship as they seek to meet their own accountability requirements and negotiate the relationship?
4. How might tension between the two be resolved or reduced?

3.2.2 METHODOLOGY

This dissertation developed from the Overburden Report (2009) which investigated the major enablers and barriers to PHC delivery entrenched in the government models of funding and accountability for PHC services to ACCHOs in Australia. Data was not used from this study because it lacked the depth needed to explore the issues specific to this research.

This is a separate study that focused specifically on the funding relationship in terms of the provider/funder perceptions of trust and accountability and how these concepts are perceived in practice. What are the gaps in understanding, what are the barriers that impede their relationship and how can this relationship be improved for better health care delivery to Australia's First Peoples?

I began with an understanding of contract theory and asked about trust and accountability in general. From the interviews, new information emerged about particular dimensions of trust and the fact that it's a relational phenomenon that needs a space to maintain. The ACCHO staff said that trust is about their relationship with the funders but they don't have regular space in which they can have the discussions that would allow them to build trust. The government staff said that they are constrained by what they have to do. How can they build relationships in this situation? It is in this broader metaphor that people need a

space. If contracting is perceived as an exchange in a space that incorporates a discussion of world views, then maybe we can learn from this. This is an explanation of how trust emerged during this study.

I used a reflective approach whereby I had regular face-to-face conversations with my supervisors and supportive colleagues, which has influenced my thinking towards new understandings. I took note of my observations, reactions and learnings in a journal and applied these to inform my actions, practice and research. I assessed myself and my position, including identifying as an Aboriginal woman of Malyangapa/Barkindji descent and the impact of my position on this research. Translating these into practice in Aboriginal health reaffirms my learning in this field.

This research involved an in-depth study of the working relationship between a small ACCHO and its government funders. The methodology involved:

- analysis of the ACCHO service agreement, strategic plan and governance policies (not included to protect identity of the ACCHO)
- analysis of government policy documents pertinent to ACCHOs
- analysis of publicly available government documents pertinent to the study
- interviews with ACCHO management and government funding staff from OATSIH, ICC and DFC (now Department for Communities and Social Inclusion - DCSI)
- discussion of the initial themes and findings with ACCHO and government-funding staff for clarification and confirmation (October 2013)
- a case study approach incorporating inductive content analysis (Thomas 2003) to extrapolate understandings of the funding relationship – what's good, what gets in the way of improvement and what needs to change to strengthen it?
- theoretical treatment of the research through an Indigenous research approach which, in part, takes account of a synthesis of Indigenous and non-Indigenous practices and ethics that translate into the research process

- The initial research proposal included data collection from service users of the ACCHO to ascertain perceptions of their relationship with the ACCHO. However, Indigenous service users did not volunteer to participate hence the research focus only included data collection from the service provider (ACCHO) and the government funding departments.

3.3 LOCATING THE RESEARCH AS INDIGENOUS AND ETHICAL

This study has followed the ethical guidelines of the National Health and Medical Research Council (NHMRC 2004; 2005) to ensure ethical conduct was maintained in the research process. At the time of writing this dissertation, the NHMRC awarded a contract to a partnership between The Lowitja Institute and the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) to undertake an evaluation of these resources - Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Research (2004) and Keeping Research on Track: A guide for Aboriginal and Torres Strait Islander peoples about health research ethics (2005). At the time of finalising this dissertation, the consultation and evaluation report is now complete and awaiting sign-off by NHMRC. (http://www.lowitja.org.au/nhmrc-research-ethics)

Ethics approval was obtained from the Aboriginal Health Research Ethics Committee of SA *(approval 04-11-395)* and Flinders University Social Behavioural Research Ethics Committee *(Approval 5222)*.

3.3.1 AUSTRALIA'S FIRST PEOPLES' RESEARCH VALUES

Responsibility, reciprocity, respect, equality, survival and protection, spirit and integrity are the principles that were developed by Indigenous researchers and health professionals working in Aboriginal health to guide the way researchers are required to work with Indigenous communities/organisations (NHMRC 2005 –

Keeping Research on Track 2005). These principles underpinned the study and examples of practice are provided in Table 3.1.

Table 3.1 Practical examples of how ethical principles were upheld in this research

Principle	Researcher Actions
Respect	Protocols identified to engage with the ACCHO and key government staff. Preliminary visit to the ACCHO to meet with the Chief Executive Officer (CEO), staff and some Board members at times convenient to them. Protocols followed during sorry business – interviews deferred immediately and rescheduled with the ACCHO CEO two months later. Care was taken to ensure that the dignity of all participants was respected, and that their opinions and judgements were valued.
Responsibility	In October 2013 the analysis of themes and findings was emailed to the ACCHO and government participants for comment, leaving open a variety of ways to return feedback; eg by phone, email, face-to-face visit to the workplace. This was to ensure the information, and any requests for amendments based on factual or interpretation errors, were addressed. I also telephoned those participants I did not receive feedback from to ensure they received the information in the first instance. This also provided an opportunity for discussion if the email was overlooked in the busy day-to-day operational management of the organisation.
Equality	I met with the ACCHO CEO on a separate trip (August 2011), prior to the conduct of interviews, to establish protocols for the management of possible risks recorded in a Memorandum of Understanding (MOU). It describes in writing how we would conduct our working relationship and the way we would manage problems that may arise.
Reciprocity	The results were reported back to the ACCHO and government participants for comment by email in October 2013 and followed up with phone calls as requested. Provision of electronic copies of the complete dissertation is offered to all participants and/or a summary report, presentation of the results at community meetings, seminars and Board meetings etc in the following twelve months. *Unplanned outcomes:* during the interview week (November 2011), while having lunch with an ACCHO staff member, she expressed her desire to study medicine. Information about the Indigenous Entry Stream into the Flinders Medical program was provided. The staff member made enquiries, applied and was accepted into the 2013 program.

	I worked with the CEO (via email) to draft a survey for community perspectives about understandings of the ACCHO and ways the ACCHO could better engage with community.
Survival and protection	Acknowledgment of the role of Aboriginal history in Australia, including colonisation and dispossession, underpinned by systemic racist policies and adjusting my practice accordingly to decolonise. The research was guided by the ACCHO's Complaints, Grievance and Conflict Resolution policy. There were no adverse events from the questions asked. It has not been included as an appendix to protect the ACCHO's identity.
Spirit and integrity	Both ACCHO and government funding staff were provided ample time during the interviews to provide their perspectives, enabling the practice of *dadirri* (deep listening). The interviews were more conversational with the aim to have participants feel comfortable. Participants were offered the transcripts of their interview to check against my analysis and to provide comment. Only one government funder requested to receive their interview transcript. A community report is planned for the ACCHO, to provide the evidence base to benefit the ACCHO in its endeavours to improve engagement with funders and service users, for consolidation and expansion of its service, to improve the health outcomes of Aboriginal people in its region.

3.4 AN INDIGENOUS APPROACH TO THE RESEARCH

The process of research is not neutral. Research can help understand problems or it can perpetuate problems, which is particularly evident in research that involves Australia's First People because the power and control undercurrents exist in multiple ways (Martin 2010). Research has almost always benefited the researcher, more than the researched (Martin 2008). It has been used as a tool of colonialism to erase, erode, silence or marginalise the voices of Australia's First Peoples (Smith 1999; Martin 2010). Unless the critical issues of power and control are explicitly named, discussed, analysed and addressed 'upfront' (in Aboriginal vernacular), research and what constitutes an ethical practice will continue to be denied – thus adding to the trust divide that prolongs and denies true equity and equality within Indigenous communities and, specifically, for the way in which governments use classical contracting with ACCHOs.

I have written this dissertation as an Indigenous woman specifically a Malyangapa/Barkindji woman and researcher, whose daily life throughout this research reflects the disadvantage, grief and despair behind the statistics that are so often reported to describe the appalling gap in the life expectancy of Australia's First Peoples. For this reason, I was attracted to that component of an indigenous research approach that allowed me to seek hope and opportunity: both personally and professionally as a way to survive- to be an agent of change not a subject for further punishment, (Baker 2012). Determined hopefulness is the force of commitment and action for positive change, (Baker 2012) which allowed me to not give up the fight and to be reflective throughout this dissertation. While similar debates are found in other research approaches, these matters are more heart rending and immediate for Indigenous researchers given the amount of grief and loss experienced and managed on a daily basis compared to other Australians. An example is upfront in this dissertation which is dedicated to the thirty one members of my extended family ranging in age from two years to sixty five years young who passed away during the writing of this dissertation between 2010 and 2014.

Another component of an indigenous research approach is an ultimate privileging of our First Peoples' ways of understanding performed through my own knowing that locates the research in a way that is meaningful to other indigenous people. In doing so, the answers imbue the research with a deeper level of understanding. These are codes of lexicon that need to be flexible enough in their usage so that, when applied within the context of Australia's First Peoples, the knowledge is understood but can also be translated into non-Indigenous contexts (Tracey Bunda, pers. comm., 17 Sept 2013). These practices used by indigenous researchers worldwide contribute to a building of theory that is indigenous and drawn from indigenous cultures. For example, Eileen Moreton-Robinson's (2000) book *Talkin up to the white woman is* a play on English words that holds one meaning within the Indigenous community but is meaningful enough to translate across the cultural boundaries. The example enables dialogue across cultural positions but holds onto the original meaning of 'talkin up' and the way it is used in Indigenous

communities. In this way the lexicon, informed by the value systems of indigenous people, relates both objectively and subjectively, and aids in deriving meaning for the research (Tracey Bunda, pers. comm., 17 Sept 2013).

Metaphors are also used as learning tools of indirectness, as a substitution of direct words that may be regarded as disrespectful, offensive or prohibited by cultural groups (Chilisa 2012), in order to avoid shame (loss of face) and in situations where expressing one's experiences directly in written and spoken form can be considered a face-threatening act (Allan & Burridge 1994). Table 3.2 summarises the characteristics of an indigenous research approach – one that is grounded in the belief that knowledge comes from the relationships people develop over time between each other and the environment. It is a form of qualitative research, a method of inquiry utilised in different academic disciplines, traditionally in the social sciences, (Green and Thorogood 2009) but also in market research and other contexts such as research with Indigenous communities. I aimed to gather an in-depth understanding of the funding relationship and the reasons that govern such behaviour on both the provider and funder sides. An indigenous research approach is like the qualitative method that investigates the why and how of decision-making, (not just what, where, and when). Hence, smaller but focused samples are more often used than large samples.

In the conventional view, qualitative methods produce information only on the particular cases studied, and any more general conclusions are only propositions (informed assertions). However, in the context of Indigenous research, the politics of Indigenous identity is at the centre, with Indigenous researchers as agents for change (Laycock, Walker et. al. 2011).

Table 3.2 Indigenous research approach (adapted from Chilisa 2012:40)

	Indigenous research approach
Reason for doing the research	To build on the construction of a body of knowledge that is developed by an Indigenous researcher that carries **hope** and promotes transformation and social change in the funding regime and relationship between Indigenous communities and government. This is qualified by my adoption of a viewpoint that 'stands beside' the ACCHO, and examines the actions of government, rather than the reverse.
Philosophical underpinnings	Informed by Indigenous and non-Indigenous knowledge systems that have influenced the researcher, including knowledge gained from being and working with Peppimenarti and Mutawintji Lands communities, the ACCHO in this study, the Aboriginal Health Council SA, Yunggorendi First Nations Centre, Health Care Management at Flinders University and The Lowitja Institute.
Ontological assumptions (way of being and belonging)	This research approach understands the importance of connection between Indigenous staff who are the focus of this study and the community in which they work and live and the cultural and spiritual practices that inform both. A key discussion point and ontological position for the ACCHO Indigenous staff is the importance of hopefulness, identity and place in Australia and the need to become visible and valued for the unique work carried out as a part of the whole health care system.
Place of values in the research process	This research is guided by a relational accountability that follows respectful representation, reciprocity and rights of the researched. The ethics invoke an in-between space for conversations and planning to improve trust and accountability relations between ACCHOs and governments in terms of implementation of Aboriginal health policies.
Methodology	This research is based on methodologies that draw from Indigenous knowledge systems (including understandings of colonisation and its continuing impact) and non-Indigenous knowledge systems (including qualitative methods).
Techniques of gathering data	Techniques based on Indigenous knowledge systems, eg lexicon among Australia's First Peoples and adapted techniques from other approaches.

The next section of this chapter is a personal story based on my experience prior to working in the academy, to provide connection and meaning to the methodology pertained in this chapter.

I drew on concepts developed by Indigenous academics about what it means to be Indigenous (Moreton-Robinson 2000; Atkinson 2001; Anderson 2006; Wilson 2008; Franks 2008; Marsh 2010; Bunda 2012; Chilisa 2012; Baker 2012),my own experiences and the experiences of the ACCHO Aboriginal staff. I also drew on concepts about what it means to be non-Indigenous (Kelly 2008; Wilson 2011; Eckermann; Dowd et al. 2006) working with Indigenous people. These two and interconnected positions helped to provide answers to the gaps and overlaps in understanding the beliefs and values infused in the different ways knowledge is gained, interpreted or misinterpreted and applied in the funding relationship – a relationship where each party seeks to meet its own accountability requirements within government reporting and regulation structures. Concepts developed by both Indigenous and non-Indigenous academics were also relevant to understandings expressed by funders and ACCHO staff and contributed to framing the methodology and/or understanding the whole inter-relational context of the research.

Methodological nuances operated when interviewing participants who were Indigenous compared to interviews with non-Indigenous staff. For example, it was important to replace the term 'interview' with 'yarn up' in some instances. My intention here was to ensure Indigenous staff felt at ease by using language commonly spoken by Australia's First Peoples and, moreover, because I have relational accountability (Wilson 2008) with participants (that is, it is my responsibility to practice respectful representation, reciprocity and rights of Australia's First Peoples and other marginalised groups).

The identification of the phenomenon of interest – funding relationships between staff in Aboriginal community-controlled health organisations and in government funding departments – was the starting point of the case study. Interest in the particular area grew from my experience growing up around ACCHOs and years later in 2007, I was offered the opportunity to coordinate the Overburden Project (2007–2009).

Further research exploring trust and accountability between ACCHOs and government departments was identified in the project. The formulation of the research questions and the generation of a statement of the research topic ensued from the original work. This study is researcher-driven; that is, I chose the research topic. However, trust and accountability issues emerged from a larger study that was commissioned on behalf of the ACCHO sector and OATSIH (Dwyer et al. 2009). I acknowledge that my own Indigenous way of knowing has been influenced and informed by a multitude of experiences; however, one of the foremost was my teaching experience in the Aboriginal Community of Peppimenarti in the Northern Territory (NT).

3.5 THE RESEARCH WEAVE

In 1986, after graduating from Mitchell College, New South Wales (now Charles Sturt University), I was offered a teaching position at Peppimenarti, NT. Peppimenarti is a remote cattle station managed by Ngan'gikurunggurr and Ngangiwumurri people, carers of that particular 'country', and was established in the mid-1970s within the Daly River Aboriginal Reserve. It was later consolidated by the *Aboriginal Land Rights (Northern Territory) Act 1976*.

Figure 3.2 Northern Territory map - rural and remote schools

Source: Google Maps

The community is located 250 kilometres south-west of Darwin and 100 kilometres from the Daly River (Figure 3.2). Harry Wilson (senior) was instrumental in the community's establishment. He used both his Aboriginal and European ancestry to negotiate the interpretation of Aboriginal needs into European contexts, at the same time preserving authentic Aboriginal voices in the decision-making process. Today, the community has a population of approximately 250 people.

I arrived at Peppimenarti in January 1986 and stayed until December 1988. It was my first teaching position since completing my university degree. Once a week I would take girls between the ages of 10 and 16 to meet with the Elder women to learn the skills of weaving. Some days we would sit out by the general store, other days we would wander the country searching for colour (root dyes), pandanus and sand palm to prepare and weave together to make dilly bags, baskets, fishing nets and sun mats. These products were entered into craft shows, displayed in galleries, sold to art dealers and used for the purpose they were made. In these yarning circles, knowledge was exchanged to guide future Elders to continue an age-old tradition, melding past knowledge into the present, adapting styles and introducing new techniques, sharing knowledge and initiating business ideas in the process of weaving. Today Regina Wilson, a prominent Elder of the community, leads a small business called Durrmu Arts which has taken the women on national and international journeys to share Ngan'gikurunggurr and Ngangiwumurri knowledge, on their terms, with the rest of the world. These are also the 'country' and language groups of Miriam Rose Ungunmerr, who, in 1993, introduced *dadirri* (deep listening) into western academia as a principle to enable reflection of one's own beliefs, influences, assumptions, intrusions, decisions and choices – factors that impact on research and ongoing relationships in both positive and negative ways.

I borrow from the sun mat (Figure 3.3) and hopefully adopt both its simplicity and its complication to represent an Indigenous approach to the methodology for the research that I have undertaken. In the same way that the women of Peppimenarti

searched for the dyes and made selections about the plants for the production of an end product, I too am creating a methodological weft and weave through the use of technical analysis of literature, including publicly-available government and organisational documents, face- to-face interviews, observation and reflection. Each of these components acknowledges the touchstone of knowledge provided in previous studies. I am able to diagrammatically represent the research, which is informed by multiple theories, including an Indigenous research approach, contract, trust and accountability theory, Indigenous intercultural concepts of engagement (eg Ganma/Dadirri) and other theories that address intercultural engagement between Indigenous and non-Indigenous cultures (explained briefly below).

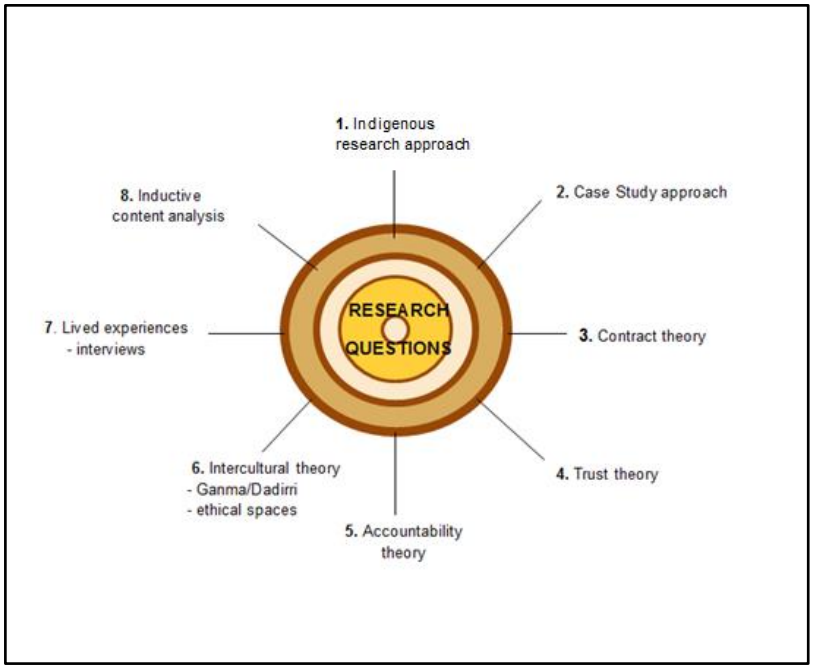
Figure 3.3: Theresa Lemon and Noonook Wilson display a sun mat

Source: http://www.durrmu.com.au/community (retrieved 15/07/2013)

3.6 THEORETICAL FRAMEWORK

The knowledge generated from this research is informed by various knowledge sources in order to answer the research questions and these are briefly described below.

Figure 3.4: Theoretical framework - knowledge informing this study



3.6.1 AN INDIGENOUS RESEARCH APPROACH

This research is informed by an Indigenous research approach. An Indigenous research approach articulates the shared characteristics of ontology (ways of being), epistemology (how one thinks about reality), axiology (beliefs and values) and research methods of Indigenous peoples around the world with similar colonial histories of dispossession (Moreton-Robinson and Walter 2009). A common thread that cuts across the beliefs of Indigenous peoples worldwide is that people are spiritual beings with multiple relationships that should be nurtured throughout the research process (Chilisa 2012). In the research being conducted, this becomes an important challenge because I have a subjective relationship which is viewed as advantageous rather than deficit. As previously noted, I am Indigenous and this location provides me with a particular worldview for the research that is

undertaken in this study. My subjective engagement does mean that Indigenous voices will be heard.

Indigenous approaches are those that support and enable Indigenous researchers to be who they are while actively engaged in the research (Weber-Pillwax 2001). The way of being (ontology) not only creates new knowledge but transforms who researchers are and where they are located (Weber-Pillwax 2001). Wilson (2001) suggests an indigenous approach implies articulating relational accountability, of which I am accountable to all relations. An indigenous approach draws from the fundamental belief that knowledge is created based on the relationships one has with the world, including interpersonal relationships, relationships with the research subjects, with animals, plants and the earth, and that the knowledge generated is shared ideally with all creation (Wilson 2001) to sustain our existence as human beings. Thinking in terms of 'the collective' is another key characteristic of an indigenous approach. It requires a sense of commitment to the people in many indigenous societies. Intrinsic in the commitment to the people is the understanding of the reciprocity of life and relational accountability to one another.

A final point is the emphasis on practicality – an Indigenous approach includes the assumption that knowledge gained can be utilised practically (Kovach 2005) by the ACCHOs, government departments and myself as the researcher. This is a particularly important aspect of the research and will be developed as an action and ethical commitment by myself as the researcher beyond the completion of this dissertation. This research represents a pedagogy of hope for our communities, theorising from the place of the positive, looking at what works and learning from what has failed, having dialogue about how we can recognise and prevent the continuation of colonisation and dispossession that has led to racism in the workplace - "No one is born a racist. Everyone makes a choice" (Hooks 2003:23). The methodology using a case study approach also draws on a growing number of methodologies being written from the experiences of Indigenous researchers in international, national and regional geographic locations 'to counteract imperialist,

deficit-driven and damage-centred research and literature, which chronicle only the pain and hopelessness of the colonised other and which entrench existing structures of domination' (Chilisa 2012). The methodology draws from the philosophical and theoretical assumptions of an indigenous research approach to emphasise the unique contribution of socio-historical, cultural and political factors to public health and related research. The main emphasis is that people should be understood within their social context, which is influenced by their cultural, political and historical contexts. Contexts and culture may differ from region to region and within each region, by location, nationality or ethnic group (Chilisa 2012). Recognition of the diversity in culture and contexts should be seen not as promoting fragmentation of knowledge but, rather, as giving voice to all, irrespective of race, location, gender and ethnic group.

It is hoped that this research will provide practical guidance for improving the funding relationship between Australia's First Peoples' organisations and government departments. An Indigenous research approach cuts across Western constructs of research. The challenge is internationalising culturally-responsive methodologies, and integrating Western culture-informed perspectives, in positive ways that permit respectful dialogue between researchers, policy-makers, communities and nations (Chilisa 2012) that lead to mutual actions for change. The methodology used in this study seeks to rise to this challenge.

3.6.2 CASE STUDY APPROACH

This research used a case study that presents detailed information about people in a particular context, including their perspectives, to inform the research. A case study method is used where there are multiple variables (for example, trust and accountability) that cannot be 'controlled' but must be observed, understood and supported (Stake 1995; Yin 2003). A form of qualitative or mixed-methods descriptive research, the case study looks intensely at a small ACCHO and government departments, drawing conclusions only about these groups and only in that specific context (Yin 2003). It is a flexible approach to research that focuses on a particular phenomenon – in this case, how ACCHO and government staff

perceives their working relationship with each other; within a complex and highly context-specific situation. Luck et al. (2006) describes a case study as a 'paradigmatic bridge.' In other words, the work's emphasis is placed on exploration and description of contemporary phenomena, especially where complex interrelated issues are involved (Yin 2003), rather than on the finding of a universal, generalised truth, or a stereotypical search for cause–effect relationships. Mixed methods with multiple sources of data to capture the complexity are utilised.

A case study approach was particularly helpful because it directed attention to one Aboriginal community controlled health organisation and the relationship of the organisation to the funding body. The approach is also suitable from the perspective of the Ganma/Dadirri concept (see below) – that is, the case study approach allows for examination of the salt (western) and fresh (Indigenous) water knowledge, as well as understanding the new knowledge that exists in the 'foam' they produce when mixed.

As Yin (2003) has identified, the variables that could not be controlled in the case study give attention to that which is fluid and shifts (eg. trust and the processes and understandings of accountability). This study highlights this important factor and the case study approach provides a way to incorporate understandings of Indigenous knowledge and experiences. This case study is instrumental in nature because it focused on understanding a predetermined issue: trust and accountability in the funding relationship between ACCHOs and government departments.

3.6.3 CONTRACT THEORY

As discussed in Chapter Two, Australian governments contract in two main ways: classical and relational (Dwyer et al. 2011; Lavoie et al. 2010). Classical contracting is based on distrust and creates administrative overburden for both the ACCHOs and government staff who manage the contracts. Classical contracts are tightly controlled by government, making them rigid and inflexible to changing

circumstances of the ACCHO (Dwyer et al. 2011). These contracts are short-term funded with expectations of long-term outcomes and do not enable the autonomy of the ACCHO to decide how that funding is distributed to best match their programs (Dwyer et al. 2011). While the practice of contracting occurs with mainstream organisations, it restricts the development of substantive relationships with community-controlled organisations.

Relational contracting, also known as alliance, is used by governments and is often a long-term funding arrangement. It is a better fit for self-determination and community control because it has flexible methods that support long-term outcomes – working 'with' the organisation rather than working 'on' the organisation. Failures and successes are shared between the government funding body and community organisation with the key emphasis on the relationship. Contract theory is helpful to this study to generate shared understandings of the different theories and the influences of these theories on the quality of the relationship, outcomes of funding arrangements and analysis of the data. This study brings these understandings to the front, particularly when ACCHOs desire a better working relationship with government funding departments.

3.6.4 TRUST THEORY

Trust is a particularly complex phenomenon when considered within an environment of philosophical needs of Australia's First Peoples' self-determination. Self-determination is the right of Indigenous peoples worldwide to be free to choose their own ideas of development, as well as help to reconstruct current institutions to improve Indigenous peoples' situations and that of humanity as a whole. Australian Government policy fails to recognise or acknowledge the act of intergenerational dispossession of Australia's First Peoples' identity, cultures, language, lands and resources by government in the Australian context. As a consequence, many First Peoples' communities (urban, rural and remote) continue to suffer from historical and current injustices, including discrimination and marginalisation, and often our right to development is denied. Australian

governments have established a statutory framework to recognise, protect and shape agreements relating to First Peoples' right to self-determination – in other words, common law rights (Yu 2012). Yet despite these fundamental points of recognition, Australian governments continue to pursue policies that do not match Indigenous priorities (Yu 2012). For example, inflexible national funding priorities and programs tend to restrict opportunities for the ACCHO to negotiate better strategies to respond to local priorities, which has negative impacts on service delivery and the ACCHO's standing in the community, as this research demonstrates.

Government practices of intergenerational dispossession and Australia's First Peoples' experiences of continued dispossession is the great trust divide. The 2012 Reconciliation Barometer by Auspoll found First Peoples and other Australians agree that the relationship is important and that Australia's First Peoples' cultures are important to Australia's identity as a nation; however, when it comes to trusting each other, numbers in both groups are low. The ACCHO and government-funding relationship is also reflective of the great trust divide between Australia's First People and other Australians as discussed in Chapter Two's literature review.

3.6.5 ACCOUNTABILITY

As discussed in Chapter Two: literature review, the current approach to accountability does not recognise an important additional role of Indigenous community-controlled organisations. These organisations represent their communities and their clients as part of their roles. As Rowse (2005) notes, Indigenous people require community sector organisations in order to become visible as citizens (See also Dwyer, Lavoie, O'Donnell et al. 2011, Sullivan 2010). These organisations are not simply providers of health care services between service users and the purchasers (governments). ACCHOs, as the representative voice of service users themselves, can require accountability from the government that purchases the services. They have the right to this downwards accountability as the representative of the most marginalised citizens - Australia's First Peoples (Dwyer, Lavoie, O'Donnell et al. 2011). Therefore, the contractual accountability

arrangements for these organisations may require more focus on reciprocity between government and providers, as well as the need for providers to report meaningfully to their communities (Dwyer, Lavoie, O'Donnell et al. 2011, Auditor General of Canada 1996).

The major aspects of current Government contracting have serious implications regarding trust, and show a lack of reciprocal accountability that is demanded by Indigenous philosophies and ways of being for our continued survival. The need for improved engagement and relationships across cultures is clear. A theory that supports the making of equivalent relationships between black and white Australia is intercultural theory, in which Indigenous philosophies such as ganma and dadirri can be valued.

3.6.6 INTERCULTURAL THEORY

Haig-Brown (2001) and Somerville and Perkins (2010) describe the emotional determination required to engage across cultural boundaries (written and unwritten) as painful work. However, the rewards of engagement for participants are transformed in the process, through improved understanding of each other. Haig-Brown (2001) notes that the transformative nature of what she describes as 'border work' involves recognising and re-conceptualising categories (eg Indigenous/non-Indigenous) through which the border is maintained. She argues for the requirement of both border maintenance (a focus on difference) and border crossing (a focus on synthesis), as vital when working in the contact zone. This is particularly important to understandings in the provision of health care with and to Australia's First Peoples. Pratt (1999:156) argues that people should keep 'the process of border construction in view, as well as tracing the interdependencies of what lies on either side of the border.' She draws attention to the strategic possibilities of border maintenance, as complementing an attention to movement across boundaries and difference, and calls for theorising about contexts. These ideas resonate with Ganma/Dadirri and ethical space theories, as explained.

3.6.6.1 GANMA/DADIRRI

Ganma is a metaphor, a theory and a style of Indigenous social science (Watson, Chambers et al. 1989). It is an ancient metaphor derived from the Northern Territory that has guided Indigenous people from this part of Australia from which we can all learn. This knowledge was made accessible by Aboriginal Elders and given the name 'ganma' in the English language. The word may be used to refer to the situation where a river of water from the sea (western knowledge) and a river of water from the land (Indigenous knowledge) engulf each other, flowing together and becoming one (Watson, Chambers 1989:5). The theory holds (in part) that the forces of the streams combine and lead to deeper understanding and truth (Hughes 2000) and that the foam produced when salt water mixes with fresh water represents a new kind of knowledge. Basically, Ganma is a place where knowledge is (re)created (Atkinson 2002; Yunggirringa, Garnggulkpuy pers. comm. April 2007; Pyrch, Castillo 2001).

Creating foam requires more than a joining of intellect and egos. In order to hear the quiet sounds of foam, one needs to listen with one's heart, to be aware of experiencing not just the experiences, but also to recognise the importance of process, as well as outcomes. Ganma is a way to deepen an understanding of who we are, what knowledge we bring, and how we can engage in respectful relationships. It requires deep listening (Atkinson 2002; Kelly 2008; Yunggirringa and Garnggulkpuy pers. comm. April 2007).

Ngan'gikurunggurr people of the Daly River area, Northern Territory describe deep listening as Dadirri – a form of contemplation and non-obtrusive observation. People are recognised as being unique, diverse, complex and interconnected; part of a community where all people matter and all people belong (Atkinson 2002; Ungunmerr 1993). Intercultural theory is important to this research and Dadirri is especially appropriate across cultures as it recognises that shared experiences are different. However, when people are prepared to meet and listen deeply to where the other is coming from, there are opportunities to learn and grow together to resolve problems and 'in this we create community, and our shared knowledge(s)

and wisdom are expanded from our communication with each other' (Atkinson 2002:17).

My first recollection of learning about Ganma/Dadirri theories was in 2005 when I began working as a researcher at Flinders University. Professor Judith Atkinson (2002), of Jiman and Bundjalung descent, had written a book called *Trauma trails, recreating song lines: the trans-generational effects of trauma in Indigenous Australia*. It was underpinned by Ganma/Dadirri theories as a way to respectfully exchange knowledge and understandings and is particularly relevant to guide conversation in highly contested spaces between Australia's First Peoples' organisations and government departments. Orally, it is known through family-owned knowledge that the protocols and ceremonies associated with bringing together diverse Aboriginal groups occurred(s). Orally, this process is practised among Wiimpatja (Aboriginal people) custodians of the Mutawintji Lands and is referred to as 'thaltimilaali'- the closest translation is 'we listen to each other' however challenging the conversation becomes (Peter Thompson, pers. comm. 6.8.13). The process can only be successful when there is leadership that facilitates respectful conversations with a focus on solutions to issues raised. This type of leadership where power is used to unite people through equitable processes, rather than 'divide and conquer' tactics often used by government institutions and unfortunately, by some leaders of Indigenous organisations. In the spirit of tradition this research centres relationally (Wilson 2006), to form deep understandings posed by the research questions.

3.6.7 ETHICAL SPACE

In the Canadian context, Ermine's (2007) concept of the 'ethical space' parallels with Ganma/Dadirri concepts of engagement. Ethical space is formed when two societies with disparate worldviews are prepared to engage each other. Ermine explores the need for a framework for dialogue based on recognition of the differences and ways to examine diversity and positioning of indigenous peoples and Western society in order to begin a dialogue with government about First

Peoples' legal concerns. Ermine makes three important points that are relevant to the relationship between ACCHOs and governments in Australia:

- A new approach to a deeper level of communication in a cooperative spirit is required because what remains hidden and tangled are the deeper thoughts, interests and assumptions about each other that inevitably influence and stir up the kind of relationship the two can have. The deeper level underflow (systemic racism) needs to be acknowledged and brought to bear in complex situations when addressing confronting knowledge and systems in the spaces to improve indigenous peoples' lives.

- With ethical standards in mind, it's important to think about the breach of standards by others and how actions may also infringe or violate the spaces of others. Therefore, a conversation on ethics also includes the serious reflection of those crucial boundaries drawn to define personal and cultural zones and the demarcation of boundaries that others should not cross.

- Additionally, there are those ethical boundaries established by collective principles, such as knowledge systems, the autonomy of human communities, or of treaties or agreements. This is a heritage from the past that not only informs Indigenous peoples' roots to antiquity and the rights to traditions entrusted to them, but it also reminds Indigenous people of what is important in life as a future that we are able to collectively negotiate themselves.

Ermine's work resonates with Ganma/Dadirri philosophies applied in practice by First Peoples from the Northern Territory. Ganma philosophy is derived from the Yolngu people and Dadirri philosophy is derived from the Nungikurringu people. Both philosophies guide relational protocols so that the acquisition of knowledge can be exchanged and shared between human communities with different and/or similar worldviews in respectful ways, to begin righting the wrongs from the past and present situations built on systemic racism that is the underflow Ermine talks about. These intercultural philosophies and above theories are brought together and influence the analysis for discussion.

3.7 DATA COLLECTION AND MANAGEMENT

Three main types of data was collected, reviewed and analysed – unpublished literature and organisational documents, interview transcripts based on semi-structured questions, and researcher observations and personal reflections (expressed at the end of the chapter).

Information collected directly from participants was stored in the form of computer audio files, transcripts of those files (computer and hard copy) and data analysis sheets (computer and hard copy). De-identified information from the databases is stored as computer and hard copy files in my Flinders University office. Identifying information was removed from transcripts and analysis sheets and a code was assigned to each individual. I made a sheet that matches codes to identifying information and stored this in a locked filing cabinet in my Flinders University office. The information will be held for seven years, in accordance with Flinders University's archiving system and policies which have security protection in keeping with industry standards. Participants only have access to their own data to check interpretation. The intellectual property (ownership of the knowledge generated) from the study is shared between the Lowitja Institute, the ACCHO and Flinders University.

3.7.1 SUPERVISOR AND STUDENT RESPONSIBILITY

Supervisor and student researcher roles and responsibilities were clearly defined in a written agreement at the beginning of the study to ensure transparency and the practice of relational accountability (Appendix 7). Initially, Prof. Colin MacDougall and Prof. Judith Dwyer were listed as supervisors, and Dr Jenny Baker and Dr Angelita Martini as critical friends. After discussions with Dr Jenny Baker, Prof. Tracey Bunda was approached as a critical friend because she was more accessible on campus and located within walking distance to my office at Yunggorendi First Nations Centre, Flinders University. After discussions with both Tracey and Angelita, I decided to include them as supervisors because their knowledge complemented both Judith and Colin's knowledge. Long-term relationships

established with all supervisors from eight years to twenty five years enabled regular face-to face feedback and conversation about issues (eg high burden of grief and loss) that continually interrupted my studies that is not perhaps carried by other Australians to this intensity.

3.7.2 ENGAGEMENT WITH THE ACCHO AND GOVERNMENT FUNDERS

Up to three South Australian ACCHOs in regional towns were approached by email and invited to participate in the study – one responded positively. In May 2011 ethics applications were forwarded to the Aboriginal Health Research Ethics Committee SA (AHREC: 04-11-395) and to Flinders Social Behavioural Research Ethics Committee (SBREC: 5222). The ethics application was submitted to both Boards without the ACCHO approval letter, with an explanation that I was awaiting approval by the ACCHO Board. The step was taken to avoid further delay for approval given the considerable time-lag between ethics committee meetings. The ACCHO Board approved the research and a support letter followed.

3.7.3 FACE-TO-FACE PRESENTATION TO THE AHREC

I was asked to attend the AHREC meeting in person on September 1 2011 to present this study and further clarify the aim of the study, how risks would be managed and to provide assurance that no harm would occur to the ACCHO. The face-to-face meeting was also an opportunity for the Committee to determine my spirit and integrity and assess whether the committee could trust me to carry out the work respectfully in such a highly contentious context. The committee was concerned that the research was investigating staff personal relationships and required assurance that the focus was only on staff professional working relationships. Once assurance was gained, the committee approved the ethical conduct of the research.

3.7.4 RECRUITMENT

The following information was emailed to three ACCHO CEOs that I was keen to work with as I had already established working relationships through previous research:

- a Letter of Introduction from the primary supervisor, Associate Professor Colin MacDougall (Appendix 3)
- project Information (Appendix 4)
- consent form (Appendix 5)
- interview outline (Appendix 1 and 2)

An exploration of all the possibilities, to ensure understanding and to gain the most from the research for both the ACCHO and myself, initially occurred over the phone with the CEO because the ACCHO is more than four hundred kilometres from Adelaide in South Australia. The CEO of the ACCHO sought the involvement of the funding/program managers for the interviews and provided the names and contact details of the government funders responsible for managing the ACCHO funding contracts.

Funding staff were invited to participate using the same approach applied to the ACCHO invitation described above. Three government funder interviews were conducted between November 2011 and February 2012 in their respective workplaces. All participants were assured during the recruitment process that their involvement, or not, in the project would not impact on the health care delivery of the ACCHO.

3.7.5 PRELIMINARY FACE-TO-FACE MEETING WITH THE ACCHO CEO AND BOARD

I was invited to the ACCHO for a preliminary meeting on August 17 2011 and an MOU agreement was drafted (see Appendix 6) to reflect reciprocal accountability and how to manage possible risks that may arise during the study. Issues addressed were:

- the focus of the research
- management of the study, including advisory panel

- funding
- the level of participation of both the ACCHO and researcher
- capacity development for Aboriginal people
- outcomes from the study

Interviews were confirmed for November 21-26 2011. During the preliminary visit, I was introduced to staff and several Board members. In the initial research proposal, service users of the ACCHO were included. A poster was developed and placed in the waiting area of the ACCHO. Staff also provided information about the project to service users, who could decide if they wanted to be involved. There was not enough interest from service users and it was decided to only focus on the provider/funder relationship. Client questions sought client reflections and thoughts about their understanding of how the ACCHO is funded and their client/provider relationship with the particular ACCHO.

3.7.6 LIVED EXPERIENCES: SEMI-STRUCTURED INTERVIEWS

Ten semi-structured interviews with the ACCHO staff and government funding authority were conducted. Providers and funders were invited to be involved in interviews of approximately 60-90 minutes at a time and location of their choice. The research questions were developed from the results of The Overburden Report (Dwyer et al. 2009) and document/literature reviews in stage one. Field notes and a reflective journal were used to record research observations. Data was collected and recorded during meetings and discussions with full written permission of participants.

I recorded the interviews and these were transcribed by a trusted, professional colleague with experience and understanding of working in First Peoples' health. This information was included in the Letter of Introduction (Appendix 3).

Interviews were carried out onsite at times and locations that were convenient to the ten staff, inclusive of government – all chose the offices where they felt most comfortable. I visited the ACCHO from November 21-26 2011 with a colleague,

Dr Janet Kelly who presented the results of the Managing Two Worlds Together Project (2011) to ACCHO staff, Board members and hospital staff who supported the work. This was in keeping with the ACCHO preference for combined visits, ensuring the least possible interruption to the operational management of the ACCHO. An honorary lunch was provided from my project funding scholarship at the ACCHO and informal conversations took place with staff during the week about anything staff chose to talk about.

3.7.7 INDUCTIVE CONTENT ANALYSIS

Understanding the context of the ACCHO/funder relationship was a foundational requirement in the case study research. Organisational documents were used to inform this study but they are not named in this dissertation because they would identify the ACCHO. Interviews and personal reflections were also analysed using inductive content analysis. Inductive analysis was used to condense extensive and varied raw text data into a brief, summary format; to establish clear links between the research objectives and the summary findings derived from the raw data and to ensure these links are both transparent (able to be demonstrated to others) and defensible (justifiable given the objectives of the research). Inductive content analysis enabled the development of a model or theory about the underlying structure of experiences or processes evident in the text (raw data) (Thomas 2003) using Word tables.

Table 3.3 The coding process – inductive analysis

Initial read through text data	Identify specific segments of information	Label the segments of information to create categories	Reduce overlap and redundancy among the categories	Create a model incorporating most important categories
→	→	→	→	→
Many pages of text	Many segments of text	30–40 categories	15–20 categories	3–8 categories

The Thomas (2003) framework was adapted to guide the manual analysis as follows:

1. Transcripts were read repeatedly to achieve immersion and obtain a sense of the whole.
2. Transcripts were read word by word to derive codes by first highlighting the exact words from the text that appear to capture key thoughts or concepts.
3. Summary notes were made of first impressions, thoughts and initial analysis.
4. Labels for codes were developed that reflect more than one key thought for the initial coding scheme as they emerged.
5. Codes were then sorted into categories based on how different codes are related and linked.
6. Emergent categories were used to organise and group codes into meaningful clusters.
7. Relationships between subcategories were investigated and led to a smaller number of categories.
8. A framework derived from contract theory was used to help organise these categories into a structure.
9. Definitions for each category, subcategory and code were developed.
10. Examples for each code and category were identified from the data for reporting.
11. Relevant theories were considered within the discussion of the dissertation and a broad description is presented.

3.7.8 DISSEMINATION – SHARING THE RESEARCH RESULTS

A dissemination plan was factored into this study from the beginning to ensure the results were reported back to the ACCHO community and government departments to check that the interpretation of knowledge was accurate (October 2013). Results were emailed to ACCHO and government staff, including the offer to email participant transcripts. One government staff member was emailed his/her transcript upon request (October 2013). The research results will be made available to all ACCHO Boards and staff members and government funders using

presentation strategies suited to their needs while this dissertation is being considered by examiners. The results will be provided through face-to-face presentations at Board meetings, community meetings and government meetings as requested by the ACCHO and government funding departments. Feedback from all participants is incorporated into this dissertation and the full dissertation and community summary reports will be made available in electronic form for dissemination. Results will also be published in various forms as guided by Flinders University and The Lowitja Institute knowledge exchange policies. A copy of this dissertation will be made available in the Flinders University library.

3.7.9 IMPACT ACHIEVEMENT

Knowledge exchange of the results was effectively budgeted to maximise dissemination in a variety of ways. A scholarship of $30,000 and project funding of $10,000 was provided by The Lowitja Institute. Flinders University is a partner agency of The Lowitja Institute and provided part-time employment, administrative assistance, mentoring and a secure office space in which to write.

I worked with The Lowitja Institute and research users – the ACCHO staff and government funders – with the aim of maximising uptake of the results and implementing proven better practice (inclusive of different communication techniques) to improve the funding relationship. Translating research results into changes in a health policy may require the production of briefing notes, meetings with politicians and public servants, and an action–learning approach to implement future changes at the level of service provision. Promotion and uptake of results to inform policy will be facilitated and supported by The Lowitja Institute, Flinders University and NACCHO through their relational networks.

3.7.10 POLICY IMPLICATIONS AND KNOWLEDGE EXCHANGE

Evidence demonstrates that policy-makers prefer to engage with a synthesis of knowledge rather than one-off project reports (Brands & Gooda 2006). As stated above, research results will be exchanged in a variety of ways that appeal to

research users, policy-makers and practitioners employing pragmatic language and techniques and guided by The Lowitja Institute knowledge exchange policies. This strategy is outcomes-focused, targeting change for both ACCHO and government departments towards improving their funding relationship. This ensures the research is used – a fundamental component of research in Aboriginal and Torres Strait Islander health – and has a greater chance of uptake by research users because it has included them in the planning, conducting and dissemination of research findings (Brands & Gooda 2006). This will also depend on recognising opportunities that may not have been planned in this study, to promote the work to government staff that have the power to make changes to improve managerial relationships at the middle management level of the bureaucracy.

The focus in knowledge exchange will be on five methods or conclusions arising from reflections in this study. First, an Indigenous research approach makes a huge difference. This involves adding to the small amount of academic publications that re-write and re-right Aboriginal and Torres Strait Islander Peoples' position in Australian history and society (Lavallée 2009). It is a process towards decolonising the academy by including Indigenous knowledge into the research, conducted by an Aboriginal woman rather than solely relying on Western Theories (Smith, 1999). Second, I intend to submit a methods paper to a peer-reviewed journal, and to use personal reflections about methods in my teaching of the Certificate IV Indigenous Research Capacity-Building course for Aboriginal Health Workers. In the course of teaching, these reflections involve many conversations about persistent grief and loss and the impact this has on our health and wellbeing, and the importance of regular strategies that empower us to take care of ourselves in a space where we have to be able to hold our collective sadness and at the same time celebrate our resilience to remain hopeful. This includes tailoring approaches to supervision, as I have documented in Appendix 7.

Thirdly, trust in intercultural relationships depends on recognition by all involved that several kinds of knowledge (including peoples' values and beliefs based on experiential knowledge) need to be brought together. Ganma provides a way of

thinking about this, and about supporting the facilitation of safe spaces for both ACCHO and government management staff to find better ways of working and leading together. Fourth, it is important to acknowledge failures - to learn from these and counterbalance with a focus on positive achievements in Aboriginal health and to celebrate the resilience of Aboriginal communities.

Finally, I will continue to pursue a broad range of opportunities to talk about this research. To date, I have prepared a community report and presented at the following conferences and network meetings:

- NACCHO summit, 'Governance and Accountability: Untangling some knots in thinking,' October 2013, Adelaide SA
- Health Services and Policy conference, December 2013, Wellington, New Zealand
- International Network for Indigenous Health Knowledge and Development conference October 2014, Winnipeg, Canada
- SA Aboriginal Health Research Network presentation ' July 2014, South Australia Health and Medical Research Institute, Adelaide and in my continuing teaching role at the Aboriginal Health Council of SA.

This study is my contribution to influence the reconfiguration of funding relationships between ACCHOs and government departments. It also begins to inform trust and accountability theory from an Indigenous worldview in this particular area.

3.8 LIMITATIONS

My perspective as a researcher of Aboriginal descent is deeply engaged in the issues the ACCHO sector addresses. In order to address the potential for bias in my analysis I made a conscious effort to attend to the perspectives of government funding staff, recognising that this study required a balanced understanding of both perspectives. I used my reflective journal to deepen my thinking about the funder perspective, and used debriefing with peers and my supervisors to analyse my

experiences of racism and to understand its influence on the funding relationships. This study is also limited by the absence of the perspectives of service users of the ACCHO. Initial attempts to recruit service users for interviews, in order to gain their perspectives about the ways the ACCHO engages with the community, were unsuccessful. At the time of recruitment, the community was in mourning for an Elder who had passed away. It would have been disrespectful to pursue involvement at this time. Further, university-based research continues to be viewed as untrustworthy, harmful and something to be avoided because of negative past (and sometimes present) practice by academic researchers. For these reasons I did not persist with recruitment efforts, and service user perspectives about their relationship with the ACCHO and how governments fund ACCHOs are not included in this study. This limitation is not considered critical because service users are not direct participants in the relationships between funders and providers.

The fact that this study examines the perspectives of a small group of management and funding staff in one ACCHO and relevant funders may also be seen as a limitation. The case study approach was chosen to enable in-depth understanding of the experience on both sides of a particular example of the funder-provider relationship. The limitations of case studies are acknowledged, and claims for generalisations are not made.

3.9 SUMMARY

In this chapter the methodological approach and methods supporting the research were described. The chapter situated the study within an Indigenous research approach, drawing on my personal standpoint and Indigenous academic concepts. This approach was interwoven with the available literature, including publically available government and organisational documents, face-to-face interview observations and reflection. This research highlights how Australia's First Peoples' health and health care matters are complex issues derived from colonisation and dispossession. This complexity calls for a cross-cultural approach, bringing together

the knowledges of both Indigenous and non-Indigenous perspectives, experiences and worldviews respectfully.

Using a case study approach enabled this research to build the narrative of an Aboriginal community-controlled health organisation and government departments that manage the funding contracts at the micro level. This was then analysed using MacNeil's (1978) classical and relational contract theory framework, informed by trust, accountability and intercultural theories.

Data was collected via semi-structured interviews with ACCHO and government funding staff and transcribed and analysed using inductive content analysis as described by Thomas (2003). Findings were disseminated back to participants for checking and to ensure interpretation of data was accurate. The next chapter reports the results from the analysis of interviews with ACCHO and government staff in South Australia.

CHAPTER 4: RESULTS

> Some of the projects are now kind of at the higher level around themes rather than split three atoms and report tomorrow. You might be doing that so it's not less prescriptive, it's not – it's just more thematic, I think…… (GFS2)

GFS2 makes reference to splitting three atoms and reporting tomorrow as was/is the control that government legislates through its accountability processes, policies and associated programs that impact upon Australia's First Peoples. There's an uncertainty from GFS2 as to whether categorising funding applications into themes makes reporting less prescriptive for the ACCHOs.

4.1 INTRODUCTION

This chapter reports the results of interviews with ACCHO and State/Australian Government funding staff in South Australia. Ten interviews were conducted between November 2011 and February 2012 – seven interviews with primarily management staff of an ACCHO and three interviews with government funding staff from the Indigenous Coordination Centre (ICC), Office for Aboriginal and Torres Strait Islander Health (OATSIH) and Department of Families and Communities SA (DFC), now named the Department for Communities and Social Inclusion. The expression by a government funder, 'split three atoms and report tomorrow' reflects the impractical nature of government reporting and regulation of funding to ACCHOs, hence the title of this work.

Responsibilities of funding staff involved management of funding contracts and delivery of COAG programs. One government funder and five staff of the ACCHO identified as Aboriginal. All ACCHO participants were based in the regional centre and government participants were based in Adelaide.

Each interviewee was allocated a specific code. These codes are used in the chapter to identify the setting of the speakers who are being quoted. 'AMS' indicates ACCHO management staff and 'GFS' indicates government funding staff.

Participants were asked a series of open-ended questions about their funding relationships with each other – what worked, why and how, what structures got in the way of the relationship and how could the relationship be improved? The interview questions are provided in Appendix 1 and Appendix 2.

The results were analysed according to key themes, using a coding framework based on contracting theory (Lavoie, Boulton and Dwyer 2010). Inductive thematic analysis was overlayed by an Indigenous approach whereby knowledge is developed by an Indigenous researcher with the intention of producing knowledge that promotes hope, transformation and social change in the current funding regimes and relationships between ACCHOs and government departments.

Themes related to the funding arrangements are presented to provide:

- an understanding of the basis of the funding relationship;
- followed by themes related to government priority-setting and accountability;
- monitoring and accountability;
- the central problem of risk and trust in the relationship is described and;
- potential solutions or improvements to manage the relationship suggested by participants are analysed.

4.2 FUNDING ARRANGEMENTS: UNDERSTANDING THE BASIS OF THE FUNDING RELATIONSHIP

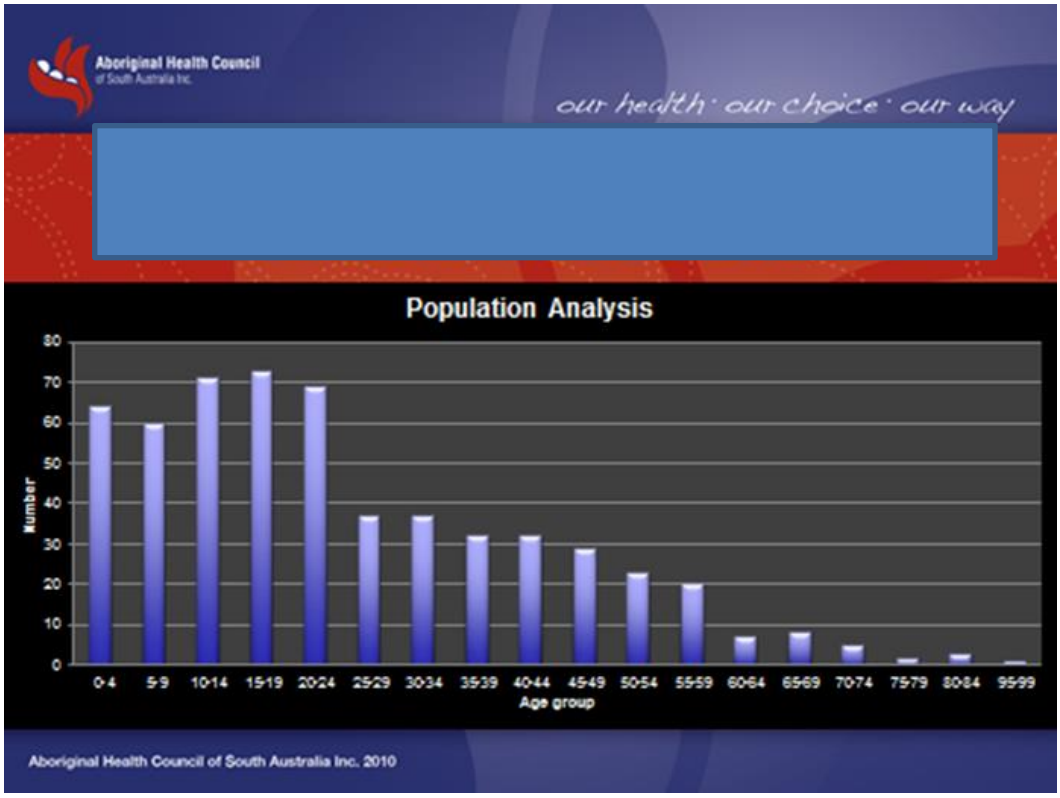
The first major category is the nature of the funding arrangements themselves. ACCHOs are generally funded through short-to-medium term (1-3 years) contracts from multiple funding sources, both within single government departments and across departments and levels of government. Most ACCHOs (including the one in

this study) receive 'core funding' (generally titled PHC funding) from OATSIH that can be used to support administration and clinical services, and a series of 'program' funding contracts that are much more tightly specified and do not generally include funding for overheads. The themes summarised in this section are generally consistent with the findings of previous research on this question (eg. Morgan & Disney 2006; Dwyer et al. 2011), indicating that change has been slow or absent.

4.2.1 ADEQUACY

The ACCHO community profile is presented below to show the age composition of the Aboriginal population in that specific area and the need to support the ACCHO to continue to provide flexible health promotion programs that respond to the high youth population.

Figure 4.1 ACCHO community profile



Source: Aboriginal Health Council of South Australia Inc, 2010

Participants on both sides of the funding relationship reported that the small ACCHO was underfunded for all of the service needs of the community (GFS2, AMS1, AMS2, AMS3, GFS3), and an increase in base funding to the ACCHO was required to support the growth of the organisation (AMS7, AMS1, AMS2, AMS3, GFS2):

> Funding is always going to be huge [problem] until they let us have our own tools and allow us to grow. You can't put us in a flowerpot and we get root bound. You've got to put us in the ground so we can spread our roots out and we'll flourish and the seeds that come from the plant will spread. (AMS7)

Community development is expected by government as part of ACCHO core business but it is not budgeted for:

> If we're expecting Aboriginal organisations to do certain things then I think they need to expect from us the ability to support them to be able to do that. (GFS2)

Staff from the ACCHO said they spend a great deal of time writing funding applications to fill the gaps in core funding, and while it could be argued that the core funding they receive is intended to support this work, it is not the case in small or remote ACCHOs. This was supported by funders:

> That's a bit of a trend in the Department which we're noticing in other mainstream areas so you might have a service that's in a remote locality that's operating on their resources or staffing and they're having to not only do clinical work but they're doing their admin, they've got to write applications and, yes, it's extremely difficult. (GFS3)

Growth of an organisation was described as:

> …the bigger you are, the more funding you get, the more you can take as your administration fee, the more you can then build staff and that's how [an ACCHO] grows. (AMS1)

The case study ACCHO is planning to consolidate and expand in stages.

4.2.2 TIMELINES

Four staff (GFS3, AMS1, AMS2, AMS3) said OATSIH's shift from one to three-year funding contracts is a positive move enabling the ACCHO to retain staff and plan longer term. The shift requires the ACCHO to prepare a three-year budget, as well as annual budgets.

An ACCHO staff member (AMS7) suggested that a five-year funding cycle should be introduced, moving beyond the three-year political cycle and supported by policy to sustain programs as the population of the community grows:

> You can't do a five year program. What's wrong with that? So it goes across into the next government that comes into power and there should be a policy not to cut those programs or not to reduce the funding we've got – when the community's growing… (AMS7)

One of the problems caused by short timelines is the pressure to spend money within financial years to avoid losing it. When the ACCHO has not spent funding within the financial year (for example, due to difficulties recruiting staff or because notification to receive funding was late in the funding cycle), this created problems for both the provider and funders:

> We're not actually worried; there's no misappropriation of funding or anything like that, however there is under-spend and that's a problem for us and OATSIH. It'll be a problem for them because – it's like, how the hell, can you have underspend in Aboriginal health? (AMS1)

> I think it defines, though, what is a late release of funds as well because yes we have all the best intentions of releasing the funding and quite often it is at the eleventh hour on 30th of June… (GFS3)

Roll-over of ACCHO funding is limited because OATSIH staff are instructed to recover the funds. The alternative is that the ACCHO is pressured to spend money 'in a hurry' at the end of the financial year:

> It's a bit of a tricky one because we're in the – you know, with the government, the current economic climate, trying to reduce our deficit and

> the Department will say 'let's recover those funds.' It's too late now. Certainly in the last twelve months or the financial year it looks a lot different to what we – the previous practice in OATSIH, where we could consider the request for those roll-overs, those decisions now are basically 'recover those funds'. If we know why ?we talk to the organisation and just give them the heads-up that 'look, you need to fill the position whatever means it takes because we're recovering these funds and you won't get it again'. (GFS3)

4.2.3 MULTIPLE SOURCES OF COMPETITIVE FUNDING CONTRACTS

There are several difficulties for the ACCHO (and others) arising from the way funding is structured. The main themes in the category were the problems of competitive submission-based funding allocation and the impact of competition on the capacity of health care provider organisations to cooperate in providing care.

ACCHO staff said competitive tendering is an inequitable way to allocate funding because small ACCHOs often miss out on much-needed funds. Large health care providers have skilled staff employed to write funding submissions who are expert in the use of bureaucratic language (AMS1, AMS2, AMS7, GFS3):

> …again it comes down to, I guess, did you write a good application to get you to the next step? Before it was just guaranteed base-funding year after year, as long as you met your contractual requirements you got it. (GFS3)

> Look, it's an age old problem and I guess – this is just my own opinion – that if you've got an organisation that doesn't have the capacity to write a really good application or can't afford to pay a consultant to write the application for them they're already disadvantaged by the time it actually goes through the process of having a criteria and accepting whether or not they make the next cut. (GFS3)

Both ACCHO staff and funders expressed the view that there is over-reliance on competitive tendering to run what should be core business funding of the ACCHO to provide comprehensive PHC (GFS2, AMS1,AMS2, AMS3, GFS3).

The second major theme was the impact of competition on collaboration among health care providers. GFS2 commented that providers should work in partnership to apply for funding with ACCHOs. However, the nature of competitive tendering doesn't support this:

> …agencies could work together a lot more - particular agencies - but because the way funding is funded, which is a tendering process and it's a competitive process, so to speak, people look after their own patch. (GFS2)

ACCHO staff complained that mainstream organisations often win funding tenders and then put pressure on the ACCHO to partner with them without first developing a relationship and, second, without understanding that the organisation operates differently to other non-government providers. There was also concern about the capacity of mainstream organisations (which may win tenders for Aboriginal health programs) to respond comprehensively to the needs of Aboriginal service users. ACCHO staff commented on health care providers who lacked understanding about working with Aboriginal service users and often passed them to the ACCHO to follow up:

> They don't know how to deal with Aboriginal clients and that communication stuff, that racism, discrimination, everything so therefore you've got a health organisation, you've got an employment organisation but we're required to work beyond what we actually deliver so it's that holistic stuff that comes back again. (AMS4)

4.2.4 SALARIES AND TRAINING

Both ACCHO (AMS1, AMS2, AMS3, AMS5, AMS7) and funding staff (GFS2, GFS3) said the salary structure within the ACCHO is inequitable compared to other health care providers. AMS1 said if the Board decided to raise the salary of staff to the levels that other health care provider staff receive for similar roles, the ACCHO would not have enough funding to provide health care to Aboriginal people. Both ACCHO and government funding staff agreed that government departments need 'a reality check' and that base funding has not kept up with the growth of the organisation (AMS3, AMS, AMS, AMS2, AMS5, GFS2, GFS3).

Staff on both sides of the funding relationship reported that government should provide more funding for ACCHO staff training and governance training for ACCHO Boards (AMS1, AMS2, GFS2, GFS3). OATSIH is currently investigating different funding models that could apply to the ACCHOs to alleviate this problem (GFS3). Funding is planned for NACCHO to administer and establish governance units for Board and ACCHO management staff training (GFS3) for each state and territory affiliate.

4.3 GOVERNMENT PRIORITY SETTING AND ACCOUNTABILITY: NEGATIVE IMPACTS ON SERVICE DELIVERY

The second major category is the way funding affects the capacity of the ACCHO to set its own priorities and respond to local needs. Inflexible national funding priorities and programs tend to restrict opportunities for the ACCHO to negotiate better ways to respond to local priorities, with negative impacts on service delivery and on the ACCHO's standing in the community. This was noted by several ACCHO staff (AMS1, AMS2, AMS3) and confirmed by funding staff (GFS1, GFS2, GFS3):

> It's that our expectation for them to fulfil the service agreement requirements goes a little bit too far when you're trying to encourage agencies who are building themselves, who are trying to become self-empowered, and that our service agreements don't necessarily take into account the cultural environment of those agencies. (GFS2)

> [We need to] work out what the community's wants and needs are and adjust that program to suit it but we don't have the flexibility to do that because the funds say this is what you have to do and this is what you have to do. (GFS3)

Service agreements (contracts) were seen to 'cause strained relationships' because they are overly restrictive and do not enable the ACCHO to have the autonomy to shift funding to match local needs or adjust program activities:

> It's…how we really actually have to deliver our programs and the restrictions on our programs. I mean, how can I possibly say to a client, 'look I can't help you because you don't fit between my guidelines'? (AMS4)

One example explained by an ACCHO staff member arose in a playgroup program. The program guidelines required playgroup workers to be employed to provide activities for parents to interact with their children and each other. However, mothers have expressed the need to have a break from their children to follow up on household activities such as shopping and paying bills. Under flexible rules, the ACCHO could implement a compromise such as negotiating with parents a mix of free time and time spent in the playgroup:

> So it's about engaging parents and they're thinking 'well I just want a break, I don't want to sit in a room with 20 other kids screaming, my one or two is enough.' You can understand all that but the funding restraints are we haven't got child care workers, we've got play group workers. (AMS3)

In other examples of the mismatch, the ACCHO is funded to facilitate a women's group but lacks funding for child care workers to take care of the children during group sessions (AMS4).

The problem is consistent with the results of previous research (Dwyer et al. 2011) and reinforces the sense that this is an entrenched problem in the way funding programs are structured.

4.4 MONITORING AND ACCOUNTABILITY: BOTH ACCHO AND GOVERNMENT RESPONSIBILITY

The third major category is the requirements built into the funding arrangements for monitoring and accountability. Accountability, as written into the contracts, is a top-down concept and most of the discussion in this section is about the

accountability of the ACCHO to the government funder. However, it needs to be noted that ACCHO participants took the view that ensuring Aboriginal people have access to appropriate health care is both the ACCHO and government's responsibility (AMS1, AMS2, AMS4); the government participants also acknowledged the reciprocal nature of accountability (GFS1,GFS2).

Previous research has established that a complex, fragmented funding system results in an overburden of reporting and other accountability arrangements (Lavoie 2005; Dwyer et al. 2011) and the results of this study are consistent with that earlier work. There are three main sets of themes: the costs of this kind of approach to accountability, the overburden of reporting and the problems in contract management.

4.4.1 THE COST OF ACCOUNTABILITY

Staff from the ACCHO (AMS1, AMS2, AMS3) accepted that the ACCHO needs to improve on its risk assessment and accreditation status, and they noted pressure from government to meet these requirements. However, they also noted that there is a lack of funding to support employment of an extra Finance/Human Resources Officer to undertake the work required. As one ACCHO staff described the situation:

> We're filling in the gaps at the moment but we're not plugging the holes very well. (AMS2)

There were several kinds of costs of accountability requirements causing frustration and stress for staff. For example, ACCHO staff (AMS1, AMS2) reported not being able to negotiate a way forward to employ suitable people because the funding agreement prohibits the employment of people with particular types of criminal convictions, even though convictions occurred more than 20 years ago.

At least one government funding staff member also reported that the funding requirements were too restrictive for organisations that are growing and developing their roles and competence; and that contracts don't necessarily take

into account the cultural environment of those agencies. ACCHO staff commented on only hearing from a funding body when they require more information:

> There's no 'how are things going?' and 'do you need any assistance here?' There's none of that. It's all reactive, not proactive, there's no proactive stuff. (AMS3)

4.4.2 THE OVERBURDEN OF REPORTING

OATSIH has moved to simplify and consolidate contracts from various areas of the Australian Government's Department of Health and Ageing into one contract (head agreement) with a number of funding schedules, in a bid to reduce the overburden of reporting. However, ACCHO staff said that reduction in reporting hasn't occurred because separate reporting requirements are built into the schedules. In effect, the contracts have been 'rebadged' as schedules (AMS2, AMS1, GFS3):

> They give us all these things but it's in the format of the big, heavy duty agreement. (AMS1)

The ACCHO staff reported one example of the reporting burden. One grant of $60,000 required quarterly activity reports and two financial reports. The funding was seen as inadequate, as well as onerous. It was used to employ a Youth Worker to undertake health promotion activities. Although the youth program has grown because of the high population of Aboriginal youth accessing the program, the funding has not matched the growth. The Youth Worker relies heavily on volunteers to assist in facilitating activities and to raise extra funds.

The ACCHO will not automatically receive the next round of youth program funding. It will have to apply through competitive tendering, which is an inequitable process because small organisations do not have the administrative capacity to compete with large, well-established ones (ACCHO CEO, pers. comm., August 2013).

The cost of producing reports is an important part of the accountability burden, as noted by funding staff:

> I think in some of our agencies, a lot of our funding goes out in paying accountants to do their accounting reports and all that, which is to me – it hurts me because to me the money needs to go to the individuals that we're funding and that's the clients and that's the young people but poor old Aboriginal agencies have to pay these accountants big bucks just to do reports for them. (GFS2)

4.4.3 CONTRACT MANAGEMENT AND COMMUNICATION

The limited flexibility to negotiate the terms of contracts and to change the way funding is to be used to keep up with growth and changing community needs is reported above. The approach to contracting is almost inevitably not consistent with the principle of community control. ACCHO staff (AMS7, AMS1, AMS5) said some funders do not have an understanding of the values and principles of community control, particularly as it relates to self-determination in the context of Aboriginal health, which was also acknowledged by funders:

> [The ACCHO] had the funds this year so that's a very practical example of the relationship. It's just slightly distanced from this community controlled thing. (GFS1)

ACCHO staff said there is an expectation from government for ACCHOs to respond quickly to their demands:

> It's on and off [the relationship], depending on how quickly we respond to their requests, although when we have a request of them they're busy, they've got other priorities and that's okay, we can wait until they're ready, so it's not a two way street, I don't believe. (AMS3)

However, there is some flexibility to accommodate, for example, late reporting. Both ACCHO and funding staff noted that there is some flexibility for late submission of reports during sorry business, which impacts on the whole community (GFS3, GFS1, AMS1). ACCHO staff commented that the ACCHO plays a

significant role in assisting families to cope, and provides a meeting place where gatherings are held after funerals. Both ACCHO and funding staff spoke about the importance of understanding sorry business. The term 'sorry' is significant as it carries symbolic burden for many Aboriginal families. 'Sorry business' or 'sorry camp' occurs when someone dies and after a period of time mourners are able to move to a space of healing. In many instances families do not have the luxury of time to heal before the next lot of 'sorry business' is upon them.

ACCHO staff concerns about only hearing from a funding body when it requires more information was clearly expressed (as the opening quote to the chapter also demonstrates):

> We just got an email on the weekend where the list of questions is just astounding and it just kind of keeps coming and coming and there's more questions and more questions and there's absolutely no give at all, it's just take and take. (AMS2)

The second major issue discussed in interviews was the withholding of funding when further information is required by funders (AMS1, AMS2, AMS3, GFS1, GFS2):

> The delay has often been with the organisation when we go back and say – we fund you for the particular comprehensive PHC but you don't have detail about how you have community involvement or how you would even improve your service or there's a bit of a discrepancy in the funding. Can you perhaps just go back to the Board and just revise it for us so you get that level of detail? Then we would have to wait for the Board to meet again and then they endorse it and then it comes back to us. Often it has been that lag time between whoever's at the organisation updating the information and getting the Board clearance again because until it comes back to us and we're happy and signed off on it they're not going to get their payment. Before we might have said 'you've submitted it, that's great, we'll release the payment, we'll review it later; it doesn't matter how long it takes'. (GFS3)

The third major issue was relationships, discussed by almost all participants. Most acknowledged that it was important for government staff to be friendly, responsive and approachable to ACCHOs when they have a broader enquiry about issues (GFS1, GFS2, AMS1, AMS2, GFS3, AMS7). AMS6 said more politicians should visit ACCHOs on a regular basis to broaden their understanding of the unique role of ACCHOs and their responsibility in the broader health care system.

When asked to provide an example of what makes building good working relationships difficult with government funding staff, ACCHO staff said the government seems to always be restructuring and there's a constant turnover of project officers. It seems that just when the relationship is going well, the Project Officer leaves and the ACCHO has to begin training up' another Project Officer, who comes with his/her own beliefs and values about working with the ACCHO.

There is goodwill to support the ACCHO from the perspectives of the funding staff (GFS1, GFS2, GFS3) but there is also a lack of understanding about PHC principles of community control and governance (operational management) of Aboriginal health organisations in general (GFS1).

ACCHO staff acknowledged they also needed to understand more about how funding rules and regulations impact on service delivery instead of 'sitting back here just wondering why we have no money to do anything' (AMS4).

One contributor to communication problems, particularly when funders are distanced from the ACCHO, is an over-reliance on email as the main form of communication (AMS1, AMS2, AMS3). For example, ACCHO staff reported on a problem when the government reporting guidelines had changed and the timeline was brought forward by a month. An email was sent to the Finance/Business Officer of the ACCHO detailing these changes but the email was overlooked. When the error was realised, the report was already late. The ACCHO was reported as being 'in breach of the contract', which placed it at risk of losing its funding and

reputation (AMS1, AMS2, AMS3):

> It's that comedy of errors I was talking about – it has a cost for us because we're the ones in breach, not OATSIH. Nobody actually gave us a call and said 'how are you fellahs going?' (AMS1)

The over-reliance on emails as the main form of communication was also noted by government staff:

> I think too many funding people have to sit behind desks and operate from computers and communicate with Aboriginal people like that; that's not good. (GFS2)

When asked how the situation could have been avoided, staff suggested the email should also have been sent to the CEO and Program Manager, followed by a phone call within two weeks to check the information was received and to attend to issues that may have been raised.

GFS2 said it is understandable ACCHOs may be late reporting because they also have reports to other government departments to complete. Reporting requirements still remain too prescriptive (AMS1, AMS2). Some government-funding staff have introduced more flexible formats of reporting to include artwork, newsletters, photographs and community brochures (GFS2, GFS3).

One government funder noted a practical problem with communication caused by the legalistic language used in contract documents:

> I'm still going to be working with [colleague] in relation to that, to get it right, having service agreements culturally receptive of our audience. What I mean by that is we've got to get away from a lot of the legal jargon and words that I believe frighten Aboriginal people. (GFS2)

4.4.4 ACCOUNTABILITY AND TRANSPARENCY

All ACCHO staff and government-funding staff spoke about the importance of accountability and the word was used interchangeably with 'transparency' (AMS1). ACCHO staff spoke admiringly about some government staff who demonstrated openness and a willingness to assist in their funding relationship (AMS5, AMS1, AMS2). An example was regular informal phone calls to the CEO to ask how they were going and whether they required assistance, and to share information about new funding opportunities (AMS1).

To improve accountability to community by the ACCHO in this study, new Board practices were introduced (AMS1). The Treasurer position is now supported by an audit subcommittee of the Board as recommended by NACCHO to create a transparent and accountable process whereby more discussion and more people are included in an in-depth examination of the finances of the ACCHO, thus building the capacity of the group. An example provided was that when the Treasurer provides the financial report to the Board, Board members will have a better understanding because they have been involved in financial conversations that have taken place in audit sub-committee discussions. If the Treasurer has difficulty explaining the finances, sub-committee members can provide assistance. This enables the Treasurer to 'talk up' and feel confident in explaining the financial expenditure of the organisation, particularly at community meetings. The more financially transparent the ACCHO is and the more community members understand, the lesser the risk of accusations of financial mismanagement from both community members and government departments. The process places the power of financial understanding and management in the hands of the Board members and the community, not the Finance Officer alone. This reduces the risk of mismanagement of funding and places the responsibility with all Board members to have understanding and control of financial management (AMS1, AMS2).

Trust grows from the Board's capacity to explain the financial management of the organisation to community – why and how decisions are made. The more

community understand, the more trust is developed for better relationships. During community meetings and at annual general meetings, questions can then be asked in non-accusatory ways and at the right time, rather than random, unrelated questions that are asked due to a lack of understanding of meeting protocols, financial requirements and management of the ACCHO. These processes promote transparency and collective understandings and meetings become more constructive (AMS1).

Government funding staff also reported on the value of more open approaches, commenting on the role of the SA Aboriginal Health Partnership – between the Aboriginal Health Council of SA, the South Australian Government and the Department of Health and Ageing – which provides regular forums and opportunities to strategically work together and to coordinate funding to, and with ACCHOs (GFS3, GFS1).

4.4.5 ACCOUNTABILITY AND LISTENING TO COMMUNITY

Both providers and funders identified a lack of regular community consultation processes (GFS2, AMS1, AMS2), an aspect of accountability by government that is absent (AMS5), and that government actions fail to demonstrate an interest in listening to community opinions. The ACCHO is left to manage community anger and frustration about not receiving the services it expects:

> I've lost count of how many reports I have here where there's hardly any government conversation or communication that happens with the communities or the Boards and I think that's an accountability that's missing, it really is. You get it sometimes but at the end of the day it's not true collaboration, it's not true engagement. (AMS2)

> Government actions don't show that they're talking to community, that they're interested in community opinions, that they're interested in what's happening in the community. It's very sad; it's really sad because community just don't feel listened to. They come to us and they say, why is this happening? Why are we not getting the service? (AMS1)

ACCHO staff (AMS1, AMS2) said they also need to improve communication processes with community and provide clear explanations about their roles and responsibilities, partly as a strategy to prevent gossip and unrealistic expectations:

> It's a matter of getting the message out to the community of what we can and can't do and being very clear about that because it doesn't take long for rumours to start and then to escalate and it just gets bigger and bigger so it's really important to stay on top of what's going on in the community, what's being said and dealing with it. (AMS3)

ACCHO staff acknowledged they need to trial different ways of communicating and engaging more Aboriginal families to use the service (AMS1, AMS2). Holding community meetings onsite attracted the same families who generally had access to transport to attend. The CEO began visiting families that did not attend meetings as a way of building relationships and gauging feedback on ways the ACCHO could improve its service to make it more accessible. The CEO reported that a bi-monthly newsletter was introduced to keep the community up-to-date and weekly staff meetings are held as a mechanism to share information, advice and support with problems that staff may be having.

At an informal meeting with the CEO of the ACCHO in the case study (held in August 2012), there was a discussion about community engagement when there is a crisis, and how the community comes together to attend to problems. Informing the community early about the nature of competitive tendering in terms of the youth program may be an opportunity for community to vote against this 'with their feet'.

4.5 RISK AND TRUST

The sharing and management of risk is an important element in the funding relationship. Risk was not a particular problem in the study as the ACCHO had 'passed' the OATSIH risk assessment (which focuses strongly on corporate governance and financial management) and had been notified it would be moved from annual to three-yearly funding. However, distrust was seen as a powerful

component of the funding relationship. Participants reported on good, as well as poor, relationships and experiences of trust and distrust. Staff on both sides of the funding relationship said they were more likely to trust each other if they had time to get to know each other (GFS2, AMS6). ACCHO staff spoke frequently about the need for funders to visit on a more informal basis, with the aim of meeting community members, including the Board (AMS1, AMS5) and to demonstrate an interest in understanding how the ACCHO operates from the ground up (AMS4, AMS5, AMS2):

> …it takes an enormous amount of time to build up trust between non-Aboriginal and Aboriginal people because of what's happened, because of perceptions and the way that things have occurred and the way, I believe, white people exhibit themselves at times as being the dominant person, that they know more. Aboriginal people can feel that; they can feel that they're being belittled…being overpowered, not empowered. (GFS2)

When asked how issues could be resolved between the ACCHO and government funding department, a non-Indigenous funding staff member implied that trust is important in resolving problems but it takes time to build trust. The funder also implied systemic racism through the continued dispossession of Australia's First Peoples' place in society. As a result, the relationship is a forced or a 'hidden relationship' (GFS1) whereby government is stuck in a collective colonial mindset that renders Indigenous perspectives and expertise invisible and/or less valuable. Resistance and stand-offs by Indigenous organisations has become a way of protecting ongoing connection between past, present and future generations (spirit) and the respectful and honourable behaviours that hold Australia's First Peoples' values and cultures together (integrity) as a collective Indigenous voice.

Participants commented that trust in the relationship is important – both funders and ACCHO staff noted that government staff in general need to take more time to build relationships with ACCHOs (AMS5, AMS6, GFS2, GFS1) – to be honest and upfront and 'not telling you one thing but planning to pull the rug out from under you' (AMS2). Developing trust in the relationship was associated with respect,

reliability, honesty and mutuality and an understanding that it just isn't always about funding:

> Trust is very important because if you don't have trust you second guess everything and you second guess everything you're doing as a service as well. I've seen it work, where the relationship is mutual, it's a mutual trust, there's a respect there. (AMS2)

> I'd just say on that, again generally, [trust] comes – like people get to know people…I think trust, to me, equals reliability, it's like another word for it, because you can trust someone to be reliable. They won't do what you want, you won't get your way but they'll get back to you. It's not all about the money either. (GFS1)

As noted above, the importance of reporting and being accountable for expenditure of public funding was acknowledged by ACCHO staff, as well as by government funding staff. However, the strong focus on compliance was resented by most participants and was seen to create stress and tension in the relationship (AMS1, AMS2, AMS3, AMS4, GFS2, GFS3):

> We are actually grateful for the funding. We do like to be able to provide a service, we do want to provide a service and we'll try and do it by any means we can but sometimes the relationship is really hard, it frustrates you. You come to work and you go, what arguments am I going to have this time? (AMS2)

There is also a perception that the tension or conflict in the relationship with funders, combined with the lack of downwards accountability of government to the community, has a damaging effect on the relationship between the ACCHO and its community:

> We end up being the bad guys and we don't have that trust that comes – you know, they're [government] not accountable to us, they're not accountable to community. That's the way it gets perceived by us and then by community because they [community] feel that we're not accountable to community because we're not changing things, we're not fighting for them, and we're trying to, it's just not working. (GFS2)

4.5.1 POWER AND CONTROL

ACCHO staff noted that government controls the power in the relationship because it controls the resources (AMS1, AMS2, AMS3, AMS5). The ACCHO is always going to be in a vulnerable position – it has no choice but to trust government to continue to fund the ACCHO to provide health care:

> …at the end of the day they are the funder and they are the ones that can pull the plug and that trust is kind of – that's always going to be there. There's an imbalance of power in the relationship. (AMS1)

> Well, I find that when we fund, or in part we've funded Aboriginal agencies, I think there's been, I would say, a dominant culture requirement to accountability, which is across the board. (GFS2)

The second quote above implies a hint of racism on the government's part, demonstrated by stricter accountability requirements when funding ACCHOs compared to other non-government organisations.

4.5.2 SYSTEMIC RACISM

When ACCHO participants spoke about problems with government funders demonstrating distrust, withholding information, not releasing funding until gaps in reports are complete and reluctance to assist with ACCHO problems, they suggested that this occurred when funding bodies did not value the role of the ACCHO within the health care system (AMS1, AMS2). The lack of understanding is seen as a source of inflexibility, of reluctance in discussing problems to gain better understanding and in approving proposals from the ACCHO. Some of these problems have been found in the relationships between governments and all categories of NGOs. However, ACCHO staff named racism as a problem. They suggested racist attitudes about Aboriginal communities and organisations are reinforced and spread by an emphasis on negative stories:

> There are so many good stories out there that you don't hear, that aren't told about, which should be because whether we like it or not the colour of

> our skin creates publicity, good or bad and they like to do the bad on the news because that's what gets people watching so we need to change that. (AMS7)

4.5.3 ABORIGINAL-SPECIFIC FUNDING

There is a concern, expressed by both funders and ACCHO staff, that Aboriginal-specific funding is being used by other providers for non-Aboriginal CALD (culturally and linguistically diverse) people, thus creating unreliable data in terms of Aboriginal-specific funding expenditure:

> Well, in some of our service agreements here to non-Aboriginal agencies, that there is a requirement, and the optional thing is CALD clients; they use the word CALD – which is culturally and linguistically diverse people, and – well, because say for urban here there's Sudanese, there's all that, and so there has to be a high number of clients in their data collection that they have to see. (GFS2)

4.5.4 STRESS AND BURNOUT

The mismatch between the application of tightly targeted funding guidelines, inflexible national funding priorities and a lack of support for ACCHOs to deliver appropriate PHC contributes to stress and burnout of staff in both sectors and is not sustainable. There is also the tendency for government to blame the ACCHO when it's unable to keep up with compliance demands:

> There's not an area there that's funded to ensure that they achieve what we're supposedly wanting them to achieve and what they want to achieve in the first place because we don't provide that ongoing support – that's not just us, I'm talking about all other areas – and because there's no ongoing support and because there's probably an over-expectation of requirements, any goodness for them to achieve gets put down the tube because they failed to [include] something when they've applied for funding again and they've been knocked back. (GFS2)

> I've had breaks, I've had breakdowns as well, meltdowns if you like, when I worked for DFC and there was no support there so I left there, didn't renew my contract, and that screwed me up for a long time. (AMS7)

> We have two [administration staff members] with 13 to 15 staff and about six different funding sources. It's not sustainable, what they're asking us to do. (AMS2)

4.5.5 CONFLICT RESOLUTION

Conflicts are usually settled quickly when there are good working relationships between management staff of both agencies (AMS1, GFS1, GFS2). However, when issues aren't resolved the ACCHO CEO approaches the Director of OATSIH. If a timely and reasonable response is not forthcoming from the Director, the ACCHO asks the Aboriginal Health Council of SA to advocate on its behalf, which occurs frequently (AMS1, AMS2). GFS3 said there is room to negotiate alternative ways to deliver programs because some strategies may not work for every community. This was also noted by ACCHO staff.

The expectation by government for ACCHO staff to attend government meetings in Adelaide at the ACCHO's expense was seen to create tension in the relationship (AMS1, AMS2, AMS3). Regular video conferencing as a strategy was suggested as a way to reduce the tension and the extra strain on the ACCHO's budget, and to improve communication (AMS2, GFS2). An example of good communication practice by government was provided by ACCHO staff (GFS1, GFS2), whereby government staff travelled to the ACCHO town and delivered a local two-hour workshop (with all health service providers funded under a particular program) to inform them about the new funding guidelines.

Quarterly phone conversations (GFS3, GFS2) have been introduced as a way for both agencies to keep abreast of issues or changes within government and community settings. ACCHO staff said they can understand OATSIH's unresponsiveness at times because they are busy managing other organisations

and portfolios, as well as managing policy initiatives (GFS1, GFS3). However, when there is no follow-up and limited assistance for the ACCHO, and it is unable to sign off on reports in a timely manner, the ACCHO is often blamed for the delay.

4.6 POTENTIAL SOLUTIONS OR IMPROVEMENTS TO MANAGE THE RELATIONSHIP

The results reported above present an overview of the challenges, and some of the strengths, in the contracting regime and relationships from the perspectives of the ACCHO and staff in the government funding departments. Participants also spoke of solutions and ways forward, and there are two important categories of themes – the desire for a more supportive approach from the funder to the provider, and suggestions for better ways to manage the relationship.

4.6.1 SUPPORT IS NEEDED

The shift from one-year to three-year funding cycles was viewed by ACCHO and OATSIH staff as a positive first step to supporting the ACCHO (AMS1, AMS2, GFS3). However, as a consequence, the shift reduced the face-to-face visits by OATSIH funders to the ACCHO (AMS1, AMS2,), who commented that the organisation was not visited by OATSIH staff once in three years. Unlike assumptions about ACCHOs, that they just required the funding and for government to leave them to manage alone, ACCHO staff (AMS1, AMS2, AMS5) implied the need to build better supportive relationships:

> It might be contentious but I think support is a good one. I think that their accountability around support, that you can't just give people money or give them these requirements and not support...sometimes I don't think they understand that quite so well, they think that they're giving you all the money, you should be able to do it, we don't have to talk to you at all and it's not quite that way. (AMS2)

> They're accountable to us to also make sure that we're able to actually implement it, that we can deliver that program, not just go, oh here's the money and away you go. Making sure that we are actually able to deliver

> what we say we will but doing it in a way that is supportive and encouraging and all of those things. (AMS2)

Participants identified two areas that have created tension in the relationship between the ACCHO and funders and between funders and funders. The first is that OATSIH's budget has been reduced and it no longer has flexible funds for community-initiated health programs. These funds were shifted (mainstreamed) from OATSIH to other program areas. OATSIH's core business is funding services and monitoring funding agreements, with limited influence on setting national priorities:

> Just in terms of the relationships with some of our other organisations, the bottom line always comes down to funding – as long as we're monitoring the organisation in terms of what's in their funding agreement. (GFS3)

> …we've certainly moved to a point where organisations now have to look outside of OATSIH for funding, whether that's [to] apply for a grant through our health branch or looking more broadly at other grant rounds because quite often there could be a really good program that they want to deliver but in OATSIH we don't have those flexible funds as we used to. Going back a couple of years ago an organisation could say 'look, we need some extra funds to do this' so we'd collate a big list together and share that information and recommend organisations to receive extra funding but those days have gone now so really all it's coming back to is about the base funding that they receive and how well they're going to deliver that program. (GFS3)

Government funding staff (GFS2, GFS3) said it's important to keep enforcing the fact with government staff that they are in their positions to support ACCHOs to operate in ways that provide appropriate services to Aboriginal people.

4.6.1.1 FACE-TO-FACE MEETINGS

Staff suggested that twice-yearly face-to-face visits to the organisation, with some informal joint visits with state government departments, were valuable and provided opportunities for government staff to see 'first hand' the context of service delivery and how the organisation operates and is a practical way to strengthen the funding relationship (GFS1, GFS2, GFS3, AMS1, AMS2, AMS7, AMS4, AMS5). Regular phone conversations to problem-solve together and to clarify available funding from governments was also valued by staff (AMS1, AMS2, AMS7, GFS2, GFS1).

4.6.1.2 STREAMLINING FUNDING AND REPORTING

When asked how government could improve its relationship with the ACCHO, three ACCHO staff suggested streamlining the funding from the multiple funding sources to one main funding source (whereby the ACCHO has the autonomy [community control] to decide where the funding should be allocated based on its own needs analysis and agreed governance arrangements):

> The other thing that would be really, really good is if we were able to just do one reporting so that we could send our annual report or an annual plan, or whatever it is, and everybody sees it and then they pick out the bits instead of us having to report multiple times because we get multiple funding sources and that's from different areas. (GFS1)

4.6.1.3 A SINGLE FUNDING SOURCE

Both funders and providers suggested that the Australian government should provide one main division to fund all aspects of Aboriginal health and that they should work together to ensure all government staff understand the process. The move by government would reduce administrative loads, stress and tensions for both the ACCHO and funders and allow time for genuine face-to-face engagement:

> So the strategies that would make things easier would be something about streamlining the funding from the multiple funding sources. It

> would be about things like this because they're [ACCHOs] under-resourced. (AMS1)

4.6.1.4 MATCH CONTRACT TO PROVIDER SITUATION

Governments lack a flexible, yet accountable, system to fit with provider priorities, especially ACCHOs' principle of community control which reflects self-determination. Both ACCHO and government funding staff agreed that standardised service agreements need to change to better reflect the service provider situation and context in which they provide the services. A government funding staff said governance processes should be funded to run the organisations and this is a casualty of multiple, specific purpose funding streams.

4.6.1.5 TRANSPARENCY

When asked if he/she or the department have a good working relationship with ACCHOs, GFS2 said it's viewed as a good relationship based on funding and that sometimes it's a hidden relationship. They are working towards developing better partnerships and building stronger relationships. There is a hint of doing things differently, including more planned visits from government funding staff to learn and experience how the ACCHO operates.

SUMMARY

This chapter presented the results and demonstrates significant commonality in the ways that both ACCHO and government staff think about their relationship. They clearly acknowledge the importance of building and maintaining workable relationships and that these take time to build. Funding that support face-to-face meetings to build and rebuild trust in the relationship was expressed. However, systemic health system barriers impede their ability to do so. These include short-term program funding contracts from multiple funding sources, which are much more tightly specified and do not generally include funding for overheads, such as the employment of extra administration staff required for such highly specified reporting. A great deal of time is spent by staff from the ACCHO writing funding applications for competitive funding grants to fill the gaps in core funding, and that

core funding (intended to support this work) doesn't, particularly for small or remote ACCHOs. This places further stress and burden on small organisations that are already underfunded.

Community development is expected by government as part of the ACCHO core business but time to engage face-to-face with community members is not budgeted or supported by government. A five-year funding cycle was suggested by both sectors to move beyond the three-year political cycle, supported by policy to sustain programs as the population of the community grows. Competitive tendering is an inequitable way to allocate funding because small ACCHOs often miss out on much-needed funds, whereas large health care providers have skilled staff employed to write funding submissions who are expert in the use of bureaucratic language. Mainstream organisations often win funding tenders and then apply pressure on the ACCHO to partner with them without first developing a relationship and including the ACCHO in the funding proposal from the beginning. There was agreement by both sectors that government departments need 'a reality check' and that base funding has not kept up with the growth of the organisation.

ACCHOs operate differently to other NGOs and contracts don't take into account the cultural accountability of those agencies. The way funding is structured affects the capacity of the ACCHO to set its own priorities and respond to local needs. Inflexible national funding priorities and programs tend to restrict opportunities for the ACCHO to negotiate better ways to respond to local priorities, resulting in negative impacts on service delivery and on the ACCHO's standing in the community. The requirements and legalistic language used in service agreements (contracts) were seen to 'cause strained relationships' because they are overly restrictive and do not enable the ACCHO to have the autonomy to shift funding to match local needs or adjust program activities. This problem is consistent with the results of previous scarce research (Dwyer et al. 2011) in this field and reinforces the sense that this is an entrenched government problem in the way funding programs are currently structured.

The requirement for monitoring and accountability which is written into the contracts and built into the funding arrangements is a top-down concept and most of the discussion is about the accountability of the ACCHO up to the government funder. However, it needs to be noted that both ACCHO and government participants' perspectives in ensuring Aboriginal people have access to appropriate health care is both the ACCHO and government's responsibility, acknowledging the reciprocal nature of accountability.

The funding requirements were too restrictive for organisations that are growing and developing their roles and competence; and contracts don't necessarily take into account the cultural environment of those agencies. Although OATSIH has moved to simplify and consolidate contracts from various areas of the Australian government's Department of Health and Ageing into one contract (head agreement) with the aim of reducing the overburden of reporting, a reduction in reporting hasn't occurred.

The limited flexibility to negotiate the terms of contracts and to change the way funding is to be used to keep up with growth and changing community needs is a problem that impacts on the relationship. The approach to contracting is almost inevitably not consistent with the principles of community control as described in detail in the literature review and some funders do not have an understanding of these values, particularly as it relates to self-determination. There is also an expectation from government for ACCHOs to respond quickly to their demands. However, there is some flexibility to accommodate late reporting during sorry business, which impacts on the whole community. Unlike mainstream organisations, the ACCHO plays a significant role in assisting families to cope, and provides a meeting place for healing. In many instances, families, including ACCHO staff, do not have the luxury of time to heal before the next funeral comes around.

Withholding of funding when further reporting information is required by funders is a major concern. In previous funding arrangements with government, payment was released with the understanding and trust that the organisation will follow up

on gaps in reporting at a later date, agreed to by both parties. It is important for government staff to be friendly, responsive and approachable towards ACCHOs when they have funding and reporting enquiries. It is suggested that politicians visit ACCHOs on a regular basis to broaden their understanding of the unique role of ACCHOs and their responsibility in the wider health care system. Restructuring and the constant turnover of project officers who arrive with their own beliefs and values about working with the ACCHOs affects the building and maintenance of trust in the relationship. There is goodwill to support the ACCHO from the perspectives of the funding staff but there is also a lack of understanding about PHC principles of community control and governance (operational management) of Aboriginal health organisations in general.

A communication problem specific to funders being remote from the ACCHO, is an over-reliance on email as the main form of communication and restrictions on funding to enable government staff to travel to ACCHOs. Reporting requirements still remain too prescriptive, although some individual government funding staff have introduced more flexible formats of reporting to include artwork, newsletters, photographs and community brochures. Both providers and funders identified a lack of regular community consultation processes, an aspect of accountability by government that is absent and government actions fail to demonstrate an interest in listening to community or Board opinions. The ACCHO is left to manage community anger and frustration about not receiving the services it expects which places strain on the relationship between the ACCHO and community.

The sharing and management of risk is an important element in the funding relationship. However, distrust was seen as a powerful component of this relationship. Both ACCHO and government funding staff experienced good, as well as poor, relationships and experiences of trust and distrust. Staff on both sides of the funding relationship said they were more likely to trust if they had time to get to know each other and ACCHO staff spoke frequently about the need for funders to visit the organisation on a more informal basis, with the aim of meeting

community members, including the Board, and to demonstrate an interest in understanding how the ACCHO operates from the ground up.

Trust is important in resolving problems but it takes time to build trust. A funder implied systemic racism through the continued dispossession of Australia's First Peoples' place in society, and as a result the relationship is a forced or a 'hidden relationship' whereby government is stuck in a collective colonial mindset that renders Indigenous perspectives and expertise invisible and/or less valuable. Resistance and stand-offs by Indigenous organisations has become a way of protecting ongoing connection between past, present and future generations (spirit) and the respectful and honourable behaviours that hold Australia's First Peoples' values and cultures together (integrity) as a collective Indigenous voice.

The importance of reporting and being accountable for expenditure of public funding was acknowledged by both ACCHO and government funding staff but the strong focus on compliance was resented by most participants and was seen to create stress and tension in the relationship. The perception that the tension or conflict in the relationship with funders, combined with the lack of downwards accountability of government to the ACCHO, has a damaging effect on the relationship between the ACCHO and its community.

ACCHO staff noted that government controls the power in the relationship because it controls the resources and that the ACCHO is always going to be in a vulnerable position – it has no choice but to trust government to continue to fund the ACCHO to provide health care and there's an imbalance of power over the relationship. Systemic racism is implied on the government's part, demonstrated by stricter accountability requirements when funding ACCHOs compared to other non-government organisations.

It was also suggested that Government funders demonstrating distrust by withholding information, not releasing funding until gaps in reports are complete and a reluctance to assist with ACCHO problems, occurred when funding bodies did

not value the role of the ACCHO within the health care system. This lack of understanding is seen as a source of inflexibility, an unwillingness to discuss problems to reach a better understanding and a reluctance to approve proposals from the ACCHO. Some of these problems have been found in the relationships between governments and all categories of NGOs. However, ACCHO staff named racism as a problem and suggested racist attitudes about Aboriginal communities and organisations are reinforced and spread by an emphasis on negative stories in mainstream media.

The concern expressed by both funders and ACCHO staff - that Aboriginal-specific funding is being used by other providers for non-Aboriginal CALD (culturally and linguistically diverse) people, creates unreliable data in terms of Aboriginal-specific funding expenditure. The mismatch between the application of tightly targeted funding guidelines, inflexible national funding priorities and the lack of support for ACCHOs to deliver appropriate PHC contributes to stress and burnout of staff in both sectors is not sustainable and there is a tendency for government to blame the ACCHO when it's unable to keep up with compliance demands.

Conflicts are usually settled quickly when there are good working relationships between management staff of both agencies; when relationships are healthy? there is room to negotiate alternative ways to deliver programs because some strategies may not work for every community. However, the expectation by government for the ACCHO staff to attend government meetings in Adelaide at the ACCHO's expense was seen to create tension in the relationship and that regular video conferencing is suggested as a strategy to reduce the tension and the extra strain on the ACCHO's budget and will improve communication. Participants also spoke of solutions and ways forward - the yearning for a more supportive approach from the funder to the provider and suggestions for better ways to manage the relationship.

Chapter 5 presents a discussion on the results and overall conclusion of this study.

CHAPTER 5: DISCUSSION AND CONCLUSION

> You need trust. If there's no trust your communications are lapsed and your faith in others to assist and collaborate together is very limited. (AMS7)

5.1 INTRODUCTION

This study of the funding relationship confirms that trust is perceived by participants as enabling more effective working relationships. However, current barriers promote distrust and ACCHO and government staff managing the funding contracts struggle to maintain effective working relationships. The funding and regulation requirements imposed by Australian governments are burdensome – funding arrangements are complex and fragmented, and reporting is often duplicated and excessively time consuming for all. The process is not monitored or managed in a nationally consistent way because unlinked policy and program decisions have, in effect, become more complicated over time. Conflicting values and beliefs (intentional and unintentional) about each sector undermine the funding relationship. This chapter discusses the implications of these barriers and provides a framework to guide government departments and ACCHOs to strengthen the relationship between them for better alignment with ACCHOs' core business and government policy objectives, and to reduce the burden on administrative and clinical staff.

Throughout Australia's recent history (225 years) relations between the dominant Anglo Saxon society and Indigenous peoples have been profoundly shaped by dispossession, distrust and uncertainty. The struggles are complex, as are the diverse forms of engagement (and disengagement) between government and Aboriginal community controlled organisations over the years. Government departments continue to distrust ACCHOs to manage and provide effective health care services. On the other hand, ACCHOs distrust governments based on intergenerational experiences of systemic racism that continue to impact on the health and wellbeing of Australia's First Peoples today. The Aboriginal people interviewed for this study experienced the structure of the relationship with their

government funders as an expression of government's persistent strategies of power, privilege and control over relations with Aboriginal communities and their representative organisations. Repeatedly, when the two groups engage each other, the space between them is contested – tempers flare, stand-offs arise, a 'comedy of errors' prevails, and the potential to find common ground to co-produce knowledge and understanding for effective implementation of Aboriginal health policies is often lost. The outcome is 'business as usual' (with its reliance on the established bureaucratic methods of consultation and multi-party committees) and effective engagement methods and tools that are co-created by both Indigenous and non-Indigenous people are not taken seriously by government as an enabling mechanism for implementation.

The implications of the results described in Chapter 4 are discussed in this chapter, informed by the theoretical models on which this work is based and influenced by my values, beliefs and learning throughout this study. These concepts are integrated into a framework for dialogue.

This section is arranged under four main subheadings:

1. similarities in how staff think about the relationship
2. perceptions - gaps, overlaps and conflicts
3. approaches to resolving or reducing the accountability tension
4. a practice of safe places for dialogue.

This discussion provides an analysis of the results to answer these research questions:

1. How do staff in an ACCHO think about and enact their accountabilities to community and government funding departments?
2. How do staff in an ACCHO think about and enact their accountabilities to stakeholders (government and community)?

3. How do staff in the government-funding agencies think about and enact their accountability to the ACCHO?
4. What are the gaps, overlaps or conflicts between the parties of the working relationship as they seek to meet their own accountability requirements and negotiate the relationship?
5. How might tension between the two be resolved or reduced?

5.2 SIMILARITIES IN HOW STAFF THINK ABOUT THE RELATIONSHIPS

ACCHO and government funding staff indicated significant common understandings of the way their relationship works, and of the underlying factors that support or impede the effectiveness of the relationship. Staff on both sides acknowledged the importance of building productive working relationships, while recognising their instrumental nature and the difficulties arising from their different locations. In particular, both groups showed an understanding of the way rewards and sanctions operate and their intended results, and they showed an understanding of the importance of workable levels of trust as a modifier to the otherwise oppositional nature of formal accountability requirements.

5.2.1 REWARDS AND SANCTIONS

Several ACCHO staff used the 'carrot and the stick' metaphor to describe their funding relationship – from the traditional alternatives of driving a donkey on by either holding out a carrot or whipping it with a stick. The metaphor is used to illustrate the policy alternatives of reward and punishment that can be exercised in a relationship of power. The carrot in this context represents PHC funding and the stick is punishment (ie withholding funding or other sanctions) when ACCHOs do not fully comply with the rules and regulations of government administration. However, there was consistent acceptance that ACCHOs are accountable for their use of public funds.

5.2.2 WORKABLE LEVELS OF TRUST

Both funders and the ACCHO staff acknowledged trust as a kind of lubricant or mediator for the management of accountability requirements and commented on the issue of distrust. They related both to performance and reporting factors and the underlying problem of distrust across cultures and racial groups.

One of the best ways for mainstream society to improve trust is to engage meaningfully with Aboriginal and Torres Strait Islander people. Most non-Indigenous Australians take their empowerment and success for granted, and their privilege is invisible to them. The lack of reflection and insight can also mean that they struggle to understand how intergenerational trauma and disempowerment are at the heart of Aboriginal and Torres Strait Islander disadvantage, and they tend to attribute relative disadvantage instead to characteristics of Aboriginal people. This way of thinking tends to result in incorrect assumptions and interpretations of Aboriginal priorities, ways and intentions. Non-Indigenous staff working in government departments are affected by dominant ways of thinking about Aboriginal people, but are often more informed and sometimes less prejudiced.

5.3 PERCEPTIONS: GAPS, OVERLAPS AND CONFLICTS

The main differences in the thinking of participants from the ACCHO and the government funders related to accountability outside the contractual relationship, with both sides claiming (explicitly or implicitly) to represent the interests of the service users and/or community. Staff in government funding agencies and in the ACCHO spoke about the tension in the relationship arising from contested ideas about accountability to the service users or community served by the ACCHO.

ACCHOs operate in a complex relational environment that seems to not be well understood by government, particularly administrators and lawyers who design the formal characteristics of the funding contracts. The current contracts are microcosms of the relationship founded on distrust of the ACCHO. The carrot and

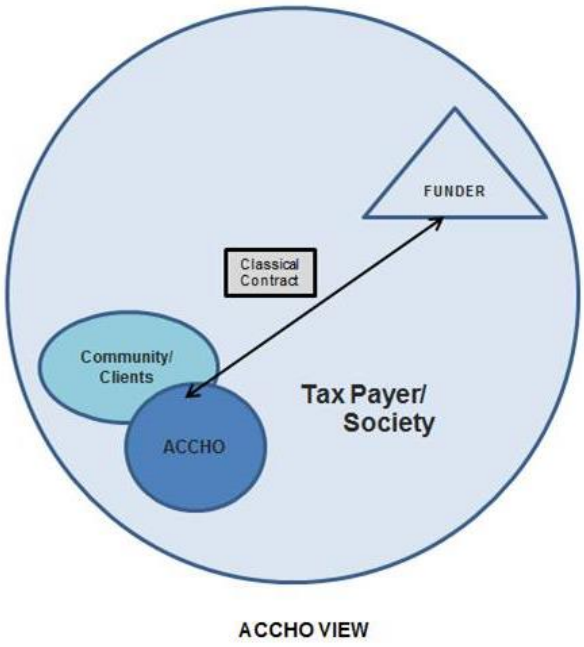
stick behaviour by government is reinforced by the written word (contracts) and enacted in a situation of political sensitivity to Australia's First Peoples that 'challenges foundational notions of national identity' (Dixson 1999:43; see also Sullivan 2009; Dwyer et al. 2011; Howse 2011).

First Peoples' representative organisations are in a challenging situation: advocacy to bring the Australian government's attention to Aboriginal needs and to acquire resources is politically sensitive. Recognition of the status of Aboriginal people as the First People of Australia is controversial, particularly when there is little recognition in national and sub-national laws for the health needs of Australia's First Peoples. This 'leaves a weak or non-existent legislative structure on which to found stewardship and governance for Australia's First Peoples' health' (Howse 2011:2). Pointing out the failure of government accountability provides a way of attracting attention to First Peoples' needs. However, this tends to lead to the kind of over-administration confirmed in the literature (Dwyer et al. 2009; Morgan and Disney 2006). Likewise, government policy and program staff confront heightened pressure to demonstrate value for money and report on data that indicates 'Closing the Gap' national priority targets are being achieved, as well as the challenges of using government power, privilege and control tactfully when they respond top-down to ACCHOs' issues in complying with government accountability measures.

The use of the carrot and stick approach in this context fails to recognise an important additional role of ACCHOs that is common around the world: these organisations can represent and, in a sense, symbolise the service users themselves (Sullivan 2009). As Rowse (2005) points out, indigenous people require community sector organisations in order to become visible as citizens (see also Sullivan 2010; Howse 2011). The ACCHOs, in their role as the representative organisations of the oldest surviving culture in the world, thus have an implied right to petition the government (which purchases the services) to also be accountable for the expenditure of Aboriginal-specific funding. Figure 5.1 is a diagram of the ACCHO view of accountability. The two-way arrow demonstrates reciprocal accountability which is currently limited by the NPM approaches to accountability

in Australian Aboriginal affairs. The view to accountability could reset the funding relationship by rendering the account within and between the sectors so that the ACCHO and government funding departments can begin by negotiating their identity, obligations and commitments in relation to each other.

Figure 5.1: ACCHO view of accountability



Source: Adapted from Dwyer et al. (2012)

5.3.1 ACCOUNTABILITY: WHAT DOES IT MEAN?

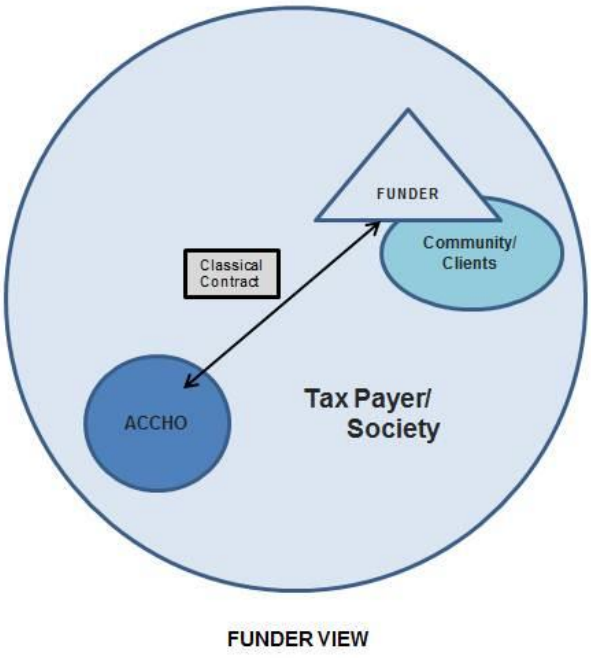
As described in the literature review, accountability is generally understood as a power relationship where an accountability holder (government) has the right to information, auditing and scrutiny of the actions of an accountability giver (ACCHOs) (Mulgan 2002). The 'contracting' idea of funding – the exchange of money for information and compliance – fits appropriately with the definition. However, accountability originated from the concept of those with power being held to account by those who entrusted the power – citizens holding governments to account in a democratic society. Applying the notion of downwards accountability, ACCHO Boards are accountable to community service users to ensure access to safe and respectful health care service.

5.3.2 WHY IS CONTRACT ACCOUNTABILITY SO 'TOP DOWN'?

The thinking behind the funding contracts is that the government decides what services should be provided and pays the contractor (ACCHOs) to provide the services on its behalf. That is, the government is acting in the interests of service users/the community, seeking the 'best buys' to meet their needs. It is this perception that gives the government the moral authority to hold the contractor (ACCHOs) to account, along with the fact that governments have the power and control of taxpayer money. Figure 5.2 is a diagram of the funder's view of accountability.

It also shows the two-way arrow but the difference in thinking is based on the funders (government) belief that they represent the community/service users, a type of 'protectionist' role because they are responsible for the expenditure of government funding (which is the peoples' through taxes). ACCHOs must account to government to provide government-directed services on behalf of the service users/community as their moral authority suggests.

Figure 5.2 Funder's view of accountability



Source: Adapted from Dwyer and O'Donnell (2013)

5.3.3 TOP-DOWN ACCOUNTABILITY IS NECESSARY BUT NOT SUFFICIENT

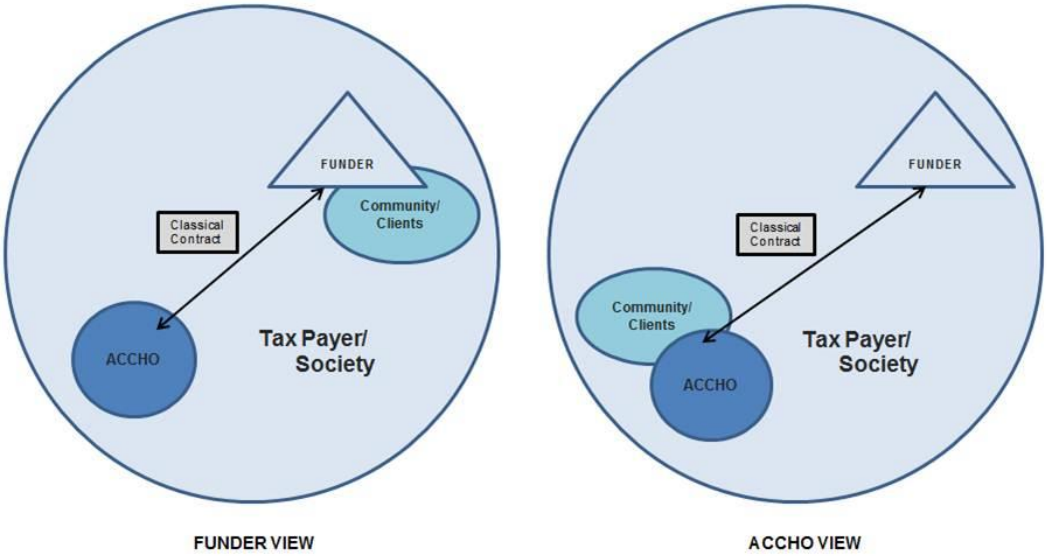
There are three problems with the application of contract accountability in the work of ACCHOs (Dwyer & O'Donnell 2013).

1. Governments lack knowledge about ACCHOs. It is normal for those contracting services to know less about the service than the providers do. However, in the case of 'buying' PHC, it is simply not possible to specify exactly what should be done. OATSIH is aware of this and has provided more flexible PHC (core) funding than other health program funding contracts. 'Buying' PHC for Australia's First Peoples is especially difficult and this is precisely why government accepts the role of ACCHOs – because they hold knowledge and can speak on behalf of their communities.

2. The ACCHO sector is the voice of communities in health. Communities (citizens) can hold governments to account in a democracy and First Peoples claim and hold a special kind of citizenship, with specific additional rights as documented in the United Nations Declaration on the Rights of Indigenous Peoples (2007), endorsed by the Australian Government in 2009. The ACCHO sector is the representative voice of Australia's First Peoples in health, and is also accountable to communities to provide equitable, appropriate and timely PHC. The Australian governments are also accountable to Australia's First Peoples as citizens to ensure equitable, appropriate and timely health care services. However, there are conflicting worldviews about accountability to Australia's First Peoples, as demonstrated in the Figure 5.3.

Figure 5.3 Conflicting world views

Conflicting Worldviews



Source: Adapted from Dwyer and O'Donnell (2013)

3. The system doesn't work well for ACCHOs or funders. As the study has found, the current system is seen as problematic by both sides. ACCHOs are overburdened with unnecessary monitoring and reporting. The 'body-part' funding is a challenge to comprehensive PHC, as the 'split three atoms and report tomorrow' metaphor indicates. In an environment of low trust, funders are sceptical about Aboriginal governance, and their response to the risk is to impose stricter and more onerous reporting requirements. The growth in 'red tape' results in additional work for the funders as well. It is problematic when funding is split up in so many ways because equity can't be ensured. The development of useful data about outcomes and quality is compromised by the short-sighted counting of 'heads through the door' for 'biggest bangs for bucks' in spite of considerable effort and real progress in the development of meaningful data.

5.4 APPROACHES TO RESOLVING OR REDUCING THE ACCOUNTABILITY TENSION

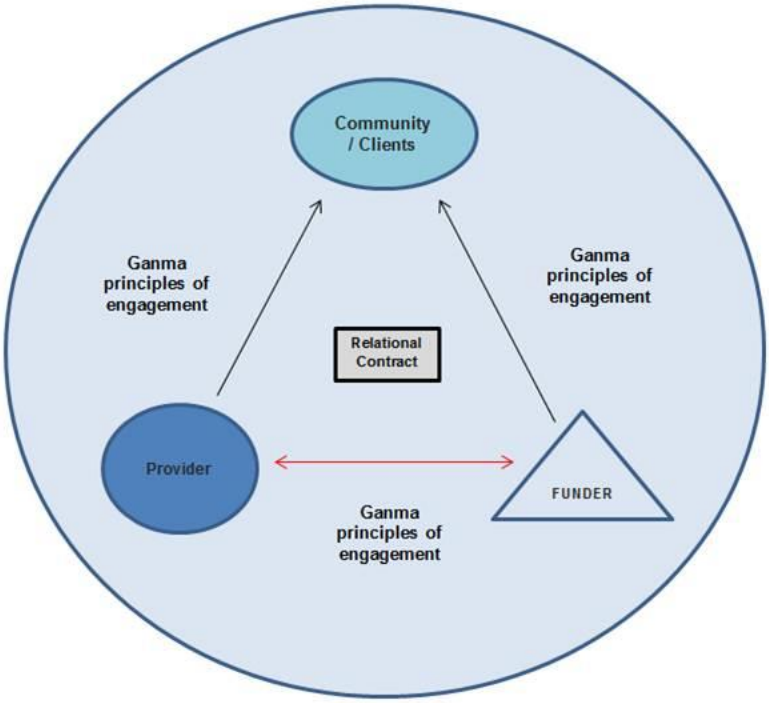
For ACCHOs there is a need to ensure their legitimacy as the community voice through effective engagement with and responsiveness to their communities. For government, concern about ACCHO governance results in stricter, more onerous reporting and compliance requirements. For the resulting tension to be reduced, governments need to disentangle their concerns about governance from accountability requirements because strict and punitive accountability requirements can't create effective governance of ACCHOs (Dwyer & O'Donnell 2013). Effective governance is achieved by the Board and senior staff working with community members. As was expressed by ACCHO staff in the study, ACCHOs need to strengthen the visibility and vigour of their accountability to communities through their efforts to engage more families to support the ACCHO as a collective voice. The ACCHO staff also expressed their desire to have increased funder engagement, albeit on their terms. The challenge for ACCHO management is how to engage families who suffer from chronic diseases, who are stressed and burnt out from trying to take care of each other, while also trying to cope with the multiple burdens of grief and loss, and engage funders to support them in the challenge.

5.5 A PRACTICE OF SAFE PLACES FOR DIALOGUE

Sullivan (2009:66) considers the limitations of NPM approaches to accountability in Australian Aboriginal affairs and offers an alternative understanding of an accountability environment in which accountability is 'the activity of rendering an account within a group and between groups so that the actors negotiate their identity, obligations and commitments in relation to each other, producing an environment of reciprocal accountabilities'. See Figure 5.4. This conception of accountability is consistent with the Ganma way of thinking about the sharing of knowledge and interpretations, and the need for synthesis.

Figure 5.4 Reciprocal accountability

Reciprocal accountability…can it be realised?



Source: Adapted from Dwyer and O'Donnell (2013)

This study confirms the findings of other research: that reform in the methods of contracting ACCHOs is required. Funding needs to be more integrated, through bringing together the multiple 'body part' funding programs and streamlining the sources of funding to ACCHOs. Contracts need to be long-term in order to support the development of a robust PHC system. Therefore, a shift to relational contracting is needed which could be used as the tool to enable genuine attention be given to the relationship between the sector and its government funders with a focus on developing workable levels of trust, supported by sound accountability requirements. Dialogue includes the provision of safe spaces for First Peoples' representative organisations and governments to explore the challenges of intercultural work and to address systemic racism and its profound impact in the lives of Australia's First People. The Ganma framework, founded on ethical principles and Indigenous knowledge for respectful and critical mutual

understanding across cultural and racial divides, can provide a strong basis for respectful dialogue, an essential step in the process of reform.

5.6 CONCLUSION

This research adds to knowledge about the broader implications of the use of relational contracting to relationships of trust in public health care provision – knowledge which is also applicable to mainstream health care funding and provision, and potentially applicable to funding and provision of other human and environmental services. A key discussion point and ontological position for the ACCHO Indigenous staff is the importance of identity and place in Australia and the need to become visible and valued for the unique work that ACCHOs carry out as a part of the overall health care system. As an Indigenous researcher who operates as an agent for change, this study has positioned Indigenous identity at the centre of the complex relationship between government funders and ACCHO providers. This study provides an illustration of how trust and accountability are differently understood by both parties. The research identifies a contested intersection of moral responsibilities in the relationships between government funders and ACCHO providers.

Returning to the image of Ganma, where the salt and fresh water combine in turbulence, we have yet to see opportunities and processes that could create the productive 'foam' that may resolve this moral conflict. I believe that to find a way forward, principles to guide dadirri (deep listening) should be incorporated, which enable an understanding and acknowledgement that Indigenous identity is at the core of the unique function of ACCHOs.

My research has thrown light on an area that is contested and dysfunctional and I expect that future research can build on the concepts and frameworks presented to make the long overdue changes necessary to create safe spaces for dialogue. There is the potential for working with these findings to develop a change in strategies which facilitate and maintain long-term relationships between the

partners to improve continuity of care, workforce sustainability and system development in ACCHOs.

It is hoped that the understandings and strategies outlined in this study will underpin a revolution in relationships, which can include: a simplification of ACCHO administrative and reporting requirements attached to funding; reciprocal and effective communication; respect for each other's roles and responsibilities within the health care system; focused collection of relevant data; the freeing-up of resources for on-the-ground service delivery and ultimately, to improved health and wellbeing for Australia's First Peoples.

Foam creation where the River Murray meets the sea,
The Coorong, South Australia. Photo by Kim O'Donnell 2011

APPENDIX 1: INTERVIEW OUTLINE – GOVERNMENT FUNDING STAFF QUESTIONS

I'd like to talk about three things and find out what you think personally about them: *trust, relationships and accountability*. I'd like to hear your personal opinions and what these mean in practice when you're working with Government funders.

1. **First of all, could you tell me about your role as (insert job title)**

   Probe points mentioned and turn them into questions. If (mis)trust, accountability and relationships are mentioned or implied, probe further. If not, continue with Q.2.

2. **Relationships - do you have a good relationship with the ACCHO? (If asked, what do you mean: rephrase as, I'd like to know what you see as a good relationship).**

   - What are the key things that make/define a good relationship in your view?
   - Could you give me some practical examples?
   - Are there structures that get in the way of a good relationship? How do you work around these?

3. **Trust - Reconciliation Australia commissioned a survey last year which found a high level of goodwill but a serious lack of trust between Aboriginal people and other Australians. Do you think trust in the relationship is important? Why? Why not?**

   - Do meetings help you to talk about (mis)trust issues between you? How are these resolved? When issues aren't resolved, how are they dealt with? Can you give me a positive example?

4. **What do you find difficult to talk about with the ACCHO? Why?**
   (Or, for on-the-ground staff: what do you think middle management (government) staff have difficulty talking about with the ACCHO?)

   - If you had the power, what strategies would you put in place to improve communication/relationships so people feel safe to talk about the difficult stuff?

5. **Is there anything else you find difficult to talk about in your working relationship?**

6. **Accountability - what do you think accountability means in practice (in your own words)?**

   Could you give me some examples?

7. **What do you think Government is accountable to the ACCHOs for?**

   - What do you think funders are accountable to community for?
   - What do you think the ACCHO is accountable to Government for?
   - What do you think the ACCHO is accountable to community for?

   Could you give me some examples?

8. **What are the gaps, conflict areas? How would you resolve them?**

9. **Is there anything else you'd like to talk about that you feel was not covered in the interview questions?**

10. **If you think of other things later that you forgot to talk about, don't hesitate to ring or email me. Do you have any questions for me about the work?**

APPENDIX 2: INTERVIEW OUTLINE – ACCHO STAFF

I'd like to talk about three things and find out what you think personally about them: trust, relationships and accountability. I'd like to hear your personal opinions and what these mean in practice when you're working with Government funders.

1. **First of all, could you tell me about your role as (insert job title)?**

   Probe points mentioned and turn them into questions. If trust, accountability and relationships are mentioned, probe further. If not mentioned, continue with Q.2.

2. **Relationships - do you have a good relationship with your Government funders? (If asked what do you mean, say: I'd like to know what you see as a good relationship). What are the key things that make/define a good relationship in your view?**

   - Could you give me some practical examples?
   - Are there structures that get in the way of a good relationship? How do you work around these?

3. **Trust - Reconciliation Australia commissioned a survey last year which found a high level of goodwill but a serious lack of trust between Aboriginal people and other Australians. Do you think trust in the relationship is important? Why? Why not?**

   - Do meetings help you to talk about (mis)trust issues between you?
   - How are these resolved?
   - When issues aren't resolved, how are they dealt with?
   - Can you give me a positive example?

4. **What do you find difficult to talk about with Government funders? Why? (Or, for on-the-ground staff: what do you think the ACCHO Management staff have difficulty talking about with government funders?)**

   - If you had the power, what strategies would you put in place to improve communication/relationships so people feel safe to talk about the difficult stuff?

5. **Is there anything else you find difficult to talk about in your working relationship?**

6. **Accountability - what do you think accountability means in practice (in your own words)?**

   Could you give me some examples?

7. **What do you think [the ACCHO] is accountable to Government funders for?**

   - What do you think [the ACCHO] is accountable to their clients for?
   - What do you think Government funders are accountable to [the ACCHO] for?
   - What do you think Governments are accountable to community for?

   Could you give me some examples?

8. **What are the gaps, conflict areas? How would you resolve them?**

9. **Is there anything else you'd like to talk about that you feel was not covered in the interview questions?**

10. **If you think of other things later that you forgot to talk about, don't hesitate to ring or email me. Do you have any questions for me about the work?**

APPENDIX 3: LETTER OF INTRODUCTION

Colin MacDougall PhD
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Tel: +61 8 7221 8412
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LETTER OF INTRODUCTION

Dear _____

This letter is to introduce Ms Kim O'Donnell who is a Doctor of Public Health student in the Discipline of Public Health at Flinders University. She will produce her student card, which carries a photograph, as proof of identity.

Kim is undertaking research leading to the production of a dissertation and other publications on the subject of, "How might conflicts between existing government funder accountability requirements and the capacity of Aboriginal Community Controlled Health Organisations (ACCHOs) to respond be managed or resolved?"

She would be most grateful if you would volunteer to assist in the project, by granting an interview which covers certain aspects of the topic. The interview time will take 1–1.5 hours. Be assured that any information provided will be treated in the strictest confidence and none of the participants will be individually identifiable in the resulting dissertation, report or other publications. You are, of course, entirely free to discontinue your participation at any time or to decline to answer particular questions.

Since she intends to make a tape recording of the interview, she will seek your consent, on the attached form, to record the interview, to use the recording or a transcription in preparing the dissertation, report or other publications, on condition that your name or identity is not revealed, and to make the recording available to other researchers on the same conditions.

It may be necessary to make the recording available to secretarial assistants for transcription, in which case you may be assured that such persons will be advised of the requirement that your name or identity not be revealed and that the confidentiality of the material is respected and maintained.

Any enquiries you may have concerning the project should be directed to me at the address given above or by telephone on 08 7221 8412, by fax on 08 7221 8424 or by email (colin.macdougall@flinders.edu.au).

Thank you for your attention and assistance.

Yours sincerely

Colin MacDougall PhD
A/Professor of Public Health and Course Co-ordinator
Doctor of Public Health

The research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project Number: 5222). For more information regarding ethical approval of the project, the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au

APPENDIX 4: PROJECT INFORMATION

Ms Kim O'Donnell
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GPO Box 2100 Adelaide SA 5001
Tel: +61 8 8201 7768
Fax: +61 8 8201 7766
kim.odonnell@flinders.edu.au
http://www.flinders.edu.au/medicine/
sites/health-care-management/
CRICOS Provider No. 00114A

Project Information: Aboriginal Community Controlled Health Organisations and Government funders: accountability relationships to whom and for what?

The Project

The research project, funded by the Lowitja Institute (Australia's National Institute for Aboriginal and Torres Strait Islander Health Research) explores the mismatch between government accountability requirements and Aboriginal Community Controlled Health Organisations (ACCHOs) operational realities.

Previous research found that relationships are significant in negotiating accountability between ACCHOs and government funders and this is an area for further investigation for better health outcomes for Aboriginal and Torres Strait Islander people. The project will address the following question:

- How might conflicts between existing government funder accountability requirements and the capacity of ACCHOs to respond be managed or resolved?

The interview

I am approaching you to participate in the project by giving an interview based on your knowledge and experience in the area. The interview will take between 1 and 1.5 hours.

Confidentiality and anonymity

Be assured that any information you provide that is not on the public record or is of a confidential nature will be treated in the strictest confidence, and in any case, none of the participants will be individually identifiable in the resulting reports or other publications.

I intend to offer all those who assist with the project the opportunity to be thanked in the acknowledgement. Your name will not be used except with express written consent.

Recording and protection of data

With your permission a voice recording of the interview will be made. I will use the recording, or a transcription of it, in preparing reports or other publications. Your name and identity will not be revealed. It may be necessary to make the recording available to secretarial assistants for transcription, in which case you may be assured that such persons will be advised of the requirement that your name or identity not be revealed and that confidentiality of the material is respected and maintained. The recording and all other forms of data collected or created in the project will be held securely for at least seven years after completion of the project in a secure manner at Flinders University. Stored material will be de-identified as much as possible, and a coding system will be used to minimise any risk of identification.

You will have an opportunity to review the report

If you agree to participate, I will provide you with a copy of my draft report and invite you to suggest amendments to any errors of fact or interpretation. Research

results will be communicated to participants and the health sector more broadly in forms that are 'user friendly' (short reports in plain language).

You can withdraw at any time

You are entirely free to discontinue your participation at any time or to decline to answer particular questions.

If you have any questions or concerns now or later

Any enquiries or concerns about the project should be directed to me at the address provided above or by telephone 08 8201 7768, fax 08 8201 7766 or email: kim.odonnell@flinders.edu.au

If at any time you are not comfortable with any aspect of your involvement in the project and would like to discuss your concerns with someone other than the researcher, you may contact the Executive Officer of Flinders University Social and Behavioural Research Ethics Committee, Mrs Andrea Mather by telephone on 8201 3116 or email human.researchethics@flinders.edu.au) or the Chairperson, Prof Paul Ward on 7221 8415.

APPENDIX 5: CONSENT FORM

FLINDERS UNIVERSITY AUSTRALIA

Social and Behavioural Research Ethics Committee

CONSENT FORM FOR PARTICIPATION IN RESEARCH

(by interview)

I ……..

being over the age of 18 years hereby consent to participate as requested in an interview for the research project on Aboriginal Community Controlled Health Organisations and Government funders: Accountability to whom and for what?

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I agree to my information and participation being recorded on tape.
4. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
5. I understand that:
   - I may not directly benefit from taking part in the research.
   - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
   - While the information gained in the study will be published as explained, I will not be identified, and individual information will remain confidential unless I elect otherwise.
   - I may ask that the interview and/or recording be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.

- I will receive a copy of the draft report of the project, and will have the opportunity to suggest corrections to any errors of fact or interpretation.

6. I have had the opportunity to discuss taking part in the research with a family member or friend.

Participant's name……..……..

Participant's signature……**Date**……..

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name…….....

Researcher's signature……..**Date**…….

APPENDIX 6: MEMORANDUM OF UNDERSTANDING

The MOU is between [the ACCHO] and Kim O'Donnell, researcher and Doctorate of Public Health student, Flinders University, 23 September 2011.

De-identified original document has short overview of the ACCHO here.

Kim O'Donnell is lead researcher of the project: Aboriginal Community Controlled Health Organisations and Government funders - funding relationships to whom and for what? The study explores the relationships between an Aboriginal Community Controlled Health Organisation (ACCHO) and their government funders to further understand what works, why and how in terms of the funding relationships; what needs to improve from both perspectives and what are the practical approaches to engagement and to programs that work for both the ACCHO and their funders for better health outcomes. This is a qualitative case study and includes a document and literature review, and approximately fifteen interviews:

- Group 1- 3 ACCHO management staff
- Group 2- 3 ACCHO 'on-the-ground' staff
- Group 3 - 5 clients (including Elders, middle-aged clients and young people, 18 years and over)
- Group 4- 4 government funders

(Above participation changed only to Groups 1 and 4, as explained in limitations)

These interviews will be recorded or notes taken (dependent upon peoples' comfort) and thematically analysed, ie the text will be read, similar comments and ideas will be grouped together to produce a big picture of relationship concerns between the ACCHO (including clients) and funders - what works, what doesn't work, and suggestions for improvement with implications for [the ACCHO], the health care system and for health care delivery.

Protocols

We will be guided by [the ACCHO] Complaints, Grievance and Conflict Resolution policy. The only foreseeable adverse event of the project is if a client, staff or funder becomes upset by the questions Kim asks (Attachment 1). Dependent on the circumstances, firstly Kim will try to resolve the issue personally and confidentially with the individual/group to understand the causes of their distress and to find ways to work through them. She will cease asking questions immediately and use her interpersonal skills to ensure participants feel safe and secure. If they continue to feel distressed, Kim will seek assistance.

Steps to be taken to ensure that the ACCHO is not:

a) Exposed to unintended consequences that may cause social, legal or financial harm?

We, [names of CEO, Program Manager and researcher] agree to adhere to [the ACCHO] Complaints, Grievance and Conflict Resolution policy to address any unintended consequences. Kim will be guided by [the ACCHO] and will have regular discussions with the CEO for updates on the progress of the work.

Kim will also be guided by four supervisors (Assoc. Prof Colin MacDougall, Prof Judith Dwyer, Dr Angelita Martini and Assoc. Prof Tracey Bunda) and will also meet with them regularly to discuss the progress of the study. There will always be risks involved, particularly in this field of work and it will be Kim's responsibility as lead researcher to have processes in place in consultation with [the ACCHO] to minimise unexpected risks. The careful writing-up of results that benefit all key stakeholders will minimise these risks.

b) Identified?

Data will be coded and carefully de-identified to prevent the ACCHO and individual participants from being identified. The work will not be published without prior consent from [the ACCHO] and the Aboriginal Health Council of SA. Results will be

written to benefit [the ACCHO] in their endeavour to improve engagement with their funders and clients for consolidation and expansion of their service to improve the health outcomes of Aboriginal people in [named region].

Roles and Responsibilities:

CEO:

- seek involvement of the funding/program managers for the interviews. Staff will be approached to arrange a time for interviews.

Staff:

- provide explanation and information about the project to clients, who can decide if they would like to be involved or not
- offer clients the following options:

  a) contact Kim directly by phone on the number provided or
  b) introduce themselves to Kim who is located in the building and she will follow up directly by phone with clients who wish to be involved.

Researcher:

- arrange with clinic staff to be present in the building at the time that the information is provided. This will enable interested clients to approach Kim directly to initiate contact
- may introduce herself to clients directly to seek their interest
- repeat explanation of the project and forms, including the client consent form, once clients have chosen to participate and prior to the interview taking place
- provide morning tea/lunch/afternoon tea to participating clients
- provide a one-off contribution of $200.00 to [the ACCHO] to cover resource costs, eg stationery, use of phone and office space

Rigour

The work is supported by the Lowitja Institute and sits under a larger project: Funding Accountability and Results for Aboriginal Health Services - Closing the

policy: implementation gap? The project seeks to engage with funders and providers in the Northern Territory and Queensland in order to study the reforms (health care services progressing to community control) as they develop and generate evidence about what works and why and is led by Professor Judith Dwyer in partnership with AMSANT, OATSIH, Northern Territory Government and partners in Queensland.

[The ACCHO] will drive the research benefits of the project in terms of using the outcomes to support consolidation and expansion of the organisation as it relates to their Strategic Plan 2011-2015 to:

- strengthen [the ACCHO]'s accountability to community, clients and organisation
- strengthen partnerships with other agencies to build all of our capacity to improve quality of life and to tackle the social determinants of health

In partnership,

On behalf of [The ACCHO] Name and signature of CEO (Confidential)	On behalf of Flinders University and the Lowitja Institute  Kim O'Donnell (Lead Researcher)

APPENDIX 7: SUPERVISION AGREEMENT

Supervisors: Colin MacDougall, Judith Dwyer, Tracey Bunda and Angelita Martini)

Student: (Kim O'Donnell)

Agreement: 10 June 2010

Assoc Prof Colin MacDougall (Principal Supervisor)

- Adhere to Principal Supervisor responsibilities as listed for post graduate coursework students on Flinders University website
- Broker, advise and assist Kim to negotiate working/admin systems within Flinders University
- Provide knowledge/expertise - content and research methodology

Verbal agreement acknowledged 10 June 2010

Prof Judith Dwyer (Assoc. Supervisor)

- Advise and assist Kim to project manage her Doctorate
- Provide knowledge/expertise - content and research methodology
- Provide managerial perspectives and broker research relationships and formalities
- Provide study/office space when available within Flinders Health Care Management

Verbal agreement acknowledged 10 June 2010

NB: Jenny Baker was replaced by Tracey Bunda, as explained in Chapter Three

Assoc. Prof. Tracey Bunda (Assoc. Supervisor)

- Indigenous Knowledge Advisor
- Meet with Kim for individual informal working/discussion sessions as required
- Provide knowledge/expertise - content and research methodology
- Emotional support

Verbal agreement acknowledged 3 June 2010

Dr Angelita Martini (Assoc. Supervisor)

- Provide knowledge/expertise - content and research methodology
- Supervision of writing sessions
- Emotional support

Verbal Agreement acknowledged 9 July 2010

Kim O'Donnell (Student)

- Adhere to student responsibilities as listed for post graduate coursework students on Flinders University website
- Discuss with supervisors the type of help considered most useful, and keeping to an agreed schedule of meetings which will ensure regular contact
- Email meeting agenda 1-2 days prior to meeting and record minutes of meetings with supervisors. Email minutes within the week.
- Email material at least a week before meetings, unless otherwise negotiated

- Maintain the progress of the work in accordance with stages agreed to with the supervisors, in particular, presentation of any required written material in sufficient time to allow for comments and discussions before proceeding to the next stage
- Discussion at regular intervals of the progress towards, and impediments to, maintaining the agreed timetable with the supervisors

Verbal agreement acknowledged 10 June 2010

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