Transition to Governance: Building Capacity in an Indigenous Community

The Australian Social Policy Conference
11th to 13th July 2007
Sydney

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Abstract

This paper outlines the challenges and opportunities currently experienced by the Transition to Governance project, its partners and the Indigenous community members who are committed to establishing an Aboriginal Community Controlled Health Organisation.

Historically the Indigenous community in outer eastern Melbourne was serviced by an Aboriginal Community Controlled Health Organisation (ACCHO). However, in 1998 following a review by the Office of Aboriginal and Torres Strait Islander Health (OATSIH) the health service was de-funded and OATSIH approached Yarra Valley Community Health Service (YVCHS) to accept the auspice for the delivery of Indigenous health services in the Shire of Yarra Ranges. The Indigenous community’s response to the transmission of services to YVCHS was varied as the Indigenous community is in principle committed to Aboriginal control of health services. The transmission of service delivery to an Indigenous specific team within a mainstream health organisation was a bold move and a new model of management for OATSIH. The auspice arrangement was an interim arrangement, subject to review with the intention to develop an accountable Aboriginal community controlled organisation, in the future.

In 2004 a report was commissioned to investigate and propose models for the governance of the Indigenous health service. The preferred proposal was the transfer of Indigenous health services back to community control and subsequently the transition to governance project was established. This paper provides a case study of the journey undertaken by partners and Indigenous Australian community members as they undertake the ‘transmission of business’ from Yarra Valley Community Health Service to a newly constituted Aboriginal Community Controlled Health Organisation (ACCHO).
Preamble

The authors of this paper respectfully acknowledge the traditional custodians, the Wurundjeri people past and present of the Kulin Nation. The authors also pay respect to all Aboriginal Community Elders and people, past and present who have resided in the Eastern Metropolitan Region and have been an integral part of the history of this Region. The authors also acknowledge the past and present injustice and disadvantage experienced by Indigenous Australians.

Transition to Governance: Building Capacity in an Indigenous Community

1. Introduction

Prior to 1998 Indigenous health services in outer eastern Melbourne were provided by an Aboriginal Cooperative. However, in 1998 following a review by the Office of Aboriginal and Torres Strait Islander Health (OATSIH) the health service was de-funded and OATSIH approached Yarra Valley Community Health Service (YVCHS) to accept the auspice for the delivery of Indigenous heath services in the Shire of Yarra Ranges.

The Indigenous community’s response to the transmission of services to YVCHS was varied as the Indigenous community is in principle committed to Aboriginal control of health services. The transmission of service delivery to an Indigenous specific team within a mainstream health organisation was a bold move and a new model of management for OATSIH. The auspice arrangement was an interim arrangement, subject to review with the intention to develop an accountable Aboriginal community controlled organisation, in the future. In 2004 a report was commissioned to investigate and propose models for the governance of the Indigenous health service. The preferred proposal was the transfer of Indigenous health services back to community control and subsequently the transition to governance project was established.
In ‘White guilt, victim hood and the quest for a radical centre’ Noel Pearson calls for an agenda not only of right and reconciliation but also of responsibility. Previous studies and community consultations identified the Indigenous community in outer eastern Melbourne expect a quality health service, this is their right. Improvements in Indigenous health can be realised when responsibility as well as rights are recognised by Governments, the wider society and the individual (Pearson, 2007).

This paper provides a case study of the journey undertaken by partners and Indigenous community members as they undertake the ‘transmission of business’ from Yarra Valley Community Health Service to a newly constituted Aboriginal Community Controlled Health Organisation (ACCHO). The first chapter explores Indigenous governance theory and key issues that inform current practice. The next chapter explores how Commonwealth, State, Regional and Local initiatives contribute toward building community capacity in the Indigenous community of eastern Melbourne. The reader is then taken on a journey through time as the key stakeholders in health and the Indigenous community come together to ‘yarn up’ and establish strategies to achieve the vision of a community controlled health service. The final chapter identifies opportunities and challenges experienced by the Indigenous Health Service. Finally, the local response by an Indigenous community to local governance issues and challenges is highlighted.

The transition to governance project is an example of how key stakeholders in health and Indigenous community members can work together to embrace the three-fold agenda of right, responsibility and reconciliation. Noel Pearson calls for right, reconciliation and responsibility to be equally placed on the Indigenous agenda, without one subsuming the other. The transition to governance project seeks to embrace this three-fold agenda. It identifies that a phased approach enables parties to reflect upon and respond to a changing political and local environment.
2. Literature Review

Governance has attracted considerable attention across both the private and the public sector due to corporate failure, the emergence of new risks, increasing complexity of stakeholder relationships and expectations and increasing need for organisations to adopt best corporate governance standards by regulators and government (Sharma, 2005).

Governance refers to the systems and processes that are used to direct and manage the operations of an organisation to achieve its objectives (Dept. Human Service, 2006). Governance has four main attributes – legitimacy, power, resources and accountability with problems occurring where some or all of these attributes are missing, under-developed or ill-matched (Smith, 2005). Poor governance is characterised by ‘corruption, favouritism, nepotism, apathy, neglect, red tape and self-serving political leaders and public officials’ (Knight et al., 2002). Indigenous governance can operate within a community governance environment, regionally and within the State or Federal governance environments (Smith, 2005).

Corporate governance can be defined narrowly ‘as the processes by which the board is accountable to the organisation’s owners’ or more broadly as ‘the processes by which the board is accountable to all stakeholders, including owners, creditors, employees and the community’ (Sharma, 2005:24).

Several theories provide a framework of corporate governance: Agency, Stewardship and Cultural theory. Agency theory suggests that the best organised relationships are where one party (the principal) determines the work, which another party (the agent) undertakes. In contrast stewardship theory argues the reverse. Managers are able to be good stewards of the corporations they work for when they are ‘free from subservience to non executive director dominated boards’ (Sharma, 2005:30). Middle ground can be realised when Directors act simultaneously within the stewardship and agency paradigm, particularly when firms are in a regulated
industry or which possess a dominant shareholder acting as a supervisory board or relationship investor (Sharma, 2005).

2.1 Cultural theory

Cultural theory of corporate governance illustrates the difference in the perceptions from dominant western society and its values and Aboriginal people (Sharma, 2005). Western thinking limits and constrains the capacity of Indigenous communities to respond to the requirements of corporate governance because western values do not align with Indigenous values of kinship, relatedness and participation. In addition, Indigenous organisations and communities are submitted to accountability and compliance that are in direct conflict with the core Australian Indigenous values of sharing and relatedness (Sharma, 2005:39).

Cultural theory is consistently ignored by funding agencies and academics that argue that the profit sector corporate governance template should be applicable to Indigenous organisations. They take little account of:

- Respect for elders
- Obligation to look after one’s family and friends
- Obligation to share money and food
- Management roles for women
- Recognition of the past injustices done to the Indigenous people of Australia (Sharma, 2005:44).

A report by Reconciliation Australia (2006) highlights recent research regarding Indigenous community governance. These authors claim research is uncovering problems of scale, particularly in dispersed communities, as small organisations struggle to develop and sustain their service capacity, administrative systems, continuity of professional staffing, and to deliver tangible outcomes for their members. The challenge is compounded because Indigenous organisations or communities work within a background of social and economic disadvantage (Atkinson Kerr & Associates, 2004; Sharma, 2005). What is needed is for Indigenous
leaders and communities to give hard-headed consideration to the organisational structures and processes that best represent their strategic goal (Reconciliation Australia, 2006).

Creating the conditions for capable rule and collective action is the goal of good governance practice. It requires open, transparent policy-making debate carried out in conjunction with clear understandable executive implementation of decisions and accountability (Plumptre & Graham, 1999)

To conclude Sharma argues conceptualisation of culture based on a mainstream structural functionalist perspective fails to examine how culture is embedded and entangled in the exercise of power, resistance, and conflict in a given society. One solution offered by Sharma (2005) is the establishment of a cultural issues committee to assist organisations with such matters as kinship and social obligation to ensure everything is kept above board.

2.3 Governance and Organisation: Quality and Systems

A growing interest in monitoring the quality of service in Indigenous organisations is highlighted by this report. Good governance principles and practice contribute toward increased awareness by the governance body of the organisation, its functions and achievements.

Educational opportunities and government initiatives are building capacity within Indigenous communities. But, according to Sharma (2005) further changes are needed. He claims new governance systems need to be developed that incorporate the traditional values and the reflect cultural beliefs within them (Sharma, 2005:42-43). Kenny (1994) also adds that external funds often have strings attached. Energy is expended on developing strategies for negotiating with funding bodies and there is little room for real negotiation about needs (p. 192). Organisations are increasingly under pressure to prove efficiency and effectiveness resulting in a tightening of strategies, structures and resource utilisation rather than focusing on training and
development to develop technical skills, human skills and or conceptual skills (Sharma, 2005:189).

For instance, the Australian Government’s Healthy for Life program, which YVCHS was successful in securing, is committed to supporting capacity development in Indigenous primary care using continuous quality improvement (CQI) techniques. Bailie, Si, O’Donoghue and Dowden (2007) identify the challenges for the engagement of Indigenous health services in CQI activities. These include heavy demands for acute care services (and service orientation towards acute care), a preoccupation of middle-level management with staffing and budgets ahead of service quality and outcomes, and limited human resources in primary care services.

Several tools are available to organisations to monitor service quality and governance practice. For instance, annual risk assessments and desk top audits are undertaken by funding bodies. Unfortunately, these processes do not always provide an organisation with information about best practice by which to benchmark. For example in 2006/07 OATSIIH provided specific feedback to organisations that were rated as “organisations of concern” whereas organisations that were of “no concern” were just provided with their rating and a score.

For 2007/08 OATSIIH is currently developing a more comprehensive ‘OATSIIH Organisational Risk Assessment Profile’ which covers management structure and standards, control monitoring and reporting, accountability and financial management. Hopefully the development of the new organisational risk assessment profile checklist will enable Indigenous health services to better benchmark achievements, identify good practice and early indicators of risk or poor practice.

OATSIIH is committed to working with stakeholders to develop a framework of support that is flexible and meets the needs of services. This includes options such as training for board members and managers.
Similarly, DHS also is committed to supporting Indigenous organisations. For instance, in 2007 the Eastern Metropolitan Region of the Department of Human Services (EMR DHS) conducted governance training for non government organisations receiving state funding. The free training sessions provided an overview of governance highlighting legislative requirements. In addition the ‘Considering Organisational Governance Guide & Checklist’ (2004) was produced to enable organisations to self-assess against good practice guidelines. In 2003 the Eastern Aboriginal Reference Group (ARG) was established to facilitate the development of an effective partnership between EMR staff, Indigenous groups and service providers, and mainstream services operating in the Region. The led to the development of the Aboriginal Services Plan 2006-2009: Walking together for the future (DHS 2006).

The DHS and OATSIH organisational and governance checklist documents are very similar highlighting the potential lack of communication between State and National funding bodies. However in Victoria both DHS and OATSIH have come to an understanding that if an Indigenous organisation receives funding from both sources, only one assessment will be conducted. In all likelihood the OATSIH Risk assessment tool will be used to assess organisations by both DHS and OATSIH. It is also noted that although the DHS assessment is voluntary, the OATSIH assessment is mandatory. Other questions remain such as, are organisations sufficiently resourced to meet increased assessment requirements and if an organisation is deemed at risk; what sanctions, processes or supports will be implemented to address short comings.

Following research of Indigenous corporate structures and functionality in Indigenous corporate governance, Sharma (2005) posits for two governance checklists to account for cultural differences between urban and sub-urban and rural and remote Indigenous organisations. The checklist covers seven areas of governance: board appointment and training; definition of roles and powers; board skills, independence and resources; code of conduct; strategy setting; financial and operational reporting; sub-committees.
To conclude, Indigenous organisations and communities have been increasingly submitted to accountability and compliance that, according to Sharma (2005) are in direct conflict with the core Australian Indigenous values of sharing and relatedness. Government bodies and peak organisations seek to address this through strategies and policy initiatives.

2.4 Commonwealth and State Initiatives

*A Fairer Victoria* outlines actions the Government will take to improve access to vital services, reduce barriers to opportunity, strengthen assistance to disadvantaged groups and places and ensure that people get the help they need at critical times of their lives. A core component of this strategy is *Building a New Partnership with Indigenous Victorians* within this framework.‘Improving the lives of Indigenous Victorians.’ Of the six actions ‘Building Indigenous capacity’ includes:

- Increasing workforce participation by Indigenous people in the public sector in ways which can drive improvements in the Victorian Strategic Areas for Action;
- Increase the proportion of board members of large Indigenous organisations having undertaken rigorous governance training; and
- Increase the proportion of Indigenous cooperatives and other organisations meeting their statutory obligations.

At a regional level, the Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) is a Department of Human Services strategy that provides the policy framework for health services in receipt of the 30% WIES supplement¹ to continuously improve the cultural sensitivity and quality of their service provision to Aboriginal patients and communities. Providing quality care for Aboriginal patients requires progress to be made in the following four key result areas of the ICAP strategy:

- Relationships with Aboriginal communities

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¹ 30% Aboriginal and Torres Strait Islander Weighted Inlier Equivalent Separations Supplement funding for the implementation of the ICAP strategy
• Culturally aware staff
• Discharge planning
• Primary care referrals

To ensure that Eastern Health complies with government policy regarding ICAP, a three-phase plan has been developed. Outcomes include an employment strategy, provision of Aboriginal identification training to front line staff at the public acute interface, establishment of an Aboriginal patient Ambassador program, cultural awareness training for staff, and establishment of an Aboriginal Health Advisory Committee.

On the 18th May 2007 the Minister for Aboriginal Affairs, Gavin Jennings, announced $2.10 million to boost capacity of Koori community. Funded through the Indigenous Community Capacity Building Program, the Governance Training Program is managed by Aboriginal Affairs Victoria in partnership with Consumer Affairs Victoria and the Commonwealth Office of the Registrar of Aboriginal Corporations (Media Release, 18.05.07).

Since its inception in 2006, more than 160 Indigenous people have undertaken workshops and more than 35 have completed the Certificate IV in Business Governance. The governance training is culturally appropriate and designed to meet the specific needs of Indigenous participants. It also reflects the commitment by the Brack’s Government to build Indigenous capacity.

To conclude, Commonwealth, State, Regional and Local initiatives contribute toward building community capacity in the Indigenous community of eastern Melbourne. Each organisation needs to customise the governance structure to its particular circumstances (Sharma, 2005; Smith, 2005) and there are no ‘quick fixes’ to building capacity and development for leadership and governance (Dodson, 2003).
3. **Methodology**

A literature review was undertaken to identify previous research and current issues in Indigenous governance in Australia. A review of minutes of meetings held by the Interim Community Group and Transition to Governance Project Steering Committee was undertaken. Relevant local reports were sourced and reviewed. Consultation was undertaken with key stakeholders involved in the Transition to Governance project, Indigenous community members and staff from Yarra Valley Community Health Service to verify factual information.

4. **Service Profile**

Eastern Health is the major public sector provider of acute, sub acute and mental health services in the eastern region. Eastern Health has five main campuses: Angliss Hospital, Box Hill Hospital, Maroondah Hospital, Healesville and District Hospital and the Peter James Centre. Eastern Health employs over 6000 staff with a budget of $407 million. Community based services are delivered from fifty sites within the eastern region. The organisation provides services through four program areas: Acute Health, Aged Care & Rehabilitation, Community Health and Mental Health. Indigenous health services are delivered from Yarra Valley Community Health Service in the Shire of Yarra Ranges.

The YVCHS Indigenous Health Service’ purpose is to provide a culturally appropriate quality health service to improve the cultural, spiritual, physical, social and emotional well being of Indigenous community members in order to enhance life potential and opportunities. It is to provide a health service to the Indigenous community within the Shire of Yarra Ranges in the Eastern Metropolitan Region of Melbourne, Victoria.

Currently the profile of the indigenous health team is:

- Management and coordination;
- Health Nurse;
• Aboriginal Health Worker (Male);
• Community Development Worker
• Stolen Generations Worker;
• Indigenous Family Support Worker who provides assistance to the Stolen Generation in association with a Social Worker/Counsellor; and
• Operation Support Officer

Recent funding increases of $298K from the Commonwealth Healthy for Life program have been received and recruitment strategies are underway. These positions include

• Service System Coordinator;
• Service Intake Coordinator
• Female Aboriginal Health Worker;
• Care Coordinator

The State Government funds Home and Community Care (HACC) workers who provide domestic assistance, social support, property and garden maintenance. As well as Indigenous specific Planned Activity Groups the service also has a Volunteer Coordinator.

The State Government also provides Psychiatric Disability Rehabilitation support service funding for home based outreach.

In 2005/2006 there were 198 registered clients with Yarra Valley Community Health Service (124 females and 74 males). Total client contact has ranged from 2000-3000 contacts from 1999 to 2006. This data may not reflect the actual capacity of the Indigenous Health Service to meet community need because it is generally understood that Indigenous Australians do not always identify themselves as Indigenous nor choose to access Indigenous specific services.
5. Transition to Governance - Background

The Yarra Valley Community Health Service (YVCHS), a member of Eastern Health, is the auspice agency for the Indigenous Health Service. The auspice commenced in 1999, when the Victorian State Manager of the Commonwealth Department of Health and Aged Care approved a transfer of the auspice from Coranderrk Koori Cooperative to a mainstream health service – Yarra Valley Community Health Service, which is a member of Eastern Health. The transfer was made in response to a number of reviews\(^2\) (conducted between 1996-1998) which documented the poor health status of the Indigenous community in Healesville and the reluctance of community members to access the Aboriginal Health Service due to perceived and actual lack of confidentiality and safety.

Tan (1998) concluded that ‘if the resources or policies of the Co-operative to provide health and community services are so limited that primary health care services are not effectively delivered for the community then alternative approaches to access the necessary, basic services need to be implemented.’ (Tan, 1998:141).

Several community consultations and forums were initiated to identify community needs. In 1999 an Indigenous Health Service steering committee was established to act as a link between the Indigenous community and Yarra Valley Community Health Service. The purpose of the steering committee was to ensure that all services were relevant and appropriate to the needs of eligible Indigenous clients in the community and that services were delivered in a fair and equitable manner. This also met the criteria that OATSIH funding is made only available for community controlled health organisations because the Indigenous Health Service steering committee had a direct role in shaping services, staffing appointments and

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reporting structures to OATSIH. The Coordinator liaised with the Indigenous steering committee to develop a service profile based on identified need.

In 2003 OATSIH funded a further review of Indigenous health services in Healesville. This review found the Indigenous Health Team was providing an efficient and effective service which enjoyed a high level of satisfaction from clients. The review identified 14 strategies to address service delivery gaps and needs (Frizzell, 2003).

In summary Frizzell (2003) recommended:
1. Moving the Indigenous Health Service towards a model of greater community control over the next three years;
2. That the service should develop strategies to strengthen its accountability to the community, and;
3. That a Manager be appointed to oversee the Indigenous Health Service.

The Frizzell report didn’t provide a detailed pathway for the present Indigenous Health Service to move toward becoming a community controlled service. In March 2004 more than eighty Indigenous community members attended an annual community forum to determine how the community will work together, what programs and services are available to the community and to identify current gaps in program service delivery. Following the forum an action plan was prepared which identified program and service areas, initiatives and tasks to be actioned and how they should be implemented.

Milward (2004) identified the following recommendations by community at the forum:
- A more effective Community Development Employment Project (CDEP)
- An indigenous community centre (including clinical and health promotion)
- A range of educational and training initiatives
- Development of economic development opportunities
- A neighbourhood house for the Inner East of Melbourne
A drop-in centre for young persons

Following the community forum and consensus that a pathway to establish an ACCHO was needed, another review was initiated.

In 2004 Atkinson Kerr & Associates undertook community and stakeholder consultations to determine different governance models for an ACCHO. Four options were put forward for consideration:

1. Status quo: that the Yarra Valley Indigenous Health Service continues to be managed by the major health service provider in the local area – Eastern Health (with or without some changes).
2. Stand alone: that an Indigenous Health Service for the Yarra Valley be established as an independent entity
3. Co-operative: that the responsibility for the Indigenous Health Service of the Yarra Valley be transferred to a Koorie organisation such as a cooperative, alongside a range of other programs
4. Partnership: that an independent Indigenous Health Service (to be established) and Eastern Health develop a partnership to share the responsibility for the provision of Indigenous Health Services for the Yarra Valley.

The four options were assessed against four criteria. Based on the report and review the recommended option put forward by Atkinson Kerr & Associates was option four: a partnership between a properly constituted Indigenous health association and the YVCHS to manage the Indigenous Health Service for the next three years. This option allowed both an increased role for the community while maintaining the strong bonds with YVCHS. It also allowed for change to be phased in over time, according to the resources available from both within the community and the Funding bodies.

This review resulted in the developed a three year plan for the establishment an Aboriginal Community Controlled Health Organisation (ACCHO). In August 2004 the TTG Project Steering Committee indicated
‘they were receptive to the indigenous health service continuing and strengthening its partnership arrangement with YVCHS but also to the notion that steps be planned for the governing committee to become an independent legal entity and indigenous stand alone service’

The need to identify major risks and a contingency plan for the transition to governance project were also noted (TTG Project Steering Committee minutes, 2004).

Atkinson Kerr & Associates recommended a staged approach toward community control of the Indigenous Health Service. Figure one and three below indicate the different governance stages in the transition of governance from mainstream to community control put forward by Atkinson Kerr & Associates. The current governance structure is represented by Figure 1 with Atkinson Kerr & Associates recommending the transition to a governance structure and full community control shown as Figure 3 after establishment of the ACCHO.

However, several challenges and opportunities have arisen since the Atkinson Kerr & Association report and thus there is an interim governance structure proposed which is represented by Figure 2. This will see the signing of a Partnership Memorandum of Understanding between the legally constituted ACCHO and Eastern Health to oversee the management of the Indigenous Health Service.

Figures one, two and three below show diagrammatic representation of the transition of governance at different stages during the transition to community control.
Figure 1 Current governance structure (source: Atkinson Kerr & Associates, 2004)

Figure 2 Proposed interim governance structure (July 2007)

Figure 3 Final governance structure and community control of the Indigenous Health Service (source: Atkinson Kerr & Associates, 2004).
6. Let’s ‘Yarn Up’

The following section outlines the two main groups involved in the transition to governance from YVCHS to Aboriginal control. The first is the Transition to Governance Project steering committee and the second is the Interim Community Group. The final section provides an overview of the work undertaken by the Transition to Governance Project Officer.

6.1 The Transition to Governance Project Steering Committee

In order to further the recommendations of the three year plan the Transition to Governance Project was formalised in May 2005 with the adoption of the terms of reference (TTG Project Steering Committee minutes May, 2005). Letters had been sent to community and key stakeholders interested in Indigenous health outcomes to participate on the Transition to Governance Project Steering Committee. Members of the TTG Project Steering Committee represent a broad spectrum of Indigenous health stakeholders and include representatives from Yarra Valley Community Health Service, Aboriginal Affairs Victoria, Victorian Aboriginal Community Controlled Health Organisation, Department of Human Services (EMR), Office Aboriginal and Torres Strait Islander Health and members of the Interim Community Group. The Transition to Governance (TTG) Project Steering Committee functions include to:

- work collaboratively to develop a work plan to oversee the implementation of the recommendations made in the OATSIH funded “Three Year Plan for the Transition of Governance”
- receive reports from the Project Officer’s Implementation work plan.
- provide feedback and direction to the Indigenous Health Service Interim Community Group on the progress of the implementation of the agreed recommendations.
- maximize stakeholder input including potential funding sources by providing a forum for discussion and resolution of issues associated with the implementation of the agreed recommendation.
• communicate with key stakeholders to progress the Governance Report.
• identify opportunities for improvement in delivery of Primary Health Care Services.

In July 2005 the TTG Project Steering Committee identified the need to resource the Interim Community Group (ICG) and the Indigenous Health Service to realise the Atkinson Kerr recommendation. YVCHS sought OATSIH funding to appoint a Project Officer. The steering committee ‘emphasised the importance of seeing partnerships in place in order to sustain Indigenous organisations’ (TTG Project Steering Committee minutes July, 2005).

6.2 The Interim Community Group

Since 1998 the auspice of Indigenous health services in outer eastern Melbourne was transferred to an Indigenous Health Service steering committee which was developed to provide a link between Yarra Valley Community Health Service and the Indigenous community. This group later became known as the Interim Community Group (ICG). Membership to the group was canvassed through letters of invitation. The Indigenous Health Service steering committee had expressed its concerns about the risk of transferring the Indigenous Health Service back to community control. Therefore the key focus was to ensure that everything was ready before any transition occurred.

The first meeting of the ICG was held on the 22nd August 2005 with nine Indigenous community members. Committee membership and role has remained constant. It functions to ensure the continuing development of Indigenous health services in the area as found in the Service Agreements. However the group is now also committed to working towards establishing an ACCHO whose primary aim is to improve health outcomes for Indigenous Australians (ICG minutes, February 2007). The ICG provides advice through the Manager’s position into the health programs of the YVCHS Indigenous Health Team, monitors the standard and quality of delivery throughout the programs, assists in identifying Indigenous health and well being
issues and needs hence expanding existing health services and lastly, develops the new legal entity.

The ICG meets monthly, sometimes fortnightly to achieve its vision to establish an ACCHO to meet the health needs of its community. Good governance meeting procedures are adhered to and each member is provided with a folder containing minutes, terms of reference, iterations of the Constitution, copies of funding and service agreements and any other relevant information requested. The TTG Project Officer reports monthly to the ICG with a written progress report outlining achievements and challenges. In addition the ICG receives reports from the Manager and Operational Support of the Indigenous Health Service.

Key dates and achievements are noted in the minutes of the Interim Community Group. In April 2007 a Governance Work Plan was adopted by the ICG. In July 2006 and June 2007 OATSIH met with the ICG to discuss funding and service agreement requirements. In July 2007 OATSIH eluded to a changing landscape indicating the possibility of a future move toward accreditation of health services (ICG minutes, July 2007). The terms of reference were modified in February and July 2007 to reflect the changing landscape and journey as the group moved closer to self determination. Constant reflection and re-evaluation of the function of the group and the future look and feel of the ACCHO are highlighted within the minutes.

Following two years of discussion and drafts a Constitution was tabled at the ICG February 2007 meeting. The Constitution is a reflection of the issues and concerns expressed by the ICG members with regard to challenges, failures and successes of past Indigenous governance groups in outer eastern Melbourne.

The Constitution is unique in that the eligibility requirements are stringent and represent a response to issues and concerns expressed by the ICG members. The Company will have at least five but no more than seven directors. The Constitution states that directors must be of Aboriginal and Torres Strait Islander descent; live in outer east Melbourne, encompassing the Shires of Yarra Ranges, Maroondah City and
Knox City; represent a diversity of interests in the area of Aboriginal and Torres Strait Islander health; agree to undertake and complete a “Certificate IV in Governance” course; and be unrelated to each other by reason of family unless unanimously agreed by all the other unrelated directors, with the exception that any 2 directors may be so related at any time.

The ICG formalised its Constitution in July 2007 and application was made to the Australian Securities and Investment Commission (ASIC) to register a Company Limited by Guarantee under the name of ‘Gumeril Aboriginal Health Service Ltd’. Six members of the Interim Community Group have nominated as Interim Board members of Gumeril.

### 6.3 Transition to Governance Project

In October 2006 the Transition to Governance Project Officer was employed to assist the Interim Community Group and key stakeholders to realise the recommendations of the Atkinson Kerr & Associates report. The main duties and responsibilities of the project officer cover five areas – communication, governance support, transition (transmission of business) and due diligence, service agreement and report.

#### 6.3.1 Due Diligence

Key outcomes of the project include the completion of a due diligence report, change impact statement, development of a memorandum of understanding between the ACCHO and key stakeholders and a policy manual. To support these outcomes several work plans have been developed including a governance work plan and a transmission of business work plan. Progress reports are presented to the TTG Project Steering Committee and the ICG.

The due diligence report is in progress and identifies the scope of issues around the transmission of business from Yarra Valley Community Health Service to the ACCHO. Issues such as what assets will be transferred, work cover statements, human resource issues (awards, benefits, entitlements), transfer of client files,
statements of incidence reports or claims, rental and lease arrangements, insurance requirements and adoption of policies and procedures will be covered within the due diligence report. In summary, the due diligence report outlines the health and viability of the Indigenous Health Service and the legislative requirements for transferring one business to another.

Progress to date includes:

- development of a policy manual;
- development of a Board Induction Folder;
- dissemination of three Transition to Governance newsletter to the Indigenous community; and
- a good governance checklist has been developed to assist the Interim Board to monitor and assess good governance processes and procedures.

6.3.2 Communication

A significant round table meeting was held in January 2007 with representatives from OATSIH, DHS and YVCHS. The round table discussion concluded that open transparent communication between the key stakeholders was valuable and that future meetings could be scheduled to identify strategies for State and Commonwealth bodies to work in closer alliance with the health service to optimise outcomes for the Indigenous community.

6.3.3 Draft Memorandum of Understanding

A draft Partnership Memorandum of Understanding (MOU) is currently being reviewed by the ICG/Interim Board and Eastern Health. The MOU sets out the terrain for the coming year and is real and tangible evidence of the commitment by all parties to transfer Indigenous health services back to community control. The MOU endorses the findings of Atkinson Kerr & Associates (2004) that partnering between the Indigenous community and the mainstream health organisation will realise the best outcomes for Indigenous health. Upon signing the MOU Eastern Health and Gumeril Aboriginal Health Service Ltd will agree to jointly manage the YVCHS
Indigenous Health Team for the duration of the Agreement including matters relating to human resource management, service delivery management, financial management, physical resource management, and development of partnerships and alliances.

The final stage of the transition to governance project is yet to be realised, which is the formal signing of funding and service agreements between Gumeril Aboriginal Health Service Ltd, OATSIH and DHS. At the February 2007 meeting of the TTG Project Steering Committee it was noted that in order to receive funding an organisation (Indigenous or non-Indigenous specific) must be able to demonstrate it can deliver services outlined in the funding and service agreement. The parties agreed the YVCHS Indigenous Health Team needs to maintain a healthy, viable and accountable health service.

4. Challenges and Opportunities

4.1 An Indigenous Health Service within a Mainstream Health Service

The Indigenous Health Team is located in a mainstream Community Health Service and this provides an ideal opportunity to access allied health and general practitioner services through a brokerage model in order to strengthen the Primary Care and Chronic and Complex Care services of the Indigenous Health team.

To supplement existing recurrent funding from the Commonwealth and State Governments, opportunities to apply through a submission based process have augmented the service delivery budget. The team has been particularly successful in attracting Commonwealth Nutrition Funding for a 3 year Nutrition project between 2003 – 2006 which developed strong relationships with local schools, material aid agencies and the local CDEP program.

Seeding grants to establish a Family Violence program called Healing the Hurt and pre school playgroups attracted Best Start funding. Best Start and Innovations funding were Victorian Government initiatives to support families experiencing stress
in their parenting role. The high incidence of child protection notifications in the Shire of Yarra Ranges and the low pre school attendance rates of Indigenous children, within the Shire were the basis for this additional rural urban fringe funding for our Interface Local Government Council.

The Indigenous Health Team has worked closely with educational partners through the LAECG (Local Aboriginal Education Community Group), Swinburne TAFE Indigenous Pathways program and the Department of Education Employment and Training through local Neighbourhood Houses where programs operate to promote post secondary school education, employment and training placement opportunities for indigenous youth. A very effective primary to secondary school transition program has been operational now for some years.

Social Connectedness within the Indigenous Elder community is a high priority and the Planned Activity Group (PAG) for HACC eligible residents, have proved to be extremely successful in bringing people together in social settings. Indigenous participants participate in PAG planning and have advocated for this funding to provide overnight “camps” to Indigenous cooperatives and historically linked indigenous communities within Victoria. These camps enable families to reconnect either with a historical location which has interfamilial history or reunite with extended family members.

As an Indigenous specific program inside a mainstream health service, there is no funding source specifically for provision of transport services. This has been an ongoing challenge for team members as many community members had previously experienced unrestricted access to supported transport through the Coranderrk Cooperative. Changing community expectations that a general transport service was not a health service was problematic, in spite of both the OATSIH and DHS HACC service funding guidelines specifying that transport perse, unrelated to health needs, was not an acceptable primary health service outcome.
Changing community perception is an ongoing challenge for team members. We encourage community to be “independent” of the service rather than dependent on it. The delivery of services to empower people and to maintain people’s independence in the community is fundamental principles underpinning the Indigenous Health Team. Encouraging family members to support each other with assisted transport continues at times to be the subject of protest for community members.

Educating the community about their entitlements to service, Government eligibility criteria and the concept of supporting rather than ‘doing’ for the community continues to require diligence and enforcement of boundaries, which at times are seen as bureaucratic and uncaring. Maintaining professional boundaries around staff members when at work and clarifying their roles and responsibilities to their employer separately from their role as a community member continues to be a challenge.

Previous studies have identified that heavy demands for acute care services (and service orientation towards acute care), a preoccupation of middle-level management with staffing and budgets ahead of service quality and outcomes, and limited human resources in primary care services are challenges experienced by Indigenous health services (Bailie, Si, O’Donoghue & Dowden, 2007). These challenges impact upon the capacity of the health service to implement continuous quality improvement (CQI) techniques attached to initiatives such as Healthy For Life. According Bailie et al., (2007) the continuous quality improvement techniques developed for Healthy for Life are well suited to the Indigenous Australian setting and to the principles of Indigenous research and service delivery. Participatory-action principles, providing strong clinical and managerial leadership for a CQI culture at all levels of health service organisation and management, and developing the capacity to support community-level service organisations are required for success. The Indigenous Health Service has received Healthy for Life funding and is committed to a culture of continuous quality improvement through its motto ‘doing it right, doing it better’.
4.2 Governance, Community Participation and Capacity Building

Although the Indigenous health service has been very successful in increasing its funding base and thus service capacity under the auspice of Eastern Health, there have been occasions where the service has been disadvantaged in funding applications because it is deemed to lack Aboriginal community control. The establishment of Gumeril Aboriginal Health Service Ltd will enable the Indigenous community to access and source Indigenous specific funding opportunities in the future.

The ICG provides advice through the Manager’s position into the health programs of the YVCHS Indigenous health team, monitors the standard and quality of delivery throughout programs, assists in identifying Indigenous health and well being issues and needs and is responsible for developing the legal entity. However, the capacity of the ICG to affect real change or to have direct input into the functioning of the health service has been limited. This is because the ICG has no formal mechanism to affect or implement change in the health service, other than in an advisory capacity. It is anticipated registration of Gumeril Aboriginal Health Service Ltd will enable the Indigenous community to play a more active role in contributing to the strategic direction of the health service. The draft Partnership MOU sets an agenda for shared responsibility and is under review by key stakeholders.

The Partnership Management Group, responsible for implementing the Partnership MOU, will comprise members of Gumeril Aboriginal Health Service Interim Board, members from Eastern Health and one Independent member and will represent the first move toward community control of the health service, in partnership with Eastern Health.

Monitoring the standard and quality of delivery throughout programs requires the ICG to be aware of the issues and challenges experienced by the health service. The Manager provides the ICG with monthly reports that, in general, provide an indication of the outcomes achieved and any concerns. In 2007 a strategic planning day was held with the ICG and Indigenous health service staff members. In order to achieve funding and service agreement requirements, key action plans and reports
need to be submitted on time and involve input from both staff and the governance body.

Eastern Health is a large, bureaucratic organisation that employs over 6000 staff with a budget of $407 million. The Indigenous Health Service is but a drop in the ocean and thus at times struggles with the overarching systems and processes imposed upon it that a stand alone service would not experience. Navigating through Departments to identify key personnel and to monitor the status of actions has proved problematic. In addition, the Indigenous Health Service is subject to policies, procedures and at times a culture that does not enable a response to community need, as identified in the previous chapter. The ICAP initiative seeks to address some of these challenges.

Relocation of the team in 2005 to a separate building with no direct access by clients has led to challenges in communication both within YVCHS and with the community. In 2007/2008 an additional shopfront facility and a funded receptionist position will enhance service delivery to and by the team.

The literature review identified some of the challenges of Indigenous governance. Although some of these governance issues are unique to Indigenous communities, others are shared with governance boards’ world-wide. The ICG, in establishing the ACCHO, has clearly articulated these issues at a local level and has developed a Constitution to address these concerns. Review and reflection of the past coupled with a commitment by Interim Board Members of the new ACCHO to complete Certificate IV in Governance training stands the governance board in good stead.

The phased approach to transition has enabled parties to reflect and thus plan for the changing political landscape. The mooted Commonwealth accreditation of Indigenous health services coupled with current State regulation and accreditation of HACC services has the potential to move the focus from service outcome to service quality. A culture of continuous quality improvement that underpins the Health for
Life program is yet to be realised. Currently the Indigenous Health Service has access to the expertise within a large mainstream health service to assist in the accreditation of its services and to monitor and assist in the realisation of a quality service. Previous reports have highlighted the concerns of the Indigenous community regarding the quality and standard of care expected (Atkinson Kerr & Associates, 2004; Frizzell, 2003). The Indigenous community deserves the same level of care and professionalism as that expected by the non-Indigenous community.

According to VACCHO, the peak body representing Aboriginal Community Controlled Health Organisations in Victoria ‘each Aboriginal community needs its own community based, locally owned, culturally appropriate and adequately resourced, primary health care facility – that is our right’ (VACCHO website 2007). At a recent meeting with the Project Officer, a representative from the ICG and VACCHO the particular challenges that smaller Aboriginal health organisations experience were highlighted. These include ensuring the Board has a broad cross representation of skills and is in touch with its community; that the right senior staff is appointed and that the board thinks and acts strategically rather than operationally and; that it is important to support staff given they are often required to be multi skilled to cover a broad range of community needs. VACCHO is committed to building know-how and getting resources to local communities so that they can make real improvements (VACCHO website 2007).

The phased approach taken by parties, in transition to governance, has enabled parties to identify and respond to unexpected challenges and opportunities. For instance, the health service is not registered with VACCHO as an Aboriginal Community Controlled Health Organisation, even though it is in receipt of OATSIH funding. However, in 2002 through reciprocal partnering VACCHO agreed to enable the Aboriginal Health Worker to access training at VACCHO and YVCHS enabled VACCHO access to expertise within the Indigenous Health Service.

To conclude, this chapter has explored some of the challenges and opportunities experienced by Indigenous community members, key stakeholders and
the Indigenous Health Service as they move through toward community control of the health service. A phased approach and the development of locally based responses have been highlighted. The Indigenous community in outer eastern Melbourne has the right to access a culturally appropriate and professional Indigenous health service. Key health stakeholders and Indigenous community members have embarked on a journey of responsibility to address the challenge of transitioning a healthy, viable Indigenous health service. This includes responding to the lessons of the past by developing local responses to governance and service delivery.

5. Conclusion

The transmission of services from an ACCHO to a mainstream health organisation was a bold move by OATSIH. The sound recommendation by Atkinson Kerr & Associates for a phased approach to the transition to governance back to community control has enabled the partners to reflect on the journey and past lessons and respond to a changing political environment. The ongoing challenge is to develop a culturally appropriate health service that delivers a quality service to its clients. The balance between what is culturally appropriate and the achievement of a quality service remains both an opportunity and challenge for the Indigenous Health Team and the future governance board. The opportunity is to instil within the Indigenous Health Service best practice principles within the Quality and Safety Environment frameworks, (policies, procedures, protocols and systems) Eastern Health has established to meet the Australian Council on Healthcare Standards (EQuIP). In the future, OATSIH initiated accreditation will compliment the continuous improvement quality initiatives embodied within Healthy for Life. This paper does not imply that Western health systems lack the core values of caring and relatedness that also lie at the heart of Indigenous culture. Merely, that Western health systems do not function within the overarching disadvantage experienced by the Indigenous community including some members of its workforce and thus is better resourced to achieve the imposition of quality systems.
Strategies such as Healthy for Life, the ICAP initiative and various Commonwealth and State programs seek to build indigenous community capacity. The vision held by Indigenous community members of full community control of the Indigenous health service is yet to be realised. However, in a spirit of partnering the draft Partnership MOU provides a vehicle to move forward. The Partnership MOU will enable the Interim Board of Gumeril Aboriginal Health Service Ltd the capacity to further cement the skills they have gained through the Governance training course and to increase the knowledge base and expertise required to govern the Indigenous health service with confidence and diligence. The Partnership MOU will also enable the parties to reflect and review on the progress of the Indigenous health service and to work towards the transmission of business, including funding and service agreements, back to community control.

Kenny reminds us

‘For empowerment to occur, disadvantaged groups must have confidence in their ability to manage their own affairs and increase their levels of democratic participation. People must develop a belief that they actually can collectively control their lives. People need to have a sense of their own history and society; they need to overcome pessimism and fatalism; they need to see new possibilities for human societies’ (1994:118)

Noel Pearson calls for rights, reconciliation and responsibility to be equally placed on the Indigenous agenda, without one subsuming the other. The transition to governance project seeks to embrace this three-fold agenda. The phased approach has enabled parties to reflect and respond to a changing political climate and the challenges and opportunities of establishing a quality Indigenous health service. The Constitution developed by the Interim Community Group is a reflection of the issues and concerns expressed by the ICG members with regard to challenges, failures and successes of past Indigenous governance groups in outer eastern Melbourne. Each
member who has nominated to the Interim Board of Gumeril Aboriginal Health Service Ltd has completed or committed to complete Certificate IV in Governance.

According to Smith (2005) governance is not static, it is developmental; ‘it is about institution building, and mobilising the leadership, knowledge, skills and resources of a group of people’ (p. 17). Informed choice to build a governance structure that meets local needs is a key feature of the Transition to Governance story. The Transition to Governance story is also about the journey that embodies a cultural mandate whilst at the same time getting the job done (Smith, 2005).

The Transition to Governance project is a capacity building opportunity, not only for the Indigenous community in the Yarra Valley of Victoria, but for the non-Indigenous community as well. With the single goal of achieving a healthy viable, community controlled health service parties strive to find common ground, mutual respect and understanding to realise the vision articulated by the community in 1998. It is a journey of rights, responsibility and reconciliation.
References


LGANT. (2002). *An Examination of the Structural Relationships in Indigenous Affairs and Indigenous Governance within the Northern Territory*.


**Glossary**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AAV</td>
<td>Aboriginal Affairs Victoria</td>
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<tr>
<td>BTH</td>
<td>Bringing Them Home</td>
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<tr>
<td>CAV</td>
<td>Consumer Affairs Victoria</td>
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<td>DHS</td>
<td>Department Human Service</td>
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<td>EFT</td>
<td>Equivalent Full-Time Position</td>
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<td>EH</td>
<td>Eastern Health</td>
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<td>EMR</td>
<td>Eastern Metropolitan Region</td>
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<td>HACC</td>
<td>Home and Community Care</td>
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<td>ICAP</td>
<td>Improving Care for Aboriginal and Torres Strait Islander Patients</td>
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<tr>
<td>ICG</td>
<td>Interim Community Group (some members became the Interim Board)</td>
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<tr>
<td>IHT</td>
<td>Indigenous Health Team interchangeable with Indigenous Health Service</td>
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<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
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<td>OATSIH</td>
<td>Office for Aboriginal and Torres Strait Island Health</td>
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<td>PAG</td>
<td>Planned Activity Group</td>
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<td>SDRF</td>
<td>Service Delivery Reporting Framework</td>
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<td>SAR</td>
<td>Service Activity Report</td>
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<td>SOYR</td>
<td>Shire of Yarra Ranges</td>
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<td>TAFE</td>
<td>Technical and Further Education</td>
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<td>TTG</td>
<td>Transition to Governance</td>
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<td>TTGPSC</td>
<td>Transition to Governance Project Steering Committee</td>
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<td>NACCHO</td>
<td>National Aboriginal Community Controlled Health Organisations</td>
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<td>VACCHO</td>
<td>Victorian Aboriginal Community Controlled Health Organisations</td>
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<tr>
<td>YVCHS</td>
<td>Yarra Valley Community Health Service</td>
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This is our odyssey of Governance for all of the board members and members

We will endeavour to have a clear order of our service protocols and a clearer view of the direction in which we are to develop as an Indigenous Australian community Health service that takes a holistic approach so we will have the potential means to strengthen the health outcomes of our current and future community environment.

This success relies on the constant motion of positive Governance by a highly skilled and reflective board that looks to the development and mentoring of the communities youth for the evolution of future successful strong Governance.

Our individual commitment to this transition to governance has held firm as a direct reflection of our passion to the substance of this voyage we are participating in, we only hope that with time and work the fruits of our labour will be meet in the objectives and aims of this transition to governance committee.

Profile of ICG Members and future Board members:

**Shane Charles – Chairperson**
Shane works in the Indigenous unit of Swinburne Tafe as the Community Agency in this unit, he is currently working on the Governance Programs running in the Indigenous unit. Shane has completed his certificate 1V in (Business) Governance this year. Shane is currently doing his Training and Assessment certificate 1V. He has a Diploma in Cultural Heritage a Diploma in Frontline Management a certificate1V in Community Development and is accredited national facilitator Shane is also the Chairperson of the Local Aboriginal Education Consultative Group (LAECG ) and is the chairperson for the Healesville Indigenous Arts Enterprise as well he sits on many other Indigenous Australian committees. Shane is a Yorta Yorta man.

Shane Charles’ aspiration for the health service is ‘To build a holistic service delivery that takes into account all things that impact on health and well-being’.

**Perry Wandin – Vice Chairperson**
Perry is currently setting up his business. He is a Wurundjeri man and well respected in community. Perry has just started his Certificate 1V in (Business) Governance and is looking forward to completing this course by the end of August 2007. Perry sits on many other Indigenous Australian committees.

Perry Wandin’s aspiration for the health service is ‘To support the organisation’s move to independence and becoming its own landlord, making it strong and solid.’

**Anne Jenkins – Secretary**
Anne works in the Indigenous Unit of Swinburne Tafe as the Senior Indigenous Educational Officer. Anne was in the very first lot of Graduates of the Certificate 1V (Business) Governance to complete this course. Anne has her TAA Certificate 1V. Anne is an Indigenous woman from Mooree N.S.W

Anne Jenkins’ aspiration for the health service is ‘To ensure survival through change – we care about what we do and we know how to do it. To build a good foundation for the future.’
Miranda Madgwick – Treasurer (above photo, middle)
Miranda works in the Indigenous Unit of Swinburne TAFE as the Indigenous Support Officer. Miranda is currently working with the Pathways programs and assisting Anne and Shane. Miranda has completed her Certificate IV (Business) Governance in November 2006. Currently doing her Training and Assessment Certificate IV and is the Vice Chairperson of the Local Aboriginal Education Consultative Group (LAECG) and also sits on a few other Indigenous Australian committees. Miranda is a Worimi woman from N.S.W.

Miranda Madgwick’s aspiration for the health service is ‘To assist my community through building an independent, solid structure and role model for others.’

Aunty Glenys Merry a Tangarong Elder
Aunty Glenys Merry is a TAUNGURUNG Elder of Victoria, her outstanding community work throughout the years is endless. Aunty Glenys obtained her Certificate IV (Business) Governance this year. Aunty Glenys Merry has developed the vegetable garden from dirt to a fully grown vegetable garden site for the community and with her rock and knife has continued to work on it. Aunty Glenys has also setup and runs the community FOOD BANK, all the time and effort is given on a volunteer basis. Doing these services for community has given Aunty Glenys Merry the respect of community and many others.

Aunty Glenys Merry’s aspiration for the health service is ‘To take the organisation forward, working from positives and to make sure the children are being fed, including establishing a food bank.’

Aunty Dot Peters is an Elder in Community
Aunty Dot Peters has lived in Healesville all of her life, her mother was born at Corranderrk mission in Healesville in 1870, her father was born on Cummeragunja mission. Aunty Dot’s father died as a service man in Changi prisoner of war camp, her recent work with the R.S.L’s of Australia has see a national move to the commemoration of all Indigenous Australian service men and women. Aunty Dot Peters community work has see her as the first Koorie Educator in Healesville and to this day is still a very active community member sitting on many community committees and teaching her basket coiling to the youth.

Aunty Dot Peters’ aspiration for the health service is ‘To promote Aboriginal culture in all things and to help people understand each other better, to build respect, caring and sharing.’