The participation of Indigenous people in national
Indigenous health policy processes

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Submitted in total fulfilment of the requirements
of the degree of Doctor of Philosophy

October 2008

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Dedication

This thesis is dedicated to my grandmother, Marjorie Woodrow, one of the Stolen Generations of Indigenous Australians. I can trace the motivation behind this thesis to a single act that occurred in 1978, when she presented me with a small silver trophy as a reward for my efforts in school that year. I remember that moment being filled with a sense of joy and pride at such a statement of support coming from someone of her history.
Abstract

It is acknowledged that part of the failure to improve Indigenous health is due to the lack of participation of Indigenous people in national policy and decision making processes. In this three part study I investigated the nature of Indigenous people’s participation in national Indigenous health policy processes. I combined quantitative and qualitative methods through the perspective of policy networks.

The first part of the study was directed at the prominence of informal networks in the evolution of Indigenous affairs policy. I aimed to determine and describe the structural location of Indigenous people in an informal network of influential people. I administered a network survey questionnaire during the period 2003/04. In a snowball nomination process influential people nominated a total of 227 influential people. Of these, 173 people received surveys of which 44 people returned surveys, a return rate of 25 per cent. I analysed the data to detect the existence of network groups; measure the degree of group interconnectivity; measure the characteristics of bonds between influential people; and I used demographic information to characterise the network and its groups. I found a stable pattern of relationships in the three features of the informal network: the whole network was diverse, and the Indigenous people were integrated and embedded in the network. It would not have existed without Indigenous people due to a combination of their greater number, their distribution throughout the network groups, and the interconnections between the groups. I argued that the findings showed that Indigenous people were fundamental in this informal network of influential people.

The second part of the study was directed at the role of national health committees in engaging with advice about Indigenous health. I aimed to describe the structural location of Indigenous people in national health committees. Using internet sites I identified 121 national health committees at the end of 2003, and obtained information from 77 committees or 64 per cent of all committees. I calculated the proportion of members who were Indigenous within each committee; the proportion of committees which were Indigenous health committees; and constructed a visual representation of the formal reporting relationship between all the committees and Cabinet. I then determined the importance of each committee in terms of a committee network using eigenvector centrality scores. Finally, I identified the linking people between the informal network and the national health committees. I found that in a traditional
hierarchical view that Indigenous people and Indigenous health committees were small in number and distant from Cabinet. In contrast a network view assumes that the importance of a committee depends on the combination of the number of interlocks, comembership, and betweenness with other committees. In this network view, Indigenous health committees were similarly located to other committees. A small number of elite knowledge brokers linked the informal networks and the national health committees. I argued that the findings showed a formal systemic deficiency in the strategic location of Indigenous people.

The third part of the study was directed at the significance of inter-personal bonds between influential people in influencing policy processes. I aimed to describe the interpersonal relationships between influential people through a semi-structured interview. The interview questions were designed to elicit responses in the broad context of knowledge and influence in national Indigenous health policy processes. From a list of 47 potential interviewees I obtained 34 interviews (a response rate of 72 per cent), transcribed 32 interviews and coded them thematically. I found that underlying the episodic meetings of national health committees was the constant activities of informal networking. The influential non-Indigenous people had to pass some rules of entry in order to engage in and utilise informal processes. The interviewees demonstrated a value of connectedness in interpersonal relationships through agreement with principles such as social models of health. However, advice about Indigenous health issues may need to be continually rediscovered as it remains anchored to local contexts in a macro context where advice faces pathways that are confusing and convoluted. I argued that the findings indicated a meta-level vacuum in conceptualising the relationship between the concepts of participation and advice in national Indigenous health policy processes.

The findings from the three parts indicated three characteristics of an ongoing meta-process (informal network), absence of a meta-perspective (national health committees), and a meta-concept of participation (interviews). I suggest that they form a meta-frame of participation. In this frame the energy dispersed in the many efforts at improving Indigenous peoples’ participation are unfocussed because of multiple and uncoordinated policy origins. Therefore I concluded that the nature of participation of Indigenous people in national Indigenous health policy processes is one of unfocussed energy.
Declaration

This is to certify that

1. the thesis comprises only my original work towards the PhD except where indicated in the Preface;

2. due acknowledgement has been made in the text to all other material used;

3. the thesis is less than 100,000 words in length, exclusive of tables, maps, bibliographies and appendices.

Mark Lock BSc (Hons) MPH
Preface

Professor Pip Pattison demonstrated the basic use of the network analysis software and the correct mathematical procedures to execute for the network analysis of the data in chapters 3 and 4. I undertook all the data collection and interpretation, and was responsible for the design, conception, and writing chapters 3 and 4.
Acknowledgements

Various aspects of this PhD have been greatly enhanced by the kind assistance of a range of colleagues and funding bodies. I am especially grateful to my wife Stephanie Lock for her support throughout the thesis. My daughter Phoebe, born mid-way through the thesis, provides unending joy. The Lock family as a whole have given me a critically important supportive and accepting intellectual environment that encourages high level developmental endeavours such as a thesis.

Thank you to the supervisors not only for their assistance throughout the research but for their support that allowed the study to continue. Dr Jenny Lewis was the principal for the period 2003-2005 and Dr David Thomas for the period up to and including 2008. The additional supervisors were Professor Ian Anderson, Professor Pip Pattison, and Professor Tom Snijders.

Financial support was received through the National Health and Medical Research Council Training Scholarship for Indigenous Health Research (#251799) from February until December 2003. This was enhanced by a top-up from Cooperative Research Centre for Aboriginal Health from February 2003 until December 2003, as well as a one-off special grant from the Victorian Health Promotion Foundation. The Cooperative Research Centre for Aboriginal Health provided full scholarship support from January 2004 until March 2007. Coverage for some research expenses was provided through the research project Capacity Building in Indigenous Policy-relevant Health Research, funded through the National Health and Medical Research Council Population Health Capacity-Building Grant (#236235).
Ethical clearance

Ethical clearance for the research conducted as part of this thesis was granted by the Human Research Ethics Sub-committee of the School of Population Health at the University of Melbourne (Reference: DPH 12/2003, Ethics ID: 030339X).
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<tr>
<td>ACCHSs</td>
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<td>ATSIC</td>
<td>Aboriginal and Torres Strait Islander Commission</td>
</tr>
<tr>
<td>CAA</td>
<td>Council for Aboriginal Affairs</td>
</tr>
<tr>
<td>FCAATSI</td>
<td>Federal Council for the Advancement of Aboriginal and Torres Strait Islanders</td>
</tr>
<tr>
<td>ICCs</td>
<td>Indigenous Coordination Centres</td>
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<tr>
<td>NACCHO</td>
<td>National Aboriginal Community Controlled Health Organisation</td>
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<td>NAHS</td>
<td>National Aboriginal Health Strategy</td>
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<tr>
<td>OATSIH</td>
<td>Office for Aboriginal and Torres Strait Islander Health</td>
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<td>OIPC</td>
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Chapter 1 - Study Context

Introduction

The initial idea for this project was to study an apparent disconnect between high Indigenous health needs and low resource allocation. Indigenous life expectancy (for the period 1996-2001) was 17 years less for both males and females compared to non-Indigenous people (1). Health expenditure figures (2004-05) show only seventeen cents more spent on the health of Indigenous Australians compared to non-Indigenous Australians (2). Many decades of reports of poor Indigenous health describe it as distressingly poor, shocking, appalling, disastrous, disgraceful, damming, a sad indictment, and a national crisis (3-11).

It seemed to me that decision makers were not listening to the evidence - perhaps a problem of evidence to policy transfer. However, Professor Ian Anderson encouraged me to think in terms broader than ‘evidence’ to one of knowledge in its different forms (12). Subsequent reading of policy literature showed that the latest thinking was about ‘transformation’, where information was transformed into knowledge by political, cultural and social values (13-15).

This rang true with my experience in Indigenous health where ‘politics’ was the key ingredient in health decisions, and health research evidence was (sometimes) used to support particular arguments. Since 1995 my work experience in the Indigenous health sector included positions of a less influential nature from health promotion, project management, policy advice, and lecturing. These occurred in a variety of organisations: an Aboriginal medical service, commonwealth and state governments, and universities. From many meetings between and within these different organisations, I knew that political negotiation behind the scenes was a normal process used in order to make pre-decisions which could then be validated in the official forum.

I was aware of the informal negotiations, some of the people involved and the political tactics used, and with some experience I could foretell the outcomes of some meetings.

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1 The term Indigenous is used here to refer to Australian Aboriginal and/or Torres Strait Islander people and is capitalised when denoting this specific social group rather than indigenous peoples more generally.
It is evident in a wide range of Indigenous affairs literature that Indigenous and non-Indigenous people interact, formally and informally, inside and outside their organisations, to influence policy (16-18). The importance of informal networks is contained in the truism ‘It’s not what you know, but who you know’ (19). The study shifted from evidence transfer to the knowledge transformation that occurs in informal networks.

I had been involved in some informal networks. The ice breaker easing my entry into them was always conversations about my personal story. The predominant memories of my life are grounded in a set of experiences that seem common amongst many Kooris, but I am Indigenous, English and Latvian. Being passionate about improving Indigenous health was directly the result of encouragement from my Nan to be educated in the ‘white man’s way’ as she put it. These aspects of my personal story proved compelling in informal discussions such that I became introduced into other people’s networks.

Coincidentally, during the second year of the study (2004) the New Arrangements in Indigenous Affairs were announced which cast networks (although not deliberately) as the primary way to govern Indigenous affairs and to acquire Indigenous peoples’ advice (21-23). Some necessary questions about informal networks are: who is involved, how do they work, and how do you become involved in them? In more general terms, what are the features of participation of Indigenous people in an informal network of influential people?

A suitable method was required to investigate the composition and structure of informal networks. Professor Anderson directed me to the policy networks approach of Dr Jenny Lewis (24). Discussions with Dr Lewis proved pivotal in seeing networks as a way to conceptualise national Indigenous health policy as ongoing interactions between a variety of different people located in various components of the Australian health system (see Chapter 2).

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2 My grandmother, Marjorie Woodrow, has published her story about tracking her origins (20).
One site for these interactions is the many national health committees that provide ongoing advice to governments. They offer important routes for Indigenous advice to influence the outcomes of national health policy. Some questions about committees are: how many Indigenous people participate in them and where, what are the interrelationships between committees, and how does advice travel to the ultimate committee of Cabinet? These questions infer a more general question, what are the features of participation of Indigenous people in national health committees?

The lack of Indigenous people employed in governments at senior (decision making) levels is one reason cited for the lack of any significant improvement in Indigenous health (25). However, it is obvious in Indigenous affairs literature that senior non-Indigenous people have strong personal relationships with, and use advice from Indigenous people in their formal decisions (26). Indeed, as I became more ‘known’ and ‘trusted’ in informal networks, I was invited to meetings with senior decision makers. This would not have occurred through the traditional hierarchical processes. It was then necessary to consider relationship dynamics by asking what are the features of the interpersonal relationships between influential people in national Indigenous health policy processes?

The study had shifted dramatically in focus from evidence transfer to the knowledge transformation that occurs in informal networks and national health committees. A further shift was precipitated by ongoing discussions with Dr David Thomas. I made the decision in 2007 to focus on the concept of ‘participation’ as a locus for thinking about how Indigenous people take part in many different policy processes. The concepts of participation and network fitted together nicely. The overarching question of the study is what is the nature of Indigenous people’s participation in national Indigenous health policy processes?

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3 You will notice in the study forms (Appendix A) that the survey questionnaire is couched in terms of research to policy transfer, and that the interview was couched in terms of knowledge and policy making. This shows that the transformation of the focus of the study from evidence to policy to an exclusive focus on participation evolved during the study.
The importance of participation of Indigenous people

The basic purpose of Indigenous people’s participation in policy processes is for the resulting policies to include the perspectives of Indigenous peoples’. As policies stand as a framework for the development of strategies, resource allocation, and health service provision and so on, then arguably Indigenous perspectives would be flow through into the operationalisation of policies. The resulting policy outcomes may then be more effective in improving Indigenous peoples’ health status. Thus the importance of the participation of Indigenous people’s in health policy processes is linked to improved health gains and broader concerns of redressing social inequalities.

In the earlier history of Australia, Indigenous people were excluded from formal participation in policy processes and the decisions taken that affected their lives, as I outline further in Chapter 2. This exclusion may account for some of the current inequities across a wide range of areas from health to education to employment. There are now over forty years of history of formal processes to include the participation of Indigenous people in national policy processes. However, although there have been some positive developments, Indigenous health and social well-being remain stubbornly worse than that of the general Australian population

Indigenous disadvantage

In 2006 the Australian Indigenous population was 410,000 people or 2.2% of the total Australian population (27). In 1997, the Australian Bureau of Statistics, Australia’s national statistical agency, released the first report of a biennial series entitled The Health and Welfare of Australia’s Aboriginal and Torres Strait Islander Peoples (28). These reports present a comprehensive statistical overview of health, welfare and socioeconomic indicators (29). In the 2005 report, Indigenous life expectancy at birth was approximately 17 years less for Indigenous people than non-Indigenous people, and the infant mortality rate was almost three times that of non-Indigenous infants (30). However, there were improvements in Indigenous all-cause mortality, deaths from circulatory diseases, infant mortality, and hospitalisations from pneumonia (31).
Indigenous people are disadvantaged across a range of socioeconomic factors that impact on health. The following statistics from the report *Overcoming Indigenous Disadvantage: Key Indicators 2007* describe some of this disadvantage (32).

1. Life expectancy at birth (in 2006) was 59 years for Indigenous males compared with 77 years for males in the total population, and 65 years for Indigenous females compared with 82 years for females in the total population.

2. Indigenous people reported an increase in the number of long term health conditions for which they had higher rates than non-Indigenous people. In 2001, Indigenous people reported higher rates of asthma, diabetes/high sugar levels and kidney disease than non-Indigenous people. In 2004-05, Indigenous people also reported higher rates of arthritis, back pain/problems and heart and circulatory diseases.

3. In terms of education (in 2006/7), twenty-one per cent of 15 year old Indigenous people were not participating in school education, compared to 5 per cent for non-Indigenous 15 year olds; and Indigenous students were half as likely as non-Indigenous students to continue to year 12.

4. The unemployment rate for Indigenous people of 12.9 per cent was about 3 times the rate for non-Indigenous people of 4.4 per cent in 2004-05.

5. The gross weekly household income (in 2004-05) for Indigenous people was $340 compared to $618 for non-Indigenous households; and over half of Indigenous people (51.6 per cent) received most of their income from government pensions and allowances.

6. A much lower proportion of Indigenous adults (27.4 per cent) than non-Indigenous adults (73.7 per cent), lived in homes owned or being purchased by a member of the household (in 2002); though the proportion of Indigenous adults living in homes owned or being purchased by a member of the household increased from 21.5 per cent in 1994 to 25.4 per cent in 2004-05.

7. Three in every 1000 Indigenous people were hospitalised for non-fatal intentional self-harm, compared with 2 per 1000 non-Indigenous people (in 2004-05).
8. Indigenous children (in 2004-05) were nearly four times as likely as other children to be the subject of a substantiation of abuse or neglect.

9. The hospitalisation rate for assault (in 2004-05) for Indigenous people was 17.3 times the rate of non-Indigenous people; and Indigenous females were 44.1 times more likely to be hospitalised for assault than non-Indigenous females.

10. Indigenous people (in 2006) were 12.9 times more likely than non-Indigenous Australians to be imprisoned.

**Inequitable resource allocation**

In the past, Australian Government legislation resulted in the systematic exclusion of Indigenous people from a range of benefits (33). Now, health and welfare services are provided according to a principle of equity - access to health care should be proportionate to need rather than ability to pay (34, 35). Australian Government Indigenous affairs expenditure has increased from $13,000 in 1967-68 to $3.5 billion in 2007-08 (36, 37). Nevertheless, it is argued that primary health care provision (expenditure) on Indigenous health is inequitable for greater Indigenous health needs (34, 38-41).

The Australian Institute of Health and Welfare, Australia’s national health and welfare statistics and information agency, in 1998 produced the first comprehensive statistical report on expenditure in Indigenous health, entitled *Expenditures on Health Services for Aboriginal and Torres Strait Islander People* (2, 42-44). The report of 2008 stated that ‘between 1995–96 and 2004–05 there has been little change in the per person health expenditure ratio for Indigenous compared to non-Indigenous Australians’ (2:x). The key figures are that $1.17 per Indigenous person was spent compared to $1.00 per non-Indigenous person (for the period 2004–05) (2).

The key decision-making body for Australia’s national budget is the Expenditure Review Committee (ERC) of Cabinet (45). In 2001 the Commonwealth Grants

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4 The legend of committee acronyms is provided as an insert and is valid for the entire thesis.
Commission released the findings of its *Inquiry into Indigenous Health* (39). In its recommendations to ‘promote a better alignment of funding with needs’ was a principle for ‘the full and effective participation of Indigenous people in decisions affecting funding distribution and service delivery’ (39:xvii). There was no detail provided defining the phrase ‘full and effective participation’ and how this would fit with the governance structures of the Australian health system.

Beyond asserting the fundamental principle of ‘Indigenous Indigenous people’s participation’ there are few direct or explicit references in publications or research about the mechanics of how Indigenous participation is operationalised in the context of Australian society and government, the Australian health system, or within the Indigenous health sector. I now provide a brief overview of each of these areas and the status of Indigenous participation in these areas.

**Australian society and government**

Australian society is tolerant and socially inclusive as seen in the acceptance of cultural diversity and various freedoms (speech, association, assembly, religion and movement). It is a Western liberal democracy governed in accordance with the Australian Constitution (1901) that ensures a sharing of power between six states, two territories, and the Australian Government (46-48). There are more than eight hundred and fifty local government areas established under the legislation of the States (35). This federal system of intergovernmental relations means that the Australian Government has the fiscal responsibility, as it collects about eighty per cent of all tax revenue, and the States have functional responsibility to provide services (35).

The Australian Government provides a unified approach to some common matters of national interest (46). It governs through three institutions according to a separation of powers based on the notion of responsible government (47). The Australian Parliament makes the laws (the legislative branch), the Executive implements and supervises the

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5 The Commonwealth Grants Commission is a statutory authority whose role is to provide advice to the Australian Government, in response to terms of reference from the Treasurer, on matters of federal financing.

laws (the executive branch), and the Courts interpret them (the judicial branch) (35, 46). The Australian Parliament is bicameral with the House of Representatives (226 members) and the Senate (76 members) (48).

**Citizen participation**

Participation in health policy processes is but one aspect of a broader notion of citizen participation. Australian citizens over the age of eighteen have the right to vote, or stand as a candidate, in an election for the Australian Government, as well as in State elections. Australian citizens can choose from a total of sixty two registered political parties (48). The political party that gains the majority of seats in the House of Representatives choose parliamentarians (from the House of Representative and the Senate) to become ministers (there were thirty one ministers in 2004). All ministers are members of the Federal Executive Council (FEC or the Executive branch). The Cabinet (there were seventeen ministers in 2004) is drawn from the FEC and the Cabinet chairperson is the Prime Minister.

Cabinet can be considered the ‘board of directors’ of government because it is where the political and policy decisions are made, where most bills (draft legislation) originate, and its decisions are binding on all ministers (45, 49). The Cabinet shape, structure and operation are determined by the political party that wins government (49). The processes of Cabinet have evolved to deal with increased social complexity, with an increase in the number of ministers and cabinet meetings, and cabinet committees (49-51). It is recognised that the political party that forms government uses the administrative structures in accordance with its political ideology (52).

In the Australian Parliamentary process parliamentarians enact their political party’s policies by proposing draft legislation or amendments to existing legislation in the form of ‘bills’, which are seen as the formal expression of party policy (53). Proposed bills need to be authorised by Cabinet before being tabled in the House of Representatives for debate and amendment, after which they are referred to the Senate for review. If passed by both chambers, the bills receive assent by the Queen through her representative the Governor-General in Council (the Federal Executive Council) before
they become law as Acts of Parliament (53, 54). In order to set a course or principle of action a policy must travel through this process of debate and review, as have many proposals about Indigenous people (33).

Indigenous people are rarely elected into the Australian Parliament. There is the suggestion to have reserved seats for Indigenous people in the Australian Parliament as a symbol of self-determination and inclusion (55, 56). While few Indigenous people have been elected, they can also become involved in any of the thousands of lobby groups (57) or participate in the Australian Parliament as individuals involved in parliamentary committees (58, 59). However, it is only ministers who are members of intergovernmental (that it, between the Australian Government, six States and two Territory governments) committees that discuss a range of issues requiring federal coordination.

**Intergovernmental fora**

The Council of Australian Governments (COAG) is the peak intergovernmental forum in Australia, whose primary role is to increase cooperation among governments in the national interest (60, 61). It was established in 1992 under the Keating Labor Government, in order to ‘maintain discussions on intergovernmental matters’ (62:109). It comprises the Prime Minister, Premiers, Chief Ministers and the President of the Australian Local Government Association. It is the main strategic forum for the federal coordination of Indigenous affairs ‘acknowledging that Australia needs a new type of federalism to serve Indigenous people where the responsibilities of different levels of governments are clarified’ (21:19).

Established through the authority of the COAG are intergovernmental Ministerial Councils (there were thirty-one in 2004) only some of which are directly relevant to Indigenous health. The Ministerial Council for Aboriginal and Torres Strait Islander Affairs (MCATSIA) was ‘established as a forum to discuss issues of mutual interest and to consider reports on relevant government activities’ (60:18). The voting members are Australian Government and State Government Ministers with responsibility for

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7 The legend of committee acronyms is provided as an insert and is valid for the entire thesis.
Indigenous affairs. It is the ‘highest level policy advising and policy driving body on Indigenous affairs in Australia’ (63:23). MCATSIA is provided advice and recommendations from a Standing Committee of Officials in Aboriginal and Torres Strait Islander Affairs (SCATSIA). Its members are the secretaries (chief executive officers) of Australian Government and State Government departments with responsibility for Indigenous affairs.

Another COAG committee is the Health and Community Services Ministerial Council (HCSMC) with an objective to provide ‘a consistent and coordinated approach to community services and health policy, development and implementation’ (60:51). The HCSMC operates as a plenary forum for the members of the Australian Health Ministers’ Conference and the Community Services Ministers’ Conference (60). Its members are ministers of the Australian Government, State and Territory Governments, and the minister of health from New Zealand. The Australian Government’s Minister for Health is a member of the MTIA, Cabinet, and several other COAG councils (the Ministerial Council on Drugs Strategy, the Gene Technology Ministerial Council, and the Australian and New Zealand Food Regulation Ministerial Council).

The Australian Health Ministers’ Conference (AHMC) is advised by the Australian Health Ministers’ Advisory Council (AHMAC), which is responsible for the ‘overall coordination of major components of the health care system’ (64). Its members are the secretaries and senior members from the departments of health in the Australian Government, State Government, and the new Zealand Government (60). The AHMAC has many sub-committees which were reviewed in 2005 (65). The Australian Government’s Secretary for the Department of Health is a member of both the AHMAC and the Secretaries Group on Indigenous Issues (SGII). These ministerial councils and the meetings of senior officials are said to be ‘important decision-making points in the process of Australian-State negotiations’ (66:100).

**The Australian Public Service**

The Australian Public Service collectively refers to the administrative structures of government. Its entities are responsible for the implementation of laws, provision of
policy advice, facilitating delivery of programs, and performing the business of
government (67). As a whole the Australian Public Service consists of eighteen
government departments, sixty-five statutory authorities, five executive agencies and
twenty-three other government bodies (48).

The Australian Government’s administration is geared for connecting the diverse issues
of Australian society through whole-of-government coordination (68). The Australian
Government Department of Prime Minister and Cabinet is the axis of government
administration (69). It coordinates the policy of eighteen government departments (48),
thirty-one intergovernmental ministerial councils (70), numerous inter-departmental
ministerial committees (69), as well as Cabinet processes (49).

**Inter-departmental committees**

There are a number of cross-portfolio committees in the Australian Government. The
Ministerial Taskforce on Indigenous Affairs (MTIA) provides ‘high-level direction to
Australian Government policy development, as well as coordination and flexible
resource allocation to improve outcomes for Aboriginal and Torres Strait Islander
people’ (21:11). It reports to the Expenditure Review Committee (ERC) of Cabinet,
and had a membership (in 2004) of nine ministers and the Attorney-General (21). The
Australian Government Minister for Indigenous Affairs chairs the MTIA and is a
member of Cabinet, and a member of MCATSIA.

The MTIA was advised by a Secretaries’ Group on Indigenous Issues (SGII) and which
also lead coordination across government agencies. Its members were the secretaries of
departments administering the Australian Government’s Indigenous programs, chaired
by the Secretary of the Australian Government’s Department of Prime Minister and
Cabinet (21). The secretary of the Australian Government department for Indigenous
affairs was thus a member of the SCATSIA for MCATSIA and the SGII.

In summary, Australia is a western democracy of federated states and territories with a
national Australian Government whose elected citizens govern according to a
constitution. The Australian Parliament is bicameral with the majority party in the
House of Representatives selecting ministers to form the Cabinet, which is the decision-making body or Government. Ministers direct, according to party policy, the business of the Australian Public Service; discuss matters of national importance through intergovernmental committees; and coordinate Australian Government portfolios through a number of inter-departmental committees. One of the portfolios is the Australian health system.

The Australian health system

The complexity of governance structures in the Australian health system reflects the basic federal structure of intergovernmental relations. The Australian Constitution (1901) explicitly left health care for all Australian citizens and the provision of any services for Indigenous people in the remit of the State governments (71). However, the Australian Government has gradually assumed a central policy and coordination role in the health system through various amendments and interpretations to the Constitution, as well as through its capacity to raise revenue through taxation (35). I will now describe the basic elements of the health system.

Financing and expenditure

Australia spent 9.7% ($78.6 billion dollars) of its gross domestic product on health in 2003-04 (64). The sources of revenue are: about seventy percent from general taxation, which includes a small statutory insurance levy, and thirty percent from private payments (35). The distribution of health funds occurs through three schemes: Medicare (a national health insurance scheme which reimburses non-hospital private medical care of doctors), the Pharmaceutical Benefits Scheme (a subsidy program for pharmaceuticals), and the Australian Health Care Agreements (funding for public hospitals) (35). The States also receive general purpose funds from the Commonwealth, a process negotiated through the Commonwealth Grants Commission, for services such as public health provided by non-hospital organisations. In the period 2004-05, Indigenous people used services through Medicare and the Pharmaceutical Benefits Scheme at less than half the rate of non-Indigenous people (43).
Australian Government Department of Health

The Australian Government Department of Health and Ageing (hereafter the Health Department) ‘plays a lead role in negotiating and strategically developing the nation’s health care financing system’ (72:4). In the period 2007-2008, the Health Department budget was $46,057 billion, of which $619,538 million was for Australian Government Indigenous Expenditure across all divisions (73). It provides policy advice and support services to the Ministers and the Parliamentary Secretary (74). Its approach to raising the health status of Indigenous people is based on the principle that ‘a long term partnership is required to achieve sustainable gains in health status’ (75:33). It contains the Office for Aboriginal and Torres Strait Islander Health (described later) an administrative and coordinating unit which works across different Australian Government portfolios to improve Indigenous health.

Australian Government departments have service charters that set out the standards of service the public can expect (76). In these charters there are no central guidelines on ‘how and when to consult with citizens’ (77). In the 2006 Annual Report, the Health Department stated that ‘Public consultation, consumer and stakeholder participation is widely encouraged at varying levels, across all fields of policy and output delivery’ (74:342). One important formal way to participate in the Health Department is through its many national advisory committees, the subject of Chapter 4.

Health services

All levels of government and the private sector and non-profit sectors are involved in funding and/or delivery of health services (78). Health service provision is based on providing a range of services through a platform of organisations based on the concept of primary health care (34). It is acknowledged that ‘ready access to local primary health care is universally recognised as the foundation of a functioning health system’, and that ‘the current level of primary health care provision to Indigenous Australians is inadequate to meet that need’ (34:viii). Mainstream health services are those ‘health and health related services that are available to, and accessed by, the general community’ (79:37). This context refers to service coordination:
‘Comprehensive primary health care involves the delivery of a broad range of services. Whilst it is possible for a stand-alone health service to provide all the necessary service elements, it is more likely that a range of health providers and organisations will work together to provide the different service elements of the system for the given population’ (78:21).

Usually the first point of contact with the health system is through a general medical practitioner or doctor (64). Doctors may refer their patients to specialist medical practitioners, other health professions, hospitals and community organisations. Community based services can be accessed directly by citizens, for public health services such as family planning, mental health, and alcohol and drugs. Emergency medical care is usually provided through public hospitals, which provide these and outpatient services free of charge. Emergency ambulance services are not free of charge. Citizens can pay for other services either directly or through private insurance, such as private hospitals, chiropractors and physiotherapists (64).

**Health information and health research**

Both the Australian Bureau of Statistics and the Australian Institute of Health and Welfare provide independent statistical information to the Australian Government, principally through the Health Department. The National Health and Medical Research Council (NHMRC) provides policy advice, ethics advice and recommendations about research funding to the Australian Government’s Health Department (66). It is responsible to the Minister for Health who appoints the membership drawn from representatives of the major stakeholders in the health system (35, 79). The Secretary to the NHMRC is also the Head of the Office of the National Health and Medical Research Council which is located in the Health Department (66).

The NHMRC had a unique character of being a committee, an independent statutory organisation, and an institution. The annual budget was $417 million by 2005 (35). In terms of health research: ‘Consultation and other strategies that facilitate Indigenous participation are critical in all phases of this research process.’ (80:23). As such, addressing Indigenous health is a strategic research priority 5% of the research budget targeted to Indigenous health research, and the development (in 2007) of an Indigenous
health research advisory committee (81). This committee was the Aboriginal and Torres Strait Islander Research Advisory Committee (ATSIRAC).

**Workforce**

In 2005 there were 570,000 people employed in health occupations (such as doctors, nurses, dentists, allied health workers, Aboriginal health workers, and pharmacists) (64). It is suggested that ‘the capacity of the workforce is a key limiting factor in the provision of health services to Indigenous Australians, in rural, remote and urban areas’ (34:63). In 2001 only 0.9% of health care providers were Indigenous (34:63). The primary focus is to increase the numbers of Indigenous doctors and other health workers (82-84).

**The Indigenous health sector**

Improving Indigenous health is one priority of the Australian health system, that is, the administration of Indigenous health is integrated into the health system’s architecture. However, there are unique organisations, administrative units, committees, strategies and processes which comprise the Indigenous health sector, as outlined below.

**Aboriginal medical services**

The first Aboriginal medical service was established in 1971 at Redfern in Sydney (85). In the year 2000 there were one hundred and forty Aboriginal medical services collectively referred to as Aboriginal Community Controlled Health Services (ACCHS) (64, 86). They were established as a response ‘to the racism and marginalisation that Aboriginal Australians experiences in health care’ (87:10). They are seen as ‘an important institutional manifestation of the politics of self-determination…they championed Aboriginal control and participation in both health care policy and service delivery’ (71:5). Their model of participation is said to be ‘an engaged and developmental process in which community control predominates’ (88:30).
The organisational model is one where health services are ‘initiated, planned and governed by local Aboriginal communities through their elected Aboriginal board of directors’ (86:75). They represent and advocate for Aboriginal communities on a wide range of health matters, provide culturally appropriate health care, assess health needs of communities, and liaise with government departments and mainstream health services (86). They were represented at the national level by the first national health advocacy group, the National Aboriginal and Islander Health Organisation (1974-1988), which then became the National Aboriginal Community Controlled Health Organisation (NACCHO) (89).

**A national Aboriginal health strategy**

In 1987 an intergovernmental committee of health and Indigenous affairs ministers agreed to establish the National Aboriginal Health Strategy Working Party (71). It established a pattern followed in the development of national strategies in Indigenous health, notably with mostly Indigenous people including an Indigenous chairperson. After an extensive national consultation process, it released its report in 1989 entitled *A National Aboriginal Health Strategy* (NAHS). The NAHS had the key themes of land rights, self-determination, inter-sectoral collaboration, the World Health Organization’s definition of primary health care, and a definition of health referred to as ‘holistic’ (90). It is a landmark process in Indigenous health policy being the first strategy to comprehensively include Indigenous people.

Previous attempts at developing national Indigenous health plans excluded Indigenous people, often in contrast to political statements expressing more participatory processes. The Whitlam Labor government (1972-1975) adopted a policy of self-determination to ‘restore to Aboriginal people their lost power of self-determination in economic, social and political affairs’ (91:510). Then the Fraser Coalition government (1975-1983) decided that self-management as commonwealth policy would allow a ‘significant degree of participation by Aboriginal people in decision making’ (91:511). However, the 1973 ‘Ten Year Plan for Aboriginal Health’ and the 1980 ‘Program Effectiveness Review’ ‘occurred without any process for consideration of Aboriginal views on these matters’ (92:120).
**Partnership agreements**

In 1994 a review found the NAHS was ‘never effectively implemented’ (93). Part of the failure to implement the NAHS was attributed to ‘the absence of meaningful partnerships between the mainstream health system and Aboriginal and Torres Strait Islander peoples’ (78:13). In health, partnerships are said to be important because of the range of influences on health and the need to work intersectorally, so that limited resources are best utilised, and that other sectors consider the health impacts of their decisions (94). Agreements are statements of intent that can formalise and guide collaborative activity by setting out roles and responsibilities and the processes for working together (95). NACCHO states that ‘Partnership arrangements are very important to us, because at the table you can plan for broad resource allocation.’ (96:80).

A range of agreements set-out the principles of relationships between the Australian Government, State Governments and Indigenous people (97). Federal coordination is driven through three agreements of the COAG (98-100). One of these is the 1992 *National Commitment to Improved Outcomes in the Delivery of Programs and Services for Aboriginal Peoples and Torres Strait Islanders* which ‘foreshadowed the making of more specific bilateral agreements in areas such as health’(71:14). Another is the 2004 *National Framework of Principles for Government Service Delivery to Indigenous Australians* which was about ‘consolidating the new era of cooperative federalism in Indigenous Affairs’ (23:48). This meant a framework for the negotiation of bilateral agreements between the Australian Government and State/Territory Governments (23:48) which a number of states signed agreements (101). It also meant a commitment to ‘indigenous participation at all levels’ (102:3).

In 1995 the Australian Health Ministers Advisory Council oversaw the development of the *Agreements on Aboriginal and Torres Strait Islander Health* (hereafter *Framework Agreements*) which represented ‘milestones in inter-agency cooperation’ (103:13). Three principles underlie the *Framework Agreements* (104:94), namely the: acceptance of Aboriginal and Torres Strait Islander peoples’ holistic view of health; recognition of

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the importance of local Indigenous community control and participation; and intersectoral collaboration. Each of the Framework Agreements has a number of key areas one of which is for ‘Joint planning processes which allow for full and formal Aboriginal and Torres Strait Islander participation in decision-making and determination of priorities’ (105:2). The Framework Agreements, which are not funding agreements, are linked to the Australian Health Care Agreements (87:13).

**The Office for Aboriginal and Torres Strait Islander Health**

The Office for Aboriginal and Torres Strait Islander Health (OATSIH) was established in 1994 as a cross-portfolio unit within the Health Department (71). It has four strategic planks to improving Indigenous health outcomes (106:1):

1. developing the infrastructure and resources necessary to achieve comprehensive and effective health care for Indigenous Australians;
2. addressing some of the specific health issues and risk factors affecting the health status of Indigenous Australians;
3. improving the evidence base which underpins the health interventions; and
4. improving communication with health care services, Indigenous Australians and the general population.

Under these strategic planks, ‘all policies relating to the health of Aboriginal and Torres Strait Islander peoples are based on the principle of community empowerment and participation in the development and delivery of health care services and partnerships with stakeholders’ (107:166). Furthermore ‘All OATSIH funding programs aim to maximise community participation, influence and where desired by the community, control of funds and/or service delivery’ (108:16).

**The National Aboriginal and Torres Strait Islander Health Council**

The National Aboriginal and Torres Strait Islander Health Council (NATSIHC) was established in 1995 by the Health Department because it recognised ‘the importance of broad participation in service planning’ (104:84). Its membership is drawn from
Australian and State Governments, the National Aboriginal Community Controlled Health Organisation, and Indigenous and non-Indigenous people with expertise in different areas (79:47). It ‘monitors and advises on implementation of the Framework Agreements and on ways to improve the interaction between mainstream services and ACCHSs at the national level’ (78:25). The secretariat support is provided by the OATSIH. There are also similar State-based ‘Framework Agreements’ (85) or ‘partnership forums’ who undertake the joint needs analysis and planning specified in the Framework Agreements (78:23).

**Health information**

In response to the lack of accurate statistical information about Indigenous health, the Australian Health Minister’s Advisory Council (AHMAC) oversaw the development of the 1997 *Aboriginal and Torres Strait Islander Health Information Plan...This Time, Let's Make it Happen* (109). Already in development at this time was the *National Performance Indicators and Targets in Aboriginal Health* to be reported against by national, state and territory government health agencies to the AHMAC (110). Its indicators provided a ‘remarkable multi-dimensional overview of the health of Aboriginal and Torres Strait Islander peoples’ (111:19). National health indicator reports attempt to combine information from different sources in order to provide a complete picture of Indigenous disadvantage (31, 32, 111-113).

In a separate process in 2002 the COAG commissioned the Steering Committee for the Review of Commonwealth/State Service Provision (SSRCSSP) to prepare a regular report on key indicators of Indigenous disadvantage (114). The SSRCSSP was established in 1993 to monitor the performance of all government services, and comprises senior officials from the central agencies of all Australian Governments (114). The SSRCSSP, after consultation, produced a reporting framework first published in 2003 in the report *Overcoming Indigenous Disadvantage: Key Indicators* (32, 115, 116).

This framework underpins the current indicator framework in Indigenous health, the *Aboriginal and Torres Strait Islander Health Performance Framework* (34, 117). This
framework includes a tier of indicators for the broad range of factors that influence health status and outcomes, developed from the National Health Performance Committee’s *Health Performance Framework* developed in 2000 (118). The Aboriginal and Torres Strait Islander Health Performance Framework is used to report progress in the implementation and outcomes of the *National Strategic Framework for Aboriginal and Torres Strait Island Health*.

### National Strategic Framework

In 2001 the development of the *National Strategic Framework for Aboriginal and Torres Strait Island Health* (hereafter the *National Strategic Framework*) began under the auspices of the NATSIHC (119). After an extensive consultation process in 2003 the *National Strategic Framework* was released and is the national umbrella framework for activities to improve Indigenous health, augmenting but not replacing the 1989 NAHS (79, 120). All governments are signatories to the *National Strategic Framework*, agreeing to ‘multilateral, bipartisan and whole-of-government commitment to its implementation’ (34:11).

The *National Strategic Framework* includes many references of the importance of Indigenous people’s participation in decision making processes to health research to mainstream health planning processes. For example, it reaffirms the participation elements of the *Framework Agreements*, noted above (120:2). It also contains the principle that partnerships should be established and strengthened between ACCHSs and mainstream health services so that Indigenous people ‘have access to the full range of services expected within the comprehensive primary health care context’ (120:14). However, as in other policy documents, statements about Indigenous people’s participation do not provide any direct or explicit references to publications or research about the mechanics of operationalising participation in the context of Australian society and government, the Australian health system, or within the Indigenous health sector.
Developmental context of Indigenous affairs

The purpose of this section is to provide some understanding of the development of Indigenous people’s participation in national Indigenous health policy. The belief in racial superiority ‘played a defining role in the foundation of the nation’ (121:2). The first law passed by the new federal parliament in 1901 was the Immigration Restriction Act, which evolved to be a series of rules, resources and structures termed the ‘white Australia policy’ lasting from 1901 to 1973 (121). This did not officially end until the introduction of the Racial Discrimination Act 1975 (122).

Racial marginalisation

Many publications provide detail about the historically located social values and their reflection in the ‘race clauses’ of the Australian Constitution (1901) and as expressed in legislation and practice (17, 18, 123-128). It is claimed that ‘every act imposed on Aboriginal people between the 1890s and the 1960s can be classified as an example of institutional racism’ (129:34). As a result Dr John Gardiner-Garden has characterised the first century and a half (1788 to 1938) of European-Indigenous relations in Australia as a ‘period of dispossession, physical ill-treatment, social disruption, population decline, economic exploitation, codified discrimination, and cultural devastation’ (130). Indigenous people were seen as a ‘doomed race’ whose extinction was thought inevitable and that all that was to be done was to record anthropological and other data about Indigenous people for ‘science’ (131).

However, many non-Indigenous people had been outspoken about the poor treatment of Indigenous people since settlement (16-18). Prior to Federation in 1901, humanitarian societies ensured that their concern for the welfare of Indigenous people made an impact (132). Nevertheless, the discussions and debates informing the writing of the Australian Constitution (1901) did not include Indigenous people (133).

In 1937 a Commonwealth-State Native Welfare Conference was held and it was the first time that Aboriginal affairs had been discussed at the national level (134). A policy of ‘absorption’ was adopted for ‘natives of aboriginal origin, but not of the full bloods, lies in their ultimate absorption by the people of the Commonwealth’ (134). The term
‘absorption’ refers to the loss of physical characteristics through interracial relationships (135). The policy of ‘assimilation’ was adopted at the third conference in 1951, and again in 1961 and 1965 (134). This refers to ‘cultural assimilation’ where it was believed that Indigenous people could be taught how to live as non-Indigenous people (135).

**Pressure groups**

Having been excluded from participation in formal processes, Indigenous people influenced social policy through social networks and interest groups (16, 33, 85). Indigenous political organisations based on state, regional and local interests began to be founded in the 1920s and 1930s (16). The first national advocacy body was the Federal Council for the Advancement of Aborigines (later the Federal Council for the Advancement of Aboriginal and Torres Strait Islanders - FCAATSI, 1958 to 1972). It was a multicultural organisation whose leadership included many non-Indigenous people (16). Initially, it focussed on promoting citizenship and civic rights for Indigenous people (the right to vote, access to welfare or employment) (85). One of its co-founders, Gordon Bryant, later became the first Aboriginal Affairs Minister in the Whitlam Labor Government (1972-1975).

It was in 1965 that a student group called the Student Action for Aborigines organised the Freedom Rides lead by Indigenous activist Charles Perkins (also a member of FCAATSI) (16). Indigenous land rights became a significant campaign issue for the FCAATSI and many other pressure groups after a strike of Indigenous stock workers in 1966 lead to the Gurindji land claim (16). In 1969 the Yolgnu on Gove Peninsula challenged the doctrine of ‘terra nullius’, a bid which failed at the time until the Mabo decision in 1992 (16). The momentum for land rights reached its apogee in the establishment in 1972 of the Aboriginal Tent Embassy on the lawns of Australia’s Old Parliament House (136).
**The Constitutional referendum of 1967**

The decade-long advocacy lead by the FCAATSI resulted in the 1967 constitutional referendum (85, 137). The social attitudes of ministers from the Australian and state governments at the time was evident in the 1965 Native Welfare Conference (134). The Ministers reaffirmed the policy of assimilation (138:3):

‘The policy of assimilation seeks that all persons of Aboriginal descent will choose to attain a similar manner and standard of living to that of other Australians and live as members of a single Australian community-enjoying the same rights and privileges, accepting the same responsibilities and influenced by the same hopes and loyalties as other Australians’

In the activities leading up to the referendum and thereafter, Anderson (2003) stated that ‘the Indigenous movement at this time drew heavily on existing social networks within indigenous Australian communities as well as on political allies in the non-indigenous society’ (85:229).

The successful referendum of 1967 to remove the ‘race clauses’ of the Australian Constitution (1901) is seen as a watershed in Indigenous affairs policy (85, 139). The significance of the referendum lies in its symbolism and its head of power for legislative changes (139). For example, the Australian Government could fund Indigenous health programs and ‘develop a lead role in national health policy and strategy’ (87:10). Thereafter, Indigenous participation shifted from being solely through social networks and interest groups, following the development of formal processes for Indigenous participation in national policy.

**The beginning of participation experiments**

The Liberal-Country Party government led by Harold Holt responded to the referendum by establishing the Council for Aboriginal Affairs (CAA, 1967-1976) (138). Thus began the various ‘experiments’ by governments to gain Indigenous representation
(137, 140). The establishment of the CAA also marked a shift from the policy of assimilation to self-management and self-determination (141).\(^\text{10}\)

This era saw the rise of community participation and consumer involvement in mainstream health care, a period of social revolution (environment movement, women’s movement, anti-Vietnam war protests) (143). There were ‘New Left’ policies of self-management and participatory democracy, with strong links to human rights (144, 145). The Whitlam Labor Government (1972-1975) was elected after twenty-three years of Liberal government (1949-1972).

In Indigenous affairs, a new political terrain emerged by 1972 where the focus was on Indigenous autonomy and Indigenous rights, through principles such as sovereignty, self-determination, and community control (85). Indigenous activists operated in a political context of anti-colonial subversion (85). In 1970 a group within FCAATSI formed a separate organisation (National Tribal Council) to better reflect the value of Indigenous autonomy (16). The FCAATSI continued but soon ‘became a pale shadow of its former self’ (16:21) being renamed in 1975 as the National Aboriginal Islanders Liberation Movement.\(^\text{11}\) A unified national Indigenous advocacy group did not emerge in the new political terrain. Subsequent coalitions of Indigenous organisations have failed to remain together (130, 146).

Amongst the many reforms initiated by the Whitlam government, such as the first national health insurance scheme leading to the current Medicare system, it initiated the Aboriginal Councils and Associations Act 1975. This legislation was enacted in 1978 after lengthy debate and some modification by the Fraser Liberal/Country Party government (147). It is the mechanism that allows for the direct federal funding (bypassing the States) of thousands of Indigenous organisations (141). Now, there are more than three thousand Aboriginal organisations (148), each with their formal structures for Indigenous governance (149). This diversity of organisations has also

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\(^{10}\) Self-determination ‘was the idea that Aboriginal people should be involved in the management of their own affairs’ (142:3).

\(^{11}\) See the papers of Charles Perkins at http://nla.gov.au/nla.ms-ms8047
become a maze of representative structures through which different Indigenous advice can be given to government departments (150).

From the CAA in 1967 onwards there have been many changes to the participation structures, policy processes, and administrative arrangements in Indigenous affairs (142, 151). The details are beyond the scope of this overview suffice to say that only one piece of research, based on interviewees and documentary research, has been conducted focussing on the development of Indigenous participation mechanisms (137, 140). That research shows that Indigenous participation mechanisms are vulnerable to changes in government, social values, and tensions between different Indigenous groups.

**The Aboriginal and Torres Strait Islander Commission**

A significant point in the history of Indigenous affairs occurred in 1987 when the Hawke Labor Government (1983-1991) announced its intention to establish the Aboriginal and Torres Strait Islander Commission (ATSIC) (152). It was not until 1990 that the ATSIC (1990-2004) was established as a statutory authority ‘to ensure the maximum participation of Aboriginal persons and Torres Strait Islanders in the formulation and implementation of programs’ (153:15). Significantly, it combined both representative (Indigenous members elected through democratic election processes) and executive roles (such as decision making capacity on resource allocation) (142). The ATSIC was administratively outside the mainstream structures of the Australian Government, and had responsibility for Indigenous specific programs including health.

Upon the release of the NAHS in 1989, a National Council for Aboriginal Health (1990-93) was established to oversee the implementation of the NAHS. The National Council for Aboriginal Health had secretarial support through the ATSIC, and was a standing committee reporting to the Australian Health Ministers’ Conference and the Australian Aboriginal Affairs Council (forerunner of the COAG’s MCATSIA) (104, 154). In a move seen to reflect the representation of the ACCHSs and the NACCHO on the National Council for Aboriginal Health, it passed a resolution that Indigenous health funding be transferred from ATSIC to the Health Department (71). This transfer was sought because within ATSIC, the ACCHSs were in ‘unwanted competition for
resources with other Aboriginal community controlled organisations’ (104:126). Furthermore, there was ‘resentment’ from the ACCHSs that the majority of resources for the NAHS were directed outside of the health sector, even though they supported concepts such as inter-sectoral collaboration (155).

The National Council for Aboriginal Health met only four times, commencing in 1992 (156). Sustained mechanisms for participation did not occur until the transfer of Indigenous health from ATSIC in 1995 to the Health Department, and the development of the Framework Agreements and the establishment of the National Aboriginal and Torres Strait Islander Health Council (see ‘Partnership Agreements’ subsection, above). The credibility of ATSIC was undermined by the transfer of health functions to the Health Department and by failing to engender consistent high voter turnout among the Indigenous population (151, 157). While its role was ‘subject to the powers of the Minister’ (158:234), it made deliberate attempts at advocacy rather than advice, and to distance itself from the government and ATSIC’s role as an advisory body of government (149).

**New Arrangements in Indigenous Affairs**

The changes to governance structures in Indigenous affairs continued in 2004 when the Howard Liberal/National Coalition Government (1996-2007) abolished the ATSIC and implemented a number of reforms, known as the New Arrangements in Indigenous Affairs (hereafter the New Arrangements) (21). From the beginning of the Howard Government’s leadership many changes in Indigenous affairs occurred underlain by the principles of ‘shared responsibility’ and ‘mutual obligation’ (21, 159). The New Arrangements were underpinned by the principles of shared responsibility, partnership, whole-of-government processes, a regional focus, flexibility, and outcomes (21:1-2).

Although not deliberately, networks became the primary way of gaining Indigenous people’s participation in coordinating administrative activities (governance) and gaining advice from Indigenous people (knowledge management). Local Indigenous communities were able to ‘decide on their own representative networks, whether they be regions, communities, groups of organisations, clans or families’ (22:17). The
Ministerial Taskforce for Indigenous Affairs (MTIA) provided a single coordinated budget submission to Cabinet that was ‘informed by experience at the regional level, advice from regional Indigenous networks and the professional expertise represented on the National Indigenous Council’ (21:6). The National Indigenous Council was composed of government appointed Indigenous experts providing their views as individuals rather than as representatives (160). The National Indigenous Council was disbanded in 2008 by the Kevin Rudd Labor Government (elected November 2007). The Rudd Government has introduced a number of changes which I review in the section ‘Closing the Gap’, below.

The programs administered by ATSIC were moved into different Australian Government Departments (21). The various coordination structures were required to work together ‘as reflected in the network of cooperative structures from top to bottom – from the Ministerial Taskforce to the ICCs [Indigenous Coordination Centres]’ (22:5). Networks were formed to facilitate departmental administration where ‘the Department began work on the process of establishing a Solutions Brokers network to support the Department’s engagement in SRA [Shared Responsibility Agreement] and Regional Partnership Agreement’ (161:182).

Whole-of-government coordination and administration of programs now occurs through the Office of Indigenous Policy Coordination (OIPC) within the Department of Families, Housing, Community Services and Indigenous Affairs (21:15). Each satellite OIPC in each State is responsible for the administration of the multi-agency Indigenous Coordination Centres (ICCs) (23). The ICCs are the vehicle for whole-of-government coordination, engagement and managing the delivery of Australian Government programs at the local level (23). They are ‘Indigenous people’s way to talk to government’ (23:2). The Health Department worked with the OIPC to align administrative processes in terms of whole-of-government coordination (74).

The inter-relationships between different structures is represented in terms of diagrams, such as the two reproduced below. The first represents the ‘national policy and planning structures’ in health (79:26) and the second represents the national framework for the

New Arrangements (23:3). They represent a continuing process of developing mechanisms and processes to govern Indigenous affairs and engage with Indigenous people.
**Closing the Gap**

In the debate preceding the changes to ATSIC in 2004 both the Liberal/National party coalition government and the Labor party opposition stated that they would abolish ATSIC (162). In contrast to the Howard conservative government which refused to say ‘sorry’ to the Stolen Generations of Indigenous people, Prime Minister Kevin Rudd issued a national apology to the Stolen Generations at the opening of Australian Parliament in 2008 (163). However, in general terms the Rudd government has retained many of the administrative changes of the *New Arrangements* outlined above, although changing the wording to ‘Whole-of-government arrangements in Indigenous Affairs’.\(^\text{13}\)

It disbanded the National Indigenous Council and is conducting consultations on the development of a National Indigenous Representative Body, with no outcomes as of September 2008.\(^\text{14}\)

In March 2008, the Rudd government signed a statement of intent to ‘close the gap’: the seventeen year life expectancy gap between Indigenous and non-Indigenous people. The ‘Close the Gap’ campaign was developed by the aid organisation OXFAM and more than forty other organisations (11). As part of the effort to reduce the life expectancy gap the Rudd government, in March 2008, announced the establishment of the National Indigenous Health Equality Council (164). Whatever changes this or future governments make, a key theme will be to effectively link the different elements of different sectors together in order to improve Indigenous health outcomes.

**Network analysis and health policy**

The network metaphor is a way to describe how actors (from people to organisations to countries and so on) are linked together in political, social or economic life (165). The links between people are routes of influence where material and non-material resources are exchanged to pursue shared interests ‘acknowledging that cooperation is the best way to achieve common goals’ (166:254). The field of social network analysis focuses

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on examining the patterns of relationships between actors and the implications of different network patterns for social processes (167). It is the established patterns of relationships which are seen to shape and constrain, thus policy networks may be seen as ‘more or less stable patterns of social relations between interdependent actors, which take shape around policy problems and/or programmes’ (168:14).

**Interpersonal influence**

The particular value of the approach taken in this study is that it focuses on the interpersonal nature of influence, rather than merely correlating positional seniority or employing organisation with influence in policy processes. The value and strength of informal and interpersonal links can be seen in Indigenous affairs. For example, Indigenous activist and academic Marcia Langton said of Charles Perkins, ‘It was a sign of being connected in the right way if someone could say at one of the many meetings of Indigenous people that were held in these heady times that Charlie had been on the ‘phone and given advice or encouragement’ (169). Indigenous activist and lawyer Noel Pearson said of Charles Perkins, ‘I was glad to make his friendship late in his life. He was a source of support and guidance to me in my hardest times. There was a lot of laughter too.’ (170). The non-material resources involved in friendship may mediate political negotiations through a ‘loosening’ or ‘flexibilising’ effect (171:267).

Being linked to other people is more effective in getting interests realised because the ‘power of individuals in any political system is greatly magnified when they form groups’ (172:81). As stated earlier, Indigenous people influenced social policy through inclusion in social networks and interest groups because they were formally excluded from participating in policy processes. The formal mathematical methods of social network analysis offer a range of methods and analytical concepts that add analytical strength to the metaphorical concept of the network. In this study I use two particular network approaches applied to data collected in the period October 2003 to December 2004, during which time the ATSIC was abolished and the *New Arrangements* began to be implemented.
**Detecting invisible groups of influential people**

In one key approach of network analysis it is possible to detect the invisible group structure of an informal network of influential people (the subject of Chapter 3). In Australia as in the United Kingdom the interests of the medical profession are said to be dominant in the health system (57, 173). Jenny Lewis used the methods of social network analysis to study the influence of the medical profession in health policy in the Australian state of Victoria (174, 175).

She identified influential policy actors by administering a network name generator in the form of a request to ‘nominate those regarded as influential’ (175). Everyone nominated was then asked to make their own list of people they regarded as influential, and so on, in what is called a snowball nomination process. Eventually few new names are being added to the whole list of influential people. The nominations of influential people provide relational data that can be used to examine the structure of a network. The way the network is structured has implications for the outcomes of policy, strategy, and resource allocation.

Lewis (2006) used the block modelling technique to identify groups of actors with similar patterns of nominations. This method aggregates the relational data without using *a priori* categories or attributes of actors (175). Subsequent analysis allows the exploration of relationships in terms other than a person’s organisation or job position. She found eight blocks or groups of influential people, uncovering ‘the cohesiveness and centrality of a group of medical professionals…despite decades of policy change aimed at reducing medicine’s power’ (175:2134). She concluded that the embedded nature of medical expertise throughout the network makes it difficult for others to be seen as influential.

**Detecting links between national health committees**

In the second key approach used in this study I used network methods to examine the links between national health committees providing advice to the Australian government (the subject of Chapter 4). This type of network analysis is usually applied to detecting intercorporate and interpersonal networks of boardroom contacts among the
directors of companies (176). Given the significance of committees (intergovernmental, interdepartmental, and advisory committees) as decision making and organising points in the Australian health system (see Figure 1 above), then interpersonal networks may be significant for the strategic acquisition and use of information.

In complex societies and health systems, information is an important resource which often depends on making and maintaining contact with the right people (177). However, descriptions in Australian health policy publications focus on individual committees (21, 66, 79, 87, 104, 123, 127, 128, 143, 178-191). Seeing committees as interlinked involves collecting the membership data of the committees, and then determining which people link which committees. The result is a network of committees linked through common members. One can then analyse the committee network to determine the importance of committees and who links them.

**Thesis structure**

The resulting approach of the study combines quantitative and qualitative methods through the perspective of a policy networks approach (Chapter 2). The first quantitative analysis is of the informal network of influential people in national Indigenous health policy (Chapter 3). The second quantitative analysis is of the system of national health committees (Chapter 4). The qualitative component focussed on determining and describing the opinions of influential people involved in national Indigenous health policy processes (Chapter 5). I unify the findings from the three data streams in a discussion of their implications for policy, research and practice in national Indigenous health policy (Chapter 6).
Chapter 2 - Investigating Participation

*Vague participation*

The purpose of the study was to identify and describe the nature of participation. The concept of ‘nature’ can be defined as ‘the basic or inherent features, character, or qualities of something’ (192:1172). In this study the ‘something’ is participation which is defined as ‘the action of taking part in something’ (192:1283). In this chapter my purpose is to provide the context for the methods used, further detail of which is contained in the three data chapters (Chapters 3, 4, and 5).

The concept of participation has potent symbolism yet is often left wanting due to detailed exploration of the context, processes and mechanisms by which it might be operationalised (145, 193, 194). Participation can occur at different levels from individual care, health services planning and review, to health system policy development (195). Different processes are thus required for different levels and different purposes. Such processes include commissions, committees, task forces, forums, reference groups, steering and advisory committees (196). For example, the Consumer Focus Collaboration (2000) listed forty-three strategies and techniques that can be used for consumer participation in different types of health care organisations (197).

A key principle of Indigenous health policy is the participation of Indigenous people in national policy processes. Among the multiple factors which contribute to the continuing poor Indigenous health one is ‘a lack of involvement of Indigenous people in policy and decision-making processes’ (25:12). This statement is an example that in the Indigenous healthy policy literature the concept of participation is used vaguely without form or limits. In the many policy documents containing statements about participation, none contained any reference to publications about definitional, conceptual, or implementation issues pertaining to participation (39, 79, 80, 104, 107, 108, 120, 198).

The vague use of the concept of participation is seen in two key committee reports separated by two decades. In the 1979 report *Aboriginal Health*, the House of
Representatives Standing Committee on Aboriginal Affairs stated that ‘the level of ill health will only be reduced…if there is maximum participation by Aboriginals in all stages of the planning and delivery of health care’ (199:iii). A little over two decades later in the 2000 report *Inquiry into Indigenous Health*, the House of Representatives Standing Committee on Family and Community Affairs stated that ‘The Committee believes there has been little meaningful dialogue arising from earlier reports…about how to ensure a greater level of community participation in the planning and delivery of health services.’ (181:28). The vagueness of the use of the term participation is underscored by the abject lack of empirical research on Indigenous health policy processes using any policy making models or theories.

Published Indigenous health literature is dominated by descriptive research on health patterns and determinants (200, 201). Publications on interest group relationships are descriptive only (71, 85, 87, 133). In both Indigenous and in mainstream health literature, the different levels of participation are most commonly expressed as a ladder (195, 197, 202-204). But it is argued that ‘policy participation is best understood as a discontinuous set of techniques, chosen according to the issue in hand and the political imperative of the times’ (205:26). Thus, a full investigation of the nature of participation should consider research about participation at different levels on different issues. This was clearly beyond the scope of single study conducted at the national level by an individual researcher.

**A networked society**

Different models and methods may be used to investigate any question. In the health policy literature there are many models that are drawn on to understand the structures, processes and outcomes of policy processes (13, 206, 207, 208). Rather than labelling any one model as being the best or the right one or the most appropriate, the models represent a continuum or spectrum of conceptual lenses that lead to different interpretations of events (13, 209). In Australia, Jenny Lewis has pioneered a particular policy network approach that combines the metaphorical and the mathematical views of networks (24). I used Lewis’s policy networks approach to investigate the study question (see Chapter 1).
The network as metaphor (such as a web of connections) is useful for describing the connections of people and organisations in a policy sector (173, 210). In many ways policy networks fit naturally with trends in Australian society and its health system. The trends signal an increasing complexity which involves the interactions of many influential people located in different components of the health system. Policy networks are seen as a way to govern the increasingly numerous stakeholder and interest groups, to share knowledge about complex issues, and to influence decisions through interpersonal bonds with influential people (13, 57, 165, 166, 175, 194, 210-214).

The developments of the Australian health system mirror broader social changes (143). Good health is defined in broad terms to reflect social models of health, and as such health is linked with a number of social policy issues (69, 215). Indigenous health is one of ten areas in the domain of Indigenous affairs (22). The poor health of the Indigenous population is also one of a number of concerns in the health system (35, 64, 74). The health system has a number of underlying principles and concepts such as equity, primary health care, inter-sectoral collaboration, and intra-sectoral integration (35, 66, 143). These concepts require principles of coordination, collaboration, and consultation that are embedded in a range of multilateral partnership agreements (35).

The Australian Government’s administration is geared for connecting the diverse issues of Australian society through whole-of-government coordination (68). The Australian Department of Prime Minister and Cabinet is the axis for government administration (69). It coordinates the policy of eighteen government departments (48), thirty-one intergovernmental ministerial councils (70), numerous intra-governmental ministerial committees (69), as well as Cabinet (49). This broader agenda for connecting government received expression in Indigenous affairs in 2004 when the Howard Liberal/National Coalition Government (1996-2007) announced a number of reforms in the New Arrangements in Indigenous Affairs (21). The Rudd Labor Government (elected late 2007) has largely continued these reforms under the banner of ‘Whole-of-government arrangements in Indigenous Affairs’.

The increasing complexity of social issues and concomitant responses to them reverberate with the multiple special reasons for Indigenous people's participation. They are ideological (distinct cultural boundaries between Indigenous and non-
Indigenous peoples), human rights (self-determination), historical (massacres, missions, stolen generations) and conceptual (different concepts of health) (71, 86, 120, 129, 216). These are permuted with the hundreds of groups that constitute Indigenous peoples, with their different local historical experiences of colonisation, and their diverse lifestyles (12). As such there are thousands of different Indigenous organisations with different models of governance and service delivery (149). Improving Indigenous health through intersectoral, multidisciplinary, partnership approaches are long-standing aspects of Indigenous health policy (79, 90, 120).

The inclusive Australian society, complex health system, connected administrative structures, and multiple special reasons for Indigenous peoples’ participation, provide a natural fit with a network view of policy processes. The underlying assumptions of policy networks differ substantially from other models or perspectives and were important in their selection for use in this study.

**Assumptions of policy networks**

In the Indigenous health context, power is seen as located with the decision making government which controls the Indigenous community (204). A ‘structural interest’ perspective emphasises power as based solely on professional position (a single relation), and has been applied to relationships in mainstream health (217) and Indigenous health (133). In contrast networks are seen as dynamic processes where power is a property of all relations between individuals and groups (175, 218). Thus, a health policy network consists of many categories of people whom are bonded together and thus interconnect the different components of the health system (24).

The outcomes of policy making are seen in terms of the core of network theory called the principle of relationality where ‘interrelated actors and their actions are interdependent’ (167:4). In general terms people bonded together work to produce changes in society which affect the work of other bonded people. Because people are bonded together to form an invisible and larger social structure (24, 165, 219), networks are a meso-level of analysis between the structural and agency perspectives of society (210, 219-221). This contrasts with the Advocacy Coalition Framework, which has
coalitions of people from multiple organisations whom nevertheless act individually as ‘instrumentally rational’ beings (207:131). The individual rationalist perspective holds that people make decisions independently of the decisions of others, in contrast to the interdependency of the relationality principle.

In networks the outcomes of policy are conceptualised as the result of complex interactions. This contrasts with the most commonly deployed model ‘stages heuristic’ or ‘phases’ view of policy making (207). A stages view organises policy processes as neatly logical, rational and systematic. Australian authors use the ‘stages’ approach in health (143), Indigenous health (204) and public policy (52). In Lewis’ (2005) view of networks, policy processes are complex and non-linear systems rather than logically mechanical (24).

That ‘policy’ is seen as ongoing interactions between people rather than concrete outputs conforms with a ‘policy as process’ perspective (13, 222). Policy as process is apparent in Indigenous health with many national level strategies constructed independent of one another and at different points throughout history (180, 223). They involve a constellation of different people in their construction through to their operationalisation via a myriad of programs (223). Therefore, Indigenous health policy is consistent with the view of policy as ‘a series of ongoing interactions between people, ideas, and structures, all of which affect each other and reshape positions and connections in an interdependent network’ (24:170).

Policy is thus more than a single statement or strategy or program. It has fluidity because from conceptualisation to operationalisation ‘policy’ involves many dynamic processes. These are iterative, interdependent activities and decisions arrayed through time and which are affected by social, political and historical contexts (143, 180, 182, 186, 206, 224). As such achieving influence through the use of interpersonal networks can short-circuit interconnected policy processes and the often convoluted ‘bureaucratic planning maze’ (225:1).

Within networks, Lewis (2005) suggests that ideas and decisions are inherently political rather than the value-free product of a rational-comprehensive search for the best solution (24). This is readily apparent in Indigenous affairs, where participation
structures repetitively appear and disband due to changes *inter alia* of political parties, politics of inter- and intra-cultural tensions, and changing social values (71, 137, 140, 226-228). However, most stakeholder analysis in Indigenous health policy reduces these complex human interconnections *a priori* to simplified dichotomous categories. People are categorised as either Aboriginal or non-Aboriginal, organisations are categorised as either mainstream or community, and cultures are categorised as either non-Indigenous or Indigenous (80, 87, 104, 229, 230).

People may form bonds on the basis of similar ideological beliefs despite differences in their conceptual filters, aspirations, needs and world views (231-235). This means that social network methods defer the selection of influential people to the people themselves (based on a definition of influence supplied in a questionnaire (175), see ‘Methods’ section, Chapter 3). Most policy research focuses on the position or reputation of the policy actor as the prime determiner of influence (236).

In social network methods only after the data is collated and analysed to determine the pattern of bonds between people is group membership determined *a posteriori* by mathematical modelling procedures (167) (see ‘Methods’ section, Chapter 3). This allows the researcher to ‘move beyond considerations of atomised individuals locked into organisational straight jackets’ (24:60). The quantification of patterns in relationships are then used to try and describe, explain and predict the outcomes of policy making (165, 166, 168, 173, 210, 238-240).

**Guaranteed but vulnerable participation**

For most of Australia’s history (1788-1967) Indigenous people could only influence social policy through informal social networks and interest groups (16, 33, 85). Considering the many developments in Indigenous affairs since the Constitutional referendum of 1967, Indigenous peoples’ participation in formal processes can be seen as guaranteed but vulnerable. Participation is guaranteed through constant reaffirmation in many policy statements and demonstrated in the variety of Indigenous organisations and consultation processes. It is vulnerable due to many changes inherent in a
democratic society with changes in social values and governments leading to rearrangement of participation structures (137, 140).

The evolution of administrative structures in Indigenous affairs continued in 2004 upon the announcement of reforms in the *New Arrangements in Indigenous Affairs* (21). Although not deliberately, networks became the primary way of gaining Indigenous peoples participation through coordinating administrative activities (governance) and through gaining advice from Indigenous people (knowledge management) (21). The composition and structure of a network affects what issues reach a health policy agenda, the diffusion of ideas and flow of information, the credibility of information, and subsequently policy decisions (167, 174, 177, 241, 242). Thus it is valuable to determine and analyse the features of participation of Indigenous people in an informal network of influential people (see Chapter 3).

The analysis of the structure of a network will place people with similar patterns of relations into the same group. In social network analysis terms they are ‘structurally equivalent’ - they have identical links to and from all other people in the network (167:356). However, the mathematical models of social network analysis are many and varied (167). Lewis (2006) applied the commonly used block modelling procedure to detect groups (blocks) of people that were similar to one another in their patterns of relations (see ‘Methods’ section, Chapter 3). The interpretation of their results is often a combination of network theory and knowledge of the field under study (167, 243).

**Interlocked corporate directorates**

The collective action through informal social networks was fundamental to the development of formal mechanisms for the participation of Indigenous people in Australia’s health system (85). Given the policy emphasis on the value of Indigenous people’s participation in formal processes it is necessary to determine and describe the features of participation of Indigenous people in national health committees (see Chapter 4).
Previously, suggested formal mechanisms have always focussed on the development of one committee to advise government (90, 93, 199, 244). However, network studies of interlocking corporate directorates reveal that all national health committees can be examined in terms of an interconnected system of advice collecting (176, 245-247). The advice may ultimately influence the decisions of Cabinet whose ministers are considered to be the Government (46, 52). Cabinet can be considered the ‘board of directors’ because it is where the political and policy decisions are made, where most bills (draft legislation) originate, and its decisions are binding on all ministers (45, 49).

It is also necessary to examine the links between an informal network and national health committees to think about the potential effect of networks on policy processes (242). Formal processes are criticised as inadequate in engaging with the informal knowledge of Indigenous people in terms of, for example, cultural interpretations of health and subjective experiences of health service delivery (12). Furthermore, participation in formal processes allows informal networking to occur (171, 248). The links between informal and formal processes are people and the focus is on the qualities of the interpersonal relationships between influential people.

**Qualities of bonds**

An examination of the qualities of the bonds is necessary because there is not a simple proportional relationship between participation and influence in policy processes. Social network research shows that it is the lasting and sustained – rather than transient – interactions which influence the long-term and stable interaction patterns of networks (168). As such a definition of influence was used in order to capture lasting and sustained interpersonal interactions (see ‘Methods’ section, Chapter 3). These interactions may vary in their degree of significance.

The sociological significance of a bond such as friendship may mediate political negotiations through a ‘loosening’ effect on political discourse (171:267). People may also exercise their influence through the use of organisational resources, personal resources, and their bonds to others (175). Furthermore, influence involves relations of authority, identification, expertise, and geographic proximity (249, 250). These
variations in the degree of significance of bonds can be measured in social network analysis where people indicate the nature of their relationship to others.

People may be asked to indicate individual or multiple relations (such as friend or relative), the direction (friend or not), content (such as information or money), intensity (such as sometimes or always) and strength (such as weak of strong) (175, 177, 251, 252). Whilst many variables can be selected it is important to balance the need for information with the time constraints required to complete network surveys (167). In Indigenous health policy literature particular emphasis is given to the value of ongoing contact between people (committees), their different cultures (cross-cultural training), employing organisations (partnerships), and education (Indigenous content), and the development of friendships (personal stories) (85, 169, 253-255). While these variables were selected in this study, it was also important to gain an understanding of the cultural and social-psychological aspects - or ‘stories’ - that are imbued in bonds (221, 250).

I obtained the opinions of influential people through the use of semi-structured interviews which allow an in-depth exploration of the features of interpersonal relationships (Chapter 5). Semi-structured interviews are not the only method suitable for obtaining subjective opinions of people (232). In Indigenous health research, focus groups and workshops are widely used (80, 256). These group methods are unsuitable for obtaining personal opinions about using interpersonal influence through informal networks.

**Dynamic social phenomena**

The institutional and socio-political context affect people’s behaviour and interactions, and the way they operate and affect policy (173, 210, 257). The changes in social values of Australian society are arguably reflected in principles underlying national policies through time, from separation and protectionism to assimilation to self-determination to mutual obligation (123, 130). In reading the history of experiments with structures for Indigenous peoples’ participation, the dominant motivation behind participation for Indigenous activists was about influence to gain control, while for governments it was about influence to gain advice (137, 140). A fine grained analysis of the three data
streams - informal networks, national health committees, and interview data - requires synthesis with the historical and contemporary context (Chapter 6).

This contextualisation process reveals that networks are social phenomena that ‘can not be assumed to remain in stasis’ (167:58). This means that a test and re-test for reliability is invalid because repeating the same snowball nomination method at a different time may result in a different network composition (167, 175). However, network studies show that people are better at reporting on their routine and established relations and interactions (251). Social networks analysts argue that it is the stable patterns of relations that give rise to a structured social environment (167).

The social environment now is vastly different than that in the relatively recent (since 1967) and certainly more distant past of Australian history. There are remarkable changes from anti-discrimination legislation, to a plethora of affirmative participation statements, to thousands of Indigenous organisations, to innumerable consultation mechanisms, and to ongoing advisory committees. These have occurred due to an enormous amount of energy by people connected by shared values such as human rights and self-determination (16). Further developments in participation processes will be helped by this multi-method study to determine and describe the nature of participation of Indigenous people in national Indigenous health policy processes.
Chapter 3 - An informal network of influential people

Introduction

Australian governments have a long history of experimenting with mechanisms to gain Indigenous peoples participation in national policy processes (85, 137, 140). The mechanism usually deployed is that of formal committees drawing on official representatives of civil society organisations.\(^{15}\) This shifted in 2004 to more reliance on informal networks drawing on an invisible web of informants. In this chapter I will describe the features of Indigenous people’s participation in an informal network of influential people in national Indigenous health policy (for the period October 2003 to August 2004).

Methods

In network research a network can consist of companies or countries or people or other entities. A different approach to data collection is required in each case. Surveys are most appropriate when the sample population is people and the relations that are being studied are ones that the they can report on (167:45). The survey used in this study is contained in Appendix A. I describe below the survey’s salient elements: a network name generator, a definition of influence, questions about relational variables (degree of contact and affiliation with other influential people), and questions about demographic information (gender, organisation, position, Indigenous status). Thereafter, I describe the process of survey administration, data collection and data analysis.

Network survey design

The survey was designed based on the network studies of Dr. Jenny Lewis (174, 175, 242), and all of its elements re-configured through discussions with Professor Anderson

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\(^{15}\) Civil society organisations are those that ‘work in an arena between the household, the private sector and the state to negotiate matters of public concern’ (193:6). These include: non-governmental organisations, faith-based institutions, community groups, professional associations, trade unions, media organisations, research institutes and think tanks.
and Dr. Lewis. A network name generator asked people to generate a list of names (called free recall) of any size (called free choice) (167:46-47). Survey recipients were asked to ‘list the people you regard as having considerable influence in the Indigenous health sector in Australia’. The definition of influence supplied was:

A demonstrated capacity to do one or more of the following: shape ideas about policy, initiate policy proposals, substantially change or veto others’ proposals, or substantially affect the implementation of policy, in relation to Indigenous health. Influential people are those who make a significant difference at one or more stages of the health policy process.

Survey recipients were asked to provide information on the bonds (relations) they had with other people: their type, direction and strength. The choice of relational type and associated variables depends on the nature of the subject and research question, resources available for the study, tools and techniques available for data collection, and the length and complexity of the survey (252). In this case there were two relational types: affiliation (friend, work colleague or relative) and contact frequency (ongoing, met but no ongoing contact, or never met). Each relational type describes the social significance of a bond. For example, the ‘relative’ variable for the ‘affiliation’ relation was chosen because of the significance attributed to family ties referred to in Indigenous policy literature (79). I collected demographic information about gender, Indigenous status, organisation, job position and jurisdiction.

**Survey administration**

The completed survey was administered using a snowball nomination process. This process is necessary to enumerate networks of unknown size and composition (167:45). The first set of people to receive the survey can be identified through a positional, reputational, or modified method.

Positional methods use organisational charts and assume that influential people are in the top levels of organisations. This favours people with impressive titles and may exclude important community groups or individuals (174, 258). Reputational methods use ‘elites’ to nominate influential people. This favours the selection of friends, neighbours, or vocal actors (175). A modified reputational method, for example as used by Lewis (174), may be more suited to health policy networks. Influential people are to
be found in different components of the health system (from high level policy forums, service delivery organisations, to interest groups). Relying on organisations or elites alone misses this complexity.

I chose the first set of people in accordance with network principles and the complexity of the Indigenous health sector. The four people chosen had: a continuing and long-term engagement in the Indigenous health sector; were Indigenous and non-Indigenous; and were from different stakeholder organisations (a university, an Indigenous community controlled organisation, a state government and the Commonwealth government). The first survey was sent on 13 October 2003. The first set of people nominated a second set of people to whom they had bonds of affiliation and contact. The second set of people was contacted and nominated a third set and so on. I attempted to contact all the non-respondents by telephone.

The names of the nominees were added to a consensual list (the total number of people nominated). A decision rule needs to be applied to end a snowball process (175:2129). In this case, the process ended after two months with few new names being added to the consensual list. The last survey was sent on 25 August 2004. The de-identified survey data was entered into a Microsoft Excel database. The database was checked to remove errors and inconsistencies. It was exported into the network software analysis program Ucinet 6.117 (259).

**Data analysis**

I aimed to determine and describe the structural location of Indigenous people in the network. Firstly, I used the NetDraw (260) software to draw the network. Secondly, I applied a block modelling algorithm (in Ucinet 6.117) to detect groups in the network. This algorithm assigned influential people to groups based on the similarity in patterns of bonds between pairs of people in the network (167, 243). I varied the criterion for similarity until interpretable groups were formed (167:408, 243:131).

Thirdly, I determined the degree of interconnectivity between the network groups. This was assessed using indicators for betweenness centrality, density scores, group
prominence, and the direction of interlinks. Betweenness centrality is the proportion of times a group is on the pathways ‘between’ other pairs of groups in the network (167:188). The density score is a measure of the proportion of nominations from the members of one group to the members of another group (167:404). Group prominence is the sum of the number of links to each group (167:199). The direction of links between groups indicates whether the members of a group see the members of another group as influential or not (167:202).

The interconnectivity calculations are affected by missing data. I used a mathematical algorithm known as an Exponential Random Graph Model to simulate the effects of missing data, as in Hancock and Gile (2007) and performed using the software PNet (261, 262). The algorithm uses the original network data to generate simulated network as though all the network data were available.

Fourthly, I used the demographic information to describe the network groups (167:408). Fifthly, I determined the characteristics of bonds between influential people. These were personal indegree and the relational variables. Personal indegree is the total number of nominations a person received (167:175). Patterns in relational variables can indicate differences in bond strength (167:140).
Key features

The following three key features encapsulate Indigenous people’s participation in an informal network of influential people in national Indigenous health policy.

**Diverse**

The whole network was diverse. The influential people were Indigenous and non-Indigenous, of different genders, from different organisations and job positions, and lived in different jurisdictions. No whole network divisions were apparent based on any single variable, such as Indigenous versus non-Indigenous. The network groups were also diverse. Multiple demographic information and relational variables were needed to characterise the network and the groups within it.

**Integral**

Indigenous people were integral to the network. The network would not have existed without their participation. This is evidenced by the high proportion of Indigenous people in the network, their distribution throughout the sixteen groups, and the interconnections between the groups.

**Embedded**

Indigenous people were embedded in the network. There was a similar distribution of personal indegree scores for Indigenous and non-Indigenous people. However, Indigenous people indicated a greater number of strong combined relations with other Indigenous people, than they did with non-Indigenous people. And Indigenous people preferred to nominate other Indigenous people. Nevertheless, both Indigenous and non-Indigenous prestigious people had high personal indegree scores and strong combined relations with other Indigenous and non-Indigenous people.

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16 Personal indegree is the total number of nominations received by an individual.
17 Strong combined relations are defined as people in ongoing contact as work colleagues and/or friends.
Results

The survey return was both low and slow. Surveys were returned by all of the four people identified to begin the snowball process. These four were later nominated by others as influential in the snowball process. The consensual list grew slowly to 227 influential people (Figure 3).

Figure 3: Nomination progression

Some people (n=54) were not sent surveys because their nominations were received after 25 August 2004 (n=40), or because a postal address could not be found (n=14). Therefore, 173 people were sent surveys. There were 129 non-respondents of which only a small number of non-respondents (n=9) answered the follow-up telephone calls. They cited time constraints or over-commitments or just refused to complete survey. The survey return rate was low at 25 per cent (44/173).
This section shows that the influential people were of different: Indigenous status and gender, organisation and job position, and jurisdiction. The distribution of demographic data did not reveal any patterns of division of the whole network, as will be visually evident in the network sociogram (Figure 4).

The network contained 277 people (Table 1): with 133 Indigenous people (59%) and 94 non-Indigenous people (41%), and an average number of three nominations for both Indigenous and non-Indigenous people. The network contained 56% males (48% Indigenous, 52% non-Indigenous) and 44% females (71% Indigenous, 29% non-Indigenous).

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th></th>
<th></th>
<th>Male</th>
<th></th>
<th>Total (Indigenous status)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>p</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>a</td>
<td>p</td>
</tr>
<tr>
<td>Indigenous</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>72</td>
<td>71</td>
<td>200</td>
<td>62</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>29</td>
<td>29</td>
<td>124</td>
<td>38</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Total (gender)</td>
<td>101</td>
<td>100</td>
<td>324</td>
<td>100</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

This table includes the number of people nominated as influential (p), percentages (%), the number of nominations (n) and the average number of nominations (a).
The influential people were from different jurisdictions (Table 2): zero were from Tasmania, 4% were from South Australia, 5% were from Victoria, 10% were from New South Wales, 15% were from the Australian Capital Territory, 19% were from the Northern Territory, 20% were from Western Australia, and 28% were from Queensland.

Table 2: The nominees voting pattern by jurisdiction and Indigenous status

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Overall</th>
<th>Indigenous</th>
<th>Non-Indigenous</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>p' % P n % a</td>
<td>p % n % a</td>
<td>p % n % a</td>
</tr>
<tr>
<td>Queensland</td>
<td>63 28 27.4 166 25 3</td>
<td>50 38 126 31 3</td>
<td>13 14 40 14 3</td>
</tr>
<tr>
<td>Western Australia</td>
<td>46 20 14.4 109 16 2</td>
<td>27 20 54 14 2</td>
<td>19 20 55 20 3</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>42 19 12.5 167 25 4</td>
<td>21 16 101 25 5</td>
<td>21 22 66 24 3</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>34 15 0.9 116 17 3</td>
<td>11 8 30 8 3</td>
<td>23 24 86 31 4</td>
</tr>
<tr>
<td>New South Wales</td>
<td>22 10 29.4 53 8 2</td>
<td>10 8 31 8 3</td>
<td>12 13 22 8 2</td>
</tr>
<tr>
<td>Victoria</td>
<td>11 5 6.1 46 7 4</td>
<td>8 6 42 11 5</td>
<td>3 3 4 1 1</td>
</tr>
<tr>
<td>South Australia</td>
<td>9 4 5.6 20 3 2</td>
<td>6 5 14 4 2</td>
<td>3 3 6 2 2</td>
</tr>
<tr>
<td>Total</td>
<td>227 100 - 677 100 3</td>
<td>133 100 398 100 3</td>
<td>94 100 279 100 3</td>
</tr>
</tbody>
</table>

1This table includes the number of people nominated as influential (p), percentages (%), the number of nominations (n) and the average number of nominations (a); P = proportion of the Indigenous population of 460,140 (2.4 per cent of the Australian population).
The influential people were employed by ten different categories of organisation (Table 3): 4% by the Aboriginal and Torres Strait Islander Commission, 20% by academic organisations, a combined 26% by State, Territory and Commonwealth governments, and 33% by Indigenous community controlled organisations.

Table 3: The nominees’ voting pattern by organisation and Indigenous status

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Overall</th>
<th>Indigenous</th>
<th>Non-Indigenous</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>p (%)</td>
<td>n (%)</td>
<td>a (%)</td>
</tr>
<tr>
<td>Indigenous Community Controlled Organisations¹</td>
<td>76 33</td>
<td>201 30</td>
<td>3</td>
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<tr>
<td>Academic²</td>
<td>42 19</td>
<td>193 29</td>
<td>5</td>
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<tr>
<td>State &amp; Territory Government</td>
<td>32 14</td>
<td>97 14</td>
<td>3</td>
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<tr>
<td>Commonwealth Government</td>
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<td>109 15</td>
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<tr>
<td>Non-government Organisation³³</td>
<td>20 9</td>
<td>40 6</td>
<td>2</td>
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<tr>
<td>Aboriginal and Torres Strait Islander Commission</td>
<td>8 4</td>
<td>12 2</td>
<td>2</td>
</tr>
<tr>
<td>Other⁴</td>
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<td>3</td>
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<td>Political Party</td>
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<td>1</td>
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<tr>
<td>Mainstream Health⁵</td>
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<td>24 4</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>227 100</td>
<td>677 100</td>
<td>3</td>
</tr>
</tbody>
</table>

¹This table includes the number of people nominated as influential (p), percentages (%), the number of nominations (n) and the average number of nominations (a).
Includes ACCO (such as Central Australian Aboriginal Congress, Cape York Land Council, Aboriginal Drug and Alcohol Council), Aboriginal community controlled health services, peak Aboriginal health representative bodies.

Includes university and research organisations.

AIDS councils, foundations, associations, colleges, beneficent organisations.

Includes court, retired, private and statutory authority.

Includes hospital and community health centre.
The influential people had thirteen job types (Table 4): 1% each were Aboriginal health workers and Indigenous elders, 2% were ATSIC commissioners, 21% were chief executive officers, and were 26% directors.

<table>
<thead>
<tr>
<th>Position</th>
<th>Overall</th>
<th>Indigenous</th>
<th>Non-indigenous</th>
</tr>
</thead>
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<td>22</td>
<td>36</td>
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<tr>
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<td>7</td>
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<tr>
<td>Coordinator&lt;sup&gt;3&lt;/sup&gt;</td>
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<td>18</td>
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<tr>
<td>Chairperson&lt;sup&gt;4&lt;/sup&gt;</td>
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<td>14</td>
<td>3</td>
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<tr>
<td>Politician&lt;sup&gt;5&lt;/sup&gt;</td>
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<td>Manager</td>
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<td>11</td>
<td>4</td>
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<tr>
<td>Secretarial&lt;sup&gt;6&lt;/sup&gt;</td>
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<td>10</td>
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<td>-</td>
</tr>
<tr>
<td>Elder</td>
<td>2</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>227</td>
<td>133</td>
<td>94</td>
</tr>
</tbody>
</table>

Table 4: The nominees voting pattern by job position and Indigenous status
This table includes the number of people nominated as influential (p), percentages (%), the number of nominations (n), and the average number of nominations (a).

1 Includes director and head.
2 Includes chief executive officer, deputy chief executive officer, principal and dean.
3 Includes coordinator and project officer.
4 Includes chairperson and president.
5 Includes minister, shadow minister and chancellor.
6 Includes secretary, assistant secretary, associate secretary, first assistant secretary and commissioner.
7 Includes senior medical advisors, medical officers and doctors.
8 Includes advisors, board members, representatives and policy officers.
9 Includes lecturer, student and research fellow.
10 Includes magistrate and unknown positions.
**Network sociogram**

The sociogram shows the dispersion of influential people based on the bonds between them (Figure 4). The numbers denote each person’s order of entry into the network database. Each line denotes a nomination of influence, and each arrow head denotes the direction of a nomination. It was evident that every person was not bonded to every other person. There were a total number of 677 bonds from a theoretical 51,302 bonds, which resulted in a low network density of 1.3 per cent.

The sociogram shows the variation in personal indegree score.\(^{18}\) The non-respondents tend to be located on the periphery of the sociogram because information about their relational links was not available. There was a dense core consisting of highly nominated people. There is an obvious outer periphery consisting of people with few nominations. The middle layer consists of people with a personal indegree between the two extremes.

The distribution of Indigenous people (squares) and non-Indigenous people (circles) reveals that the network was not divided according to this criterion (Figure 4). Instead, Indigenous people appear distributed throughout the network. This was also the case for each piece of demographic information. Instead, there were sixteen groups in the network, as denoted by the sixteen colours (Figure 5).

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\(^{18}\) Personal indegree is the total number of nominations received by an individual.
Figure 4: An informal network of influential people
**Multiple groups**

The block modelling algorithm assigned the influential people into sixteen groups (Figure 5).\(^\text{19}\) No group could be described in terms of any single piece of demographic information. For example, there was a roughly equal gender balance within each group, although some groups had a predominance of one demographic characteristic.

A jurisdictional effect (Queensland) was evident in groups 12, 13, 14, 15 and 16. But the Queensland groups had people of different gender, and employed in different organisations with different job positions. As another example, Indigenous people from Indigenous community controlled organisations were in groups 7, 10, 11, 13, 14 and 15. Nevertheless, a person from an Indigenous community controlled organisation was present in all the other groups.

However, the low survey return rate (see the limitations section), means that the group analysis presented is suggestive at best. The lack of relational information from the non-respondents casts doubt on the true composition of each group.

**Assessing data limitations**

The block model was created by grouping together people who had similar patterns of incoming nominations. It can be assumed that the patterns of nominations displayed by the respondents were similar to those of the non-respondents. Therefore, the blockmodeling analysis and the analysis of actor indegree centrality (see Table 8, below) are not unduly affected by missing observations and are regarded as robust in the presence of missing data.

The analysis using betweenness centrality (see Table 5, below) is dependent on missing observations since the computation of betweenness centrality depends on shortest paths in the network. The approach taken was to use the original network information as the

---

\(^\text{19}\) The block modelling algorithm was used to detect groups in the network by assigning influential people to groups based on the similarity in patterns of bonds between pairs of people in the network.
basis for estimating missing data, which was performed using the software PNet (261, 262). Using a mathematical algorithm known as an Exponential Random Graph Model, the algorithm uses the original network data to generate different models of the network as if all the nominees had responded to the network survey, as in Hancock and Gile (2007).

The ratio of missing to observed data was relatively high and it proved possible to perform the estimation of missing data with only a relatively simple model. The model assumes that the probability of a graph depends only on the number of its arcs and reciprocated arcs; it therefore takes account of only the density of ties and level of reciprocity among ties. The approach yields tie probabilities for missing network observations.

These tie probabilities were used to construct a new network without missing observations and this network was then used in the analysis of betweenness centrality. As a result, the robustness of the original findings reached by using the available data could be assessed. The same original sixteen network groups were used and then reconstructed network data used for calculation of a model density matrix (see Table 7, below). The imputed betweenness centrality scores and the model densities are displayed visually as model groups (Figure 6). As Figure 6 is similar to Figure 5, the betweenness scores are not too dissimilar (Table 5) and suggest that the conclusions reached earlier are relatively robust in spite of the missing data.

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20 The arc and reciprocity effects were -3.472 and 1.995, with estimated standard errors of 0.073 and 0.237, respectively.
Figure 5: Sixteen groups within the network

Curved links indicate within-group nominations

Arrows indicate reciprocal links

Group size indicates betweenness centrality scores

Kernel group

Line thickness indicates density scores
Figure 6: New group structure from simulation modelling
**Kernel group**

A number of points indicate that the kernel group is true in its composition. Most of the kernel group members (10 of 15) returned surveys showing that they nominated each other (Figure 7). The demographic information revealed that the kernel group was diverse. It exemplified the unsuitability of using any single piece of demographic information to describe each group. It consisted of: 8 females and 7 males, 5 Indigenous and 10 non-Indigenous people, and people from 6 different jurisdictions. Although job position appeared important as most people occupied director level positions (directors, heads). However, they were from different organisations (government, community, and research).

Figure 7: Kernel group bonds

I further examined the kernel groups’ composition using relational information. It had had many people with a high personal indegree, although highly nominated people were contained in other groups. The members of the kernel group had strong combined

---

21 The kernel group is the most highly nominated influential people in the core of the network nominated by members of all the other groups.
relational variables.\textsuperscript{22} This is visible as a high proportion of within-group nominations (thick black line, Figure 5). They were in ongoing contact with combined affiliations as friends and work colleagues, which is partially indicated by the arrowed lines between people (Figure 7). Based on the above points, I suggest that the kernel group composition is robust.

However, there were three kernel group members (not shown in Figure 7) who were neither nominated by any other members of the kernel group, nor did they return surveys. At a higher level of criterion for similarity (called splits in the blockmodel algorithm) these three members split into their own group while the rest of the kernel group composition remained the same. Thus further supporting the robustness of the kernel group whilst highlighting interpretive limitations placed on the data by lack of relational information.

\textbf{Integral}

In this section I demonstrate that Indigenous people were integral to the kernel group and to the whole network. The kernel group had interconnectivity characteristics to indicate that it was integral to the network. It had a high betweenness centrality, density scores, group prominence, and direction of interlinks.\textsuperscript{23} Each of these measures is indicated in the group sociogram (Figure 5). The varied size of each group indicated different betweenness centrality scores (Table 5). For example, the large size of the kernel group (Table 5, group 1) indicates that it was on the pathway between many of the groups. In contrast, the small size of group 16 shows that it was not on the pathway between any groups (Figure 5).

\textsuperscript{22} Strong combined relations occur between people in ongoing contact as work colleagues and/or friends.

\textsuperscript{23} Betweenness centrality is the proportion of times a group is on the pathways ‘between’ other pairs of groups in the network. Density score is the proportion of nominations from the members of one group to the members of another group. Group prominence is the sum of the number of links to each group.
Table 5: Betweenness centrality scores for the sixteen network groups

<table>
<thead>
<tr>
<th>Group</th>
<th>Original Score 24</th>
<th>Imputed Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>1.12300002574921</td>
<td>1.62271702289581</td>
</tr>
<tr>
<td>1</td>
<td>1.069000000572205</td>
<td>1.25948226451874</td>
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<tr>
<td>5</td>
<td>1.03600001335144</td>
<td>1.03321325778961</td>
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<td>12</td>
<td>0.648999989032745</td>
<td>1.23257482051849</td>
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<td>10</td>
<td>0.172999992966652</td>
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</tr>
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<td>15</td>
<td>0.168999999761581</td>
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<td>3</td>
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<td>0.571096003055573</td>
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<td>11</td>
<td>0.0640000030398369</td>
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<td>0.052999993741512</td>
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<tr>
<td>16</td>
<td>0</td>
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</tr>
</tbody>
</table>

The different link thicknesses between groups (Figure 5) reflect varied density scores (Table 6). The numbers in Table 6 indicate the proportion of ties between each of the groups. Reading from left to right, group 1 had 0.276 or 27.6% of nominations to itself, 0% of nominations to group 2, 7.5% of nominations to group 3, and so on. The thick link between group 12 and group 14 indicated a relatively high proportion (0.333 or 33%) of nominations between them. In comparison, the thin link between group 6 and group 1 indicated a relatively low proportion of nominations (5%) between them. The kernel group (group 1) had multiple thick links to other groups (Figure 5). The kernel group was the only group to have received nominations from members of all the other groups, as indicated in column 1 of Table 6 where each cell contains ties sent from the other groups to group 1.

24 Freeman Degree Centrality by indegree
Table 6: Original network density matrix

<table>
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<tr>
<th>Proportion of ties sent</th>
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<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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Table 7: New density matrix from simulation modelling

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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<td>0.346</td>
<td>0.039</td>
<td>0.046</td>
<td>0.024</td>
<td>0.047</td>
<td>0.025</td>
<td>0.040</td>
<td>0.044</td>
<td>0.025</td>
<td>0.044</td>
<td>0.037</td>
<td>0.007</td>
</tr>
<tr>
<td>2</td>
<td>0.057</td>
<td>0.024</td>
<td>0.071</td>
<td>0.008</td>
<td>0.034</td>
<td>0.050</td>
<td>0.022</td>
<td>0.006</td>
<td>0.000</td>
<td>0.009</td>
<td>0.071</td>
<td>0.000</td>
<td>0.054</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>3</td>
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<td>0.036</td>
<td>0.036</td>
<td>0.000</td>
<td>0.149</td>
<td>0.059</td>
<td>0.024</td>
<td>0.023</td>
<td>0.050</td>
<td>0.016</td>
<td>0.019</td>
<td>0.167</td>
<td>0.024</td>
<td>0.000</td>
<td>0.000</td>
<td>0.013</td>
</tr>
<tr>
<td>4</td>
<td>0.025</td>
<td>0.045</td>
<td>0.020</td>
<td>0.003</td>
<td>0.073</td>
<td>0.031</td>
<td>0.040</td>
<td>0.012</td>
<td>0.032</td>
<td>0.016</td>
<td>0.039</td>
<td>0.018</td>
<td>0.033</td>
<td>0.000</td>
<td>0.029</td>
<td>0.000</td>
</tr>
<tr>
<td>5</td>
<td>0.105</td>
<td>0.034</td>
<td>0.060</td>
<td>0.018</td>
<td>0.069</td>
<td>0.014</td>
<td>0.042</td>
<td>0.032</td>
<td>0.019</td>
<td>0.012</td>
<td>0.029</td>
<td>0.063</td>
<td>0.043</td>
<td>0.048</td>
<td>0.026</td>
<td>0.000</td>
</tr>
<tr>
<td>6</td>
<td>0.063</td>
<td>0.050</td>
<td>0.029</td>
<td>0.012</td>
<td>0.017</td>
<td>0.033</td>
<td>0.027</td>
<td>0.024</td>
<td>0.006</td>
<td>0.051</td>
<td>0.032</td>
<td>0.020</td>
<td>0.039</td>
<td>0.039</td>
<td>0.020</td>
<td>0.000</td>
</tr>
<tr>
<td>7</td>
<td>0.110</td>
<td>0.016</td>
<td>0.048</td>
<td>0.012</td>
<td>0.114</td>
<td>0.025</td>
<td>0.032</td>
<td>0.017</td>
<td>0.023</td>
<td>0.038</td>
<td>0.031</td>
<td>0.115</td>
<td>0.029</td>
<td>0.038</td>
<td>0.064</td>
<td>0.004</td>
</tr>
<tr>
<td>8</td>
<td>0.036</td>
<td>0.019</td>
<td>0.028</td>
<td>0.010</td>
<td>0.056</td>
<td>0.027</td>
<td>0.026</td>
<td>0.011</td>
<td>0.032</td>
<td>0.028</td>
<td>0.036</td>
<td>0.030</td>
<td>0.041</td>
<td>0.000</td>
<td>0.035</td>
<td>0.005</td>
</tr>
<tr>
<td>9</td>
<td>0.040</td>
<td>0.000</td>
<td>0.050</td>
<td>0.005</td>
<td>0.010</td>
<td>0.071</td>
<td>0.027</td>
<td>0.005</td>
<td>0.078</td>
<td>0.031</td>
<td>0.065</td>
<td>0.033</td>
<td>0.043</td>
<td>0.000</td>
<td>0.011</td>
<td>0.000</td>
</tr>
<tr>
<td>10</td>
<td>0.008</td>
<td>0.045</td>
<td>0.023</td>
<td>0.010</td>
<td>0.027</td>
<td>0.011</td>
<td>0.053</td>
<td>0.020</td>
<td>0.031</td>
<td>0.029</td>
<td>0.028</td>
<td>0.083</td>
<td>0.060</td>
<td>0.063</td>
<td>0.021</td>
<td>0.000</td>
</tr>
<tr>
<td>11</td>
<td>0.087</td>
<td>0.036</td>
<td>0.025</td>
<td>0.003</td>
<td>0.019</td>
<td>0.047</td>
<td>0.037</td>
<td>0.023</td>
<td>0.015</td>
<td>0.034</td>
<td>0.032</td>
<td>0.017</td>
<td>0.040</td>
<td>0.033</td>
<td>0.033</td>
<td>0.000</td>
</tr>
<tr>
<td>12</td>
<td>0.133</td>
<td>0.000</td>
<td>0.000</td>
<td>0.018</td>
<td>0.079</td>
<td>0.039</td>
<td>0.077</td>
<td>0.000</td>
<td>0.033</td>
<td>0.042</td>
<td>0.033</td>
<td>0.333</td>
<td>0.079</td>
<td>0.444</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>13</td>
<td>0.022</td>
<td>0.034</td>
<td>0.018</td>
<td>0.003</td>
<td>0.000</td>
<td>0.020</td>
<td>0.033</td>
<td>0.017</td>
<td>0.029</td>
<td>0.071</td>
<td>0.017</td>
<td>0.016</td>
<td>0.029</td>
<td>0.079</td>
<td>0.032</td>
<td>0.005</td>
</tr>
<tr>
<td>14</td>
<td>0.044</td>
<td>0.000</td>
<td>0.042</td>
<td>0.018</td>
<td>0.032</td>
<td>0.000</td>
<td>0.038</td>
<td>0.000</td>
<td>0.000</td>
<td>0.083</td>
<td>0.017</td>
<td>0.222</td>
<td>0.048</td>
<td>0.500</td>
<td>0.148</td>
<td>0.000</td>
</tr>
<tr>
<td>15</td>
<td>0.022</td>
<td>0.032</td>
<td>0.000</td>
<td>0.018</td>
<td>0.000</td>
<td>0.059</td>
<td>0.021</td>
<td>0.010</td>
<td>0.044</td>
<td>0.000</td>
<td>0.056</td>
<td>0.037</td>
<td>0.005</td>
<td>0.333</td>
<td>0.042</td>
<td>0.000</td>
</tr>
<tr>
<td>16</td>
<td>0.027</td>
<td>0.014</td>
<td>0.013</td>
<td>0.021</td>
<td>0.010</td>
<td>0.047</td>
<td>0.031</td>
<td>0.009</td>
<td>0.030</td>
<td>0.013</td>
<td>0.040</td>
<td>0.033</td>
<td>0.029</td>
<td>0.000</td>
<td>0.156</td>
<td>0.011</td>
</tr>
</tbody>
</table>
Multiple links between groups is a measure of their prominence. For example, group 16 did not receive nominations from any group (Figure 5). In contrast the kernel group received multiple nominations (n=11) from different groups (Figure 5). This also shows that the kernel group was interconnected to different groups. The kernel group was also the centre of two triads (1, 5, 12 and 1, 5, and 3), each of which had reciprocally nominated each other (Figure 5). Therefore, the kernel group was integral to the network, and by extension so were its Indigenous members. The analysis in the next section (embedded) further supports this finding.

Were Indigenous people integral in the other groups, and the whole network? This can be determined through a hypothetical ‘link cutting’ exercise. The interconnectivity of nine peripheral groups (2, 4, 6, 7, 8, 9, 11, 13 and 16) was relatively weak in terms of a smaller betweenness centrality, density scores, and links with other groups (Figure 5). Cutting their links to other groups would be relatively easier than would be cutting the links for the kernel group to other groups. This would result in a loss of 72 per cent of all Indigenous people and 61 per cent of the non-Indigenous people. The removal of groups 12, 14, 15, and 16 would be more difficult, and increase to a 90 per cent loss of all Indigenous people and a 67 per cent loss of all non-Indigenous people. Groups 1, 3, and 5 would have 10% (n=13) of all Indigenous people and 33% (n=31) of non-Indigenous people. The impact of the lower response rate by Indigenous people nominated by others in the network may mean that the degree to which Indigenous people are ‘integral’ to the network is understated. As such I argue that the network would not be whole if all Indigenous people were removed.

**Embedded**

However, removing groups of people is not a simple matter of cutting links. In this section I demonstrate that Indigenous people were embedded in the network in the sense of strength and depth of bonds between people. This is indicated by personal indegree scores and combined relational variables.²⁵

²⁵ Personal indegree is the total number of nominations a person received. Combined relational variables are the combination of degree of contact (ongoing, met but not ongoing, and never met) and affiliation
**Personal indegree**

Most of the influential people (56%) received only one nomination (Table 8). The majority of these were to 75 Indigenous people compared to 52 non-Indigenous people (Table 8). However, the data also showed that ten Indigenous people (of 16) received more than nine nominations. And of the top five most nominated people, three were Indigenous. There was a similar distribution of personal indegree scores for Indigenous and non-Indigenous people.

Table 8: Number of nominations per person by Indigenous status

<table>
<thead>
<tr>
<th>Nominations</th>
<th>Frequency</th>
<th>Frequency %</th>
<th>Indigenous</th>
<th>Non-Indigenous</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>127</td>
<td>55.9</td>
<td>75</td>
<td>52</td>
</tr>
<tr>
<td>2</td>
<td>38</td>
<td>16.7</td>
<td>24</td>
<td>14</td>
</tr>
<tr>
<td>3</td>
<td>17</td>
<td>7.5</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>4</td>
<td>6</td>
<td>2.6</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>7</td>
<td>3.1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>8</td>
<td>3.5</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>7</td>
<td>3</td>
<td>1.3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>4</td>
<td>1.8</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>9</td>
<td>1</td>
<td>0.4</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td>1</td>
<td>0.4</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>11</td>
<td>3</td>
<td>1.3</td>
<td>2</td>
<td>1</td>
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<td>0.9</td>
<td>1</td>
<td>1</td>
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<tr>
<td>13</td>
<td>1</td>
<td>0.4</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>15</td>
<td>1</td>
<td>0.4</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>16</td>
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<td>0.4</td>
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</tr>
<tr>
<td>17</td>
<td>2</td>
<td>0.9</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>18</td>
<td>1</td>
<td>0.4</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>20</td>
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<td>0.4</td>
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<td>1</td>
</tr>
<tr>
<td>21</td>
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<td>0.4</td>
<td>1</td>
<td>0</td>
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<td>24</td>
<td>1</td>
<td>0.4</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>26</td>
<td>1</td>
<td>0.4</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>227</strong></td>
<td><strong>100</strong></td>
<td><strong>133</strong></td>
<td><strong>94</strong></td>
</tr>
</tbody>
</table>

The personal indegree scores were also not sufficient to describe the sixteen network groups. Some people with low indegree scores were present in the kernel group (n=2, 6). And some people with high indegree scores were present in the peripheral group 7 (n=17, 13, 12, 8). Clearly, there are other factors involved in describing group composition. A complete data set would have improved the description of the groups because all the indegree information would be available. However the indegree measure is for nominations of influence only, whereas the affiliation variables (friend, work colleague, friend, and relative).
work colleague or relative) provide more information about the depth of bonds in those nominations.

**Combined relations**

I analysed the combined relational variables (combined relations) between the influential people (Table 9). The first row shows (with the numeral 1 in the relevant cell) that survey respondents indicated ongoing contact (c) with other influential people that were friends (f), work colleagues (w) and relatives (r). A very strong bond would exist between two people on the combined relation of this type. However, only two nominations (0% of 677 nominations) of this type were made (Table 9).

**Table 9: Nomination patterns for the informal network**

<table>
<thead>
<tr>
<th>Contact</th>
<th>Affiliation</th>
<th>Nominations</th>
</tr>
</thead>
<tbody>
<tr>
<td>c m n</td>
<td>f w r</td>
<td>n total</td>
</tr>
<tr>
<td>1 0 0</td>
<td>1 1 1</td>
<td>2</td>
</tr>
<tr>
<td>1 0 0</td>
<td>1 1 0</td>
<td>211</td>
</tr>
<tr>
<td>1 0 0</td>
<td>1 0 0</td>
<td>7</td>
</tr>
<tr>
<td>1 0 0</td>
<td>0 1 1</td>
<td>2</td>
</tr>
<tr>
<td>1 0 0</td>
<td>0 1 0</td>
<td>278</td>
</tr>
<tr>
<td>1 0 0</td>
<td>0 0 1</td>
<td>2</td>
</tr>
<tr>
<td>0 1 0</td>
<td>1 1 0</td>
<td>1</td>
</tr>
<tr>
<td>0 1 0</td>
<td>1 0 0</td>
<td>1</td>
</tr>
<tr>
<td>0 1 0</td>
<td>0 1 0</td>
<td>118</td>
</tr>
<tr>
<td>0 1 0</td>
<td>0 0 0</td>
<td>16</td>
</tr>
<tr>
<td>0 0 1</td>
<td>0 1 0</td>
<td>1</td>
</tr>
<tr>
<td>0 0 1</td>
<td>0 0 0</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td></td>
<td>677</td>
</tr>
</tbody>
</table>

(i) contact (ongoing - c, met but non-ongoing - m, and never met - n); (ii) affiliation (friend - f, relative - r, work colleague - w); (iii) n=number of votes; (iv) %=percentage of all votes

Strong combined relations occurred more often between Indigenous people than between Indigenous and non-Indigenous people. At 41 per cent of all nominations the most common combined relation was of ongoing contact and work colleague (Table 9). Here, Indigenous people nominated 57 other Indigenous people versus 28 non-Indigenous people (Table 10). In contrast, non-Indigenous people nominated 96 Indigenous people and 97 non-Indigenous people (Table 10). At 31 percent of all nominations the second most common combined relation was of ongoing contact
between friends and work colleagues (Table 9). Here, Indigenous people nominated 106 other Indigenous people and 23 non-Indigenous people (Table 10). In contrast, non-Indigenous people nominated 41 Indigenous people and 41 non-Indigenous people. There are strong combined relations more often between Indigenous people, than between Indigenous and non-Indigenous people.

Table 10: Combined relations

<table>
<thead>
<tr>
<th>Ongoing contact, friend and work colleague</th>
<th>Respondent</th>
<th>Nominee</th>
<th>Non-Indigenous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous</td>
<td>Indigenous</td>
<td>106</td>
<td>23</td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>Indigenous</td>
<td>41</td>
<td>41</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ongoing contact and work colleague</th>
<th>Respondent</th>
<th>Nominee</th>
<th>Non-Indigenous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous</td>
<td>Indigenous</td>
<td>57</td>
<td>28</td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>Indigenous</td>
<td>96</td>
<td>97</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Met and work colleague</th>
<th>Respondent</th>
<th>Nominee</th>
<th>Non-Indigenous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous</td>
<td>Indigenous</td>
<td>26</td>
<td>11</td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>Indigenous</td>
<td>37</td>
<td>44</td>
</tr>
</tbody>
</table>

The findings of the combined relations is enhanced by the finding of a significant Indigenous nomination preference where Indigenous people nominated an average of ten Indigenous people and three non-Indigenous people (Table 11, P=0.00025, students paired t-test). In comparison, non-Indigenous people nominated an average of nine Indigenous and non-Indigenous people (Table 11). This Indigenous nomination preference was most evident in the Queensland groups because they were mostly Indigenous people that nominated each other (see p.59).

Table 11: Pattern of the direction of nominations

<table>
<thead>
<tr>
<th>Nominator</th>
<th>Nominee</th>
<th>Average</th>
<th>Range</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous</td>
<td>Indigenous</td>
<td>10.0</td>
<td>3-22</td>
<td>0.000246</td>
</tr>
<tr>
<td>Indigenous</td>
<td>Non-Indigenous</td>
<td>3.3</td>
<td>0-10</td>
<td></td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>Aboriginal</td>
<td>8.5</td>
<td>0-22</td>
<td></td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>Non-Indigenous</td>
<td>8.7</td>
<td>0-29</td>
<td>0.930096</td>
</tr>
</tbody>
</table>
The above factors (similar distribution of personal indegree scores, strong combined relations more often between Indigenous people, and the Indigenous nomination preference) add to the finding that Indigenous people were integral for the kernel group and for the whole network. However, the combined relations data also shows that Indigenous and non-Indigenous people nominated each other on strong combined relations, a characteristic of the kernel group. Most of the kernel group members had a high indegree, and it contained four of the five most nominated people of the network (two Indigenous people and two non-Indigenous people). I classified these people as prestigious, as they had a high personal indegree and strong combined relations with other Indigenous and non-Indigenous people.

There were four people who were the starting points for the snowball nomination process. They were mostly highly nominated people in the network \((n=26, 24, 21, 2)\), with three in the kernel group and one in group 5. This is unsurprising due to the selection criteria of ‘continuing and long-term engagement in the health sector’ and the request to nominate people regarded as having ‘considerable influence in Aboriginal health policy in Australia’.

**Data limitations**

I used a modified reputational method to identify the first set of people to receive the survey (see the ‘Survey Administration’ subsection, above). While this method is accepted as being able to capture the perceptions of influence amongst other influential people \((175)\), there is no standardised approach to use in the first step of identifying the initial survey recipients.

**Lack of relational information**

The robust analyses of social networks often require a completely enumerated set of people with all relational data – the nominations to and from people. No relational information was available for 81 per cent of the network. This was due to the low survey return rate (25\%) and missing data from 54 people who were not sent surveys.
This meant that there was a lack of relational data from Indigenous people, and from Indigenous people based in Indigenous organisations. The 129 non-respondents received 55 per cent of the 677 nominations (Table 12). Indigenous people comprised 69% (89/129) of the non-respondents with most (52) from Indigenous community controlled organisations. Within this group thirty-six people were from Aboriginal community controlled health services. In other terms, a third (28 per cent of 129) of all the non-respondents were Indigenous people based in Aboriginal community controlled health services.

Table 12: Non-respondent characteristics by gender and Indigenous status

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th></th>
<th>Male</th>
<th></th>
<th>Total (culture)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>p</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>p</td>
</tr>
<tr>
<td>Indigenous</td>
<td>49</td>
<td>83</td>
<td>141</td>
<td>82</td>
<td>3</td>
</tr>
<tr>
<td>Non-indigenous</td>
<td>10</td>
<td>17</td>
<td>32</td>
<td>18</td>
<td>3</td>
</tr>
<tr>
<td>Total (gender)</td>
<td>59</td>
<td>173</td>
<td>3</td>
<td>70</td>
<td>197</td>
</tr>
</tbody>
</table>

*p=number; %=percentage of total; n=number of nominations; a= the average number of nominations per person.

Survey respondents

Obviously, the network may have been different if all the relational information was available. However, it is not uncommon for network datasets to be incomplete (263). Lewis (2006) used a respondents’ sub-network as a proxy for the whole network, following a comparison of the respondents and the non-respondents by location, discipline and gender. The respondents in my study could not be held as a proxy for the whole network, based on the comparisons detailed below.

There were fewer women than men amongst all those nominated as influential: 44% (101 of 227) of those nominated were women (Table 13). However, amongst those who responded there were equal numbers of men (n=22) and women (n=22). Of all the women who were nominated, 71% were Indigenous (Table 13). Whereas, of the women who responded only 45% were Indigenous. In contrast, there was no such difference between the Indigenous status of men who were nominated compared to the Indigenous status of men who responded. Of all the men who were nominated, 48% were Indigenous; and of the men who responded 45% were Indigenous (Table 12).
Table 13: All people nominated as influential vs respondents, by gender and Indigenous status

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th></th>
<th>Male</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>r</td>
<td>%</td>
</tr>
<tr>
<td>Indigenous</td>
<td>72</td>
<td>71</td>
<td>10</td>
<td>45</td>
</tr>
<tr>
<td>Non-indigenous</td>
<td>29</td>
<td>29</td>
<td>12</td>
<td>55</td>
</tr>
<tr>
<td>Total</td>
<td>101</td>
<td>22</td>
<td>126</td>
<td>22</td>
</tr>
</tbody>
</table>

This table includes the number of people nominated as influential (n), the number of respondents (r) and percentages (%).

Only 45% of the respondents were Indigenous, whereas a much higher proportion (59%) all who were nominated were Indigenous (Table 14).

Table 14: All people nominated as influential vs respondents, by Indigenous status

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
<th>r</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous</td>
<td>133</td>
<td>59</td>
<td>20</td>
<td>45</td>
</tr>
<tr>
<td>Non-indigenous</td>
<td>94</td>
<td>41</td>
<td>24</td>
<td>55</td>
</tr>
<tr>
<td>Total</td>
<td>227</td>
<td>44</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There were no respondents from South Australia. New South Wales was substantially under represented amongst the respondents compared to all those nominated, with Western Australia slightly under represented. Victoria, the Australian Capital Territory, Northern Territory and Queensland were all over represented in the respondents compared to all those who were nominated (Table 14).

Table 15: All people nominated as influential vs respondents, by jurisdiction

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
<th>r</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queensland</td>
<td>63</td>
<td>27</td>
<td>13</td>
<td>30</td>
</tr>
<tr>
<td>Western Australia</td>
<td>46</td>
<td>20</td>
<td>7</td>
<td>16</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>42</td>
<td>19</td>
<td>10</td>
<td>23</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>34</td>
<td>15</td>
<td>10</td>
<td>23</td>
</tr>
<tr>
<td>New South Wales</td>
<td>22</td>
<td>10</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Victoria</td>
<td>11</td>
<td>5</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>South Australia</td>
<td>9</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>227</td>
<td>44</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

None of the differential response rate could be attributed to the researcher location and the location of the four starting people. All surveys were sent through the post with a
follow-up telephone call. In South Australia, two potential respondents said that the South Australian Aboriginal Health Ethics Committee had to grant ethical approval to the study before they would complete the survey.

There was no representation from three types of organisations in the respondents, with under representation from mainstream and non-government organisations, state and territory governments, and Aboriginal community controlled organisations (Table 16). There was substantial over representation from academic organisations, the commonwealth government and a statutory authority in the respondents compared to all those who were nominated.

Table 16: All people nominated as influential vs respondents, by organisation

<table>
<thead>
<tr>
<th>Organisation</th>
<th>n¹</th>
<th>%</th>
<th>r</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous Community Controlled Organisations¹</td>
<td>76</td>
<td>33</td>
<td>10</td>
<td>23</td>
</tr>
<tr>
<td>Academic⁵</td>
<td>42</td>
<td>19</td>
<td>16</td>
<td>36</td>
</tr>
<tr>
<td>State &amp; Territory Government</td>
<td>32</td>
<td>14</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Commonwealth Government</td>
<td>28</td>
<td>12</td>
<td>9</td>
<td>20</td>
</tr>
<tr>
<td>Non-government Organisation</td>
<td>20</td>
<td>9</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander Commission</td>
<td>8</td>
<td>4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other⁴</td>
<td>8</td>
<td>4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Political Party</td>
<td>7</td>
<td>3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mainstream Health⁵</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>227</td>
<td>44</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹This table includes the number of people nominated as influential (n), the number of respondents (r) and percentages (%).

²Includes ACCO (such as Central Australian Aboriginal Congress, Cape York Land Council, Aboriginal Drug and Alcohol Council), Aboriginal community controlled health services, peak Aboriginal health representative bodies.

³Includes university and research organisations.

⁴AIDS councils, foundations, associations, colleges, beneficent organisations.

⁵Includes court, retired, private and statutory authority.

⁶Includes hospital and community health centre.

Of the potential respondents contacted by telephone in Aboriginal Community Controlled Organisations, ‘being too busy’ was the reason given for not completing the survey. In the Northern Territory, New South Wales and the Australian Capital Territory three potential respondents said that the chairperson of the organisation may not allow the survey to be completed.
There was under representation amongst the respondents, compared to all who were nominated, of chairpersons, politicians and chief executive officers (Table 17). There was over representation in the respondents of academics, advisors, medical, and those in ‘secretarial’ positions. There were also no respondents from the five least common job categories amongst all those who were nominated.

Table 17: Job position for influential and respondents networks

<table>
<thead>
<tr>
<th>Position</th>
<th>n</th>
<th>%</th>
<th>r</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director*</td>
<td>58</td>
<td>26</td>
<td>12</td>
<td>27</td>
</tr>
<tr>
<td>Chief Executive Officer*</td>
<td>47</td>
<td>21</td>
<td>8</td>
<td>18</td>
</tr>
<tr>
<td>Coordinator*</td>
<td>18</td>
<td>8</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Chairperson*</td>
<td>17</td>
<td>7</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Politician*</td>
<td>17</td>
<td>7</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Manager</td>
<td>15</td>
<td>7</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>Secretarial</td>
<td>14</td>
<td>6</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Medical</td>
<td>12</td>
<td>5</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Advisor</td>
<td>10</td>
<td>4</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Academic</td>
<td>8</td>
<td>4</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>ATSIC Commissioner</td>
<td>4</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other*</td>
<td>3</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Indigenous Health Worker</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Elder</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>227</strong></td>
<td><strong>100%</strong></td>
<td><strong>44</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

*This table includes the number of people nominated as influential (n), the number of respondents (r) and percentages (%).
1Includes director and head.
2Includes chief executive officer, deputy chief executive officer, principal and dean.
3Includes coordinator and project officer.
4Includes chairperson and president.
5Includes minister, shadow minister and chancellor.
6Includes secretary, assistant secretary, associate secretary, first assistant secretary and commissioner.
7Includes senior medical advisors, medical officers and doctors.
8Includes advisors, board members, representatives and policy officers.
9Includes lecturer, student and research fellow.
10Includes magistrate and unknown positions.

Overall, the network of the respondents **can not** be held as a proxy for the network of influential people in national Indigenous health policy. This is because the respondents characteristics differed substantially from the characteristics of all those who were nominated.
Early appearance of basic network structure

Despite the lack of relational information, the basic network structure (dense core, middle and peripheral layers, p.57) appeared early and consolidated over the survey period. In the table below (Table 18), when read from left to right along the rows and scanned down the columns, it can be seen that the people in the core received nominations from the beginning and continued to do so, over the duration of the survey period. The appearance of the basic network structure early on in the nomination process, proves a core assumption of network analysis: that the relatively stable, long-term patterns of interaction establish the “true” structure of a network (167:57).

Table 18: Nominations received over the period of survey collection

<table>
<thead>
<tr>
<th>Number of nominations received over the survey period</th>
<th>Duration of the survey period</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>1 1 2 3 3 3 3 5 2</td>
</tr>
<tr>
<td>21</td>
<td>1 2 2 3 3 1 2 2 4 1</td>
</tr>
<tr>
<td>20</td>
<td>1 1 2 2 3 3 2 4 2</td>
</tr>
<tr>
<td>18</td>
<td>1 1 3 1 1 4 2 4 1</td>
</tr>
<tr>
<td>17</td>
<td>1 1 2 2 3 2 3 2 2</td>
</tr>
<tr>
<td>17</td>
<td>1 2 2 3 2 3 2 5 2</td>
</tr>
<tr>
<td>16</td>
<td>2 1 1 1 2 2 1 6 2</td>
</tr>
<tr>
<td>15</td>
<td>2 1 2 1 2 2 1 3 1</td>
</tr>
<tr>
<td>13</td>
<td>1 2 3 1 1 1 1 2 1</td>
</tr>
<tr>
<td>12</td>
<td>1 1 2 3 1 1 1 3 1</td>
</tr>
<tr>
<td>12</td>
<td>2 1 5 1 1 1</td>
</tr>
<tr>
<td>11</td>
<td>1 2 1 1 1 1</td>
</tr>
<tr>
<td>11</td>
<td>1 2 1 1 2 1</td>
</tr>
<tr>
<td>10</td>
<td>1 2 2 2 2 1</td>
</tr>
<tr>
<td>9</td>
<td>1 1 2 1 1 1 1</td>
</tr>
<tr>
<td>8</td>
<td>1 1 1 1 2 1</td>
</tr>
<tr>
<td>8</td>
<td>2 3 2 1</td>
</tr>
<tr>
<td>8</td>
<td>1 1 2 1 2 1</td>
</tr>
<tr>
<td>8</td>
<td>1 1 2 1 2 1</td>
</tr>
<tr>
<td>7</td>
<td>1 1 2 1 1</td>
</tr>
<tr>
<td>7</td>
<td>1 1 1 1 3</td>
</tr>
<tr>
<td>6</td>
<td>1 2 2 1</td>
</tr>
<tr>
<td>6</td>
<td>1 1 1 1 2</td>
</tr>
<tr>
<td>6</td>
<td>1 2 1 1</td>
</tr>
<tr>
<td>6</td>
<td>1 1 1 1 1</td>
</tr>
<tr>
<td>6</td>
<td>3 1 1 1</td>
</tr>
<tr>
<td>6</td>
<td>1 1 2 3</td>
</tr>
<tr>
<td>6</td>
<td>1 1 1 3</td>
</tr>
<tr>
<td>6</td>
<td>4 1 1</td>
</tr>
</tbody>
</table>

*The total number of nominations received; †the survey period in months; ‡the number of nominations received in that month.

77
Finally, the network analysis does not stand alone but is enhanced by the qualitative information from the interviews in Chapter 5. All of the thirty-two interviewees were nominated as influential and most (except four) completed the survey.

**Conclusion**

The enumeration and analysis of an informal network of influential people in national Indigenous health policy revealed three key characteristics of participation of Indigenous people’s. The diverse demographic mix revealed no network differentiation in terms of any single compositional variable (such as Indigenous and non-Indigenous). Indigenous people were integral to, and embedded within, the network and its kernel group. However, further support for the findings from this study is necessary given the limited data collected. I draw on the analysis of the next two chapters to support the overall finding that Indigenous people were fundamental in this informal network of influential people.
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Chapter 4 - National health committees

Introduction

Australian governments continually restructure the committees of the national health system (85, 145). Policy discourse on reforms focus on the restructuring of individual committees of ministers, senior officials, and key stakeholders (104, 120, 161, 179, 215). There is no conceptualisation of the committees as interlinked into a system of collecting advice. In this chapter I will describe the features of participation of Indigenous peoples in national health committees, at the end of 2004.

Methods

I aimed to describe the structural location of Indigenous people in national health committees. I identified national health committees through a search of internet home pages. The primary sources of information were:

- the Australian Government’s Indigenous Portal Internet site for resources, contacts, information and government programs and services at http://www.indigenous.gov.au/.

Committees were included in the sample only if their role, or part thereof, was to provide advice on health and health-related issues, in an ongoing capacity, to Australian government agencies. This role needed to be explicitly stated in the Terms of Reference. Thus, excluded were national committees in other areas of social policy, short-term project steering committees, and state and territory health committees.

The data was obtained from the committees’ internet sites. This data was: the official name and acronym of the committee, the superordinate committee and subordinate committees (if any), and membership details. The membership details provided varied, but
usually consisted of a person’s name, organisation, job title/position, and jurisdiction. The committees were assigned to different categories based on their advisory role. They were: parliamentary committees (members of parliaments), ministerial committees (Australian government ministers), mainstream health committees (mainstream health issues), Indigenous health specific (Indigenous health issues), and part-health (wide area of remit that included health).

I sought to identify the Indigenous status of members of all the committees, but this was explicitly denoted only for the Indigenous health committees. Therefore, I conducted an internet search in the following format: “member name” + Indigenous + Aboriginal. I followed a minimum of three links to ensure Indigenous identification. All of the committee data was entered into a Microsoft Excel database. I employed a research assistant to verify all aspects of the committee data before the analysis was undertaken.

**Data analysis**

First, I calculated the proportion of members who were Indigenous within each committee, and the proportion of committees which were Indigenous health committees. Second, I constructed a visual representation of the formal relationship between committees called the committee system. This was based on the explicitly stated reporting relationship from a subordinate to a superordinate committee. For each committee I counted how many steps were between a committee and Cabinet.

Third, I determined the importance of each committee in terms of a committee network. This was based on social network research methods applicable to affiliation networks (167:291, 243:38). An affiliation network consists of committees that are interlocked (linked) into a network structure by co-members (common members). I constructed an affiliation matrix in order to reveal the co-members that interlocked committees. Then, I determined the importance of each committee using the eigenvector centrality algorithm in the software program Ucinet 6.117 (259). Eigenvector centrality accounts for the frequency of interlocks, the frequency of co-members, and the betweenness of each committee. It is a weighted measure indicating the relative importance of a committee in terms of the global structure of the committee network (265, 266). The resulting eigenvector data was visually represented with the graph visualisation software NetDraw (260).
Fourth, I compared the databases for the informal network (described in chapter 3) and the above committee network to identify the people in both networks. Influential Indigenous people from the informal network were located in the committee system. The location of the sixteen groups of the informal network was marked on the committee network.
Key features

There were three features of Indigenous people’s participation in the health committees.

**Small and distant**

There were a very small proportion of committee members who were Indigenous. Indigenous people were concentrated on Indigenous health committees. These committees constituted a small proportion of national health committees. These Indigenous health committees were almost always located in subordinate positions to other committees and at a distance from Cabinet.

**Similar integration**

The Indigenous health committees were interlocked into the committee network. A committee that had relatively fewer steps to Cabinet did not necessarily have greater centrality. This was also valid for the Indigenous health committees. Their eigenvector centrality scores bore no relationship to the number of steps to Cabinet. The Indigenous health committees were similar to the rest of the committees in the dispersion of eigenvector centrality scores. As such the Indigenous health committees were similarly integrated in the committee network.

**Elite knowledge brokers**

A small number of people linked the national health committees and the informal network of influential people. People from the kernel group of the informal network constituted a smaller subset of linkers. The kernel group people were members of health information and health research committees. A few of the prestigious members of the kernel group interlocked central committees, which made them elite knowledge brokers in the national health committee network.

---

26 An interlock occurs where two or more committees are joined by the same person.
27 Eigenvector centrality is a global measure for the importance of a committee.
28 The kernel group is the most highly nominated influential people in the core of the network nominated by members of all the other groups. A prestigious person is a highly nominated member of the kernel group with strong combined relations to both Indigenous and non-Indigenous people.
Results

There were one hundred and twenty-one committees identified with 92 mainstream health, 10 Indigenous health, 7 ministerial, 7 parliament, and 5 part-health (Table 19). Information was obtained from seventy-seven (64%) of the committees, in total these had 1029 members that consisted of 63% males, and 37% females (Table 19). Indigenous people comprised 5% of total committee members, 4% of mainstream health committees, and 0% of parliamentary and ministerial committees, and 58% of Indigenous health committee members (Table 19).
Table 19: Gross composition of national health committees

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Mainstream Health</th>
<th>Parliamentary</th>
<th>Ministerial</th>
<th>Indigenous Health</th>
<th>Part-health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committees(^1)</td>
<td>77 (of 121)</td>
<td>56 (of 92)</td>
<td>7 (of 7)</td>
<td>5 (of 7)</td>
<td>7 (of 10)</td>
<td>2 (of 5)</td>
</tr>
<tr>
<td>Members</td>
<td>1029</td>
<td>672</td>
<td>236</td>
<td>54</td>
<td>72</td>
<td>29</td>
</tr>
<tr>
<td>Average number of members (range)</td>
<td>16 (4-150)</td>
<td>14 (4-28)</td>
<td>44 (4-150)</td>
<td>15 (9-24)</td>
<td>11 (9-16)</td>
<td>15 (9-20)</td>
</tr>
<tr>
<td>Females (%)</td>
<td>376 (37%)</td>
<td>268 (40%)</td>
<td>60 (25%)</td>
<td>17 (31%)</td>
<td>31 (43%)</td>
<td>12 (41%)</td>
</tr>
<tr>
<td>Males (%)</td>
<td>653 (63%)</td>
<td>404 (60%)</td>
<td>176 (75%)</td>
<td>37 (69%)</td>
<td>41 (57%)</td>
<td>17 (59%)</td>
</tr>
<tr>
<td>Indigenous (%)</td>
<td>56 (5%)</td>
<td>24 (4%)</td>
<td>1 (0%)</td>
<td>0</td>
<td>42 (58%)</td>
<td>0</td>
</tr>
<tr>
<td>Non-Indigenous (%)</td>
<td>883 (86%)</td>
<td>576 (86%)</td>
<td>235 (100%)</td>
<td>54 (100%)</td>
<td>22 (31%)</td>
<td>20 (69%)</td>
</tr>
<tr>
<td>Indigenous status unknown (%)</td>
<td>89 (9%)</td>
<td>72 (11%)</td>
<td>0</td>
<td>0</td>
<td>8 (11%)</td>
<td>9 (31%)</td>
</tr>
</tbody>
</table>

\(^1\) Figures based on available membership information from seventy seven of the one hundred and twenty one committees.
Committee members came from fifteen categories of organisations: 21% from state governments, 19% political parties, 8% Commonwealth Government, 1% Indigenous community controlled organisations, 0% Aboriginal and Torres Strait Islander Commission, and 25% experts (Table 20). The designation of ‘expert’ was as provided on the internet sites of the committees and shows that a committee member was selected for their expertise rather than due to their employing organisation and/or their job position.

### Table 20: Categories of organisations of the committee members

<table>
<thead>
<tr>
<th>Organisation</th>
<th>number</th>
<th>percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expert</td>
<td>296</td>
<td>25</td>
</tr>
<tr>
<td>State Government</td>
<td>257</td>
<td>21</td>
</tr>
<tr>
<td>Political Party</td>
<td>229</td>
<td>19</td>
</tr>
<tr>
<td>Commonwealth Government</td>
<td>95</td>
<td>8</td>
</tr>
<tr>
<td>State/Territory¹</td>
<td>75</td>
<td>6</td>
</tr>
<tr>
<td>University²</td>
<td>63</td>
<td>5</td>
</tr>
<tr>
<td>Non-government organisation³</td>
<td>42</td>
<td>4</td>
</tr>
<tr>
<td>Committees⁴</td>
<td>39</td>
<td>3</td>
</tr>
<tr>
<td>Professional Association⁵</td>
<td>24</td>
<td>2</td>
</tr>
<tr>
<td>Local Government</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Indigenous community controlled organisations⁶</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Statutory Authority⁷</td>
<td>17</td>
<td>1</td>
</tr>
<tr>
<td>Hospitals</td>
<td>17</td>
<td>1</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander Commission</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Other⁸</td>
<td>24</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>1198</td>
<td>100</td>
</tr>
</tbody>
</table>

¹Members of the Senate  
²University and research organisations  
³AIDS councils, foundations, associations, colleges, beneficent organisations  
⁴People representing other committees such as the NHMRC  
⁵Such as the Australian Medical Association; Consumers Association of Australia  
⁶Aboriginal Community Controlled Health Services; National Aboriginal Community Controlled Health Organisation; and Indigenous Community Controlled Organisations  
⁷The Australian Bureau of Statistics; the Australian Institute of Health and Welfare  
⁸Schools, Industry groups, consumers, New Zealand government
Committee members had fourteen categories of job positions: 27% were members of parliament, 26% were experts, 11% were directors, 5% were managers, 3% were chairperson-secretary-coordinator, 2% were advisors-chief executive officers, 1% were medical and academic, and 15% were not provided (Table 21).

<table>
<thead>
<tr>
<th>Position</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experts</td>
<td>296</td>
<td>26</td>
</tr>
<tr>
<td>Not provided</td>
<td>174</td>
<td>15</td>
</tr>
<tr>
<td>House of Representatives</td>
<td>150</td>
<td>13</td>
</tr>
<tr>
<td>Director¹</td>
<td>130</td>
<td>11</td>
</tr>
<tr>
<td>Minister²</td>
<td>78</td>
<td>7</td>
</tr>
<tr>
<td>Senate</td>
<td>75</td>
<td>7</td>
</tr>
<tr>
<td>Manager</td>
<td>52</td>
<td>5</td>
</tr>
<tr>
<td>Chairperson³</td>
<td>34</td>
<td>3</td>
</tr>
<tr>
<td>Secretarial⁴</td>
<td>30</td>
<td>3</td>
</tr>
<tr>
<td>Coordinator⁵</td>
<td>28</td>
<td>3</td>
</tr>
<tr>
<td>Advisor⁶</td>
<td>24</td>
<td>2</td>
</tr>
<tr>
<td>Chief executive officer⁷</td>
<td>22</td>
<td>2</td>
</tr>
<tr>
<td>Cross-committee⁸</td>
<td>22</td>
<td>2</td>
</tr>
<tr>
<td>Medical⁹</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Academic¹⁰</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Other¹¹</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>1137</td>
<td>100</td>
</tr>
</tbody>
</table>

¹Includes director and head.
²Includes minister, shadow minister and chancellor.
³Includes chairperson and president.
⁴Includes secretary, assistant secretary, associate secretary, first assistant secretary and commissioner.
⁵Includes coordinator and project officer.
⁶Includes advisors, board members, representatives and policy officers.
⁷Includes chief executive officer, deputy chief executive officer, principal and dean.
⁸Cross-committee means a representative of a committee on another committee.
⁹Includes senior medical advisors, medical officers and doctors.
¹⁰Includes lecturer, student and research fellow.
¹¹Includes administrator and senior evaluation officer.
Small and distant

Indigenous people comprised 5 per cent (56 of 1029) of total committee members (Table 19). The majority of Indigenous people (75%, 42 out of 56) were members of Indigenous health committees. Indigenous health committees were 8 per cent of national health committees. In terms of the pattern of the number of steps from Cabinet, the Indigenous health committees appear similar to the rest of the committees (Table 22). However, all of the Indigenous health committees were subordinate to other committees, except the NATSIHC. These facts are visually apparent on the committee system map (Figure 8).

Table 22: Number of steps to Cabinet

<table>
<thead>
<tr>
<th>Number of Steps</th>
<th>Number of Committees</th>
<th>Percent of Committees</th>
<th>Location of Indigenous Health Committees</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>1</td>
<td>1</td>
<td>NIEHF</td>
</tr>
<tr>
<td>6</td>
<td>37</td>
<td>31</td>
<td>NAGATSIHID, ATSIHWWG, ATSIIPAC</td>
</tr>
<tr>
<td>5</td>
<td>9</td>
<td>8</td>
<td>SCATSIH</td>
</tr>
<tr>
<td>4</td>
<td>17</td>
<td>14</td>
<td>ATSIRWC, NDSRGATSIP</td>
</tr>
<tr>
<td>3</td>
<td>24</td>
<td>20</td>
<td>IASHC, ATSIRG</td>
</tr>
<tr>
<td>2</td>
<td>23</td>
<td>19</td>
<td>NATSIHC</td>
</tr>
<tr>
<td>1</td>
<td>5</td>
<td>4</td>
<td>ANCD (mainstream health committee)</td>
</tr>
<tr>
<td>n/a</td>
<td>4</td>
<td>3</td>
<td>FEC (parliamentary committee)</td>
</tr>
<tr>
<td>Total</td>
<td>120</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>
Committee system

The system map shows how each committee was part of a larger system of committees. The structural location of a committee is a matter of counting the number of steps from a committee to Cabinet. However, it is a simplified two dimensional representation of complex relationships. For example, the system map could not show information about the nature of a reporting link between committees. The link could be a person or simply the provision of written minutes. For example, the Ministerial Councils are established under the authority of COAG, but are only required to present a consolidated report ‘if requested’ (70:9).

It also appears on the system map as though there were more than 56 Indigenous people (Figure 8). This was due to some Indigenous people being a member of more than one committee. Of the 56 Indigenous people, 44 were members of one committee, 7 were members of two committees, and 5 were members of three committees (see the ‘ip’ column, Table 26).

---

29 The legend of committee acronyms is provided as an insert and is valid for the entire thesis.
Figure 8: Committee system map
**Similar integration**

The eigenvector centrality algorithm requires all committees to be interlocked by co-members. However, committee membership details were not publicly available from 36 per cent (44 of 121) of committees (*shown in red italics in the committee system map, Figure 8*). The remaining 77 committees were not all interlocked. Instead, there was one major component with 59 committees, a small component of 12 committees and six committees that were not interlocked at all (Figure 9).

**Figure 9: Components of the national health committees**

The eigenvector centrality scores were calculated for the major component of 59 committees (Table 23, column E). The measures of centrality are visibly apparent in the health committee network (Figure 10). There is no relationship between the eigenvector centrality scores and the number of steps to Cabinet (Table 23, column S). Being fewer

---

30 The eigenvector centrality accounts for the frequency of interlocks, the frequency of co-members, and the betweenness of each committee.
steps to Cabinet did not translate into a more central committee in the network. The steps to Cabinet is based official reporting links, which may or may not be a person, whereas eigenvector centrality scores require the link to be a person.

Table 23: Measures of committee centrality

<table>
<thead>
<tr>
<th>Committee</th>
<th>E</th>
<th>S</th>
<th>I</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHMRC</td>
<td>0.867</td>
<td>2</td>
<td>11</td>
<td>167</td>
<td>14</td>
</tr>
<tr>
<td>RC-NHMRC</td>
<td>0.271</td>
<td>3</td>
<td>5</td>
<td>82</td>
<td>7</td>
</tr>
<tr>
<td>CDNA</td>
<td>0.213</td>
<td>6</td>
<td>5</td>
<td>36</td>
<td>6</td>
</tr>
<tr>
<td>NPHPG</td>
<td>0.171</td>
<td>5</td>
<td>11</td>
<td>180</td>
<td>15</td>
</tr>
<tr>
<td>MSAC</td>
<td>0.153</td>
<td>2</td>
<td>7</td>
<td>77</td>
<td>7</td>
</tr>
<tr>
<td>NPHIWG</td>
<td>0.118</td>
<td>6</td>
<td>10</td>
<td>129</td>
<td>10</td>
</tr>
<tr>
<td>HAC-NHMRC</td>
<td>0.117</td>
<td>3</td>
<td>8</td>
<td>78</td>
<td>8</td>
</tr>
<tr>
<td>NAGATSIHID</td>
<td>0.107</td>
<td>6</td>
<td>10</td>
<td>228</td>
<td>11</td>
</tr>
<tr>
<td>AHIC</td>
<td>0.094</td>
<td>5</td>
<td>10</td>
<td>176</td>
<td>13</td>
</tr>
<tr>
<td>AHEC-NHMRC</td>
<td>0.076</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>NHPAC</td>
<td>0.071</td>
<td>5</td>
<td>8</td>
<td>59</td>
<td>8</td>
</tr>
<tr>
<td>NATSIHIC</td>
<td>0.060</td>
<td>2</td>
<td>5</td>
<td>61</td>
<td>5</td>
</tr>
<tr>
<td>enHC</td>
<td>0.057</td>
<td>6</td>
<td>3</td>
<td>57</td>
<td>6</td>
</tr>
<tr>
<td>NDRSC</td>
<td>0.043</td>
<td>4</td>
<td>3</td>
<td>24</td>
<td>4</td>
</tr>
<tr>
<td>ACSQHC</td>
<td>0.037</td>
<td>5</td>
<td>4</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>NSCRN</td>
<td>0.032</td>
<td>6</td>
<td>6</td>
<td>43</td>
<td>7</td>
</tr>
<tr>
<td>AMWAC</td>
<td>0.031</td>
<td>6</td>
<td>7</td>
<td>60</td>
<td>9</td>
</tr>
<tr>
<td>APACSIMP</td>
<td>0.028</td>
<td>4</td>
<td>11</td>
<td>338</td>
<td>16</td>
</tr>
<tr>
<td>ATSIIHWWG</td>
<td>0.027</td>
<td>6</td>
<td>7</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>CHIP</td>
<td>0.027</td>
<td>6</td>
<td>3</td>
<td>57</td>
<td>3</td>
</tr>
<tr>
<td>NEACID</td>
<td>0.025</td>
<td>4</td>
<td>8</td>
<td>64</td>
<td>16</td>
</tr>
<tr>
<td>ANCD</td>
<td>0.023</td>
<td>1</td>
<td>11</td>
<td>57</td>
<td>16</td>
</tr>
<tr>
<td>JAG</td>
<td>0.023</td>
<td>6</td>
<td>7</td>
<td>68</td>
<td>8</td>
</tr>
<tr>
<td>SIGNAL</td>
<td>0.023</td>
<td>6</td>
<td>3</td>
<td>302</td>
<td>3</td>
</tr>
<tr>
<td>IGCD</td>
<td>0.018</td>
<td>3</td>
<td>7</td>
<td>100</td>
<td>9</td>
</tr>
<tr>
<td>PHWDSG</td>
<td>0.018</td>
<td>6</td>
<td>6</td>
<td>58</td>
<td>7</td>
</tr>
<tr>
<td>ATSIIHRWC</td>
<td>0.015</td>
<td>4</td>
<td>7</td>
<td>50</td>
<td>7</td>
</tr>
<tr>
<td>NEACT</td>
<td>0.015</td>
<td>4</td>
<td>5</td>
<td>139</td>
<td>5</td>
</tr>
<tr>
<td>NACSDE</td>
<td>0.013</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>5</td>
</tr>
</tbody>
</table>

E=eigenvector centrality score, S=number of steps to Cabinet, I=interlock, B=betweenness, C=co-member

The eigenvector calculations produce relative scores that move analysis beyond the local context of a single committee. For example, the ascending order of committees are very different for the number of interlocks (Table 23, column I), the betweenness score (Table 23, column B), and the number of co-members (Table 23, column C). The combination of these separate elements in the eigenvector centrality scores removes bias due to these local factors. For example, the APACSIMP had higher numbers of interlocks and co-members than the NHMRC (Table 23), but more important was that the NHMRC was between other more central committees compared to the APACSIMP.
(Figure 10). The score for the NHMRC made it by far the most central committee (Table 23, column E).

The dispersion of the eigenvector centrality scores indicates a network where committees were heterogeneous in their structural positions. There was a lot of variation in each committee’s centrality scores (from 0 to 0.867), a substantial variation in the whole network (standard deviation = 0.12 relative to the mean = 0.049, giving a coefficient of variation of 245 per cent), and a high network centralization index of 135.93 per cent. Many of the connections in this network have to be made via an intermediary - there is a lot of betweenness (Table 23, column B).

All of the seven Indigenous health committees were interlocked to other committees in the health committee network (Figure 10). There is also no relationship between the eigenvector centrality scores for the Indigenous health committees and the number of steps to Cabinet (Table 23, column S). The Indigenous health committees are similar to the rest of the committees in their dispersion of eigenvector centrality scores (Table 23, column E). Therefore the Indigenous health committees were similarly integrated within the health committee network.

**Health committee network**

The health committee network shows how each committee was interlocked by co-members into a network (Figure 10). The ‘size’ of the box for each committee indicates the size of the eigenvector centrality score. The number of co-members between committees is designated by the thickness of the interlocks in the committee network. For example, the thick interlock of the NDPSC and NCCTG comprised of four co-members, whereas the thin interlock between the SGII and the NATSIHC comprised of one co-member.

The health committee network shows the 69 committee members that were also nominated as influential in the informal network. They are designated a colour according to their membership in the 16 network groups (see Figure 5, Chapter 3). The eigenvector centrality score does not account for the status of committee members in terms of their membership of network groups.
Figure 10: Health committee network
Decision making committee network

The health committee network was disconnected from the decision making committee network (Figure 11). In 2004, the decision making committee network had one Indigenous person (Democrats Senator Aden Ridgeway) and 290 non-Indigenous people (Figure 11). In terms of participation rate the 18 members of cabinet participated in 2 to 6 committees at an average rate of 4 committees per minister.

Figure 11: Decision making committee network

Elite knowledge brokers

Neither the committee system nor the committee network approaches accounts for the status of committee members in terms of their informal influence. As such the following set of results is focussed on the links between the informal network data set (Chapter 3) and the committee data set. A small number of people (n=69, see columns ‘il’ and ‘nil’ in Table 26) comprised the link between the informal network and the members of the national health committees. Therefore, 70 per cent (158 of 227) of the informal network may not have been involved in national health committees. Alternatively, 93 per cent (960 of 1029) of the committee members were not considered influential in national Indigenous health policy processes. The remaining 7% of committee members (the 69
linkers) were considered influential to the extent that they received 53 per cent of all nominations (358 of 677) from other influential people. The linkers consisted of thirty influential Indigenous people, or 3% (30 of 1029) of total committee members. Most of these (24 of 30) were located on the Indigenous health specific committees.

**Health information kernel**

The linkers came from 13 of the 16 groups of the informal network (Table 24) as displayed in the health committee network (Figure 10). The health committee network shows that the kernel group people were members of health research, information and data committees (Figure 10).

<table>
<thead>
<tr>
<th>Table 24: Group membership of linkers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group</strong></td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>8</td>
</tr>
<tr>
<td>11</td>
</tr>
<tr>
<td>12</td>
</tr>
<tr>
<td>14</td>
</tr>
<tr>
<td>15</td>
</tr>
<tr>
<td>16</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>
Specifically, five of the kernel group people were members of the NAGATSIHID, most of whose members were Indigenous (Table 25). Thus health information is an important area in which influence is exercised for the kernel group.

Table 25: Indigenous health committee membership by Indigenous status

<table>
<thead>
<tr>
<th></th>
<th>Indigenous</th>
<th>Non-Indigenous</th>
<th>Unknown</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAGATSIHID¹</td>
<td>9</td>
<td>5</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>ATSIHWWG²</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>ATSIHRWC³</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>NDSRGATSIP⁴</td>
<td>11</td>
<td>1</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>NATSIHC⁵</td>
<td>7</td>
<td>5</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>IASHC⁶</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>NIEHF⁷</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>47</td>
<td>22</td>
<td>9</td>
<td>78</td>
</tr>
</tbody>
</table>

¹National Advisory Group for Aboriginal and Torres Strait Islander Health Information and Data  
²Aboriginal & Torres Strait Islander Health Workforce Working Group  
³The Aboriginal and Torres Strait Islander Health Research Working Committee  
⁴The National Data Strategy Reference Group for Aboriginal and Torres Strait Islander People  
⁵The National Aboriginal and Torres Strait Islander Health Council  
⁶Indigenous Australians Sexual Health Committee  
⁷The National Indigenous Environmental Health Forum

**Prestigious interlocks**

The large majority (84%) of committee members participated in one committee only (column ‘p’ of Table 26). So to the majority of linkers (n=45, first row of Table 26) with the informal network participated in one committee. The interlocks came from 16 per cent of the committee members with 24 linkers as interlocks. The 24 linkers/interlocks consisted of fourteen influential non-Indigenous people and ten influential Indigenous people (see columns ‘il’ and ‘nil’ of Table 26).

Multiple interlocks were provided by three prestigious people from the kernel group. They not only had the highest personal indegrees (16, 24 and 26) but they also had the strongest combined relations with other Indigenous and non-Indigenous people (see combined relations, p.70). Furthermore, they were members of the NAGATSIHID and
were interlocks to other central committees. These characteristics make the three prestigious people *elite* knowledge brokers in national Indigenous health policy processes.

**Table 26: Participation rate**

<table>
<thead>
<tr>
<th>m</th>
<th>p</th>
<th>%</th>
<th>ip</th>
<th>il</th>
<th>nip</th>
<th>nil</th>
<th>isu</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>863</td>
<td>84</td>
<td>44</td>
<td>20</td>
<td>736</td>
<td>25</td>
<td>82</td>
</tr>
<tr>
<td>2</td>
<td>113</td>
<td>11</td>
<td>7</td>
<td>5</td>
<td>100</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>3</td>
<td>31</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>25</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>19</td>
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<td>19</td>
<td>4</td>
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<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>1029</td>
<td>100%</td>
<td>56</td>
<td>30</td>
<td>883</td>
<td>39</td>
<td>89</td>
</tr>
</tbody>
</table>


**Data limitations**

The validity of findings in this chapter are affected by some data limitations. The primary issue is the difficulty in capturing the complexity of the committee relationships. The committee system approach assumes that one committee is more important than another by simple virtue of being fewer steps to Cabinet. Assessments of the relative importance (or status) of committees should also consider: the specific purpose of a committee, the frequency of meetings, the location of meetings, the resource base, the stability of a committee, and its broader context. Accounting for these factors would have improved the validity of the findings, but were outside the scope of the study.

The findings would also be stronger with a complete database of committee members. In order to do so would require contacting each committee and seeking permission from each committee member for their information to be included in the study. This would have required more time and resources than allowed within the scope of a three year study. This would also apply to correctly identifying the indigeneity of all committee members. The Indigenous status of 9 per cent of the people in all the committees, and 11 per cent in the Indigenous health committees could not be determined (Table 19).
The internet search of identified Indigenous members revealed that they not only readily identified themselves as Indigenous but also provided details of their tribal descent. Thus it is likely that the unknowns were probably non-Indigenous.

**Conclusion**

This analysis revealed three key features of participation of Indigenous peoples in national health committees. A small number of committee members were Indigenous people. They were concentrated on Indigenous health committees that were distant from Cabinet. However, the Indigenous health committees were similarly integrated into a health committee network. A few of the prestigious members of the kernel group from the previous chapter interlocked central committees, which made them *elite* knowledge brokers. The significance of these findings is tempered by an incomplete database of membership information and the simplification of the complexity of the committee relationships. In the next chapter I examine the features of the relationships between influential people in order to reveal a deeper understanding of the main finding in this chapter. This is that there is a formal system deficiency in the strategic location of Indigenous people.
Chapter 5 - Interviews

Introduction

Stakeholder relationships in national Indigenous health policy processes are framed in terms of interactions between simplified categories. People are categorised as either Aboriginal or non-Aboriginal, their cultures are categorised as either Indigenous or non-Indigenous, and their organisations are categorised as either mainstream or community (80, 87, 104, 229, 230). In contrast, a social network approach emphasises the meaning of relationships in terms of the patterns of interpersonal relations between influential people. In this chapter, I describe in more depth the relationships between influential people from informal networks and national health committees.

Method

The potential interviewees were members of the informal network of influential people in national Indigenous health policy (Chapter 3). The network was defined through a snowball nomination process (167:45). I applied a block modelling algorithm to detect groups of people in the network based on the similarity in patterns of bonds between pairs of people (167, 243). The initial aim was to sample interviewees from each of the network groups. However, the low and slow survey return rate resulted in a lack of relational data and therefore a revision of the sampling strategy (Chapter 3).

I requested interviews of people that had returned a network survey, because they were considered more likely to respond to an interview request. I also selected three other influential people to send requests for interviews, because they had certain characteristics that were not otherwise adequately included in the sample. One person was Indigenous and from the Indigenous community controlled sector. Another person was very experienced in different jurisdictions and different governments as well as being a highly nominated non-respondent and a member of a national health committee. The final person was from South Australia. Requests for interviews were sent (Appendix A), with telephone follow-up of potential interviewees. I used semi-
structured interviews administered face-to-face or via telephone over the period October 2004-March 2005. The interviews were recorded and transcribed for analysis.

**Interview questions**

The initial context of the study was of ‘policy networks and research to policy transfer in Aboriginal health’ (Appendix A). As such the questions related partly to networks and relationships, and partly to processes about knowledge access and use. In this chapter I will concentrate on responses about networks and relationships, following the shift in emphasis of this thesis (see the ‘Introduction’ to Chapter 1). The questions were based on those used by Dr. Jenny Lewis (174, 175, 242), and were re-drafted through discussions with Professor Anderson and Dr. Lewis. Interviewees were not provided with the questions either before or at the interview. The questions were:

1) What are the different types of knowledge that you draw on in making policy?

2) What are your key sources of knowledge?
   i. Do you talk (formally/informally) to people that you think are influential?
   ii. Do you draw-on knowledge from different academic disciplines?

3) What value do you place on each of the types of knowledge?
   i. How do you make that judgement?
   ii. Do you ‘synthesize’ the knowledge and assess its value/validity against some kind of decision making criteria?

4) How do you use this knowledge?

5) How do you pass on your knowledge?

6) How do you judge the effectiveness or impact of the knowledge in the policy making process?

7) What things make it easier for you to obtain, use, pass on and evaluate different types of knowledge about Aboriginal health for policy making?
   i. How important are these things?

8) What do you think could be done to improve the use of different types of knowledge in Aboriginal health policy making?

9) Brief background – qualification, length of time in current position, years of experience in Aboriginal affairs and health, institutional changes in career, and age.
Transcript analysis

The transcribed interviews were analysed inductively through a coding of themes, organised using the tools of the NVivo 7.0 software (267). This involved an interactive and inductive process of open coding, axial coding and selective coding (232:438-467). In the open coding process I identified preliminary concepts, themes and ideas and coded them into categories. NVivo tree nodes were created and aligned with each of the interview questions. Phrases and statements from the interviews were taken as the heading for sub-nodes within each tree node. After all the interview data was coded and organised into the NVivo nodes the information was exported to an MS Word document. The document was then printed with line numbers visible, so as to critically appraise the document, make notes about reorganising the data, and note ideas about concepts and themes that appeared.

In the axial coding process I reviewed the initial codes and examined the interrelations between them. I reorganised the NVivo nodes to correspond to the themes that had appeared through the open coding process. Another MS Word document was created and printed with line numbers visible and the document read critically. Again, some reorganisation of the data in NVivo was necessary to reflect the final major and minor themes.

In the selective coding process I scanned the interview transcripts and previous codes in order to detect cases that illustrated the themes. At this stage of the analysis all of the interview data was analysed and coded. I then focussed on selecting the themes and sub-themes that illustrated the responses about networks and relationships. The data in NVivo was reorganised accordingly with another MS Word document created, printed and analysed. The final themes and sub-themes pertaining to networks and relationships only are presented. The quotes were arranged to reflect membership of the groups of the informal network. The quotes were also presented with minimal guiding text in order to preserve the voice of the interviewees (268).
Key features

There were four key features of the relationships between influential people.

**Informalities**

The interviewees’ statements reflected that invisible informal processes were the normal stream of constant activities underlying the episodic and visible formal processes. Informal processes are about strategic networking, gaining political knowledge and using personal influence. The outcomes of formal processes may just be a validation of informally negotiated arrangements.

**Rules of entry**

The influential non-Indigenous people had to pass some rules of entry in order to engage in and utilise informal processes in which Indigenous people had automatic legitimacy and authority. The rules of entry were an intimidation test, displays of personal values, and motivation to engage constructively with Indigenous people. Subsequent inclusion may allow for an increased strength in trusted relations that flow from the individual to the organisational level.

**Interdependence**

There was a value of connectedness such that an interviewee could not think about oneself in isolation from other people. The influential people could be seen as different types of knowledge transformers - knowledge broker, Indigerns, or Westenes - considering the extent of connectedness with other people. Formal and informal forms of knowledge could only be combined and communicated through telling stories between connected people.

**Anchored to local contexts**

Each interviewee entered national policy processes equipped with a high degree of local context knowledge. The interviewees demonstrated individuality in the provision of national policy advice, in categorising different forms of complementary knowledges, and in the diversity of participation strategies. This occurred in a context of ad-hoc knowledge creation processes. Advice about Indigenous health issues faces pathways that are confusing and convoluted. As such, the knowledge from Indigenous and non-Indigenous people about Indigenous health issues remains anchored to local contexts and will need to be continually ‘re-discovered’.
Results

I interviewed thirty-four influential people from a list of forty-seven, a response rate of seventy-two per cent. However, two interviews were lost, one due to poor recording quality and the other due to recording failure. Most of the interviewees (90%, 29 of 32) were in the core groups of the network, which were the triad groups: 1-5-12 and 1-5-3.

Interviewee characteristics

The summary of characteristics, below, shows that the length, breadth and scope of the interviewees’ combined experiences was considerable:

- The average age of the interviewees was 48 years (range 33 to 58 years). The female average age was 48 years (range from 35 to 58 years), and the male average age was 47 years (range 33 to 58 years).
- The average length of experience in Indigenous affairs and health was 21 years (range 5 - 34 years), with the female average 20 years (range from 5 to 33 years), and male average 22 years (range 6 to 34 years).
- All the interviewees were considered influential and received 30 per cent (206 of 677) of all nominations with personal indegree scores ranging from one to twenty-six nominations.
- In terms of membership in national health committees, there were eighteen people with memberships of fifteen committees, and these eighteen received 25 per cent of all nominations.
- Each interviewee was a member of a network group in the informal network: group 5 = seventeen, kernel group = eight, group 3 = two, group 12 = two, group 6 = one, group 14 = one and group 15 = one.
The general characteristics show that the thirty-two interviewees were 53 per cent male, 47 per cent female, 56 percent non-Indigenous and 44 per cent Indigenous (Table 27).

Table 27: General characteristics of the interviewees

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>15</td>
<td>47</td>
</tr>
<tr>
<td>Male</td>
<td>17</td>
<td>53</td>
</tr>
<tr>
<td>Indigenous</td>
<td>14</td>
<td>44</td>
</tr>
<tr>
<td>Non-indigenous</td>
<td>18</td>
<td>56</td>
</tr>
<tr>
<td>Committees</td>
<td>18</td>
<td>23 (of 77)</td>
</tr>
<tr>
<td>Nominations</td>
<td>206</td>
<td>30 (of 677)</td>
</tr>
</tbody>
</table>

*Expressed as a percentage of the 32 interviewees.

The interviewees worked in seven different categories of job positions: 41 per cent were directors, 16 per cent were secretaries of government departments, 13 per cent were chief executive officers, 13 per cent were academics, 9 per cent were coordinators, 6 per cent were advisors and 3 per cent were chairpersons (Table 28).

Table 28: Interviewees by job position

<table>
<thead>
<tr>
<th>Position</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Health Worker</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Elder</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>ATSIC Commissioner</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Academic</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Advisor</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Medical</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Secretarial</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>Manager</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Chairperson</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Politician</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Coordinator</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Chief Executive Officer</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Director</td>
<td>13</td>
<td>41</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>100%</td>
</tr>
</tbody>
</table>

1 Includes magistrate and unknown positions.
2 Includes lecturer, student, research fellow.
3 Includes advisors, board members, representatives, and policy officers.
4 Includes senior medical advisors, medical officers and doctors.
5 Includes secretary, assistant secretary, associate secretary, first assistant secretary, commissioner.
6 Includes chairperson and president.
7 Includes minister, shadow minister, and chancellor.
8 Includes coordinator and project officer.
9 Includes chief executive officer, deputy chief executive officer, principal, and dean.
10 Includes director and head.
The interviewees were employed in six different categories of organisation: 41 per cent academic, 22 per cent state government, 19 per cent Australian government, 13 per cent Aboriginal community controlled organisations, 3 per cent statutory authority and 3 per cent in professional associations (Table 29).

Table 29: Interviewees by organisation

<table>
<thead>
<tr>
<th>Organisation</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Political Party</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mainstream Health&lt;sup&gt;1&lt;/sup&gt;</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander Commission</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-government Organisation&lt;sup&gt;2&lt;/sup&gt;</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Commonwealth Government</td>
<td>6</td>
<td>19</td>
</tr>
<tr>
<td>State &amp; Territory Government</td>
<td>7</td>
<td>22</td>
</tr>
<tr>
<td>Academic&lt;sup&gt;3&lt;/sup&gt;</td>
<td>13</td>
<td>41</td>
</tr>
<tr>
<td>Aboriginal Community Controlled Organisations&lt;sup&gt;4&lt;/sup&gt;</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Statutory authority</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Professional association</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Other&lt;sup&gt;5&lt;/sup&gt;</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>100%</td>
</tr>
</tbody>
</table>

<sup>1</sup>Includes hospital and community health centre.  
<sup>2</sup>AIDS councils, foundations, associations, colleges, beneficent organisations.  
<sup>3</sup>Includes university and research organisations.  
<sup>4</sup>Includes ACCO (such as Central Australian Aboriginal Congress, Cape York Land Council, Aboriginal Drug and Alcohol Council), Aboriginal community controlled health services, peak Aboriginal health representative bodies  
<sup>5</sup>Includes court, retired, private.
The interviewees were based in six jurisdictions with 28 per cent in Queensland, 28 per cent in the Australian Capital Territory, 19 per cent in the Northern Territory, 13 per cent in Western Australia, 6 per cent in New South Wales and 6 per cent in Victoria (Table 30).

Table 30: Interviewees by jurisdiction

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Australia</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Victoria</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>New South Wales</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>9</td>
<td>28</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>6</td>
<td>19</td>
</tr>
<tr>
<td>Western Australia</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Queensland</td>
<td>9</td>
<td>28</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>100</td>
</tr>
</tbody>
</table>

The interviewees had a total of fifty-three qualifications (Table 31). There were twelve interviewees with a Bachelor of Medicine. Twenty of the interviewees had multiple qualifications, nine had a single qualification, two were unknown and one had no formal qualification.

Table 31: Qualifications of interviewees

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bachelor of Medicine, MBBS</td>
<td>12</td>
</tr>
<tr>
<td>Bachelor of Arts</td>
<td>8</td>
</tr>
<tr>
<td>Master of Public Health</td>
<td>7</td>
</tr>
<tr>
<td>Bachelor of Science</td>
<td>5</td>
</tr>
<tr>
<td>Doctor of Philosophy</td>
<td>5</td>
</tr>
<tr>
<td>Diploma</td>
<td>5</td>
</tr>
<tr>
<td>Master of Business Administration</td>
<td>2</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>2</td>
</tr>
<tr>
<td>Master of Science</td>
<td>2</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>2</td>
</tr>
<tr>
<td>Bachelor Law</td>
<td>1</td>
</tr>
<tr>
<td>Bachelor of Business</td>
<td>1</td>
</tr>
<tr>
<td>Bachelor of Economics</td>
<td>1</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>53</td>
</tr>
</tbody>
</table>
**Informalities**

The focus of this feature is on the consequences of the dynamics of informal networking between influential people for the outcomes of formal processes. Informal networking consisted of the three aspects: strategic networking, gaining political knowledge and using personal influence. The interviewees’ statements reflected that invisible informal processes were the normal stream of constant activities underlying the episodic and visible formal processes, which in combination results in the term *informalities*.

**Strategic networking**

The interviewees demonstrated strategic thinking about, and use of, their informal networks. A secretary (kernel group, two committees) said that there was informal caucusing with people before meetings because “you don’t just leave things to chance”.\(^{31}\) This required convincing people to argue for a proposal, said this public servant (group 3, one committee):

(1) Because you know ultimately you’ll never get a budget proposal through, you know a new policy proposal up, or something, or funding increased for something unless you’ve got all of the right people along the line willing to you know, argue for it and sometimes to stick their necks out for it.

The motivations for the design of formal processes is strategic, indicated a professor (kernel group, two committees):

(2) This can be about power as well as getting people’s insights, in terms of getting people in an alignment to outcomes or an agreed approach to a problem, or co-opting them to a particular agenda, or shifting another agenda by strategic use of people.

The formation of a committee was about having the “right people” at the table who were “people who were representative of organisations and interests – banks of knowledge, and people who know the business” (director, group 5, and one committee). Another director from group 5 said that in the establishment of committees:

\(^{31}\) In this section I do not distinguish between mainstream and Indigenous health committees in order to protect the identity of the interviewees.
The typical way to do it is to get a bunch of people from a range of areas with an interest, cover-off the politics, get representation of key players like NACCHO and others, as well as load it up with a couple of people that might be seen as experts in the area, and do the work,

The ‘right person’ may be someone that agrees with an informally negotiated position. The director that provided statement (3) said this “would be talking to people who would then take a position to a policy table that I can then support”. Though it may not all be one-sided, as being a committee member is a strategic position to influence an organising body. For this Indigenous research manager (group 5, one committee):

Because one of the things that we try to do is work in translating information into policy, so you have people here working in working groups, that sit on advisory committees that know who the directors are of different branches that know the structures, the department of health for example, is probably our key area and we know the structure very well, we know the politics that are operating inside,

This statement (4) indicated the value of knowing about policy processes and structures for strategic thinking. An Indigenous director (group 5, one committee) said that part of the success in getting a proposal on a minister’s agenda and then accepted involved “hooking into parts of political processes” and then having “lots of conversations with lots of people”. As this professor (kernel group, two committees) said it is about ‘working the floor’ and being strategic about ‘how they go up and down the line’:

It depends on the problem. Yes absolutely if I’ve got no idea I’ll actually seek out views and I’ll be quite strategic around that and it’s not a process of being systematic it’s really about trying to find the individual who’ll actually have the answer but I’ve gotta say that it’s not about ‘I don’t know what to do’ it’s more about the application of a problem in a particular institutional context. So, I might go and talk to a range of people about a problem but I’m also trying to ‘work the floor’ so to speak and actually trying to co-opt them or to get them to agree, or to get them to give me some strategic advice about how to, so that, and you know, people who work in policy will be more effective and will be strategic in the sense of how they go up and down the line in that sort of process in a corporate structure, and also work horizontally, and operationalise their broader networks.

The interviewee that provided statement (5) also highlighted that strategic thinking was knowing that “policy is not a very linear process so that gives you opportunities to re-group and re-think and re-structure”. Thus the opportunities to affect policy outcomes may not be limited to one time or place. But it suggests the vulnerability inherent in democratic systems where ministers may change every three years and re-design formal processes. Therefore, strategic thinking may also require targeting embedded
institutional processes that continue regardless of the minister of the day. This secretary (kernel group, two committees) stated:

(6) However it would be naïve to – as some people do I think – to assume that governments come into power and have the policy which bureaucrats implement because it’s an iterative process, and I think in Aboriginal health it’s true to say that government don’t have a – they have parameters that they want to work in – but they don’t have highly developed strategy so that’s actually significantly influenced by what we put up the line and our interactions with, first of all the executive and then the minister in terms of how that policy’s shaped.

The statement (6) indicated the potential of bureaucrats to affect government policy. There is also a slight distinction between departmental processes and party political processes in that a political party may have ‘parameters’ but bureaucrats influence the development of ‘strategy’. Then, strategic networking is also about recognising that “this whole jigsaw of knowledges that I’m giving you are all important at different levels of policy making”, said a professor (kernel group).

Overall these statements indicate the constant processes of informal networking – caucusing; working up-and-down the line; and conversations with many people. The aim was always to influence the outcomes of formal processes, if not their design and composition. An important way to exert influence was through the use of political knowledge.

**Political knowledge**

The acts of strategic networking involved the acquisition and use of political knowledge. This was defined by a secretary (group 3, one committee) as:

(7) knowledge about who is thinking what, which arguments might work the best, you know, knowledge about – yeah, where there are opportunities, where opportunities might lie.

It was not gained from only one network, because “you’re absolutely conscious in the policy development process that you are working within networks, both policy networks, community networks and provider networks” (professor, kernel group, two committees). For example, a policy officer (group 5, no committee membership) gained strategic knowledge through a network encompassing different organisations and jurisdictions:
But then there’s how things are working currently in local communities and in organisations, and bouncing off ideas about how this might impact at a local level, and there’ll be different people depending on what I’m talking about, what issue I’m thinking about, what community, or whether it’s national or state or local, who I’ll talk about with that sort of thing, and I guess I’m really fortunate that there’s a range of people in any of those locations...

Having informal inter-agency networks could undercut tensions between organisations, but also be about trading strategic knowledge. A director (group 5, no committee membership) said:

I guess the value of having networks is that you can do that as an unofficial contact so it’s not your agency disagreeing with their agency it’s ‘have you really thought about these other bits of information that are not apparent in your paper?’, or ‘your secretary said this in a speech the other day, where’d you get that from?, where’s he coming from with that?’, so I mean it’s almost trading knowledge as well saying ‘why’s he saying that, that’s really interesting?’

These statements affirm the existence of informal networks cutting across formally ascribed borders (organisational, jurisdictional, and professional). They also indicate that it is normal practice to use informal networks to trade political knowledge. It seemed that the most appropriate way to utilise political knowledge was through personal influence.

**Personal influence**

The exercise of personal influence occurred through informal networks and informal communication methods. One interviewee said that the leadership of an advocacy organisation focussed on influencing policy process using informal communication through “all sorts of mechanisms”. For this non-Indigenous policy advisor (kernel group, one committee) the importance of informal communication was:

Oh yes absolutely critical, because that is how government works, you know you can talk about government having social responsibilities, an evidence-based approach, values-based system, electoral responsibilities, but all of that is superseded by personal influences and you know politicians and ministers are human beings, and they are influenced by those factors, and that’s the way that it is and Aboriginal health having a very low priority in the Australian political system, you can have the evidence staring politicians in the face and they’re not acting on it so, you have to try all sorts of other mechanisms...there’s what I do and there’s what our leadership does, and our leadership is constantly doing what you’ve just described and that is meeting key influential people, and contacts, and trying to progress issues that way, that’s the responsibility of the leadership.
The interviewee believed that personal influences superseded principles such as evidence-based approaches. This was validated by another kernel group (Indigenous, two committees) member:

(11) decision making in policy is not evidence-driven by and large, it’s driven within socio-political dynamics, so it matters a rats arse what the systematic review says if the ministers says ‘no I’m not going to do that’,

Using personal influence through informal communication affects formal arrangements. A director (group 5, no committee membership) said:

(12) Certainly around some of the new Indigenous affairs arrangements there’s been a few moments where I’ve gone “oh you know, this is not sensible at all”, and have phoned someone up and said “we’re not having this conversation but, you really want to think about a different way?” and they have, it has had an impact.

One interviewee indicated the inter-connection between formal and informal processes and different forms of communication. An Indigenous student (group 15, one committee) with extensive experience in government departments, said:

(13) Informally it might be a telephone conversation, or it might be, we might meet in the street and I’ll say “you know are you coming?”, yeah and they’ll say “you know what I wanted to talk about is this, this and this”, so you, you know, it’s both that formal and informal network that’s important.

For a professor (group 5, one committee) the mechanism deployed depended on a number of factors:

(14) Usually a phone call, or a meeting, or a meal, and, or all of them, it just depends on how big an issue it is and, whether there’s a difficult case to make, or how sensitive it is, how much-how well you know them, and that comes down to personal trust I guess, you know some people you have to work a lot harder to convince than others and, trust of you, but yeah I mean I’m sure everyone does.

The phrase ‘I’m sure everyone does’ signifies the acceptability to use personal influence to affect the outcomes of formal processes. The decision to use personal influence is also about the level of trust between influential people. For another group 5 member (a public servant, no committee membership) who would attempt to change the minds of influential people by sometimes having “a cup of coffee with them and chat with them on the side”, said this required establishing credibility by:
having good knowledge of your own subject area and those broader areas that I’ve talked about like politics and where the government’s coming from and government policy, what’s the community view sort of stuff, also helps you to have more credibility in those informal discussions.

However, an Indigenous lecturer (group 5) stated “what I think is valuable could be someone else’s rubbish”. This refers to the contextual, social and political nature of the application of knowledge, which I address further on. In trying to affect formal processes the use of personal influence appears to be a normal practice. Personal influence also seems to be more powerful than formal scientific evidence. Underlying the use of personal influence was a desire to “make a difference” to Indigenous health. This was a common thread in the interviewee responses to question 4 about using different types of knowledge.

However, ‘making a difference’ to Indigenous health through strategic networking, the use of political knowledge and personal influence, suggests that the outcomes of formal processes may just be a validation of informally negotiated arrangements. In this feature of informalities interpersonal relationships are of primary importance in order to affect formal processes. National committees are high stakes forums because influencing their outcomes can affect national policy, strategies, programs and expenditure. As such interpersonal relationships can ultimately affect institutional relationships. The development of interpersonal relationships seems to be a necessary precondition to be included in informal networks.

**Rules of entry**

This focus of this feature is on the highly personal nature of the development of interpersonal relationships. The development of interpersonal relationships between influential people involved passing an intimidation test, the development of trust and the motivation to engage constructively with Indigenous people. In this section most of the statements came from the non-Indigenous interviewees which I suggest indicated that Indigenous people had automatic legitimacy and authority in informal networks.
**Intimidation test**

All of the interviewees listed names of people to demonstrate their affiliation with them. Their reflections revealed a historical depth and breadth to relationships in the sense of time and shared experiences. The fundamental importance of relationships was stated by this Indigenous doctor (group 5) in that:

(16) responding to Aboriginal health disadvantage requires that everything we do is done through relationships, because that’s how all things are connected to all things.

In the development of relationships one of the experiences encountered was of intimidation directed towards non-Indigenous people. This secretary (kernel group) with fourteen years of experience said that:

(17) Non-Indigenous people also get very intimidated. I mean this isn’t always the case but you know, there’s often people with a lot of goodwill who want to do the right thing, and therefore they become, they lose their common sense about stuff too so, non-Indigenous people get told “that’s not culturally appropriate” so they say “I can’t do that”, and you know I have Indigenous friends who laugh and say “you know, god it’s just common sense what’s being said so you know, why would so and so not do that because they’re told it’s not culturally appropriate I mean that’s just bullshit”.

The secretary was able to check statements about cultural matters by talking with Indigenous friends. This indicates the importance of being included in networks, as those who were not included could be told something was not ‘culturally appropriate’. The intimidation had deep historical roots and was a part of the experiential memory of influential people. An organisation head (group 3) with twenty five years of experience remembered an incident in the 1970s:

(18) I got to meet some of the Aboriginal activists like [name], got abused by [name], and then started to understand some of them, and then I realised I wasn’t the first person to be abused by him.

The phrase ‘started to understand’ after being intimidated indicates a kind of transformative experience, which I address further on. Furthermore, this interviewee and others that follow use the keyword ‘understand’ in relation to intimidation by Indigenous people. This indicates their motivation to engage constructively with Indigenous people, even though intimidation was a normal behaviour evidenced by the phrase “I wasn’t the first person to be abused by him”. Speaking about a different
jurisdiction, this senior researcher (group 5) with twenty four years of experience said that:

(19) …you were reluctant to stick your head above a parapet and say anything!, because you might lose an ear or something, it was very, very real in the early 80s and 90s, the reluctance to make any comment about indigenous health was such-I ‘spose in someway understandable it is essentially, pathetically self-defeating responses as ‘you’re not black you can’t speak for us’, well I’m not trying to represent you here’s some comment on reasonably factual information which might be useful and here’s one persons opinion on what this might mean, I’m not saying I’m standing here representing Aboriginal people I’m simply saying here’s an opinion, here’s some information, so that sort of atmosphere, one person intimidating many people and I found it personally intimidating to.

The interviewee felt physically affected from one person that intimidated many people. The ‘you’re not black you’re not one of us’ statement was also issued to this secretary (kernel group):

(20) And it-you know I mean being very frank to, it’s also an issue because at the end of the day if you don’t agree on an issue there’s always a standard response ‘you just don’t understand because you’re not one of us’

The phrase ‘standard response’ indicates a normal behaviour in the contemporary policy environment of 2004. This was the context in which I asked question 8 about ways to improve the use of knowledge. A professor (group 5) with thirty years of experience in the health system, said:

(21) that’s the other problem about getting people to move on Aboriginal health, they feel like Aboriginal people hate them and you know, they’re right, and then it doesn’t matter what they do they’re always going to hate them, they’re wrong but you know…I’ve had my head bashed-up by the best.

There is a feeling that Aboriginal people hate non-Aboriginal people. But the important message is that non-Aboriginal people can do ‘things’ to earn trust. One of these is to survive the intimidation test. Reflecting on personal experience in the 1960s with a group of Indigenous women, the professor that provided statement (21) said:

(22) I mean I understand where it comes from I think it’s counter-productive, and it is like a kind of test, will you put-up with this, will you stick with us?...I got thoroughly beaten-up, in a verbal sense, and I mean not that they were wrong I was full of piss and vinegar you know…and I needed to be pulled-up…but I think that getting past the anger will be really, really helpful.
This Indigenous public servant (group 5) with twenty years of experience used an awareness of this intimidation to facilitate relationship development:

(23) I’d have probably about half a dozen joint projects running at the moment with the mainstream, in a way that none of the other parts of the department does, and that’s really about strength of relationships, honesty, and the odd banging on the table, but really respecting people and respecting that they might come from a base of no knowledge in indigenous affairs and where they are scared shitless of upsetting Aboriginal people, don’t know how to talk to blackfellas, so I understand all of those fears.

The interviewee did strategically use an overt sign of intimidation in ‘the odd banging on the table’ in the context of respectful, honest and strong relationships. The same public servant (group 5) mentioned the intimidation of Indigenous women. Full of emotion at the recollection of the situation (thick voice, watery eyes) the interviewee said:

(24) Yeah, well, I fucken sit down here and I did a fair bit of work with [name] who’s the only woman on the [organisation], up against it all, there are men on there who behave very poorly, and you know they’d roll over on issues so you’re talking about that being the leadership group, and collective knowledge needing to be harnessed,

The phrase ‘that being the leadership group’ indicated an accepted behavioural pattern amongst Indigenous peers. This research director (kernel group) with thirty three years of experience, talked about the ‘normal’ behaviour of Aboriginal domestic violence in a community:

(25) It is unbelievable how many people don’t understand it, I mean we were talking about this with a couple of Aboriginal people the other day, and one of them said you know was telling me this story about you know, Aboriginal domestic violence, and one of the Aboriginal women was saying to her friend, this was outside the [organisation] and they were talking about it and she said ‘you know the way she’s responded you’d think she’d never been raped’. You know now, can you imagine saying that, we can’t imagine a conversation like that in the circles that I move in, but in Aboriginal – ‘yeah you’d imagine, she can’t imagine you know, can’t imagine ever been raped’ – you know well as if it’s normal you know that, so that we don’t understand a lot of what goes on in Aboriginal communities you actually have to live with people I mean staying with some of my Aboriginal friends in [location], you know I know what goes on, I know a little bit, I know a little bit of what it’s like to be Aboriginal, and that kind of understanding is absolutely crucial...

In the previous quote the violent behaviour of males was entrenched to the extent that a woman who did not experience rape was positioned as abnormal. This intimidating mode of behaviour through violent acts and actions extended from the remote
communities to professional environments. This Indigenous doctor (group 5) stated that change was needed:

(26) You know I think we need a new way of doing things, and I know people do do it like that, this is certainly not a racist statement but you know the 70’s approach to engaging in political discussion I think has to change, you know it’s just bashing people over the head, and no-one’s getting anywhere, we’re all feeling bad.

These examples reveal the endemic nature of intimidation, an experience which the members of these groups (1-3-5) had in common. It had deep historical roots, was conveyed to different non-Indigenous people in different jurisdictions, and Indigenous men appeared to be the main protagonists. Nevertheless, the nature of this intimidation was understandable to non-Indigenous people who had a motivation to continue in Indigenous health and develop trusting relationships with Indigenous people.

**Levels of trust**

Nevertheless, the non-Indigenous people in the core groups had developed trusting relationships with Indigenous people. This could occur through changes in the broad socio-political context. For example, this researcher (group 5) drew on the history in a particular jurisdiction where the environment had changed such that there were:

(27) …increasing levels of trust and collaboration and respect between Indigenous people and organisations, non-indigenous people and organisations …. I ’spose respect is built on trust the two go together – if you got that then you can have formal agreements, you can develop informal links, you can develop all sorts of things, you can develop people who are willing to learn from each other,

The development of ‘increasing levels of trust’ had occurred in this jurisdiction even in the context of the Indigenous affairs changes made by a national conservative government. Maybe the high levels of trust and respect can buffer broader contextual factors. But displays of personal values were necessary to gain trust. For example, this doctor (kernel group) would advise other colleagues “white middle class doctors” to “be yourself and, and form relationships and it takes time to develop and things happen through trust”.

Indigenous people were also required to gain trust. There were two Indigenous employees of mainstream organisations in different jurisdictions, who talked about the
need to gain trust from the Indigenous community. One interviewee (group 12) had a personal mantra of the “CPR of life – be consistent, persistent and show resilience”. This mantra was invoked in the context of developing relationships to fulfil the personal commitment to “enlist people to improve Aboriginal health”. Underlying this was an awareness that “I think you gotta be mindful that in twenty years time what are your grandchildren gonna be saying?” This statement indicates a willingness to engage constructively with mainstream organisations and non-Indigenous people.

The mantra ‘CPR of life’ indicated a commitment to longevity in the health sector. Longevity was also about trusting relations, changing socio-political context, and displays of personal values. Although gaining trust and respect may take many decades, the result can be ‘increased levels of trust’, and the effect on an individual can ramify into larger arenas. For a non-Indigenous person (kernel group) the trust in the strong relationships with Indigenous people developed over thirty three years then transferred to a trust in a mainstream research organisation. This was strongly driven by the personal motivation of the director (kernel group):

> (28) The policy of this [organisation] is very much guided by my enthusiasm for this, to involve Aboriginal people as much as possible in the research, both from the point of view of what research is done, but also the way it’s done,

An Indigenous public servant (group 5) with thirty four years of experience validated this effect in the statement “We know individuals within them we think are pretty good people and we trust them, so there’s an interesting relationship between trust and service delivery”. While individuals’ values can ramify through organisations the driving philosophy of an organisation can also lead to local level changes. For example, the accurate identification of Indigenous people in its administrative processes, as this researcher (group 5) said:

> (29) the [hospital’s] governing body has a long-standing philosophy of assisting the poor and down-trodden and that’s their principle role, that’s why they developed to run health services to the poor and indigenous and everything else, and they had that respect for Indigenous people, and that motivations and they said ‘one of the ways we must know you – if we don’t know who the hell people are well we’re not fulfilling our mission, we can’t fulfil our mission of personal service, or of understanding the service we deliver’,

These examples show that ‘trust’ is an important value in the development of relationships. Trust takes time to develop, occurs to different extents, and can affect
organisational development and policy. The motivation for personal values can come from personally transformative experiences.

**Motivation to engage constructively**

A number of points indicate a motivation to engage constructively with Indigenous people. The ‘intimidation’ was ‘understandable’; the longevity in Indigenous health as evidenced by the average length of experience in Indigenous affairs and health of twenty-one years; and the development of trusting relationships. The transformative experiences of some interviewees were important in shaping their motivation to engage constructively in Indigenous health. There were some interviewees (four) that indicated the profound effect of some of their experiences. For a professor (group 5):

(30) something that really influences my thinking, and I think this is relevant to policy, is my own personal experience with Aboriginal people and particularly with my childhood experience with Aboriginal people-not that it’s that extensive, but my first best friend was a little Aboriginal girl and my friendship with her was a bit of an issue so I got ‘conscientised’ very young I think so.

Another interviewee reflected on the journey through years of activism on Indigenous issues such as being involved in the establishment of the Aboriginal Tent Embassy in 1972. This departmental head (group 5) said:

(31) I sometimes reflect back to the stolen generation, my in-laws had a young Aboriginal girl live with them in the 60s and 70s and when I was first courting my wife I knew her quite well because she was a member of the family, but when the whole of the stolen generation came out it made me reflect on that because my in-laws I’ve got no doubt had their heart in the right place, wanting to do the right thing, but it didn’t work, it didn’t work.

In the context of a professional setting early in a career that spanned twenty five years, this organisation head (group 3) said:

(32) I got taken to the clinic across the harbour from Darwin at-forgotten the name of the town-[name]-which is not it’s Aboriginal name but it’s settlement name, but I remember meeting a guy called [name] who was the Aboriginal health worker there and he told me-this is in 1981 when I was still working in [state health]-and he told me that communicable diseases weren’t the big problem in [town] they were chronic diseases, diabetes and cardiovascular diseases, and I remember being really surprised at that, that was my eye opening experience around issues in Aboriginal health,
Such kinds of transformative experiences were stated as a way to improve the understanding of non-Indigenous people that had little or no exposure to Indigenous issues. This professor (group 5) said that “I think the transformation has to be experiential and personal and inside their hearts”. The strong effect of the physical context of Indigenous circumstances was noted by another professor (group 5) that regularly took government representatives to Indigenous communities, in saying that “there is no substitute for being there”. An Indigenous researcher (kernel group) spoke of such a transformation in a minister and how it affected the minister’s ideas in a national health strategy:

(33) it came about because the minister went to [location] and saw someone in [location] worked for a week as a doc there, saw someone in [location] with a [illness] as a result of untreated [STI]. He tells this story on a number of counts, in a number of kind of, talking about that whole area of policy, and the issues there was that was his personal experience occurring in a cultural context.

However, busy executives had limited time to gain a “genuine understanding of each of the cultures” (departmental head, group 5). This was the case for four interviewees who subsequently relied on the advice gained through Indigenous staff members’ networks. This adds to the sense of the automatic authority and legitimacy of Indigenous people especially in the context of the informal network (Chapter 3) where Indigenous people were integrally embedded. Although, Indigenous people employed by mainstream organisations had to pass the rules of entry to gain membership of informal networks. But these rules seemed to be applied with more vigour to non-Indigenous people given that most of the statements for this feature came from the non-Indigenous interviewees.

The rules of entry for this informal network - passing intimidation tests, the development of trust, and the motivation to engage constructively - involved strong, personal emotions. Once entry was gained then the interviewees could exercise their personal connections to influence formal processes. This was evident in the ‘personal influence’ sub-theme of the ‘informalities’ feature (see quotes 10 and 12). However, it is was also noticeable that the interviewees often talked with many people in order to gain advice through different networks – evidence of an interdependence between people in this network.
**Interdependence**

The focus of this feature is on influential people being connected. The fundamental importance of relationships was noted in the ‘rules of entry’ feature and the sub-theme of intimidation test. All of the interviewees referred to other people as a source of knowledge in response to question 2. This was a common understanding between the members of the core groups given that most of the interviewees were from the triad groups. Then I inferred the common understanding to indicate a strong value of connectedness where an interviewee could not think about oneself in isolation from other people-in the context of this study.

**Transformers**

I also suggest that thinking about oneself in terms of connectedness to others was indicated in the earlier feature of informalities where the interviewees’ strategically networked with different people partly to obtain political knowledge. Networking was also about the gaining access to the different knowledge bases of other people because of a self-awareness of the limits of personal knowledge bases. This arose in the context of question 2 where I prompted the interviewees if they accessed knowledge from different disciplines such as sociology or politics or anthropology. The strategy of an Indigenous researcher (kernel group) was to develop ‘edges’ for engagement:

(34) Well I suppose the broadest base of my knowledge base is medical, and then I don’t have the depth of knowledge that an anthropologist would have, you know their base is different to my base, I try to you know, have edges where I can engage and converse with an anthropologist or a psychologist and there’s an interface between their knowledge and my knowledge, but I know that our base is different, and that the depth of what I know is different to an anthropologist or a philosopher or an ethicist and I could never claim to be what they are but there’s an edge at which we can have dialogue.

The desire to learn about different areas of knowledge in order to facilitate dialogue with other people indicated an important motivation for forming networks. The interviewee that provided statement (34) could also incorporate the knowledge from other Indigenous people into ‘my world view’:

(35) I ‘spose there’s historical wisdom that Aboriginal people have developed and been around and developed health services, they have that it’s not written down anywhere, you kind of get to know them over a decade or two and they tell you the history and they kind of pass it on and I try to incorporate that into my world view.
This statement (35) indicates the internal process of knowledge transformation. As another highly educated Indigenous doctor (kernel group) said, “in my mind there is personal subjective informal knowledge processes that produce a different sort of knowledge”. Thus, I suggest that each interviewee could be seen as a knowledge transformer in themselves, but who could have influence in policy processes when connected to other people.

**Brokers**

In the policy environment of Indigenous health emphasising coordination and partnerships, people need to make connections in order to pass-on their knowledge. An individuals’ capacity to pass-on knowledge depended on some modulating factors. For example, a person’s job role is a modulating factor in that the role comes with duties that can enhance or inhibit a person’s participation in informal networks. For statisticians and researchers, their core work was generating data and producing information. For doctors, their primary focus was on the provision of medical care. They brought their knowledge to bear on specific national policy issues *periodically* such as through consultation processes or national health committees.

The value of their brokerage role was important for busy executives because as this policy advisor (group 5) said:

*(36)* if you’ve got the right expert or the right networks, and you’ve chosen them on their ability to give you contemporary and relevant advice, what’s in the heads of those people is essentially what’s on the database times more, you know, and I’ve tried this with clinical stuff, to finding a question, going and doing as much as I can within an hour in terms of finding out information about it, and then going an asking a colleague, and if you pick the right colleague they will actually just short circuit that for you and give you very relevant and up to date information, people who are up to date themselves, you know, they keep-up with that particular area, are generally very good knowledge brokers themselves.

Knowledge brokers were a time-efficient way to obtain formal knowledge value-added with up-to-date information such as political knowledge. The brokerage role was clearly about certain kinds of influential people calling-on the knowledge of other people ‘depending’ on the issue. Some of the interviewees, due to a combination of their job role, level of government, and organisational resources, were *constantly* involved in
national policy discussion across a range of issues. There were four interviewees (secretaries and directors in the triad 1-3-5) where a normal aspect of their jobs was to travel and talk with Indigenous people across the country. These and other members of the core groups displayed indicators in their social relationships that placed them at an entirely different level of transformer.

**Westenes**

Some non-Indigenous people had strong interpersonal relationships with Indigenous people such as indicated by the finding of friends and work colleagues in ongoing contact (Chapter 3). The non-Indigenous interviewees were acutely aware of their cultural origins, but demonstrated a high degree of conscientiousness of the choices in the construction of relationships with Indigenous people. People can be “conscientised” through, for example, personally transformative experiences. As such I thought of non-Indigenous interviewees as Westenes - a combination of (West)ern and Indig(ene). Furthermore, the Westenes demonstrated that they could operationalise different sets of knowledges.

The construction of relationships with Indigenous people occurred through a process where the non-Indigenous interviewees gained an understanding of Indigenous people through ‘just talking with people’. This could affect a person’s ‘basic view’ as said this Westene professor (group 5), in speaking of a strong, personal relationship with an Indigenous leader (family visits, talking over beers):

(37) Your own experience of real situations is fundamentally, to me, fundamentally drives your basic view, and that’s shaped somewhat by the epidemiologic data, and given detail by what people talk about and different perspectives provide.

The next statement indicates a belief that people not only contained knowledge but applied various filters to it when it was processed. This Westene policy advisor (group 5) said:

(38) I mean if you look at knowledge as a kind of scientific technical knowledge, and experiential cultural and social knowledge, I don’t actually make that distinction, I don’t go out and say ‘well I’ve got my scientific knowledge now, I’ll got out and get some cultural with it’, but what you tend to see is whether the knowledge which you’ve got has been filtered through any of those processes, so if the knowledge is coming from
Aboriginal groups or Aboriginal people or Aboriginal colleagues, then it’s usually already got that mix in it, been pre-thought about, been pre-mixed, and you’ll be well aware if it seems to be irrelevant to the situation you’re working in.

The passed-on knowledge was then transformed with the mixed-in Indigenous knowledge. This Westene could make the judgement of the relevance of the Indigenous aspect of the knowledge which indicates a conscious sensitivity to the value of different sets of knowledges. Furthermore, the statement (38) implies that any single person could be a locus of many experiences - such as gender, scientific, organisational, and jurisdictional, as indicated in the diversity of the interviewees’ combined experiences (see ‘Interviewee Characteristics’ section, above). As such it may be unnecessary to use artificial typologies for different forms of knowledge.

Both the Indigenous and non-Indigenous interviewees talked about different activities to learn about, or maintain contact with, Indigenous cultures. This ranged from reading literature by Indigenous authors to cultural awareness training to camps to family and cultural gatherings to being friends and work colleagues. I suggest that these activities were inherently about developing, and increasing, a personal sensitivity or consciousness of Indigenous knowledges and experiences through being connected with Indigenous people.

**Indigerns**

The Indigenous interviewees had both overt and subtle indicators of the quality of their social relationships with non-Indigenous people beyond that of a brokerage role. I thought of the Indigenous interviewees as Indigerns - a combination of Indig(ene) and (West)ern.

The overt indicators were that most of the Indigenous interviewees (11 of 14) were employed by mainstream organisations and were highly educated (see ‘Interviewee Characteristics’ section, above). Indigenous people could also lead organisations, departments, programs and units that had a mainstream organisational basis. For example, this Indigern organisation head (group 5) talked about the modulating factors of ‘access and opportunity’ to be involved in a discourse:
I think access and opportunity. There’s a big difference when you’re caught-up in a system in a central way like when you’re in NACCHO or an AMS or a peak affiliate or OATSIH or prime minister and cabinet, you’re privy to a loop, and when you’re a bit removed from it sometimes they get less opportunities to you know, you’re sort of like a live participant in a discourse and sometimes you’re not in that and you’re out of it, so I think the main thing is access and opportunity, not just physical opportunity but opportunity to be included in a discourse or a dialogue.

The maintenance of an Indigeneity was indicated where the Indigenous interviewees tended (nine of fourteen) to place a higher value on Indigenous community knowledge. An Indigern doctor (group 5) ranked his response:

I put the highest stakes on community and cultural knowledge, and then the evidence base, then experts opinion on the evidence base around Aboriginal health, and then I would consider my gut next, and then it would be my head after my gut…

An Indigern state public servant (group 5) placed a weighting on the value of different forms of knowledge:

I tend to think that I place more emphasis on, that I weight more highly, it would be in an order of cultural, historic, contextual and evidence, and I think, and I wouldn’t weight them equally…I’d weight it by a factor of 30% on cultural, perhaps about 30% on historic, I’d say 20% on context, and 20% on the evidence.

An Indigern chairperson (group 12) said that “all knowledge is valuable”. The chairperson acknowledged that an Indigenous person could mix different forms of knowledge, when referring to the outcomes of a competition “an Indigenous doctor won it but, I mean see that’s biomedical knowledge over natural knowledge, no but I mean the doctor who is one that is able to mix both”. This chairperson could also mix both in being “taught me a lot of traditional ways”, through education (four degrees), and through the experience gained from managing health services in different jurisdictions.

A strong part of the Indigenous interviewees’ social relationships with non-Indigenous people was an acceptance of the value of written knowledge. This Indigern state public servant (group 5):

The difficulty I’ve got though is that we have a whole generation of people who were involved from the 1960s on who have not communicated, or not written the intent and the direction and influences that shaped action across that 30 or 40 year period and I’d be one of them, so the opportunity for people to get hold of that knowledge is very limited, that’s a major failure.
An Indigern doctor (kernel group) with multiple degrees valued different forms of knowledge and desired to develop edges of engagement with different people (see statement 34). This included gaining knowledge from other Indigenous people embedded in different contexts. For a different Indigern doctor (group 5), in the context of contrasting an urban environment upbringing with working in remote communities, said:

(43) cultural knowledge I really do draw on that, or I try to, I don’t understand it and there’s only certain things that I’m privy to know,

This could not have occurred without being connected with people. The statements above show that brokers, Westenes and Indigerns demonstrate different degrees of being connected. Obviously, influential people in ongoing contact as friends and work colleagues have strong bonds (see ‘Combined Relations’ section, Chapter 3). Whatever the strength of a bond, being connected to people is especially significant given the Indigenous oral form of knowledge.

**Telling stories**

It seemed that informal communication was the primary way for Indigenous cultural knowledge to be both learned about, and incorporated into policy processes. Indigenous oral forms of knowledge escape capture into written forms of knowledge. This non-Indigenous doctor (group 1) said “you know a text or papers that try to convey cultural knowledge I generally find totally useless, and I find it’s much more about relationships, and it’s much more about having trust between people”. Informal communication and trust between people may allow different topics for discussion (community, family, and politics) to be engaged in. For one Westene public servant (group 3), this was achieved through:

(44) …just in talking with people about their community, their family, their views on politics, you know stories about how you deal with people in the family or community and sensible ways of communicating and consulting, and not very effective ways of doing it so, I can get lots of tips in that sense just through the people that I work with and going out to communities and yeah, meeting with people a lot, yeah,…

The significance of informal communication underlying the phrase ‘just in talking with people’ lies in four aspects. These were the context of interaction, the significance of
non-verbal communication, the nature of the story and the story teller. These things may not be articulated on paper. An Indigern public servant (group 5) said that:

(45) …the other stuff that I know as an Aboriginal person is the stuff that I hear across the table and you know when you look into an elder’s eyes and there’s stuff there that you can never ever articulate on paper,

As such it is only Indigerns that can fully engage with the meaning of Indigeneity. A more limited understanding of being Indigenous can be communicated to non-Indigenous people particularly by Indigenous people in their community context. Such powerful stories from individuals can change a minister’s mind, said a different Indigern (kernel group):

(46) I know that there’ve been particular contexts where ministers minds have been captured by particular presentations of individuals who are embedded within an Aboriginal cultural framework, and they are often powerful stories.

The powerful transformative effect of stories was also acknowledged in the opinion of a Westene (Group 5) who talked about passing on any knowledge:

(47) …it’s telling stories of facts and truths, as much as anything’s true, but to tell a story is so much more powerful a way of communicating, to tell a true story, than all the dry things that people do, which just don’t have any impact…

A different Westene in the same group (group 5) had a philosophy that “with stories and statistics, the two go together”. This indicates recognition of the value of combining different forms of knowledge which are generated through different knowledge creation processes. It also indicates that it is possible for different forms of knowledge to be combined, and that this occurs through communication between connected people.

The five sub-themes of transformers, brokers, Westenes, Indigerns, and telling stories contain the concept of interdependence in different ways. There was an interdependence of knowledge from other people, formal knowledge was insufficient without informal knowledge, and formal and informal processes of knowledge generation where intertwined. I suggest that the value of connectedness demonstrated by the interviewees underlies this interdependence.
Anchored to local contexts

The focus of this feature is at the macro context level within which interpersonal connections and relationships development occurs. There was general acknowledgement of the importance of context by three Indigenous people (group 1, 5, 12) as well as nine non-Indigenous people (three from kernel group, five from group 5, and one in group 11). As this professor (kernel group) stated about knowledge “value is operationalised within a socio-political context”. In this section I have in mind a meta (higher level) context that spans the specific contexts of socio-politics or health professions or health issues.

Individuality

The national Indigenous health policy context includes macro concepts and principles, those which span many health issues, organisations, and jurisdictions. The interviewees demonstrated a common acceptance of the multifaceted determinants of health, the heterogeneity of Indigenous peoples, and the importance of context. They demonstrated values of connectedness, the fundamental importance of relationships, of only being able to make policy with Indigenous people, and of the complementarity of different forms of knowledge.

Within this common acceptance the interviewees demonstrated individuality in their approach to national policy advice. This was strongly indicated in the sub-theme of personal influence in the informalities feature. As I asked the interviewees to respond to each question from their perspective, then it is no surprise that responses were grounded within their localised context. All of the interviewees limited the implications of their responses, saying this depended on:

- jurisdiction, organisations, job positions, and culture;
- heterogeneity of Indigenous peoples, which itself contained elements of diversity in cultural groups, geographical locations, contact history, and contemporary experience;
- multifaceted nature of health as a consequence of social views of health;
- federal system and consequences for health system governance;
- different professions in the health system, from doctors to nurses to researchers;
underlying nature of service delivery through mainstream and Indigenous community controlled health services; and

- various issues in the health system, from expenditure to workforce to diseases.

I suggest that each interviewee entered national policy processes equipped with a high degree of local context knowledge. Individuality was also evident in the interviewees’ responses to question two, sub-question two about drawing-on knowledge from different academic disciplines. While a multifaceted determinants of health is a shared macro concept in Indigenous health policy, its substantive elements are only loosely developed. This allows for individual approaches to accessing knowledges from different academic disciplines. No interviewee had any kind of explicit or formal plan to access knowledge from different academic disciplines in order to build a multifaceted knowledge base.

This was also the case when it came to knowledge synthesis according to multiple determinants of health framework as in the National Strategic Framework for Aboriginal and Torres Strait Islander Health (79:10). Rather than being an explicit process for this public servant (group 5) it was “No, it’s more intuitive I think, some stuff fits with me and some stuff doesn’t.” Intuitive processes were also used in ascribing value to different forms of knowledge (question 3). The example I provided was the ‘levels of evidence’ used by the National Health and Medical Research Council (269:8). This professor (group 5) said “I think that is an intuitive, contextualised thing”. The individual contexts and individual and intuitive approaches to knowledge gathering and synthesis occur within the context of commonly accepted principles and concepts.

**Complementary knowledges**

Another concept that emerged from the localised context of responses was of the complementarity of different forms of knowledges. Whatever the typology the interviewees used in response to question 1, said an Indigenous head (group 5) “I think they complement each other". There were two kernel group members, both professors and heads of research organisations, who stated that their highest value and preferred source of knowledge was of epidemiological or data-driven research. However, they
also indicated the complementarity of different forms of knowledge, especially the value of knowledge from Indigenous people.

Indigenous people also valued different forms of knowledge (see the Indigerns sub-theme, above). For example, this Indigenous chairperson (group 12) said there is:

(48) knowledge that you pick-up, then there’s the knowledge that you experience, and there’s the knowledge that you use and I think you’ve got to combine those together, otherwise your knowledge is not worthwhile.

Different forms of knowledge were required to achieve balance, indicated a senior public servant (kernel group):

(49) there’s a very strong you know, focus on evidence-based approaches but in fact they can also inhibit making sensible, applied policy decisions, so you gotta make sure you balance.

Balance could be obtained from using qualitative research and non-research ‘contextual information’. For example, a senior public servant (group 5) stated that:

(50) the basis of the proposal is that this data shows that there’s a need to do these, but then the solution of the proposal almost flows more from that intuitive contextual information, that broader stuff that you’ve just got in your head.

The ‘broader stuff’ could partly refer to informal or oral knowledge of Indigenous cultures (see the sub-theme of telling stories, above). But it could also be informal experiential knowledge. Informal and formal knowledges could be sourced (question 2) through “it’s experience, what ya read, and what others tell ya”, said a professor (group 5). Different forms and sources of knowledge may occur in the same process such as a national health committee which involves experienced people, reading preparatory material and discussion with other committee members. As this Indigenous community worker (group 14) stated about different sources of knowledge “They sort of run into one another don’t they?” Thus, I suggest that complementary forms of knowledge imply complementarity of knowledge creation processes and communication methods.

Both informal and formal forms of knowledge, and informal and formal methods of communication, occur within participation processes. This is evident in a statement by a director of research (kernel group):
Most Aboriginal health policy has some degree of formalisation of the inclusion of informal knowledge. The classic process of consultation, so community meetings, talking with Aboriginal health workers, talking with administrators, or structured policy processes. Now that’s in terms of engaging with Aboriginal and Torres Strait Islander people and that’s been a development probably over the last 10-15 years, the period prior to that was very rarely included in the policy process.

The interviewee that provided statement (51) defined informal knowledge as “the stuff that keeps off the table most of the time is personal and subjective experience and that kind of knowledge”. It could also refer to cultural knowledge and political knowledge both of which may be gained through “just in talking with people” said one non-Indigenous secretary (group 3). This statement of seemingly an obvious and self-evident fact of ‘just’ talking to people reflects the normalisation of Indigenous people’s participation in national policy processes. This has occurred in the context of development of formal participation processes at the federal level over the ‘last 10-15 years’.

Diverse participation strategies

Individuality was reflected in the diverse participation strategies deployed to engage Indigenous people. Participation strategies are about making connections with people and garnering their knowledge, which I noted earlier, was significant for understanding Indigenous oral cultures (see the sub-theme of ‘telling stories’, above). In contrast to the term ‘diverse’ there was a common principle of “the strong recognition that you don’t make policy about Aboriginal health without Aboriginal people”, said the director of a state government health unit (group 5). This and other interviewees had the authority of senior positions to instigate various participation processes through their organisations.

The participation of Indigenous people in a national level mainstream information organisation was through “a strong advisory committee on Aboriginal health” (head, group 5). This contrasts with the ‘normal’ style of engagement embedded within the philosophy of community control. A policy advisor (kernel group) said that a national Indigenous advocacy organisation used member surveys, focus groups and workshops, and drafting policy documents and submissions to government enquiries. Given the heterogeneity of Indigenous groups, then for this non-Indigenous doctor (group 5) it
meant that “the structure of community control gives me some assurance that there’s the possibility of getting an accepted view of things”. The role of the organisation was to act as a national advocacy point in a federal system - a part of the macro context of national Indigenous health policy processes.

Indigenous people were also required to engage with community members. For an Indigenous doctor (group 5) employed in a health service the patient contact with community members was a key source of knowledge “around how the health system affects them on a day-to-day basis”. The Indigenous manager (group 5) of a mainstream research unit said:

(52) whilst it’s alright for me to say I’m Aboriginal I think that you have to go and ask people that have had nothing to do with the health system, about what do you want from the health system?

The above examples show that engaging with Indigenous people was underlain by different philosophies and goals of different organisations. This can mean that any one person may be involved in more than one participation process. For an Indigenous doctor (group 5) these were patient contact, membership of national health committees, leading a national consultation process for the development of a health strategy, a conjoint lecturing position, as well as health clinic meetings. Each participation process requires the use of different kinds of knowledge through different communication methods.

**Ad-hoc knowledge creation processes**

The diverse participation strategies reflected the localised contexts of the interviewees. The interviewees’ suggestions to improve the use of different types of knowledges in national Indigenous health policy processes (question 8) were grounded in their local context. Only this professor (kernel group) stated:

(53) what we need is systems that can actually collate and synthesise research knowledge and present it in a timely way to people who are making decisions and communicating that effectively, now we don’t have those systems and structures in Australia.

This statement (53) refers to the synthesis of formal knowledge such as reviews of peer-reviewed literature on a particular health issue. The statement also refers to an ongoing
meta-level and formal process of knowledge creation and communication. Literature reviews are ad-hoc and one-off rather than strategic and constantly updated with new research findings. The interviewees’ localised knowledges are indeed synthesised in a range of national strategy development processes and committees. However, these are without an overarching meta-synthetic process which continually collates and generates formal knowledge in an ongoing way.

Formal knowledge, in terms of written or published literature, was a source of information for all interviewees. This written information may be accessed by different people through time. As a public servant (group 5) said about policy proposals that when people read it “then it’s new knowledge for them”. The importance of this formal knowledge is that it exists beyond the biological life of a creator. A professor (group 5) said that “I live in hope that the publication of the paper might give it a bit longer life so that it becomes useful in a continuing battle”.

The statement (53) also contains an implicit recognition of the significance of combining informal knowledge and informal communication in formal processes. This occurs in the phrase ‘communicating that effectively’. What is also not communicated in formal writing is the experiential form of knowledge, which was indicated by the interviewees as the most important form of knowledge. This was stated explicitly as form and source of knowledge, but also as a key factor in processes for valuing and synthesising knowledge. It is an unwritten or informal knowledge that has less utility than written knowledge because it is held within people’s minds. It can be best communicated in contexts of personal interaction, as I demonstrated in the sub-theme of telling stories.

Personal interaction is also a way of understanding knowledge from people with different academic knowledge bases, as mentioned previously in the sub-theme of transformers where the Indigern (kernel group) developed ‘edges of engagement’. The professor (kernel group) that gave statement (53) also said that:

(54) I think we need a multi-faceted strategy often because that formal knowledge is operating across disciplines and across content, and not all systems and structures have got the capacity to do that stretch, so you need ones that are more specialised around health services research, you might need ones that are specialised around different areas of public health content like diabetes and eye health, it’s not that they occur within one monolithic
This indicated meta-thinking that considered accessing and using different knowledges according to a multifaceted view of health. The absence of a formal meta-synthetic knowledge process means that the worth of Indigenous oral knowledge remains mostly bound to localised contexts. The worth of Indigenous oral knowledge was noted by this Indigern (group 5) who said that:

(55) …indigenous knowledge and the worth of that knowledge, and the strength of that knowledge that I bring into a policy context, and I’ll drop those stories into a policy context to illustrate rather than to be applied as evidence, and some of those stories are powerful political stories to tell so,…

Indigenous oral knowledge remains mostly bound to localised contexts because a relatively small number of Indigerns occupy positions that connect informal networks, national health committees, and stakeholder organisations. As this Indigern (group 5) said about placing Indigenous people in strategic positions because “we’re spread so thinly we’re better than margarine I think”. Another Indigern (also group 5) confirmed this when commenting about being involved in diverse participation activities meant that of the policy thinking “inevitably a lot of the work is done after hours”. Furthermore, as there is no ongoing meta-process for synthesising the knowledge gained from numerous national consultation processes (such as national health strategies), then the knowledge from Indigenous and non-Indigenous people will need to be continually ‘re-discovered’.

Overall I suggest that the sub-themes of individuality, complementary knowledges, diverse participation strategies, and ad-hoc knowledge creation processes indicate that advice about Indigenous health issues faces pathways that are confusing and convoluted and perhaps disjointed. There are many different people involved in national Indigenous policy processes, with individual approaches to gathering and synthesising different but complementary knowledges through diverse participation strategies, and injecting advice into many ad-hoc national knowledge gathering processes. I suggest that because there are no meta-organising frameworks (just principles and concepts) which allow local knowledge to continually flow along clear pathways into national
policy processes, that advice about Indigenous health issues remains anchored to local contexts.

**Data limitations**

I was not able to interview people from each of the different network groups. This would have allowed an inter-group comparison to see if the themes were either universal or group-specific. There was also a lack of both Indigenous and non-Indigenous people from Indigenous community controlled organisations. The interviewees also had to respond to the general phrase ‘policy processes’ which conflates the diversity of processes that take place within different stakeholder organisations. There may have been different answers for different processes. Nevertheless the interviewees were people with substantial individual experience spanning different organisations, jurisdictions and governments.

**Conclusion**

The analysis of the interview data revealed four key features of the relationships between influential people in national Indigenous health policy processes. The analysis of the interview data revealed four key features of the relationships between influential people in national Indigenous health policy processes: informalities, rules of entry, interdependence, and being anchored to local contexts. Informalities focussed on the consequences of the dynamics of informal networking between influential people for the outcomes of formal processes. I suggest that invisible informal processes were the normal stream of constant activities underlying the episodic and visible formal processes. The rules of entry feature focussed on the highly personal nature of the development of interpersonal relationships. The influential non-Indigenous people had to pass some rules of entry in order to engage in and utilise informal processes.

Interdependence focussed on the influential people being connected. The fundamental importance of relationships was evident in the value of connectedness where an interviewee could not think about oneself in isolation from other people. Anchored to local contexts focussed on the macro context level within which interpersonal
connections and relationships development occurs. Advice about Indigenous health issues faces many pathways into national policy processes and may remain anchored to local contexts.

Each of the four features shows a great deal of complexity in interpersonal relationships. This complexity is easy to gloss over by using simplified categories such as Aboriginal or non-Aboriginal. Instead focusing on the meaning of interpersonal relationships has revealed that using such simplified categories renders invisible the meaning and significance of bonds between influential people. Although the four features represent different ways of seeing the patterns of interpersonal relations between influential people, it is possible to see one pattern running through all of them.

The pattern is the main finding being that of a meta-level vacuum in conceptualising the relationship between the concepts of participation and advice in national Indigenous health policy processes. I suggest that there is a conceptual space – currently a vacuum – where elements of complexity can be drawn together to produce improved understanding about addressing Indigenous health disadvantage. The generalisability of the main finding is uncertain due to the lack of perspectives from influential people involved in the Indigenous community controlled sector, in particular. In the next chapter I discuss all the key features from informal networks (Chapter 3), the national health committees (Chapter 4) and this interview chapter.
Chapter 6 - Discussion

Introduction

In this chapter I discuss the interpretation of the significance of the three main findings and outline the implications for policy, research and practice. Before doing so I will paraphrase the findings from each of the data chapters.

In the network analysis (Chapter 3) I found that Indigenous people were integrally embedded in this informal network of influential people. The diverse demographic mix revealed no network differentiation in terms of any single compositional variable (such as Indigenous and non-Indigenous). Indigenous people were integral to the network due to the high proportion of Indigenous people in the network, their distribution throughout the sixteen groups, and the interconnections between the groups. Indigenous people were embedded in the network because of their strong combined relations with other Indigenous people, but also because there were strong combined relations between prestigious Indigenous and non-Indigenous people.

In the national health committee analysis (Chapter 4) I found a formal system deficiency in the strategic location of Indigenous people. A small number of committee members were Indigenous people. They were concentrated on Indigenous health committees that were distant from Cabinet. However, a committee that had relatively fewer steps to Cabinet did not necessarily have greater centrality. Indeed, compared to other committees, the Indigenous health committees were similarly integrated into a health committee network. A few of the prestigious members of the kernel group from the informal network interlocked central committees, which made them *elite* knowledge brokers.

In the interview analysis (Chapter 5) I found a meta-level vacuum in conceptualising the relationship between the concepts of participation and advice in national Indigenous health policy processes. Invisible informal processes formed the normal stream of constant activities underlying the episodic and visible formal processes. The influential non-Indigenous people had to pass some rules of entry in order to engage in and utilise...
these informal processes. The fundamental importance of relationships was evident in the value of connectedness, where an interviewee could not think about oneself in isolation from other people. However, advice about Indigenous health issues may need to be continually rediscovered as it remains anchored to local contexts in a macro context where advice faces pathways that are confusing and convoluted.

I argue that the three main findings indicate three characteristics of the nature of participation of Indigenous people in national Indigenous health policy processes. These characteristics were of an ongoing meta-process (informal network), the absence of a meta-perspective (national health committees), and the absence of a meta-concept of participation (interviews). I suggest that they form a meta-frame through which can be applied critical thought about policy, research, and practice in relation to Indigenous peoples’ participation in national Indigenous health policy processes.

**Significance of findings**

This section is about describing the importance and nature of Indigenous people’s participation in national Indigenous health policy processes. The analysis was marred because of the large amount of missing relations data for the informal network and missing membership information from the national health committees. Furthermore, policy networks are but one perspective of policy processes which needs critical comparison with other models of policy making of Indigenous health policy processes. Thus the interpretation of the significance of the findings is tentative.

Social network theory asserts that it is the lasting and sustained interpersonal interactions which give rise to the stable pattern of relationships in social networks (167, 168, 243, 270). A stable pattern of relationships was found in the diverse, integral, and embedded features of the informal network. It would not have existed without Indigenous people as indicated by their greater number, their distribution throughout the network groups, and the interconnections between the groups (see ‘Integral’ subsection, Chapter 3).

There were stronger bonds between influential Indigenous people than between Indigenous and non-Indigenous people (see ‘Embedded’ subsection, Chapter 3).
Indigenous people had automatic authority and legitimacy in this informal network (see ‘Rules of Entry’ section, Chapter 5). Furthermore, Indigenous intimidation was a common experience between the members of the triad groups of this informal network (see ‘Intimidation test’ subsection, Chapter 5). There was a dominant Indigeneity of the network which contrasts with the literature where Indigenous people are constantly positioned as subordinate to non-Indigenous people (86, 123, 126, 133, 271-273).

Nevertheless, there were strong combined relations between Indigenous and non-Indigenous people (see ‘Embedded’ subsection, Chapter 3). In particular, the non-Indigenous people in this informal network did not display any cultural nomination bias (see ‘Embedded’ section, Chapter 3). Furthermore, there was the routine practice of making policy with Indigenous people (see ‘Diverse participation strategies’ subsection, Chapter 5). This sense of inclusion of Indigenous people contrasts with Australia’s past race-based history of socialisation (121). It also contrasts with reports that Indigenous people were not involved in health policy.

In Australia’s past, people with diverse backgrounds established bonds through shared beliefs in values (16). Indigenous peoples’ participation in policy processes is predicated on strong and long held human rights which includes civil rights (such as citizenship) and Indigenous rights (such as self-determination) (85). The Indigenous and non-Indigenous interviewees shared: a common objective to ‘make a difference’ to Indigenous health, a belief in the fundamental importance of relationships, the value of complementary forms of knowledge, a belief in principles of Indigenous peoples’ participation and multifaceted determinants of health (see Chapter 5).

These shared beliefs were reflected in shared informal networking activities. The interviewees practiced strategic networking, the acquisition and use of political knowledge, and the exercise of personal influence (see ‘Informalities’ section, Chapter 5). These practices have a long history where informal social networks were the primary way for Indigenous people to influence national policy processes because of the discriminatory legislation of the original Australian constitution (274).

The informal networking practices are likely to continue because informal networks allow ongoing communication where committees and organisations (formal processes)
are repetitively established and disbanded (96, 137, 140, 151). The interviewees had extensive experience in different organisations and maintained ongoing contact through decades of formal processes changes (see ‘Interviewee characteristics’ section, Chapter 5). As such this normal informal network represents an ongoing meta-process characteristic of Indigenous peoples’ participation in national health policy processes.

As Indigenous people were integrally embedded in this ongoing meta-process then so was their dominant ‘voice’. This is significant because the context of the study was near the end of eleven years of a national conservative government regarded as hostile to Indigenous peoples’ interests. Critics of the abolition of the Aboriginal and Torres Strait Islander Commission stated that this meant ‘taking away the voice of Aborigines’ (275), that Indigenous people ‘have lost their voice’ (276) and that it was ‘abolished to silence Indigenous voice’ (277). These claims could not be substantiated for the domain of Indigenous health in terms of this informal network. Even though the network data collection period did not encompass the period of the development of the New Arrangements in Indigenous Affairs (see ‘New Arrangements’ section, Chapter 2), the meta-process characteristic of the informal network is part of changes in Indigenous affairs arrangements (see ‘Guaranteed but vulnerable participation’ subsection, Chapter 2).

Furthermore, the formal outcomes of policy may adequately reflect Indigenous peoples’ perspectives contrary to popular opinion. Network theory states that the social links between individuals ramify through a society (278). Also it is suggested that value preferences are expressed within policy processes (279). The values in social links between the influential people may receive expression where the outcomes of committees may just be a validation of informally negotiated arrangements (see ‘Informalities’ section, Chapter 5). Thus the values and practices in this normal informal network may be expressed in formal policies and structures.

There are many formal partnership agreements and strategies with principles of partnership, cooperation, collaboration, coordination (98-100, 104, 120). These form the basis of national activities which include multilateral coordination through COAG, national reports based on information from a number of sources other than health information (1, 32), collaborative efforts between research organisations (280), and
coordinated care trials (281, 282). In a dynamic interplay the interrelated people network to produce change in policy outcomes which then structures their ongoing interactions and the interactions of new people entering the Indigenous health sector. As a result, I suggest that the interviewees embodied the network principle of relationality where interrelated people and their actions are seen as interdependent (167).

The relationality is important because the composition of national health committees is significantly shaped through informal networking (see ‘Strategic networking’ subsection, Chapter 5). The formal system deficiency in the strategic location of Indigenous people can thus be partly attributed to informal networking. It can also be attributed to the lack of a macro-view in the Australian health system as evidenced by the absence of research conceptualising national health committees as a system of advice collecting.

In the committee system view the formal (official) advice about Indigenous health is transmitted through many steps and thus may not receive sufficient weight in Cabinet deliberations (see ‘Small and Distant’ section, Chapter 4). Neither influential Indigenous nor non-Indigenous people are located on each committee on the pathway to Cabinet. This is particularly important in terms of the interpersonal links necessary for the communication of informal advice (cultural, political, and experiential) about Indigenous health (see ‘Telling Stories’ subsection, Chapter 5). However, this traditional hierarchy view of reporting links oversimplifies many complex factors such as the frequency of meetings and the nature of the reporting links.

The network analysis revealed that the decision making network of government was disconnected from the health committee network. All official advice about health also has to travel through the formal interface between the two networks - the bureaucratic committee system. The Australian Public Service has a number of Indigenous specific recruitment and retention strategies due to low number of Indigenous employees (283-285). Furthermore, the turnover of non-Indigenous staff may prevent the development of ongoing trusting relationships (see ‘Motivation to engage constructively’ subsection, Chapter 5). In the bureaucratic interface there are very few people that can broker informal knowledge about Indigenous health into the myriad formal bureaucratic committees.
In the health committee network view both the formal and informal advice about Indigenous health may receive greater weight in Cabinet deliberations. In this view information transmission may not occur in line with traditional hierarchical design (247). The centrality of a committee was unrelated to the number of steps to Cabinet, but depended on the combination of the number of interlocks, comembership, and betweenness with other committees (see ‘Similar Integration’ section, Chapter 4). The committee network analysis suggests that the best strategic location to increase the impact of advice about Indigenous health would be as a member of a central committee in a multiple interlock role to other central committees.

Network research on the boards of directors of companies contains a number of findings applicable to committees in a system of advice collecting. Superordinate committees can achieve better information management when interlocked (that is, by a person) with subordinate committees (245). Being a co-member (an interlock) of different committees means a greater knowledge of a broader range of activities within which to locate advice (246). More interlocks and co-members between all the committees would reduce the number of intermediary steps between committees (betweenness) and result in better information transmission throughout a network (286).

As such, a person in the best strategic location would have greater knowledge and opportunity to use that knowledge. However, the few elite knowledge brokers (both Indigenous and non-Indigenous) can not convey the perspectives of all Indigenous people (see ‘Anchored to local contexts’ section, Chapter 5). Furthermore, the elites draw-on an unrepresentative informal network which has a ‘legitimacy deficit’ due to a lack of ‘clear rules of process, transparency or judicial review to govern informal bargaining’ (165:9). In contrast the composition of and relationships between formal processes are transparent.

Mapping the network of national health committees and overlaying the data from the informal network of influence contrasts with a short-term, narrow focus in Indigenous affairs over-emphasising the potential efficacy of individual advisory committees (244). This is symptomatic of an inability to ground the relevance of local activities (that is, individual committees) in terms of a global system (that is, a system of advice
collecting). The absence of such a meta-perspective is another characteristic of Indigenous peoples’ participation in national Indigenous health policy processes.

A big picture view of history shows that the social and political context for participation has changed substantially since the 1967 constitutional referendum and the elimination of manifestations of the white Australia policy. However, Indigenous policy literature remains rooted in binary discourse where people are categorised as either Indigenous or non-Indigenous, organisations are categorised as either mainstream or community, and cultures are categorised as either non-Indigenous or Indigenous (80, 87, 104, 229, 230). Either implicitly or explicitly the outcomes of policy are positioned as the result of a competition between mutually exclusive interests (123, 124, 127, 128, 287).

There is instead a complexity in interpersonal relationships as shown in the four interview features of informalities, rules of entry, interdependence, and anchored to local contexts. Complexity was evident where a combination of different demographic variables and network measures were needed to characterise the network and its groups (see ‘Diverse’ section, Chapter 3). There is a complex explanation why non-Indigenous people were supported by Indigenous friends in the face of intimidation by other Indigenous people (see ‘Intimidation test’ subsection, Chapter 5). This cannot be accounted for through the use of single demographic variable such as Indigenous or non-Indigenous.

Complexity also means that there is an inherent individuality in the interviewees’ practices (see ‘Anchor to local contexts’ section, Chapter 5). There is a sense of individuality in the diverse variables of the influential people; as much as different variables indicate individual developmental pathways (see ‘Diverse’ section, Chapter 3). Perhaps complex factors to do with their experiences lay behind the influential people not solely nominating in accordance with single categories such as gender or organisation or jurisdiction. The Indigerns and Westenes represent a critical challenge to include the complexity of interpersonal relationships in policy literature describing the context of institutional relationships in national Indigenous health policy.

The individuality of local context knowledge can be also expressed through formal processes into formal agreements (see ‘Informalities’ section, Chapter 5). This may
result in an inbuilt fragmentation in formal structures and processes. A local context emphasis is indicated in policy terms where, due to the ‘distinct identity and culture’ (79:3) of Indigenous peoples then all efforts accede to ‘localised decision making’ (120:3). In terms of advice then a government department may hear ‘a different story every day’ through ‘the maze of representative organisational structures that we are expected to go through’ (150:xiii).

The localised and experiential basis of people’s knowledge is the root of why it is difficult for one committee or organisation to represent all the interests derived from the hundreds of Indigenous groups in Australia (288). That Indigenous people were also - to a lesser extent - subject to the intimidation test indicates the rivalries between different groups of Indigenous people which can affect the stability of organisations (16, 226). Indigenous organisations are yet to provide a unified approach to government, with coalitions of organisations failing to last (146).

The localised contexts of people’s experiences are historically embedded within this informal network in health. The sixteen network groups reflect the numerous local and state advocacy groups across Australia before a national advocacy organisation –the Federal Council for the Advancement of Aborigines in 1958 - was developed (16). In these groups, where non-Indigenous people most often pre-dominated, there was bias towards the traditionally oriented Indigenous communities which affected the advice provided by some advisors to governments (137, 140). The urbanised Indigenous people have felt a struggle against such ‘northern bias and southern suspicion’ where Indigenous people in the southern states have felt the poor cousins to the ‘real’ Aborigines living in the north (289).

A more inclusive Australian society may allow fragmentation, less obvious in past history, to fully blossom in the fertile soil of participation. There are now many policy statements affirming the need for Indigenous participation (40, 41, 45-50). There are many activities directed towards that end, such as the multiple national Indigenous health committees (see ‘Similar Integration’ section, Chapter 3). However, the agreement about ‘participation’ is in-principle only. Of all the policy statements about Indigenous participation, none contain reference to any publication (research or
otherwise) discussing conceptual, operational or practical issues (39, 79, 80, 104, 107, 108, 120, 198).

This means that the common agreement with overarching principles and values is at the in-principle level only and can be fragmented by intuitive interpretations and localised practices (see ‘Individuality’ subsection, Chapter 5). Such fragmentation is also evident where local knowledge needs to be continually ‘rediscovered’ in the ad-hoc nature of knowledge creation processes (see the ‘Ad-hoc knowledge creation processes’ subsection, Chapter 5). Although local context knowledge changes and evolves thus requiring discovery, the ad-hoc nature of participation processes may affect the effective transmission - in an ongoing fashion – of local context advice into national policy processes. The contrast of a common agreement with principles and concepts with the fragmentation underlying them, indicates a conceptual vacuum at a higher plane above a complex policy environment that involves different government sectors, health issues, organisations, participation processes, and forms of knowledge. I suggest that this meta-level vacuum is a space where the different threads of complexity could be drawn together, and a practical implication of such a conceptual space is an on-going knowledge creation process.

The value of a formal and ongoing meta-process for knowledge creation can be seen in the decision making committee network of government. This network needs a high number of interlocks, comembers and good information transmission because of the breadth and depth of knowledge coming to it from all social policy areas of Australian society (see ‘Similar integration’ section, Chapter 4). This network has full-time parliamentarians and is supported by the Australian Parliament with the resources to accrue knowledge independent of changes in parliamentary membership. For example, the Australian Parliamentary Library is a static repository of knowledge from which full-time researchers synthesise new knowledge for parliamentarians and the Australian public. 32

The lack of a formal and ongoing meta-process of knowledge creation contrasts with the presence of the invisible meta-process of the informal network. The contrast reveals an

absence of a meta-concept of participation as another characteristic of Indigenous peoples’ participation in national Indigenous health policy processes. The many policy statements affirming Indigenous participation are made within their particular context (40, 41, 45-50). Participation is said to be needed in health research or mainstream organisations or planning processes. However, subsequent participation mechanisms are developed vertically without horizontal conceptualising participation in terms of all areas that affect health.

In a policy system without a meta-synthetic knowledge creation process only a few influential people have the type of job role and organisational resources to connect informal networks, national health committees, and stakeholder organisations (see ‘Brokers’ subsection, Chapter 5). This was exemplified by the kernel group of this informal network who displayed a value of connectedness such that they could not think about oneself in isolation from other people (see ‘Interdependence’ section, Chapter 5). Changes in formal processes are required so that more people develop ongoing, interpersonal interactions necessary for the full development of complementary knowledge and its projection into a diversity of policy processes (see ‘Complementary knowledges’ subsection, Chapter 5). However, there is a meta-level vacuum in thinking about the concept of participation which I suggest means that solutions to participation may not move beyond the pathway of guaranteed but vulnerable participation processes (see Chapter 2).

Improving the context of participation requires grounding in a meta-frame which consists of a meta-concept of participation, the meta-process of the informal network, and the meta-perspective of national health committees. By meta I mean ‘denoting something of a higher or second-order kind’ (192:1102) and frame refers to a framework through which to ‘bound inquiry and direct the attention of the analyst to critical features of the social and physical landscape’ (290:234). Any framework has an underlying theoretical base of organising assumptions necessary ‘in order to interpret and represent the relationship between discrete data’ (291:249). Through this meta-frame I see participation in terms of the principle of relationality in social networks.

Currently there is much energy dispersed in the many efforts at improving Indigenous peoples’ participation in many social policy processes. As noted earlier, in the health
Many people have injected their energy into ensuring such principles are constantly present and processes developed. Through a meta-frame or ‘big-picture’ view all such participation processes are inter-related. However, current efforts are unfocussed because they come from local multiple and uncoordinated origins directed at the same target to improve Indigenous health. As such I conclude that the nature of participation of Indigenous people in national Indigenous health policy processes is one of unfocussed energy.

**Implications**

In terms of the network principle of relationality, meta-participation is about how to structure complex inter-related processes to more effectively engage with knowledge relevant to Indigenous health issues. The Australian Government’s Cabinet garners a vast amount of knowledge from different committees in different social policy areas. Indigenous health is one of ten domains of Indigenous affairs. People participate in different processes at different levels of the health system, jurisdictions, organisations and associations. All these policy areas are interrelated as should be all strategies espousing Indigenous participation in these different areas.

Focussing the energy of multiple efforts needs to occur within a policy framework which views interrelated people as a locus for national Indigenous health policy processes. An Indigenous person can be the locus of different formal and informal knowledges. They may draw-upon their knowledge as a medical doctor or a health researcher or a community advocate, and having worked within different organisations and jurisdictions. Different strategies call for their participation in separate processes such as participation in the health workforce (83), in health research (80), in local planning process through the Framework Agreements (120), through to the development of national performance indicators (114). A framework spanning these and many other strategies would link them together by the thread of participation.

Mechanisms need to be considered to strengthen the link between formal knowledge processes and Indigenous policy processes. A meta-perspective shows that participation should be more than who is on individual committees. That would just lead to a
suggestion to include at least one Indigenous person on each of the national health committees. This could be extended to encompass social models of health which imply that Indigenous people should be located on the multitude of social policy committees that feed eventually to Cabinet. However, there are not nearly enough Indigenous people to satisfy the participation needs in the components of the health system. As such, the COAG’s principle of ‘indigenous participation at all levels’ (102:3) is unrealistic. More policy research would seek to elucidate all the current national committees and the links between them with the aim to improve the strategic effectiveness of advice about Indigenous health.

Realistic strategies for Indigenous peoples’ participation need to at least consider the network concepts of interlocks, co-members, and betweenness. For example, two of the most significant national Indigenous health committees were interlocked with the most important committee, the National Health and Medical Research Council (NHMRC). The National Aboriginal and Torres Strait Islander Health Council and the National Advisory Group for Aboriginal and Torres Strait Islander Health Information and Data also had members from the kernel groups and its two triad groups (see ‘Health committee network’ subsection, Chapter 4). Thus the NHMRC receives - through interconnected people - advice about Indigenous issues from Indigenous and non-Indigenous people from the informal network of influential people.

The NHMRC has also evolved in its structure seemingly with knowledge of these network concepts. In terms of interlocks the chairperson of each principal committee is also a member of the NHMRC (292:1.1-8). The reorganisation of communication flows within a company means improved flow of information to decision makers (247). Additionally, it has a number of co-members with a variety of different committees in the Australian health system (see ‘health committee network’ subsection, Chapter 4). It thus also receives information from a broad range of committees and can formulate advice in the light of this information.

Finally, the people in the co-membership roles are brokers who, equipped with knowledge about activities in different committees, can formulate advice more strategically (246). As a result an increased number of interlocks and co-members between all the committees would reduce the number of intermediary steps
(betweenness) between them. Research shows that networks with lower betweenness results in better information flows throughout a network (286). This creates the potential for a health committee network with a high degree of cross communication which may allow for more effective advice gathering and transmission to the decision making network of government (see Chapter 4).

This could be taken to mean increasing the number of Indigenous people involved in committees. Rather, a network view means one person may be a member of several committees (the participation rate - see ‘Prestigious interlocks’ subsection, Chapter 4). However, doing so is limited by a number of factors, such as the *modus operandi* of a committee. Most of the health committees are single issue focussed whereas the NHMRC traverses all issues in order to raise the standard of public health of the Australian population.

Furthermore, the NHMRC has significant official legitimacy because of its unique characteristics as a combination of independent authority and committee, drawing on independent experts from a broad range of areas in line with its population health role, and with a multi-million dollar annual research budget. While the advice from the NHMRC still travels to Cabinet via bureaucratic committee processes, it does so through more direct senior executive committees. Overall, the current strategies of the NHMRC for gaining Indigenous advice should continue.

However, what needs to be investigated is how the Indigenous advice from all national health committees could be better communicated to the NHMRC (see ‘Similar Integration’ section, Chapter 4). Furthermore, how is the NHMRC connected to other social policy committees? Finally, a number of complicated factors about committees - such as their budget, frequency of meetings, and terms of reference - also need to be considered in research because they are important factors in the gathering and transmission of advice.

The NHMRC and the Australian Parliament share the characteristic of having a permanent organisation structure in place which continues independent of changes in membership. Such a structure should be considered for Indigenous health, tasked with being an ongoing and formal meta-synthetic process for knowledge creation and
generation. This would be a core structure of the policy framework outlined above, drawing-on all the formal knowledge generated in the different social policy areas which affect Indigenous health status. It should contain people only tasked with brokering knowledge to all policy committees in the Australian health system. Full-time knowledge brokers have the time to develop ongoing interaction with policy and decision makers.

The value of increased co-membership and the number of interlocks can be seen in terms of more interpersonal communication links between people. The informal knowledge of Indigenous cultures is most effectively communicated through informal communication between connected people (see ‘Telling Stories’ subsection, Chapter 5). The influential people valued complementary forms of knowledge and especially the informal knowledge from Indigenous people. There was clearly a lack of informal advice flow from the informal network into the national health committees, especially from the heterogeneity of Indigenous people. This could be improved where the terms of reference for national health committees could include criteria that capture subjective interpretations of influence, rather than rely solely on organisational charts and job titles.

Of course human factors need to be addressed. The endemic nature of intimidation, as well as issues of Indigenous identification and Indigenous diversity are yet to be adequately discussed in policy literature (256, 293-295). In practice the interviewees strategically activated a variety of different networks that included Indigenous friends and work colleagues that would support them in the face of intimidation from other Indigenous people. The root causes run deep and perhaps it is a matter of generations of change combined with strategies to address Indigenous violence in communities that will result in improved temperaments in policy networks.

Another human factor is the propensity towards simplification of relationships as evident in binary discourses (123, 124, 127, 128, 287). This kind of network research using participants’ own subjective interpretations of influence, combined with the subtle and in-depth information from qualitative interviews, provides the information from which to generate complex descriptions of relationships. This then needs to be allowed into policy literature. Another problem in the policy literature is the lack of critical
analysis and discussion about concepts such as participation. Assessments of the effectiveness of participation should consider the complex factors raised in this research.

Participants in policy processes need to critically evaluate their personal biases and networking practices, because these may be projected into formal processes. This is due to the diverse demographic variables in this informal network being unevenly distributed (see ‘Diverse’ section, Chapter 3). In a big-picture view, the advice drawn from such an informal network should not be held as representative advice. In comparison, at least the advice from committees can be scrutinised in terms of the publicly available demographic information of committee members.

I will now summarise the key implications of this study. There needs to be more research and discussion on the concept of participation and how it is operationalised. I suggest that focussing the energy of disparate efforts of participation requires considering the development of a policy framework using a meta-concept of participation. The development of a permanent ongoing and formal meta-synthetic knowledge creation structure would be a core structure of this policy framework. It should contain people only tasked with brokering knowledge to and from all policy committees in the Australian health system. People in national Indigenous health policy processes should critically evaluate their own network biases, their own meta-role in national Indigenous health policy processes, as well as their behavioural aspects towards other people.

**Conclusion**

The nature of Indigenous people’s participation in national health committees is one of unfocussed energy. A number of improvements can be made at the policy, research and practice levels that can strategically focus the energy in the disparate efforts of participation. This can happen through meta-framing participation as a locus for national Indigenous health policy processes. The multifaceted nature of Indigenous health disadvantage requires such complex solutions.


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Appendix A - Forms

[Plain language statement and survey form]

[Insert name]
[insert address]

[insert date]

[insert salutation],

Policy Networks and Research to Policy Transfer in Aboriginal Health

This is an invitation to participate in a study that aims to find out who is regarded as influential in Aboriginal health in Australia, and what they regard as the issues preventing the access and use of health research knowledge to inform decisions. You have been nominated as someone who is influential in the health sector in Australia.

The study is being conducted by Mark Lutschini, toward his PhD, under the supervision of Dr Jenny Lewis, Associate Professor Ian Anderson and Professor Pip Pattison of the University of Melbourne, and Professor Tom Snijders of the University of Groningen, the Netherlands. The study is supported by a scholarship from the National Health and Medical Research Council, Grant Number 251799, and has been approved by Human Research Ethics Sub-committee of the School of Population Health at the University of Melbourne. If you have any concerns about the conduct of this research project you can contact the Executive Officer, Human Research Ethics, the University of Melbourne (ph: 03 8344 2073; fax 03 9347 6739).

Could you please nominate other people you consider to be influential in Aboriginal health policy (definition provided below) on the form below and mail it to Mark Lutschini as soon as is convenient. Participation is voluntary, and the people you nominate will not know that you nominated them.

All information provided is strictly confidential. The survey information will be stored in a locked filing cabinet to prevent unauthorised access and distribution, and only the principal investigator (Mark Lutschini) will have access to the records. The transfer of survey information to computer file and database will occur so that names are removed and replaced with a code (de-identified data - your name will not be entered in the computer). Computer files will be kept for a period of five years and then destroyed using an irreversible erasing program. The surveys will be destroyed after a period of five years.
The analysis of information will be performed and results aggregated to a level that does not allow you, your job title, or the title of your organisation to be identified. The investigators are sworn to privacy in protecting your information, however the data can be subject to subpoena or freedom of information claims. If your information is compromised through an unlikely security breach, or if public discussion of the project were to begin anyway, in a way which might cause conflict among people, the investigators would notify you and seek agreed action. In any case and at any time you have the right to withdraw material at any time.

If you have any questions regarding this project, please feel free to contact me at the address provided below or my principal supervisor, Dr Jenny Lewis at jmlewis@unimelb.edu.au. Thankyou for you time and effort.

Sincerely,

Mark Lutschini
PhD Scholar

Centre for the Study of Health and Society
The University of Melbourne
Level 4, 207 Bouverie Street
Carlton VIC 3010

Tel: 03 8344 0813
Email: mjlut@unimelb.edu.au
Aboriginal Health Policy Project

1. On the table on the following page, please list the people you regard as having considerable influence in Aboriginal health policy in Australia. These can be people that you know, or people that you have heard of. Please provide details of their position and their organisation.

*For the purposes of this study, influential people make a significant difference to shaping ideas in the development of Aboriginal health policy. They are people that can:*
  
  a. shape ideas about Aboriginal health policy,
  
  b. initiate policy proposals,
  
  c. substantially change or veto other policy proposals, or
  
  d. substantially effect policy implementation and service delivery, in relation to Aboriginal health.

2. Please indicate whether you have any kind of ongoing contact with each of these people (C), or have met them but do not have any ongoing contact (M), or have never met them (N). Ongoing contact (C) can be as frequent as every day or just twice per year. Contact can be made by a range of different ways of communicating such as: phone, email, face to face meeting, letters etc. It may be formal or informal.

3. Please indicate whether you have any kind of relationship with each of these people in terms of being a relative (R), a work contact (W) – whether inside or outside your organisation, or a friend (F). List combinations as required, such as R, W, F.
Aboriginal Health Policy Project

Your Information

Nomination form from (your name): __________________________________________

| Nominations: Name, position, organisation | Contact level: C – ongoing contact  
M – met, but no ongoing contact  
N – never met | Relationship: R – relative  
W – work contact  
F – friend |
|------------------------------------------|---------------------------------------------|
| (e.g. A/Prof Joan Smith, Director of XYZ, Organisation 123)  
(e.g. Aunty Joan Smith, Community Elder, Organisation 123) | List as few or as many people as you would like – just copy this page to add more people. | |

Add as many names as you like – photocopy or extend this table to add more names.

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Aboriginal Health Policy Project

**Cultural background.** What is your cultural background? For example do you identify as an Australian, Italian, Aboriginal, Torres Strait Islander, English, etc?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**Educational background.** Do you have any formal qualifications? (tick multiple boxes if necessary)
- ☐ Secondary School
- ☐ Trade/Apprenticeship/Certificate/Diploma
- ☐ Degree/ Graduate Diploma
- ☐ Higher Degree (Masters/PhD)
- ☐ Other (please specify) ___________________________________________________
________________________________________________________________________

**Field of speciality.** Please list the discipline or disciplines you trained in, for example Aboriginal Health Worker, Doctor, Epidemiologist, Nurse, etc.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**Results dissemination.** The results of the project will be made available at appropriate times throughout the project, such as in the form of a formal literature review. In what format would you like the information to be presented (please tick one or more options):
- ☐ Academic journal article
- ☐ Brief document (two pages)
- ☐ Discussion paper
- ☐ Complete thesis
- ☐ Electronic bulletin
- ☐ Other (please specify) ___________________________________________________
________________________________________________________________________
Interview for Policy Networks and Research to Policy Transfer in Aboriginal Health

I write to ask if you would agree to be interviewed for a study of Aboriginal health policy in Australia. This study aims to investigate structures of influence in Aboriginal health policy, and determine what are regarded as the issues preventing access and use of health knowledge in health policy making. You have been identified, through a nomination process, as someone with significant influence on the health policy process in Australia.

The study is being conducted by Mark Lutschini, toward his PhD, under the supervision of Dr Jenny Lewis, Associate Professor Ian Anderson and Professor Pip Pattison of the University of Melbourne, and Professor Tom Snijders of the University of Groningen, the Netherlands. The study has been approved by Human Research Ethics Subcommittee of the School of Population Health at the University of Melbourne. If you have any concerns about the conduct of this research project you can contact the Executive Officer, Human Research Ethics, the University of Melbourne (ph: 03 8344 2073; fax 03 9347 6739).

The interview would include questions about your thoughts on accessing and using health knowledge to inform policy making. It would take about one hour and would be strictly confidential. If you agree to an interview, could you respond to this letter by Monday 27 October 2004 and calling Mark Lutschini to arrange a suitable time and location. I will be making courtesy calls after this date to ensure that you have received this letter, however participation is voluntary.

All information provided is strictly confidential. The recorded interviews will be stored in a locked filing cabinet to prevent unauthorised access and distribution, and only the principal investigator (Mark Lutschini) will have access to them. Interviews will be transcribed and sent to you for corrections and endorsement, after which the interview will be destroyed. Your transcript will be stored in a locked filing cabinet, with only the principal investigator (Mark Lutschini) allowed access to the records, which will be destroyed after a period of five years.

All interviews will undergo a thematic analysis and you will be explicitly, and in writing, be asked for permission to use any material from the transcript. The transfer of
transcript information to computer file and database will occur so that names are removed and replaced with a code (de-identified data - your name will not be entered in the computer). Computer files will be kept for a period of five years and then destroyed using an irreversible erasing program.

The analysis of information will be performed and results aggregated to a level that does not allow you, your job title, or the title of your organisation to be identified. The investigators are sworn to privacy in protecting your information, however the data can be subject to subpoena or freedom of information claims. If your information is compromised through an unlikely security breach, or if public discussion of the project were to begin anyway, in a way which might cause conflict among people, the investigators would notify you and seek agreed action. **In any case and at any time you have the right to withdraw material at any time.**

If you have any questions regarding this project, please feel free to contact me at the address provided below or my principal supervisor, Dr Jenny Lewis at jmlewis@unimelb.edu.au. Thank you for your time and effort.

Sincerely,

Mark Lutschini
PhD Scholar

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Title: The participation of Indigenous people in national Indigenous health policy processes

Date: 2008


Publication Status: Unpublished

Persistent Link: http://hdl.handle.net/11343/35282

File Description: The participation of Indigenous people in national Indigenous health policy processes

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